



The National Geriatrics
Interest Group Publication

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healthy aging

*Innovations and Strategies in
Geriatric Medicine and Research*

INNOVATIVE APPROACH TO ENGAGE OLDER ADULTS WITH TECHNOLOGY

Peter Hoang, Colin R.J. Whaley

GERIATRIC INCLUSIVE ART AS A PROMOTER OF WELLBEING: A PILOT PROGRAM

Kacper Niburski, Uyen Doan, Dr. Oliver Beauchet



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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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 National Geriatrics Interest Group

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Table of Contents

COMMENTARIES

04 A Good Death in a Good Place:
An Opportunity for Design
Michelle Knox

06 Breast Reconstruction in
Older Women: Exploring an
Underused Option
*Alexander Adibfar, Stephanie G.
Brooks, Michael D. Elfassy*

08 An Evolving Landscape in
Geriatric Care:
Why Health Professions Should
Embrace Interprofessional
Education
*Michael D. Elfassy, Alexander
Adibfar*

10 Innovative Approach to Engage
Older Adults with Technology
Peter Hoang, Colin R.J. Whaley

12 Expanding Lessons on
Caregiving: A Case for
Caregiver Experiences in
Medical Education
Kristina M. Kokorelias

14 Electroconvulsive Therapy's
80th Birthday
Amanda Canfield

INTERVIEWS

18 Bringing Geriatric Medicine to
the Emergency Department
Bonnie Cheung

INTERVIEWS CONT'D

20 MAiD: More than one year
after Canada's legalization
Tina Chen

RESEARCH

22 Geriatric Inclusive Art as a
Promoter of Wellbeing: A Pilot
Program
*Kacper Niburski, Uyen Doan,
Dr. Oliver Beauchet*

CREATIVE WRITING

26 On Growing Old
Tharshika Thangarasa

26 Veterans Through a New Lens
Liulia Povieriena

28 Wanted: Delirium Superheroes
Alishya Burrel

ARTWORK

12 Because of you, we see
Xinyuan Camilla Hong

24 The Tree of Life
Xinyuan Camilla Hong

25 Garibaldi Lake, The River of
Life, The Nature Network
Maggie Szu Ning Lin

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Kai is a third-year medical student
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Geriatric Medicine across Canada.

Letter from the NGIG Co-chairs

Dear readers,

We are excited to share with you the 6th Annual National Geriatrics Interest Group (NGIG) Publication. Medical students from across Canada have submitted inspiring articles, captivating artwork and photographs that highlight this year's theme: "Healthy Aging: Innovations and Strategies in Geriatric Medicine and Research." We are thankful for your support to help us showcase the talent and efforts of medical students who are passionate to improve and transform the care for our older adults in Canada.

The NGIG is a national medical student-run organization, supported by the Canadian Geriatrics Society (CGS), that aims to promote and enhance education and interest of geriatric care amongst medical students across Canada. The NGIG works with Geriatric Interest Groups (GIGs) at each medical school to support and unite medical students who share passion in further improving the care of our geriatric population. We are excited to announce the expansion of GIGs across Canada this year to include a new GIG from McGill University. Connecting GIGs across the country allows students to discuss their common interests, implement national initiatives, and share both successes and challenges as they learn with and from each other.

We strive to increase awareness of the diverse aspects of aging and the career opportunities in Geriatric Medicine, Family Medicine Care of the Elderly, and Geriatric Psychiatry. Our new national initiative this year is to further promote these aspects of medicine, and we are working to establish a physician mentor in Family Medicine Care of the Elderly and Geriatric Psychiatry for each GIG at their respective medical schools. In addition, our new national project aims to survey physicians across the country to learn how NGIG or GIG involvement during medical school has influenced their career options and practices. We have also continued many of our previously successful initiatives including the National Geriatrics Interest Group Student Day that will be held in conjunction with the Annual CGS Scientific Meeting in Montreal, the #whygeriatricswednesday initiative which is a social media campaign focused on increasing awareness about aging and elderly friendly care, and an interactive physician research mentor map for students to utilize when looking for research supervisors.

This publication along with our many initiatives would not have been possible without the help of many individuals and organizations. We would like to thank the CGS for their continued support, Dr. Tricia Woo for her mentorship, and the Resident Geriatrics Interest Group (RGIG) for their commitment to collaboration with medical students. We would also like to thank the publication team for their dedication and hard work, as well as the GIG and NGIG leaders for their support in advertising and contributing to the publication. Finally, we want to congratulate the writers published here and hope that this is the start of many future contributions to publishing in the field of geriatrics! This year, we are excited to have received a wide variety of submissions from not only medical students, but also residents and nursing students.

We hope you enjoy and get inspired by reading this publication!

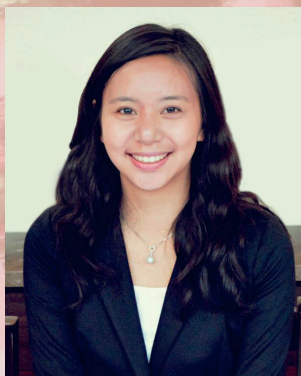
Sincerely,

Amanda Chen and Bonnie Cheung
NGIG Co-Chairs 2017-2018



AMANDA CHEN
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Amanda has a strong interest in enhancing the care and function of seniors across Canada. She is excited to pursue her passion at the University of Toronto's Internal Medicine residency program.



BONNIE CHEUNG
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Bonnie's interests in geriatrics developed while volunteering for the Hospital Elder Life Program, a delirium prevention program. She has done research in neuroimaging in elderly patients with cognitive impairment and depression as well as the use of Twitter in geriatric medical education. She is excited to continue her interests at the University of Toronto's Internal Medicine program next year.

MICHELLE KNOX
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A Good Death in a Good Place: An Opportunity for Design

Over the past few decades, the desire to enhance end-of-life care has become a globally relevant social concern. With Canada's 2016 legislation for Medical Assistance in Dying (MAiD), new questions about patient choice and end-of-life decision-making arise—not just in terms of how death occurs, but also where it may be situated.

A clear link between the quality of end-of-life and the location of death have been shown in numerous studies (1–3). Research has shown that family members favor home or hospice palliation over hospital or nursing home settings (4, 5). In 2011, a national study in the United States found that the bereaved family members of dementia patients in nursing homes and hospitals reported a greater rate of “unmet needs for symptom management, concerns with physician communication about medical decision making, a lack of emotional support for themselves, and a belief that their dying family member was not always treated with respect” (6). In contrast, families of patients with home hospice services reported higher satisfaction, fewer concerns with care, and fewer unmet needs (6). Other research has similarly shown that while most terminal cancer patients receive end-of-life care in an institutional setting, the vast majority would prefer to receive palliative care at home (7). In overview, there is evidence to suggest that—despite the limitations of home-based care—patients, families and healthcare providers generally believe medical settings to be under-equipped to meet the needs and expectations of dying persons.

Across cultures and societies, human beings exhibit behaviors, responses and values that link to physical spaces and material objects. Investigating these links reveals that appropriately designed spaces can benefit both individuals and society. What role can designers play within the current landscape of end-of-life care? First, as design critic Alice Rawsthorn suggests, design for the end-of-life can alter the social framing of and organizational controls around death and dying:

When well-designed technology can help improve our every living moment, why should it desert us in death? In theory, design could—and should—have a useful part to play in improving the quality of any aspect of daily life that is no longer fit for purpose, and death is no exception [...] analysing the strengths and weaknesses of present systems and rituals with an open mind, and applying grace, foresight, rigour, sensitivity and imagination to envisaging better outcomes could help us to die more humanely. (8)

Second, as per anthropologist, Jamer Hunt at Parsons School of Design (USA), there are also pragmatic usability and fundamental aesthetic factors to be considered in building physical care locations. This includes “making [the care experience] feel less awful. Because people aren't working in a way that's been consciously and empathically designed, there are many unintentional bad moments that add to the difficulty of the situation” (9). Both Rawsthorn and Hunt, however, warn designers that there exists the risk of “crassly commercializing or commodifying death” (9). Dying is a sphere

where “the interests of [the] government, religion, the law, capitalism and free will all converge, making it an unusually complex field” (8). Design for end-of-life care, therefore, requires us to venture into the field with sensitivity, humility, and purpose.

Overall, one must recognize that spaces for the dying are also spaces populated by the living. Stephen Verderber, Professor of Architecture and Public Health at the University of Toronto (Canada), writes that human beings are pacified by spatial conditions implying security, privacy, intrinsic meaning and value. In times of sickness, feelings of uncertainty, isolation, powerlessness, alienation and depression affect the acceptance of matters pertaining to life and death, ultimately influencing the patient's outlooks, attitudes, and quality of death. He notes that the ability to accept existential situations, find contentment with health services, and experience a sense of control—are all directly manifested in the physical appearance and design of care spaces (10).

While design that celebrates, optimizes and sustains living conditions is plentiful, relatively little design concerns itself with death and dying. As a result, even within care spaces, palliative zones are much less visible or consciously built than curative ones. Envisaging well-considered, physically comfortable, emotionally sensitive, aesthetic, and functional spaces can relieve stress and increase satisfaction with the quality care being received. Death—one of life's most vulnerable and profound moments—falls directly within design's ambit and registers an urgent call to designers today. 60

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Michelle is a first year doctoral student in the Department of Family Medicine at McGill University. She has recently completed a Master of Design (Visual Communication Design) at the University of Alberta, as part of which she undertook an ethnographic study of palliative care environments. Within her PhD research, Michelle is exploring the ethical contexts of patient choice and end-of-life decision-making, with a special focus on dying with dignity. She is interested in understanding the evolving role and identity of family physicians and palliative nurses who are affected by recent legislations on medically assisted death in Canada.





POTUN YANG

Breast Reconstruction in Older Women: Exploring an Underused Option

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Breast cancer is the most common cancer among Canadian women, accounting for 26% of newly-diagnosed cancer cases (1). While incidence rates have remained stable over the past 30 years, breast cancer affects more Canadian women now than ever before owing to our growing and aging population (1). Indeed, the Canadian Cancer Society reports that as of 2016, nearly a third of new breast cancer diagnoses occur in women aged 69 years and older—a figure that stands to increase with time and underscores the need for advancements in geriatric oncology (1). With mortality rates at record lows (1), there has been greater emphasis on quality of life for breast cancer survivors. This includes the provision of patient-centred care that empowers patients to make informed decisions based on the full range of treatment options available to them. One such area where this is lacking is breast cancer reconstruction in older women diagnosed with cancers serious enough to warrant unilateral or bilateral mastectomies.

