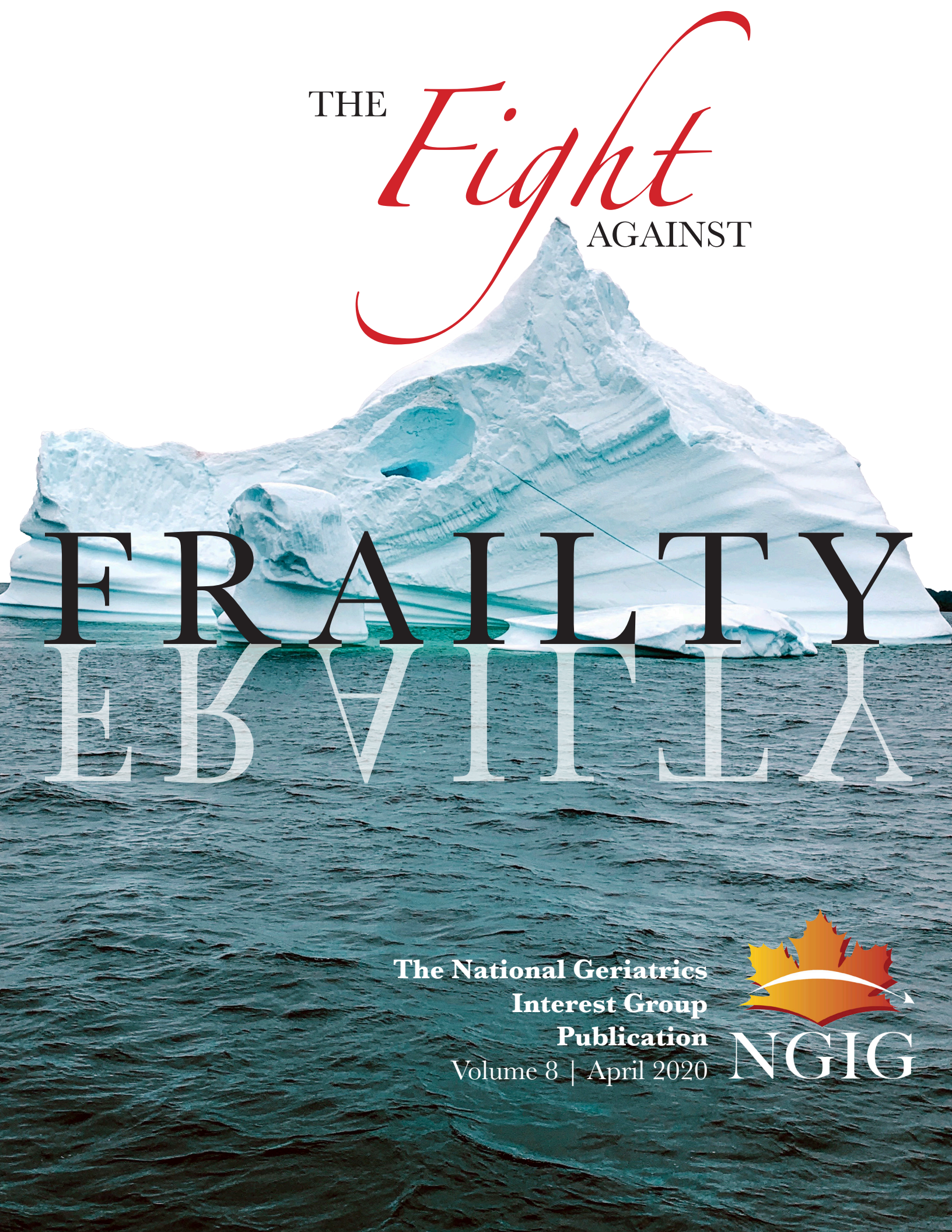
THE *Fight* AGAINST



FRAILTY

The National Geriatrics Interest Group Publication
Volume 8 | April 2020

NGIG

NGIG

The National Geriatrics Interest Group Publication
Volume 8 | April 2020

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

Cover Photography /
"Atlantic Ocean, Twillingate, Newfoundland" by Haniah Shaikh

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National Geriatrics Interest Group

@NGIG1415

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Editors-in-Chief

Alexander Adibfar
MD Candidate 2020,
University of Toronto

Alex is a fourth-year medical student at the University of Toronto. Having served as Editor-in-Chief for the University of Toronto Medical Journal and High-Impact Publications E-Newsletter, he feels honoured to be able to combine his editorial expertise with his passion for improving health outcomes in older adults, particularly in relation to geriatric surgery. Alex is thrilled to begin his surgical training in the Division of Plastic & Reconstructive Surgery at the University of Toronto.

Michael Elfassy
MD Candidate 2020,
University of Toronto

As a continuing Editor-in-Chief, Michael enjoys the opportunity to share his passion for Geriatric Medicine and to work on developing integrated strategies to care for elderly patients. He held a Canadian Frailty Network research award for his work on frailty and critical care outcomes and has advocated for increased exposure to geriatrics in medical education at the national level. He looks forward to beginning his residency training in Internal Medicine at the University of Toronto.

Shannon Gui
MD Candidate 2021,
McMaster University

Shannon's passion for geriatric medicine stems from cherished memories of making music and art with older adults as an undergraduate student. Through her involvement with NGIG, the McMaster GIG, and her own research interests, she continues to advocate for improved multidisciplinary care of older adults and increased medical education on Geriatric Medicine. She worked part-time in graphic design for the Faculty of Health Sciences during her pre-clinical training.

Leah Rusnell
MD Candidate 2021,
U. of Saskatchewan

Leah is a third year medical student with a longstanding interest in the unique health care needs of the elderly. Prior to and during her clinical training, she has been actively involved in seniors' health through extensive volunteering, the University of Saskatchewan's GIG, the NGIG, and the CFMS. She is passionate about increasing medical student exposure to geriatrics through curricular and extra-curricular experiences. She plans to integrate geriatrics into whichever future specialty she pursues.