Between 2002 and 2012, the mean age of Canadian women receiving immediate breast reconstruction was 49 years versus 62 years for mastectomy-only patients (2). This disparity does not reflect the 2016 Cancer Care Ontario guidelines, which explicitly state that age in itself should not be a contraindication for breast reconstruction surgery provided the patient is healthy (3). Nonetheless, many patients and healthcare professionals presume older women are more likely to experience complications with surgery. This cautious mindset, while surely well-intentioned, promotes a culture in which clinicians are reluctant to suggest surgery to their older patients, inadvertently depriving them of a viable option.

What options remain for those who forego breast reconstruction? Some women who were dramatically impacted by their cancer experience decide “going flat” is a fitting reflection of their post-mastectomy persona. Others choose to wear external prostheses, which have been described as hot, heavy, and irritating to scar tissue by many women who were dissatisfied with this option (4). Breast reconstruction, particularly the autologous type which uses patients’ own tissues from elsewhere in their body to recreate their breast, bypasses these problems while providing women with a natural appearance. But the advantages of offering breast reconstruction to patients extend beyond aesthetics. One study reported better patient-reported outcomes related to mental health in older women who underwent breast reconstruction compared to previously reported mastectomy-only patients and age-matched patients in the general population (5). Another found just discussing breast reconstruction may have therapeutic value, as it “lessened the trauma of mastectomy” for 39% of patients (6). However, given the association between perioperative complications and comorbidities, which tend to increase with age (7), breast surgeons’ reservations are not unfounded. While it may be tempting to conclude that older women are poorer candidates for breast reconstruction, it is important that clinicians do not allow age to confound each patient’s individual risk.

How do we overcome the barriers to offering breast reconstruction to older women? Thankfully, the road has partly been paved for us. Using progressive models such as Proactive Care of Elderly People Undergoing Surgery, which allows clinicians to better predict surgical risk in older patients, has been shown to improve perioperative outcomes and shorten hospital stays (8). Focused

history-taking and physical examinations that include assessments of functional impairment, frailty, and mental status, all of which are especially useful for older patients, have also been used preoperatively by many surgeons (9-12). These strategies clear the way for breast reconstruction procedures that are safe for healthy elders, as evidenced by a number of studies spanning two decades that have found age alone does not significantly predict overall or major complications (13-15). Moreover, there is evidence for patient satisfaction with the experience, with one study reporting that 70% of patients aged 60-77 years rated their outcome as “good or excellent” (16).

Ageism is by no means the sole factor driving the undertreatment of older women with breast reconstruction surgeries, but it appears to be playing a contributory role given the safety and outcomes associated with the procedures (13-15). Far more research is needed to discern what type of reconstruction is best suited for elders. But until then, women of all ages stand to benefit from at least being offered breast reconstruction as a treatment option. ■

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Alex and Michael are second-year UofT medical students with a keen interest in improving health outcomes for older adults, particularly in relation to geriatric surgery. Steph is a caregiver and an MA candidate in Critical Disability Studies at York University who is passionate about overcoming the systemic barriers impeding the wellbeing of elders with disabilities.

An Evolving Landscape in Geriatric Care: Why Health Professions Should Embrace Interprofessional Education

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Canada is currently facing its biggest healthcare challenge to date: providing effective, affordable, and individualized care to its aging population. The medical advancements of the 20th century gave rise to an unprecedented increase in life expectancy, and we are now beginning to experience their long-term consequences as the baby boomer cohort transitions into late adulthood. From 2011 to 2016, our senior population (aged 65+ years) increased by 20%, with seniors now outnumbering children for the first time in our country's history (1). Additionally, this five-year period saw the number of Canadians aged 85 years or more increase by 19.4%, a rate nearly four times greater than that of our overall population. These numbers are projected to grow substantially as the rest of the baby boomer cohort ages (2). This demographic shift presents a plethora of healthcare challenges, as the unique needs of seniors are currently unmet.

While our healthcare system is adept at treating and managing acute, episodic conditions, it is less equipped to handle chronic, complex diseases. As 75-80% of Canadian seniors report having one or more chronic conditions, the demand for complex care is quickly outpacing the supply (3). This systemic flaw causes many downstream

sequelae including inadequate community support, ineffective and harmful hospital admissions, and patient dissatisfaction, which collectively cost billions of dollars (4, 5). To combat these unsustainable realities, novel strategies focused primarily on interdisciplinary collaboration are restructuring the way geriatric care is delivered on a system-wide level across the country.

The Acute Care for Elders (ACE) strategy is a leading model attempting to revolutionize the way we practice geriatric medicine by transitioning from a narrow, disease-centred paradigm to a holistic, interdisciplinary, person-centred approach. ACE harnesses the skills of different care providers including physicians of different specialties, nurses, physiotherapists, volunteers, social workers, pharmacists, and administrators. This collaborative approach tends to patients' needs along the entire biopsychosocial spectrum and at every stage of care, from hospital admission to discharge and eventually home-based care. It has been successful on several fronts at Mount Sinai Hospital in Toronto, cutting average length of hospital stays by 28.3% and decreasing readmissions within 30 days by 13.4%, all while effectively reducing direct costs of care per patient by 22.7% and improving patient-reported satisfaction (6, 7).

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Strategies like ACE are quickly becoming commonplace in Canada. ACE itself is being implemented in 18 hospitals nationwide with support from the Canadian Foundation for Healthcare Improvement and are achieving similar results (8).

The near future requires greater interdisciplinary collaboration to optimize care for older adults. To meet these needs, schools for health professions in Canada are beginning to embrace interprofessional education (IPE) in their curricula (9). By cultivating the collegial spirit that has made programs like ACE a success, IPE holds the key to preparing the next generation of healthcare providers for the torrent of chronicity and complexity facing our healthcare system. As the next wave of care providers obtain these specific competencies, we are likely to move further away from the siloed multidisciplinary systems of the past and move closer toward a comprehensive, interdisciplinary strategy for geriatric care in Canada. For IPE to have the greatest possible impact on students, it will be essential to include case-based teaching modalities of older patients who not only have complex needs but also stand to benefit the most from interprofessional care. This will provide a challenging opportunity for students of different disciplines to collaborate,

clarify their individual roles, and work to integrate all aspects of patient care in a complex environment.

As standards of care evolve, so too should the education of future health professionals who will be on the front lines providing geriatric care. IPE is a relatively new concept, but will undoubtedly continue to establish and refine itself as a crucial component of healthcare education. This program should deliver specific geriatric case content to familiarize students with new paradigms to which they will be exposed upon graduation. In light of the ever-increasing demands of geriatric care, IPE as a means of training capable providers may be one of the solutions that Canada's healthcare system desperately needs. 🍌

Michael and Alex are second-year medical students interested in integrative geriatric care. Michael's research focuses on frailty and critical care outcomes, medical education, and global health. Alex is passionate about geriatric surgery as well as the improvement of care for those living with dementia and their caregivers.





XINGNAN XU, PGY-2 INTERNAL MEDICINE, UNIVERSITY OF OTTAWA

Innovative Approaches to Engage Older Adults with Technology

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COLIN R.J. WHALEY, BSC CANDIDATE, CLASS OF 2018, UNIVERSITY OF WATERLOO

Twenty-first century technologies provide numerous benefits to older adults, including increased socialization, well-being, and quality of life(1,2). As technologies such as smartphones and tablets continue to explode in popularity amongst all age groups, factors hindering the adoption of these tools by older individuals serve as barriers, ultimately limiting their use (3). Some of these barriers include income, usability, and perceived user safety (4,5). Appropriate solutions are required to encourage the

use of technology among older adults. This commentary provides a summary of select initiatives that seek to improve older adults' adoption of recreational technologies.

While continued innovations in technology have yielded a proliferation of low-cost devices, (e.g. products in Amazon's Fire tablet lineup), users' adoption of technology shows discrete stratification as a function of household earnings (3). In the United States, for

example, the Pew Research Center showed that older adults with lower income had poorer internet adoption rates. This disparity, termed the “digital divide,” includes a myriad of socioeconomic factors in its list of contributing factors (6). Despite this, innovations allowing everyone to access the internet exist. For example, in our community, the Kitchener Public Library has started a program allowing library users to borrow internet hotspot devices, allowing access anywhere there is cell signal (7). Internet service providers are also working to get more low-income households online, in some cases by offering home internet plans for more than 75% off (7).

The authors of this commentary co-founded enTECH Computer Club, a student run club at the University of Waterloo that increases technological literacy of residents at long term-care homes by engaging them with technology for recreational purposes such as email and video conferencing. Similar in-person teaching services have been developed across the country, such as Cyber-Seniors, The Gadget Guides, and programs at local libraries (8,9). However, the residents participating in enTECH have stated that there is a relative paucity of such services in their area. Fortunately, tools also exist to assist seniors where such programs are unavailable. Tech-Boomers, for example, is a free website that provides highly comprehensive text and video tutorials to popular apps and websites with a user experience optimized for older adults (10).

The users’ experience of computers differs subjectively as a function of age; this is commonly due to age related changes and chronic disease that can limit one’s ability for efficient computer interaction (11). To accommodate for these changes, Seals et al. suggests providing simple options on websites like allowing font size and contrast to be modified. Accordingly, some websites and mobile apps (e.g. Big Font) have accommodated for the physical barriers of aging by implementing buttons that can change font size, magnification, and colour inversion (12,13). In addition to physical barriers, older adults may be further dissuaded to use technology due to their self-perceived inexperience with computers, which can easily make them become intimidated by cybersecurity. Operating systems like Chrome OS, which prioritize security, allow for users to be more confident that software-based threats like viruses will not damage their machines (14). Retrofitting older computers with Chrome OS is possible through the use of software like CloudReady, which is specifically designed to work well on older systems (15). Optimizing computing environments for older adults requires considerations at both a technological and psychological levels, but can thankfully be accomplished quite readily with free software.

This commentary provides an overview of exciting initiatives that have been developed in order to improve older adult’s adoption of technology. While the efficacy of these interventions have not been studied extensively, older adults are continuing to show significant increases in smartphone and internet usage (3). Despite these improvements, it is important to continuously pursue novel methods to maintain these positive trends. One method of doing so, as stated earlier, is the increased creation of formal tutoring programs across Canada. In addition to this, the decreased expense of technology can lead to volunteer services’ ability to obtain used and refurbished products at a fraction of the original cost. This equipment can then be donated to older adults, thereby further reducing the digital divide. All in all, it is imperative that the ongoing development of initiatives to improve adoption of technology encompasses both social and technological factors. 📱

Responding to the needs of the community, Peter and Colin started the enTECH Computer Club at the University of Waterloo in 2015 to engage older adults with technology. This spurred their interests in geriatrics and human computer interaction, respectively. Peter’s key area of interest is in improving health outcomes for older adults through applied research, while Colin’s other main passion is mental health and its underlying neurobiological bases. Peter and Colin would like to thank the many older adults that they have worked with for their enthusiasm, stories and support.

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Expanding Lessons on Caregiving: A Case for Caregiver Experiences in Medical Education

KRISTINA M. KOKORELIAS, PhD (c)

TORONTO REHABILITATION INSTITUTE, FACULTY OF MEDICINE, UNIVERSITY OF TORONTO

For most Canadians faced with a health condition, the majority of their day-to-day care is not provided by a health professional, but rather by their family member or friend (1). Even for individuals who receive publicly funded home care services, the support provided by “family caregivers” becomes an integral part of the care plan (1,2).

While caregivers support our formal health system, they often do so at significant personal, social, physical, emotional, and economic costs (3). The cost of not supporting family caregivers will result in greater use of our inpatient health care institutions (3).

Physicians are well-positioned to support family caregivers in sustaining their caregiving role. Moreover, allowing space for caregivers’ narratives in patient care can provide context for individual, patient-specific meaning of illness that can help encourage empa-

thy and improve patient and their family members’ experiences within health care systems. However, the formal recognition of family caregivers as a key partner in health care delivery must begin within medical education, so that the next generation of health care providers are in a position to consider, assess, and support caregivers.

To involve caregivers, students should first learn how to informally determine caregivers’ emotional and ongoing support needs just by talking to them. Studies have found that caregivers experience less depression when physicians take the time to listen to their needs and opinions (4). Additionally, we should teach our students about formal caregiver stress assessment tools that can also be used to assess the needs of caregivers. Many caregiver stress assessment tools, such as the Caregiver Self-Assessment Questionnaire, can be administered by non-clinical staff or completed by

BECAUSE OF YOU, WE SEE ACRYLIC ON CANVAS, 120 x 50 CM

XINYUAN CAMILLA HONG, MD CANDIDATE, CLASS OF 2019, MCGILL UNIVERSITY

Before every fruit comes the support of its trunk and branches. A support so strong and so unwavering, just like that which you give us. You – our mothers, fathers, grandmothers, grandfathers, and friends – guide us to navigate the labyrinth of life, leading us to knowledge, new heights and light. Because of you, we see.



the caregivers themselves. Once a caregiver's needs are assessed, the physician is better positioned to suggest necessary supports. Knowledge of provincial and local caregiver support services should be embedded within the medical curriculum so that physicians can help patients and their caregivers navigate the health care system through appropriate referrals or information on available resources. It should be noted that current models of health care may not allow for the additional time and resources required of physicians to adequately support all caregivers needs, and thus, students should have the knowledge of when they should engage with other health care professionals, such as social workers, to provide additional assistance to caregivers.

They say there are two sides to every story, but students are only learning half of the story on patients from the patient narratives and histories they are often presented with. For medical students to learn the other half of the story, they need to hear the story from family caregivers. We should remind students that they can seek permission from patients to share relevant information with caregivers. Many caregivers even know the patient better than the patient knows themselves, which can provide a rich source of clues for diagnoses. As caregivers provide most of the care for patients, students need to hear about their struggles, so that they can learn to use this information in care planning and implementation. Caregivers' stories can also help close the gap between human experience and medical theory. Students need to hear from caregivers to understand the human repercussions, on patients and on their loved ones, of the conditions and illnesses they so incisively diagnose. Caregivers' stories, trials, heartaches, hopes, happiness, and griefs can have a profound impact on the empathy of future

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physicians.

The practice of medicine requires acting in the best interests of patients. Support from caregivers enables patients to stay at home longer contributing to a higher quality of life for patients and often, to a greater peace of mind for their families (5). In maintaining a patient focus but also acknowledging and including the caregiver in medical education, future physicians can have a positive impact on the caregiving experience. Each caregiver's situation will be uniquely different, yet completely pertinent to medical trainees, physicians, and patient care. 6

Kristina Marie Kokorelias is a doctoral student within the Toronto Rehabilitation Institute at the University of Toronto. Her current program of research aims to explore the complexities of caring for persons with dementia in the community, across the illness and caregiving trajectory, to inform the development of timely and relevant programs to support caregivers to sustain their role.



Electroconvulsive Therapy's 80th Birthday

AMANDA CANFIELD, PGY I PSYCHIATRY
McMASTER UNIVERSITY

Earlier this year, during my first year as a psychiatry resident, I helped to teach second year medical students at McMaster University an introduction to the psychiatric interview and mental status exam. During our teaching sessions, I was able to provide the students with an opportunity to interview patients with mental health concerns.

The first patient I took them to interview was an elderly individual with psychotic depression who was receiving electroconvulsive therapy (ECT) treatments. They told the students and me how ECT had essentially saved their life. Prior to their admission to hospital, they described feeling hopeless with no option to relieve their suffering other than taking their own life. Given my early interest in geriatric psychiatry during medical school, I had met multiple elderly patients with similar positive experiences with ECT. Patients who told myself, and the interprofessional teams that I worked with, that ECT had very positively impacted their lives despite many of them initially being quite hesitant to try it. I also objectively saw dramatic changes to their mental status with the treatments.

After the interview, the students told me how pleasantly surprised they were to hear such a positive experience with ECT. I had forgotten how impactful these exposures could be, particularly on any preconceived ideas we have about ECT given its often negative portrayal in the media. During a later psychiatry-teaching block, I was required to do a presentation on any area within the "History of Psychiatry". My teaching experience motivated me to complete the project on the "History of ECT" as I believe how ECT was developed plays a role in it remaining controversial within society. I hope that this will become clear after I summarize my findings.

The use of electricity in medicine may date back as early as Ancient Rome when electric eels were used for the treatment of migraine and other medical conditions. However, recent literature on the use of electricity for medical purposes starts in the 1700s (1). While many believe that this was the first step in the development of ECT, others argue that electrotherapy is not actually related as it was the electric stimulus itself that was thought to have healing properties whereas ECT focuses on the effects of convulsions (1).

Jumping forward to the 1900s, an Austrian psychiatrist named Julius Wagner-Jauregg used a widely accepted observation at the time that febrile episodes improved the symptoms of many other disorders (1,2). Wagner-Jauregg gave intramuscular injections of blood from individuals with malaria to patients with neuro-syphilis with the goal of inducing fever and ultimately improving their psychotic and physical symptoms (1,2). This was the first known time when biologic treatments were used in attempt to treat psychiatric manifestations of illness. It was an exciting time for the treatment of mental health disorders as this led to the development of four biologic treatments for schizophrenia in the 1930s. These new treat-

ments included pharmacologically-induced seizures, ECT, insulin-induced hypoglycemia, and lobotomy. Of them, ECT is the only one still in use today (2). This likely contributes to some of the lingering negative beliefs regarding ECT, as the harm of the other treatments created within the same time frame outweighed potential benefits.

I will not go into detail about the four biologic treatments, but rather will focus on convulsive therapies. A Hungarian psychiatrist, Ladislav Meduna, observationally noted that patients with schizophrenia who had seizures seemed to improve from a symptomatic perspective after them. Further, he reported based on autopsy findings that epileptic brains had hyperplasia of the glial system while schizophrenic brains showed the opposite (1). He began to trial the induction of convulsions using intramuscular injections of camphor oil in 1934 and later switched to the use of Metrazol as it produced more immediate effects (1).

Ugo Cerletti, a psychiatrist at the University of Rome, was intrigued by Meduna's theory but postulated that electrically induced convulsions could make the treatment more effective. He worked with a neurologist, Lucino Bini, to trial this idea on dogs (2). They were initially concerned about a previously documented high mortality rate in animal experiments involving electrically inducing seizures (1,2). Bini determined this to be the result of fatal arrhythmias secondary to electrode placement in the mouth and rectum and found no dogs died when he placed both leads on the temples to prevent current from passing through the heart (1,2).

After deeming the safety of ECT acceptable, the first human treatment took place in 1938 on a 40-year-old man with schizophrenia. He had thirteen treatments in total and was discharged home in reportedly good condition. Despite seemingly good outcomes, early ECT was not without side effects. Some of the noted side effects included fractures as a result of muscle spasms, high levels

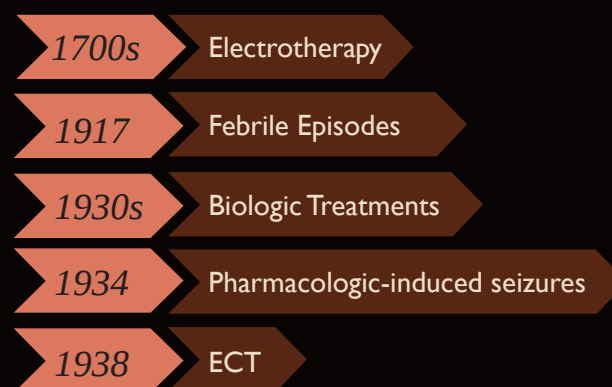


Figure 1. Summary of the Historical Development of Electroconvulsive Therapy.

of emotional distress, and cognitive changes (1). ECT has advanced significantly since this time and currently most complications can be avoided or managed. Contemporary use of ECT that includes a pre-ECT assessment, optimization of medical care, involvement of anesthesia, and prompt attention of medical concerns, has allowed it to maintain a very low rate of morbidity and mortality (3). Today, common post-ECT complaints include headache, muscle aches, nausea, and vomiting (3). However, many of the adverse effects of early ECT are displayed in media depictions of modern ECT and this likely contributes to negative views amongst society. It may also have played a role in why many of the patients I have spoken with thus far in my training were worried about adverse effects of ECT that rarely, if ever, occur today.

The year 2018 marks the 80th year since Cerletti and Bini reported their first human ECT treatment. Much has changed during this time in order to improve its efficacy and reduce adverse effects. The Canadian Psychiatric Association continues to recommend that ECT remain an available treatment option for serious mental health disorders including major depressive disorder, bipolar disorder, and schizophrenia (3). Nonetheless, ECT continues to have many negative connotations amongst society at least in part as a result of its history. I hope that medical trainees, like the students I taught in

the fall, will have opportunities to interact with patients who have received ECT and/or observe ECT sessions. Hopefully trainees can then disseminate knowledge that ECT, despite challenges during its development, is now a safe and effective treatment that can often provide significant positive effects to appropriate candidates. 🍷

Amanda is a first year psychiatry resident at McMaster University as well as the Geriatric Psychiatry Representative for the Resident Geriatric Interest Group. She is an active member of both the Canadian Geriatrics Society and the Canadian Academy of Geriatric Psychiatry. 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 and residents in the care of the elderly. Her clinical interests include delirium, late-onset depression, and behavioural and psychological symptoms of dementia. She hopes to continue on to complete subspecialty training in geriatric psychiatry.

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University of Alberta

GIG EXECS:

Lindia Xia, Alexis Fong-Lebouef

RGIG EXEC:

Mohammed Khusheim

University of Manitoba

GIG EXECS:

Suhyun Kim, Sophia Quan

The Geriatric Interest Group of University of Manitoba strives to inform students about the wide relevance and importance of geriatric medicine in various disciplines. Our hope is to encourage students to explore career options within it by connecting them to services and physicians who serve elderly population. Events this year included a talk on the senior immigrant population, which was a joint event with the Immigrant & Refugee interest group. Two speakers from "Age and Opportunity" shared case studies on elder abuse and challenges for elderly immigrants. Another event included a Valentine's Day outreach event, in which medical students shared their musical skills during the residents' monthly entertainment night at a personal care home. Flowers and handwritten cards from medical students were given out to residents.

University of British Columbia

GIG EXECS:

Cindy Ding, Shirley Guan

RGIG EXECS:

Becky Schnurr-Howsam, Keeva Lupton

The University of British Columbia Geriatrics Interest Group aims to enhance the visibility of geriatric medicine at the UBC medicine program, and to provide educational opportunities on geriatric medicine. We hope to increase awareness in relevant aspects of aging for all medical students and to generate interest in care for the elderly. For students specifically interested in geriatrics, we strive to help them develop leadership skills in geriatric medicine by encouraging and funding research participation, and creating geriatric-related community service opportunities. The UBC GIG hosts several events throughout the year, including OSCE workshops on Geriatric health, Living with Dementia and Alzheimer's speaker series, as well as Q&A events with local care for the elderly physicians. Our GIG also spearheads a community initiative that connects elementary school students with seniors in care facilities and help them to establish a lasting connection through letters and field trips.

University of Calgary

GIG EXECS:

Miryam Chacko, Mannat Dhillon
Barbara (Claire) Lothian, Xing Sun

University of Saskatchewan

GIG EXECS:

Nadine Ghazaleh, Bayan Malakouti

The University of Saskatchewan's (USask) College of Medicine Geriatric Interest Group (GIG) has had a very exciting year of events – with more events on the horizon. This year the GIG hosted an event with Dr. Lilian Thorpe, a Geriatric Psychiatrist, and her colleagues who spoke about their work and involvement with Medical Assistance in Dying (MAiD). She raised interesting points, such as, the use of the word "suicide" on the death certificates of individuals who choose MAiD – a point that her team is trying to have changed. The GIG hosted another event with speaker Greg Charnya, owner of Home Instead Senior Care in Saskatoon. He spoke about the role that physicians can play in home care plans for older adults and provided students with many resources to direct their patients to for home care options. Recently, Saskatchewan's only Geriatrician, Dr. Jenny Basran and Internal Medicine Resident, Dr. Krista Lagimodiere (who will be starting her geriatric fellowship in the Fall) spoke with members of GIG about a career as a geriatrician and the road to becoming a geriatrician. This insightful talk touched on the clinical and community level role that geriatricians can have in the healthcare field. In the next month, the GIG will be hosting an event with the Alzheimer's Society of Saskatchewan. This event will include a patient narrative outlining a patient and their caregiver's person experience with Alzheimer's. The USask GIG has been fortunate to provide our medical colleagues with continued further education in geriatric health by hosting these events.

McMaster University

GIG EXECs:

Yassmin Behzadian, Emma Gregory

RGIG EXEC: Christina Reppas

The vision of McMaster's RGIG is to create a platform for promoting greater resident awareness and engagement in issues relating to the health and wellness of older adults, and to share this with colleagues and the next generation of medical trainees through informal gatherings, mentorship, and education. Events this year included a Meet and Greet event with the medical student GIG about various career paths in geriatrics and Geriatrics Skills Day, in which geriatrics-related teaching was provided to medical students, on topics such as polypharmacy, Cultural Competency in Geriatrics, Elder Abuse, Comprehensive Geriatric Assessment, Sexuality/LGBTQ+ Health in Geriatrics and Osteoporosis and Falls.

University of Toronto

GIG EXECs:

Alexander Adibfar, Samantha Yang

Adrian Chan, Laura Wong, Vijay Sandhu

The UofT GIG is continuing to provide medical students with networking and educational opportunities in the field of geriatrics, as well as raise awareness about the health and social challenges of older adults. We started the 2017-2018 academic year with a career panel that included perspectives from family medicine, geriatric psychiatry, emergency medicine, and geriatric medicine. Our next event was an Interprofessional Education (IPE) seminar that brought together students from across 11 health science programs to learn about geriatric issues during hospitalization. Finally, we collaborated with Alzheimer Society Peel to talk about Alzheimer's disease and related dementias, brain changes, symptoms, responsive behaviours, and effective communication strategies. We are currently organizing a Geriatrics Meet & Greet dinner that will give medical students the opportunity to network with UofT residents and geriatricians. In April, we have another IPE seminar where students will participate in workshops to learn clinical skills related to caring for the elderly.

RGIG EXECs: Paula Pop, Victoria Xu

We are the University of Toronto Resident Geriatric Interest Group, our focus is on enhancing resident engagement in Geriatric scholarship and advocacy. We recognize the importance of caring for a complex and diverse aging Canadian population and we are proactively engaging with our members and sponsors to organize events which represent our vision. One way of engaging residents in Geriatric scholarship is through our bi-monthly Geriatric Newsletter which provides a synopsis of current Geriatric research. Further enhancing Geriatric scholarship and mentorship, we planned a Geriatric Medicine Meet and Greet. This event allowed residents the opportunity to engage with staff from varied Geriatric backgrounds, providing them with the opportunity for networking and mentorship. Our members engaged in Geriatric advocacy through raising funds and walking as a group, the Cognitive Enhancers, at the Alzheimer's Society Walk for Memories 2018. This gave members the opportunity not only to advocate for a good cause but also to engage with their local community. Our vision is to enhance resident engagement in Geriatric scholarship and advocacy.

Western University

GIG EXECs:

Priya Khoral, Joy Sun

RGIG EXEC: Alishya Burrell

Our vision is to educate residents on medical issues specific to older adults, with the goal of increasing interest in geriatrics as a specialty, but also to improve the care for older adults across care settings. At Western, we held our first ever RGIG journal club, and have had significant involvement in planning for World Delirium Awareness Day 2018. We are also planning to enter a team into the Alzheimer Walk in London this year.

University of Ottawa

GIG EXECs:

Yipeng Ge, Aleena Fiorotto

Francine Heelan

RGIG EXEC: Krista Whitney

Our vision is to engage medical students with the health concerns of our geriatric population in Canada specifically by exposing them to the complexities of geriatric medical care, end of life issues, and learning how to better care for patients with dementia. Our events for this winter semester include a discussion on medical assistance in dying which will discuss the legislation, practical experience of 2 physicians, and the ongoing challenges to providing this service. Our second event will be hosted with the Dementia Society of Ottawa wherein a caregiver for a patient with dementia will come to speak to the medical students. Our third event will be a multidisciplinary workshop on caring for geriatric patients. This workshop will include a physiotherapist, a pharmacist, a geriatrician and an occupational therapist who will run stations on the different aspects of geriatric care. Students will rotate through these different stations, gaining an appreciation about the multidisciplinary aspects of healthcare required to best manage the geriatric population.

McGill University

GIG EXECs:

Aradhna Sharma, Joshua Solomon

Kaylie Schachter

RGIG EXEC: Uyen Doan

University of Montreal

GIG EXECs:

Marianne Lamarre, Klara Pok

The University of Montreal GIG was founded in 2013 as the first GIG in the province of Quebec. Our goal is to sensitize medical students to the issues of the elderly population and to give students the chance to make contacts with the geriatric community in Quebec. In the past years, we have organized conferences on medical aid in dying and Alzheimer's disease, tango lessons with some elderly dancers and activities with geriatric residents.

Queen's University

GIG EXECs:

Temi Olanbiwonnu, Kate Stock

RGIG EXEC:

Katrin Dolganova

Dalhousie University

GIG EXECs:

Sebastian Copp, Nicole Roda

The Geriatrics Interest Group at Dalhousie is designed to help expose medical students to topics affecting the care of geriatric populations. Our first event involved bringing in Darce Fardy, an older gentleman who is living with dementia. He shared with our group his personal experiences with his illness. He was accompanied by his wife (who also shared her perspective and experience as a caregiver and family member), as well as Linda Bird, from the Alzheimer's Society of Nova Scotia who helped us understand how medical students and healthcare providers can best connect with, and provide care to people with dementia. Another event this year featured Dr. Ken Rockwood, who came in to give a talk about the future of healthcare in Canada. This covered important healthcare topics such as: the problems facing our healthcare system with regard to serving an aging population, how the system has been, and will have to change in order to accommodate an increase in life span without a proportionate increase in health status, and effective treatments for frailty.

Memorial University

GIG EXEC:

Jennifer Smith

Northern Ontario School of Medicine

GIG EXECs:

Teaghan Koster, Jennifer Hammell

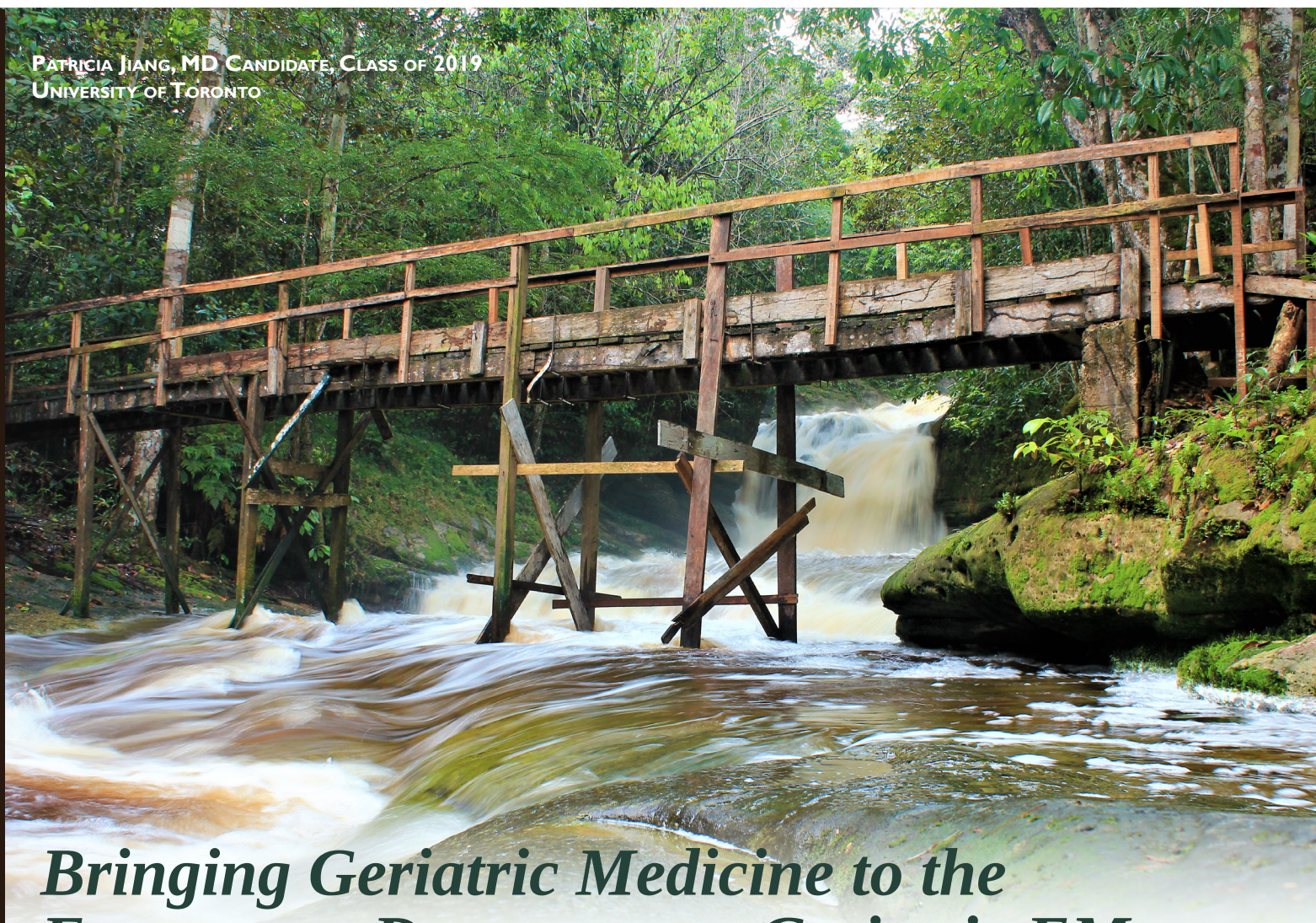
Dylan Irving

The Northern Ontario School of Medicine's Geriatrics Interest Group aims to highlight the relevance of geriatrics and care of the elderly in the changing Canadian demographics, both as a specialty and as an important knowledge base for all physicians. Our focus is on the unique challenges and opportunities for patient care in the rural and Northern context. We aim to show students that geriatric care – a sometimes undervalued area of medicine – is not only a critical part of the health care system but a viable career choice that allows physicians the challenge of working with complex medical cases involving multiple comorbidities. This is especially true in the North, where access to specialists and resources may be limited. Emphasizing the growing importance and presence of interdisciplinary geriatric care, such as the North East Specialized Geriatric Centre in Sudbury, we hope to build the visibility of our GIG to ensure this work carries on after we graduate. Our first event occurred in December when we hosted Dr. Chau who provided a talk on the care of the elderly program and touched on topical areas of care including hoarding. Our annual skills night was held in April, in which several physicians shared information regarding polypharmacy and advanced directives. The night also featured an aging simulation station and a presentation by the Alzheimer Society of Thunder Bay on communication strategies for working with individuals living with a form of dementia.



NATIONAL GERIATRICS INTEREST GROUPS

PATRICIA JIANG, MD CANDIDATE, CLASS OF 2019
UNIVERSITY OF TORONTO



Bringing Geriatric Medicine to the Emergency Department: Geriatric EM

Interview with Dr. Don Melady

BONNIE CHEUNG, MD CANDIDATE, CLASS OF 2018
UNIVERSITY OF TORONTO

Dr. Don Melady is an Emergency Physician at Mount Sinai Hospital in Toronto. He focuses his academic and educational activities on Geriatric Emergency Medicine and on quality improvement to create senior-friendly Emergency departments. Follow him at @geri_EM. Visit www.geri-EM.com



How did you develop an interest in Geriatric Emergency Medicine?

I am a career Emergency physician, completing 30 years of work as an Emergency doctor, and I have always had a special interest in older people. This goes back to my upbringing – I grew up around a lot of older people. At one point I had 32 aunts and uncles over the age of 75! I've always felt comfortable around older people, probably as a result of growing up in a small rural community where older people were not ostracized or eliminated from the usual course of society, which I think is sometimes the case in large cities. I have always had a comfort and familiarity with older people.

When I got into medicine, I continued to be interested in Geriatric Medicine because I liked the patient population. Eventually, I settled on Emergency Medicine but I have always had a special spot in my heart for older patients. In the Emergency department, which is a difficult environment for everyone, including medical students, and

especially for older people for all kinds of reasons. I was surprised, as I think many people are, to find about 10 years ago that there is actually a whole community of people interested in Geriatric Emergency Medicine (EM). The field of Geriatric EM has really developed over the last 20 years, starting in the early 1990s by a group of wise Emergency physicians who noticed that the largest group of people we see in Emergency departments are older people and that our population is changing.

What is the current state of Geriatric Emergency Medicine in Canada and in other countries across the world?

The most important thing is that societies around the world are becoming aware that older people are a larger and larger population. People in North America seem to think that this is a problem that is unique to North America but the populations of societies all over the world are getting progressively older. It's a shared international opportunity. I'm working with folks in Hong Kong, India, and Latin

America that also have expanding geriatric populations who need acute care as well.

What changes are being made in the Canadian health care system in order to support elder-friendly emergency departments? What are the challenges that still have to be overcome?

I am involved with something in the United States called the Geriatric Emergency Department Collaborative and I also direct a course in Canada called the Senior-Friendly ED Course. They are both about helping people implement quality improvement opportunities around care of older people.

Surprisingly, most of those interventions are not all that expensive. When people think about senior-friendly Emergency departments, they typically think about the physical environment, and certainly changing your physical environment can be expensive. But actually, the most important part of a senior-friendly Emergency department is the models of care and the people who work in it. It's not all that expensive to educate people so that they are more aware to the needs of older people in Emergency departments. It is also not that expensive to implement small changes, such as introducing protocols around screening for delirium, ensuring identification of other forms of cognitive impairment, making sure that there is a protocol for assessing older people who have fallen, and improving communication between long-term care homes and Emergency departments or between primary care physicians and Emergency departments. These are not expensive things; they just need someone who is interested to do them. Once you change some of the models of care and processes of care, and you enhance the education of your care-providing clinicians, you've actually done quite a lot to create a more senior-friendly Emergency department. So I don't think that cost is the challenge. I think it is a willingness to change, which is the most difficult barrier to overcome.

There is increasingly a population pressure towards making change in every part of the health care system which, I think, is going to accelerate a great deal over the next five years. In contrast to twenty years ago, if you put the word "geriatric" in front of anything, people are immediately interested and involved.

Overall, would you say that hospitals in general have been quite responsive to the idea of an elder-friendly Emergency department?

Yes, I think it is a change from 10-15 years ago. I have taught the [Senior-Friendly ED] course four times and on each occasion, we have needed to turn away hospital teams because we didn't have enough space. So I think hospitals are starting to get interested.

What changes are being made to the medical school and residency programs in Canada to educate trainees about Geriatric Emergency Medicine?

Starting at the top, there are fellowships in Geriatric EM that you can complete after you have completed your Emergency Medicine certification. I am now the director of Canada's only fellowship in Geriatric EM. There are four other fellowships around North America and probably three outside of North America. At the resident level, we collectively have identified particular topics within Emergency Medicine about older people that Emergency trainees need to learn. I have developed a seminar series here at the Univer-

sity of Toronto that has been copied across Canada that introduces Emergency trainees to core content in cognitive impairment, medication management, trauma and falls, functional assessment, atypical presentations of disease, and end-of-life issues.

We also think that geriatricians and people providing primary care to older people could benefit from learning more about the emergent care of older people. We have an elective rotation for both the Geriatric Medicine and Care of the Elderly programs for people to work with us in our Emergency department at Mount Sinai Hospital.

With the assistance of my colleague Dr. Thom Ringer, we have developed a curriculum for medical students doing their Emergency Medicine rotation to introduce them to particular issues around care of older people in the Emergency Department. It covers basic things – like cognitive assessment, identification of functional decline, appropriate medication management. But they are things that are not always a part of Emergency Medicine education.

The final area is continuing medical education, to help practicing physicians become more familiar with older people through the website, www.geri-EM.com. This site might be helpful to students or residents, but is intended for practicing clinicians, both doctors and nurses.

What advice would you give trainees who would like to advocate for the elderly?

One point of advocacy is identifying and saying often and loud that older people are our core population. They are one of the principal users and beneficiaries of the health care system and we always need to headline their care.

People go into Emergency Medicine because they like procedures and the fast pace and resuscitation. But in reality, Emergency Medicine is providing care to frail, older people and their worried family members as they try to navigate their way through a crisis. This is really what we do in Emergency department. We need to keep saying that: if you are interested in Emergency Medicine, then you better be interested in providing excellent care to older people and the complexities that come along with them. Many of us working in the field often find it odd that we have to have this subspecialty called Geriatric Emergency Medicine even though, as I just said, Emergency Medicine is Geriatric Emergency Medicine. Every Emergency department needs to be a geriatric Emergency department because that's who most of our patients are.

And of course, that applies to the whole practice of medicine. The only place where you are not going to see older people is pediatrics and obstetrics; otherwise the bulk of your patient population in your career is going to be older people. Building that reality into your career planning is essential. 🍷

Bonnie Cheung is a fourth year medical student at University of Toronto. Her interests in geriatrics developed while volunteering for the Hospital Elder Life Program, a patient-care program that prevents delirium. She has done research in neuroimaging in elderly patients with cognitive impairment and depression as well as the use of Twitter in geriatric medical education.

MAiD: More than one year after Canada's legalization

Interview with Dr. Janet Kushner-Kow

SZU-YU TINA CHEN, MD CANDIDATE, CLASS OF 2018
UNIVERSITY OF BRITISH COLUMBIA

Since Bill C-14 passed on June 17, 2016, more than two thousand people have taken advantage of medically assisted death in Canada. In fact, there was a 46.8% rise in completed Medical Assistance in Dying (MAiD) as compared to the numbers in the first six months that the legislation was in place, now comprising of approximately 1% of all deaths nationwide (1). It comes to no surprise that the average age of individuals who were provided with medical assistance in dying was 73, with the majority falling under the geriatric age group of 65+ (1). Regardless of our ethical stance, we are facing a future where our aging population will require assistance with discussions on MAiD, but how much do we really know?

British Columbia has led the country in medically assisted death, likely due to multiple factors including demographics, accessibility, and a long history of advocacy. I decided to interview **DR. JANET KUSHNER-KOW**, Clinical Associate Professor and UBC Division Head of Geriatric Medicine, to understand how MAiD has impacted the practice of geriatric medicine.

What are your experiences with patients who request MAiD?

We have a lot of requests in the lower mainland. I think it's cultural and whether that will shift, I don't know. Most of the patients know that it's an option and a lot of them feel that they are happy to have that option even if they don't go through with the assessment. I think it's because patients in B.C. want to take control of what's going to happen to them. Some patients want to have a say in how and when they are going to die. I've heard patients say: "I want [my family] holding my hand." "I want to be awake and then gone, not this slow process where they see me dying."

I was present for a patient who went through with MAiD. He was quite frail. His family was there and it happened very quickly. You're surprised when you're watching. The first vial went in and he was quiet. It was cathartic for the family. They were there. They were ready. They knew when it was going to happen. They hugged and talked to him, and it was extremely peaceful. It really changed my mind on MAiD.

Only physicians and nurse practitioners in certain provinces can provide MAiD by either assessing competency of the patient, prescribing the substances that cause death, or administering the substance. What role do geriatricians play?

It's mostly been family physicians who have taken up the role of assessing competency and administering medications. Most geriatricians here have been involved with cases because our patients tend to be more complex. We are often asked to assess whether they are suffering or whether they are depressed. We've all been involved in these cases. There are some geriatricians who have done assessments, but none of us are prescribers.

For each assisted death, there are likely many more patients who are ineligible, with the most cited reasons being loss of mental competency and the fact that death is not foreseeable (1). What role does MAiD play in a patient with dementia?

You can still have MAiD even if you have mild dementia as long as you are still capable. You need to know and understand your options, including palliative care. There have been eligible patients who have dementia and part of why they want to die is because they didn't want their disease to progress. Some have intolerable suffering while others have been turned down. It might be hard to imagine, but you can want to die and not be clinically depressed. These people are not depressed. They still find joy in life. They have a subjectively reasonable ability to look at their life. I did speak to one fellow in palliative care where pain was taken care of, but he was weak and could not get out of bed. He said he had done everything he needed to do and all he was doing was waiting to die. Although he enjoyed being with his partner, there was nothing left for him. There wasn't a lot of physical suffering. "Being here is making me feel uncomfortable not because I'm in pain. Not because I'm short of breath." "I'm not meant to be here anymore." "I'm done." It was an existential suffering. Psychiatric illnesses and advanced directives are now an area of contention that will likely be brought to the Supreme Court.

Access has been an issue that is being addressed in the media due to lack of information among the public and medical professionals. In fact, there have been concerns that many Canadians have died while waiting for an assisted death. What infrastructure is in place to ensure patients are informed and have timely access to MAiD, even in faith-based institutions?

It will just take time. There is not a clear understanding of what the process is and who is eligible, so that's still an issue. Here, each health authority has a team. Most health care professionals know the resources. When a patient requests MAiD at a faith-based institution, it goes to the regional team. If they are too frail to leave, then they can get special dispensation to get assessed on site in special circumstances due to "undue hardship." If you want to have the procedure, it would need to be at another site. In addition to the two large faith-based hospitals in the lower mainland, there are also faith-based associated nursing homes and a hospice. They are not allowed to have MAiD at home. It's going to be tough in terms of who's going to do it and where they are going to do it. The logistics will be tricky with many cases. You are allowed to use telehealth to do assessments, but a physician or NP has to be there for the procedure. This issue will probably be brought to the Supreme Court.

Thank you. Do you have any final words on how MAiD has changed end of life care?

I tell people that between cannabis and MAiD, it's changed elder care significantly. Many people are functionally impaired and they

ELIGIBILITY FOR MAiD IS AS FOLLOWS (2):

Experience unbearable physical or mental suffering from your illness, disease, disability or state of decline that cannot be relieved under conditions that you consider acceptable

Be eligible for health services funded by the federal government, or province or territory

Have a serious illness, disease or disability

Be at least 18 years old and mentally competent

Be in an advanced state of decline that cannot be reversed

Have a grievous and irremediable medical condition

Give informed consent to receive medical assistance in dying

Make a voluntary request for medical assistance in dying that is not a result of outside pressure or influence

Be at a point where your natural death has become reasonably foreseeable

are dependent on the medical system, but want help. Pain is so difficult to treat that we need these options. It has really opened up the discussion of death. In fact, it is now integral to the whole discussion of end of life, especially in palliative care. It's too early to say that's what we see here, but anecdotally, it makes the discussion easier. MAiD is going to be new for frailty, especially in B.C., where so many people are interested. End of life is getting very complex and geriatricians are in the forefront of this. There's no black and white. Everyone's story is different, family dynamics around death is enormously complex, and then you throw in psychiatric disorders. It's fascinating. 🐾

Tina is currently a fourth year medical student at UBC. She serves as the VP External of the National Geriatrics Interest Group. Her experiences with geriatrics have been overwhelmingly positive, and she looks forward to sharing her experiences.

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Geriatric Inclusive Art as a Promoter of Wellbeing: A Pilot Program

KACPER NIBURSKI, MA, MD CANDIDATE, CLASS OF 2021, MCGILL UNIVERSITY
REVIEWED BY: UYEN DOAN, MD, PGY5 GERIATRIC MEDICINE, MCGILL UNIVERSITY
APPROVED BY: DR. OLIVER BEAUCHET, DEPARTMENT OF GERIATRIC MEDICINE, MCGILL UNIVERSITY

The configuration of hospitals is largely predicated by acute care management. Multiple comorbidities and associated chronic symptoms of illness are often left either unconsidered, masked, or too overtly difficult to deal within the scheme of management-based care (1). These problems of immediate interventionist medicine are only exacerbated in geriatrics, where the constellation of disease states come into constant interaction with a patient's wellbeing. Due to their multifactorial, interacting illnesses, hospitalized older adults often suffer from a higher disease burden (2), express greater dissatisfaction in care received (3), and have a higher readmission rates due to lingering, unaddressed issues in their health care (4).

Such situations are a further challenge in cases of dementia. A recent study found that 42% of inpatients over the age of 70 had dementia, with that number expected to climb in the coming years (5). While care in patients with dementia is similar to general geriatric patients, their progressive cognitive decline poses a long-term difficulty. Studies have determined that patients with dementia experience worse health outcomes than general patients (6), longer lengths of stay (7), and complications from their disease.

Such consequences are a further result of the limited pharmacological treatment options currently accessible. Due to the novelty of many care regimes, little evidence on the medicinal efficacy and safety has been provided in the literature. This gap in care is particularly for challenging for the treatment of behavioural and psychological symptoms of dementia (BPSD) (8).

Hospitals are currently canvassing ways in which to minimize these negative outcomes while maximizing longitudinal care management strategies in geriatric patients. However, due to the unique and complex nature of disease states in older patients, especially those with dementia, dealing with the range of chronic and acute comorbidities remains a fractured, non-holistic approach.

Some solutions have been proposed. Many of them center on non-pharmacological interventions that compliment current available medical approaches (9). Creative endeavours have piqued increasing interest. Art therapy, for instance, has presented particular promise in a wide variety of patients, including older adults. From fostering a newfound sense of self to transforming the illness experience into one of personal purpose and meaning, art therapy has been shown

to increase positive indicators of wellbeing (10). Literature reviews have proven the same effect with other creative initiatives: symptoms of dementia improve with music therapy and physical activity (11); there have been lower incidences of hospital stays after a patient uses art recreational activities (12); and patients have described themselves as feeling as though they had greater control of themselves while engaging in art compared to other medical treatments (13).

The reasons for these results have not been fully elucidated, though some speculation exists. Emotional stability has been discovered as an important factor in determining disease progression. Activities which promote positive emotion during hospitalizations delay negative health outcomes while buoying positive ones (14). Critical theory proves useful in digging deeper to this mechanism; emotional instrumentalism is central to the discourse of fields like narrative medicine. At its core is the suggestion that a disordered disease is often configured into an ordered storyline. In particular, disease takes on a “temporality, singularity, causality, intersubjectivity, and ethicality” (15). Each patient is at the intersection of each of these aspects of disease, and the way patients comprehend their disease affects not only how they understand their disease, but also the entirety of their health.

Art therapy hinges on this narratology and bears witness to the disease through one's own perspective. The act of creation is inherently personal, allowing an intimacy with the materials. The piece becomes one coherent form, and in manipulating and manufacturing art from arbitrary means, the patient can relive, realize, and reconceptualize how to produce meaning to disease. They are in control. They internalize their story. They honour their continuity against its projection.

Despite this theory and previous research, no study has directly linked art therapy and its associated theory to cognitive decline (16). Nor has a study looked explicitly at health outcomes and how they are benefited in the long term by such interventions. Currently at the Jewish General Hospital in Montreal, we have worked on specializing art therapy for geriatric populations, a process entitled Geriatric Inclusive Art (GIA). Patients over the age of 65 are offered painting sessions where they can produce art with any array of four colours on a small canvas. They are guided by an art therapist, Samantha Remondière, and a research team, lead by Dr. Olivier Beauchet. The research collects a variety of touch-points based on a Likert scale, such as whether anxiety was caused or if the participant felt good while painting. Later these codified themes are compiled against hospital records to see if there was an improvement in neuropsychological outcomes such as autonomy, behavior, communication. The final objective is to determine if GIA painting sessions can decrease the incidence of adverse outcomes such as falls, lessening the number of prescribed psychotropic medication or decreasing the patients' length of stay.

GIA has proven effective in other smaller programs already. Emerging as a new field in complex care cases, it has been shown to improve emotional well-being and has been hypothesized to directly reduce morbidity and mortality. A 3-month pilot project has been completed from January to March 2017 to determine project feasibility, which was followed by the scaled project itself. The latter is currently still ongoing in 2018, and so it is too early to assess and draw a conclusion on the effects of the study. On the other hand, the anecdotal evidence is abundant. Numerous patients have reported a sense of accomplishment at producing artwork again, at having it displayed throughout the hospital, and at creating the work in relation to and with others in the ward. This type of emotional well-being as a result of community interaction has been well-documented but is minimally used on wards. Families have similarly agreed about these positive effects, noting the sense of accomplishment in their loved ones, as well as the ability to reconnect with them through the painting sessions.

Moreover, these qualitative metrics have been preceded by similar pilots of the program. A study in France showed that GIA initiatives reduced hospital lengths of stay and in-hospital mortality (17). However, it was noted that further, larger studies needed to be done to quantify the actualization that patients feel in their own work.

Some limitations of the study will present themselves. The trial is an open-label trial, therefore a non-randomized design, and the number of GIA sessions per participant has been variable, based on the size of the ward, and the patient's length of stay. We have also been limited by a small sample size, as obtaining consent, either from capable patients or families, has been difficult. Furthermore, some patients also do not feel comfortable painting, and prefer other modes of creative endeavors.

Yet despite this, the results are encouraging in the current climate of hospital care. This is especially true given the increasing efforts to diminish illness exacerbation in geriatric patients and limit pharmacological treatments for BPSD. If hospitalizations can be reduced, health outcomes can be maximized, and if health can be more sustained and stable in an inexpensive way, the ability to preserve patient's sense of self and daily activities through GIA will become a key aspect in geriatric care management. 📖

The Geriatric Inclusive Art team at the Jewish General Hospital is a team of researchers and art therapists who believe in alternate possibilities to care pathways. By focusing on developing health through emotional wellbeing and community, the team is hoping GIA will prove efficacy in decreasing health burdens in geriatric populations.

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THE TREE OF LIFE

ACRYLIC ON CANVAS, 9" x 12"

XINYUAN CAMILLA HONG
MD CANDIDATE, CLASS OF 2019, MCGILL UNIVERSITY

We had the privilege of visiting a palliative care patient back in first year of medical school. Despite their pain, he and his family graciously allowed us to enter into their lives, which for this time resided in a little room with two beds - one was a patient bed and the other was a couch made into a bed so that the wife did not have to leave the husband.

The four loved ones really helped maintain the person that the man was - they kept his humour, strength, swagger, and reminded us of his love for electronic gadgets and music. Even more so though, the man was highlighting the people his loved ones are, and was probably playing a role in molding who they were becoming: a devoted wife who was the sunshine in the room and who smiled through everything, a protective cousin who was strong but at moments was reduced to weeping, a nonchalant aunt and uncle whose poise maintained the calm through the storm.

It's all too easy to reduce people to cases and numbers; let's hope we'll not forget the intricate web of relationships built around each person and the spectrum of their needs requiring loving attention.

Camilla is a third-year medical student at McGill University. Born in China, raised in England and educated in Singapore, she came to Montreal to complete a Bachelor of Science with Honours in Anatomy and Cell Biology. Working with local communities in this city cultivated in her a desire to use her skills to serve the underserved. Outside of being a student, she enjoys dabbling in piano and painting. She draws inspiration for her art from personal experiences in hopes of capturing evanescent moments of the day-to-day.

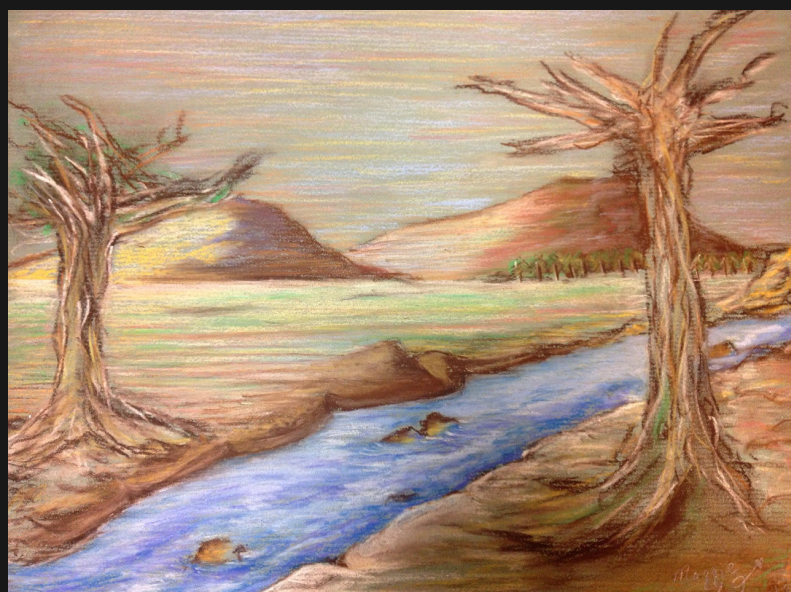
MAGGIE SZU NING LIN, BScN, RN



GARIBALDI LAKE

CONTÉ, SOFT PASTEL

Garibaldi Lake is one of the coastal mountains in the province of British Columbia. It is a place for a nice weekend getaway from the city to immerse oneself in nature and relax the heart, mind and soul.



THE RIVER OF LIFE

SOFT PASTEL

On a flight from Ottawa to Toronto, Maggie sat next to a woman in her 70s and asked this woman what "healthy aging" meant to her. The first response was "exercise", and later on she added, "it's an awkward phrase", as she explained that it meant to age but in a healthy fashion. Although to her this may have seemed like a contradicting concept, she admitted that this was possible to obtain with "[physical] exercise, good diets, social interactions, and intellectual exercises".

THE NATURE NETWORK

ACRYLIC ON CANVAS



Nature is what connects every human being - sea, land or sky.

Maggie is a recent BScN graduate from McGill University and a native of South Surrey/White Rock, BC. She currently works as a community health nurse and home care nursing supervisor in a northern Indigenous community. Upon her high school graduation, she received an arts scholarship to further the development of arts in her local community. With such encouragement, she continued creating artworks while pursuing her passion in nursing at McGill. Maggie has a special interest in geriatric and global health and loves being in nature. Hence, her creations are based on the theme of nature, which for her, symbolizes health, hope, life, and a place to relax the mind.

Like many others, I once lived in fear of aging. Although the process of growing old is continuous and inevitable, I chose to live in denial. To the young, time is a seemingly-infinite entity. Dependency is inconceivable. Actions are goal-oriented. To the young, elders are often viewed as “others” in a toxic us-versus-them dichotomy. They relentlessly consume healthcare resources and burden families.

It was not always like this. In previous eras, elders were viewed with respect and were often consulted for their wisdom. In the age of rapid technological expansion, Google has replaced age-associated insight, and it is often the young who are consulted for help with navigating this new cyber-world.

Medical professionals are unique in that their careers often mandate them to have constant exposure to individuals in the terminal phases of their lives. Hospital wards are crawling with older patients riddled with medical comorbidities, lengthy medication lists and complex social situations. They can be medical management nightmares for many internists. In a time when baby boomers have begun to flood geriatrics wards, this “problem” is on everyone’s agenda. To medical professionals, aging is frequently associated with images of frail individuals, abandoned by family, hooked up to pumps and ventilators, clinging to life. It is no surprise, then, that people grow apprehensive of reaching this state.

When the young fear aging, it creates multiple problems. Firstly, elders grow increasingly isolated. It is only natural that we avoid what is feared. Secondly, it leads to psychological turmoil when a formerly “young” person begins to feel the effects of aging on their bodies. How can one consolidate well-engrained negative percep-

tions of seniors with their newfound categorization into this social class? This cognitive dissonance inevitably leads to tremendous stress. In summary, this system of thought is detrimental to entire societies and must be eliminated. The question is—how?

One simple intervention I have found incredibly helpful for myself is to welcome rather than avoid thoughts of aging. I constantly entertain the notion of growing old and allow this reality to underlie many of the decisions I make on a daily basis. What will matter most at the end of my life? How can I best tailor my career, which is now in its infancy, to address these overarching goals? Another way I have managed to mitigate negativity surrounding aging is by spending time with older folks who are living healthy, happy lives. Aging does not need to co-exist with disease and misery. Many older individuals are so positive and have invaluable perspective to share. This comradery is mutually beneficial for myself and elders who often seek company.

Growing old is a process that individuals and entire societies continue to grapple with. However, instead of being viewed as a problem, it should be embraced as a beautiful, natural phenomenon that can inform how to best live our lives from an early age. Growing old is not just a process I no longer fear; it has become a central tenant of my life. 🐾

Tharshika is currently a daughter, sister, friend, amateur artist, writer and third year medical student at the University of Ottawa.

THARSHIKA THANGARASA, MD CANDIDATE
CLASS OF 2019, UNIVERSITY OF OTTAWA

Veterans Through a New Lens

IIULIJA POVIERIENA, MD CANDIDATE, CLASS OF 2018, UNIVERSITY OF OTTAWA

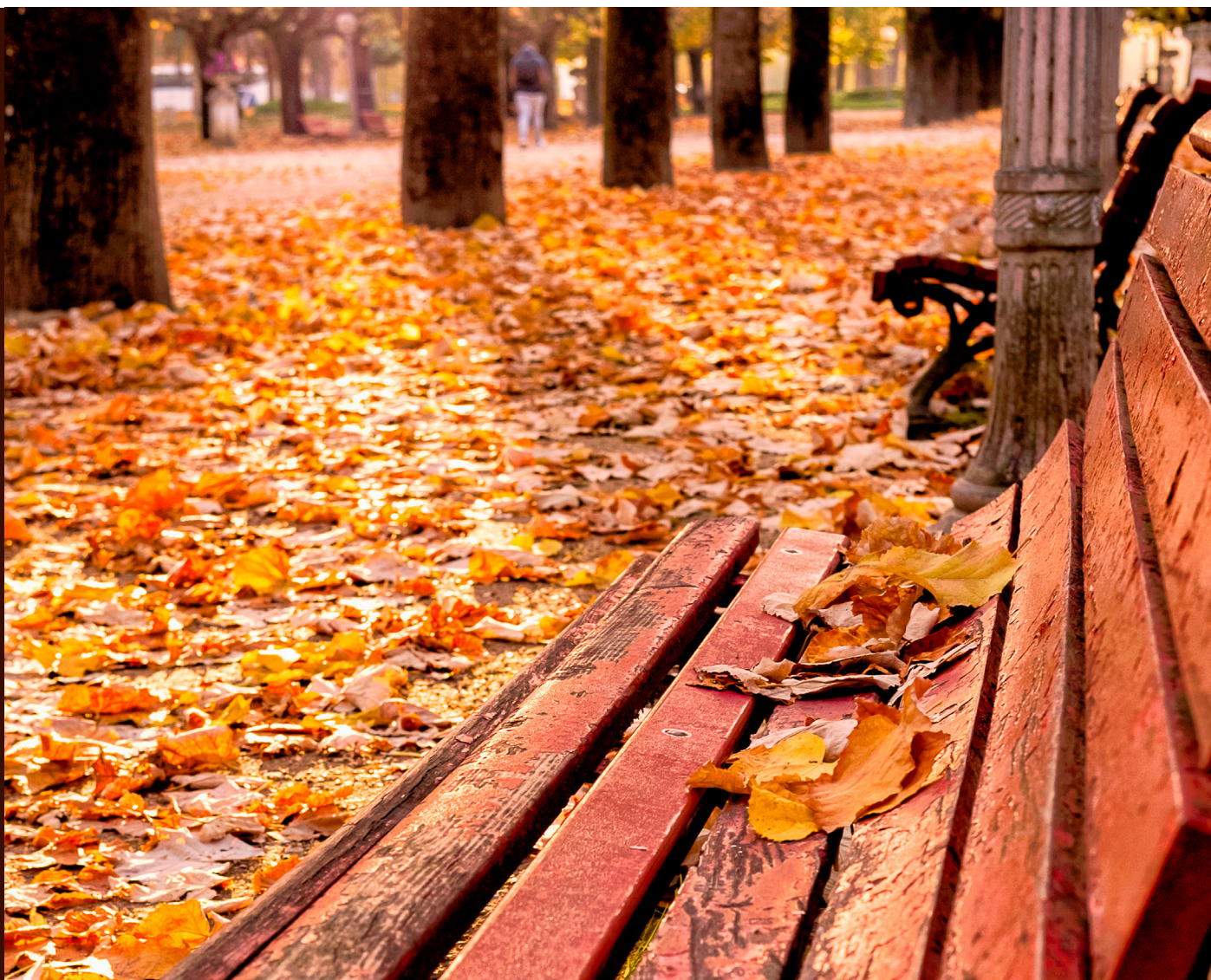
...A bright April morning started with a fresh gust of wind as a reminder that the winter had not quite let go yet. After walking in a few circles on the residential streets searching for the right building, I finally found the main entrance. The building itself resembled a small town with streets, shops and all the services inside. It was 8:45 am; the corridors were empty and quiet with no one to guide me to my ward.

I had reported to the nursing station at 9 am where I met my attending, Dr. G. She was just about to go to a family conference meeting for one resident, Mr. P. a 101 year-old veteran with moderate dementia, urinary incontinence, and congestive heart failure. Dr. G. gave me 15 minutes to review his chart so I know what they were talking about and then we went to a conference room. A team of healthcare providers was already waiting for us. There was a nurse, a pharmacist, a social worker and a dietitian. The patient’s daughter was on the teleconference call because she was having a cold and was instructed not to spread the infection in the facility with frail seniors.

Each member of the multidisciplinary team went over their updates on Mr. P.’s care and his daughter asked them questions pertaining improving the patient’s medications, vaccinations, strategies to help manage his incontinence, things he enjoys, his health status, etc.

When it came to the important aspects such as code status and early planning of the funeral, the daughter was extremely reluctant to even think about it. The purpose of early planning is to be able to fully devote all of the attention to Mr. P. instead of scrambling to organize these plans on the one unfortunate day when he passes. She requested transfer to the hospital for full resuscitation and refused to discuss plans in case the patient dies. Everybody on a team approached it in a very gentle manner and backed off for now seeing the daughter’s anxiety about it. Dr. G. told me later that they regularly counsel family members on dealing with the resident’s death and most of them cooperate fairly well. However, the most challenging thing about working in this setting is to comfort and help overcome the anxiety of family members as the patients continue to physically decline. Most residents spend about a year on the ward I was visiting, before they pass away. Although I understood the good intentions of the team, I could certainly relate to the daughter’s feelings of fear and denial that he is already 101 year-old and his health is deteriorating. The daughter had a hope that because he gained a few pounds, Mr. P. would be able to return to a retirement home.

We then went for rounds, which were much less formal than what I was used to on my past rotations. We walked down a corridor and in front of every room there was a glass cabinet filled with



SEAN CAI, PGY-I INTERNAL MEDICINE, UNIVERSITY OF TORONTO

that person's meaningful belongings: wedding pictures, awards, pictures of children and grandchildren, newspaper articles about them. Someone was a comic book writer and his books were displayed, the next room's resident was a Royal Air Force pilot who was part of a rescue in response to certain natural disasters such as an earthquake. The walls in the hall had black and white pictures from World War II - planes, soldiers, nurses, etc. I could almost hear a military march somewhere far, however, I wonder whether it was all in my imagination. Every room was very personalized with pictures, books and souvenirs. We could easily find a ninety to a 105-year old person sitting in a chair watching a black and white movie on a DVD or reading a book. They would seem to have an aged body with gray hair and wrinkles, but after learning so much about them, I would see a handsome blond soldier with blue eyes just about my age, or an elegant young skinny nurse with neatly arranged curls. I perceived them totally differently from what I would usually see in a brief emergency room encounter during my night on call. It was a safe and familiar environment for them. Thankfully, I had a generous amount of time to spend with each person I visited. Perhaps, Dr. G. wanted to demonstrate me why she is so passionate about her work by letting me appreciate her day to day interactions. This new experience really added a new dimension to my understanding of a long term care, family medicine and care for the elderly. It

was a very enjoyable encounter with a new area of medicine I have yet to explore. Seeing residents' lives in flashcards on displays, discovering the noble humans in front of me and talking to their loving children have unlocked a new perception of those patients for me. As medical students we get majority of our exposure to elderly patients in the setting of inpatient internal medicine wards which may give an incomplete impression about this patient population day to day life and where they go upon discharge from tertiary care hospitals. By seeing them outside of the acute care setting I was now able to better appreciate the socio-cultural dimension of their lives which I think is very valuable for my development as a future physician.

That day I finished early. As I exited the building, a wave of fresh and warm air hugged me on my way to the car. The sun was still up and shining brightly nurturing the juicy sprouts of the new grass. Its seeds were hiding under the blanket of snow and were now awakened by the warm light. Perhaps, the spring was gaining the power. A new path in medicine suddenly occurred to me. ☺

Lulia is a fourth year University of Ottawa medical student. This piece is an exhibit from Lulia's reflections on her first visit to the Ottawa veterans nursing home as a third year clerk.

SEAN CAI, PGY-1 INTERNAL MEDICINE, UNIVERSITY OF TORONTO

Wanted: Delirium Superheroes

ALISHYA BURRELL, PGY-4 GERIATRIC MEDICINE
SCHULICH SCHOOL OF MEDICINE & DENTISTRY

“He’s confused and hallucinating, he pulled out his IV line and catheter overnight. He was agitated, and security was called. He’s now in restraints....”...

As a fourth year subspecialty resident in geriatrics, this is a common story to be hearing over the phone. Only this time it was my mother calling from the hospital, describing the hyperactive delirium my grandfather was experiencing during his admission for a heart failure exacerbation.

I pride myself on being knowledgeable about delirium. I know the staggering statistics on its frequency in older inpatients. I know the DSM V criteria for its diagnosis. I can’t even count the number of times I’ve taught medical students and junior residents how to identify delirium and the its long list of possible triggers. I have talked to dozens of families, educating them about the sudden change they were seeing, and trying to reassure them.

However, when it’s one of your own loved ones, knowledge does not help and the reassurances fall flat. Seeing my grandfather, the stoic farmer, be changed into someone full of fear and accusations was shattering and I was fortunate enough to understand he was in a state of delirium - it was the delirium talking. Imagine what the experience would be like if you were not being educated had not been educated on the diagnosis, which is too often the case.

When speaking to my mother, none of the health care team had used the word delirium. No one had tried to explain the definition and what it can entail, particularly that agitation can be seen, and

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fluctuations are common. No one had described the typical course of delirium, or had discussed its prognosis.

Families often perceive a severe delirium as the nearing of death. Now I understand why. In that moment, when your family member is unrecognizable, it feels like the end. Even more horrifyingly, it feels like the delirium is worse than death itself. Seeing your loved one pull at their restraints brings a evokes a heartbreak that cannot be expressed. Hearing health care professionals scold them patients for actions they have no control over, is incredibly difficult.

For the second annual World Delirium Awareness Day (#WDAD2018) people are being asked to become “Delirium Superheroes”. This includes committing to use the term delirium, educating other health care professionals, and listening to patient and family stories about the experience of delirium. Now, more than ever I want to encourage readers to become actively involved in increasing delirium awareness in their own workplace. A better understanding of delirium will not erase the fear that a family experiences, but using the appropriate terms and educating the entire health care team and patients’ loved ones will build a safer and more compassionate environment for the treatment of delirium. I know my grandfather would have benefited from being surrounded by more Delirium Superheroes! 🦸

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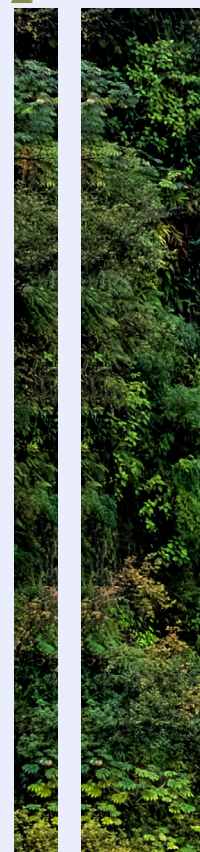
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The Canadian Geriatrics Society

Promoting excellence in healthcare for 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.

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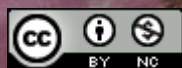
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2. Involvement in advocacy to improve seniors care
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