Letter *from* the NGIG Co-Chairs

Adrian Chan
MD Candidate 2020,
University of Toronto

Adrian is a fourth year medical student at the University of Toronto. His research involves evaluating geriatric competencies in postgraduate medical education as well as the quality of delirium documentation. He is particularly interested in optimizing transitions of care and the role of geriatricians as health system leaders in our aging communities. He is excited to continue his training at the University of Saskatchewan's Internal Medicine residency program.

Nadine Abu-Ghazaleh
MD Candidate 2020,
University of Saskatchewan

Nadine has been committed to the unique needs of older adults for several years. Prior to her clinical training, she worked as a Policy Analyst for the Ministry of Health and Long-Term Care focusing on health policies that affect Canadian seniors. Throughout medicine, her research focused on Frontotemporal Dementia and the impact it has on primary caregivers. She will be pursuing her Family Medicine Residency at McMaster University's Grand Erie Six Nations and is excited to combine her passions of geriatrics, indigenous health and public health.

Dear Readers,

We are honoured to share with you the 8th Edition of the National Geriatrics Interest Group's (NGIG) Annual Publication. Medical and allied health students across Canada submitted their articles, artwork, and photographs to highlight this year's theme: ***The Fight Against Frailty***. We are inspired by the talent and hard work of everyone involved in the development of this publication, and ecstatic to see the interest in Geriatrics grow across disciplines!

The NGIG is a national medical student-run organization, supported by the Canadian Geriatrics Society (CGS), that aims to promote the care of older adults through various initiatives. We collaborate with Geriatric Interest Groups (GIGs) at each medical school to raise awareness about the diverse aspects of aging and the career opportunities in Geriatric Medicine, Family Medicine, Care of the Elderly, and Geriatric Psychiatry. Throughout our 2019-2020 year, we continued many of our successful initiatives, including our physician research mentor map to connect students with research and shadowing opportunities, as well as our #WhyGeriatricsWednesday social media campaign to increase public engagement about issues related to elder-friendly care.

Unfortunately, this year's publication coincides with a very difficult time for our local, national and international community as we continue to battle the Novel Coronavirus (COVID-19) global pandemic. Despite the negative impacts of this pandemic, we have also witnessed tremendous resiliency and empathy within our communities as we all do our part to "flatten the curve" and protect vulnerable populations such as older adults. Canadian medical students have played an important role in this resiliency and their tremendous efforts are highlighted on page 23.

We would also like to take this opportunity to thank the incredible people and organizations that have made this year's publication possible. We would like to thank the Canadian Geriatrics Society for their continued support, Dr. Tricia Woo for her invaluable mentorship, and the Resident Geriatrics Interest Group for their commitment to working with medical students. Last but not least, we would like to thank our NGIG publication team - Shannon Gui, Leah Rusnell, Michael Elfassy, and Alexander Adibfar - thank you all for your dedication and hard work!

We are very proud to present ***The Fight Against Frailty*** and we hope you enjoy it as much as we did!

Sincerely,
Adrian Chan & Nadine Abu-Ghazaleh
NGIG Co-Chairs 2019-2020

<< Forget-me-not 1 >>
Photographer: Qamar Halat
McMaster University | SLP Class of 2021
Qamar Halat is currently a first year Speech-Language Pathology student at McMaster University. Prior to beginning her Masters, Qamar spent many years facilitating communication between stroke survivors who suffer from aphasia and cognitive communication disorders. She hopes to continue helping this population as a Speech-Language Pathologist after she graduates.

TEAM OPTIMIZE: How our Interdisciplinary Research Team is Addressing Frailty in the Context of Rehabilitation

Kristina Kokorelias, PhD(c), University of Toronto
Shawna Cronin, PhD(c), University of Toronto

Frailty places a person at increased risk of adverse health outcomes, including falls, fractures, hospitalization, and mortality (1). While frailty is recognized as a worldwide concern, in Canada it is estimated to affect one million people; this figure is expected to reach over two million in the next decade. There is growing awareness of the need to improve accessibility of services and opportunities for people with frailty. A comprehensive and coordinated approach is of utmost importance to meet their needs. However, there is a general lack of understanding among health service providers about which interventions, programs and approaches to caring are most effective in caring for patients with frailty" (2).

Team Optimize, led by Dr. Kathy McGilton, is one of several research teams at Knowledge, Innovation, Talent and Everywhere (KITE). KITE is in turn the research arm of the Toronto Rehabilitation Institute (University Health Network), an international leader in rehabilitation science. Team Optimize research aims to prevent cognitive and functional decline of persons requiring rehabilitation by focusing on restoring function and enabling independence for adults through optimization of the health care system and the home environment. Broadly, the work of Team Optimize aims to maintain or enhance the ability of patients to function independently, better support caregivers to persons deemed frail, improve health-related quality of life, and reduce health service utilization and related costs.

The team comprises an interdisciplinary team of researchers with diverse clinical and research expertise, including health service researchers, graduate student trainees (this is where we come in!), health economists, nursing researchers, physician-scientists, rehabilitation scientists, social scientists, and researchers with physical and occupational therapy clinical expertise. Team Optimize understands that people who are frail commonly have complex conditions that require an interdisciplinary rehabilitation approach to care. A recent project has focused on complex older adults with genitourinary cancer on hemodialysis, and involved the development of a clinic to increase exercise among these patients and their caregivers. Other projects include patient-centered rehabilitation models for persons with cognitive impairment, a research-based theatre production to address the stigma associated with dementia, and interprofessional clinics using telemedicine for chronic pain management. The common thread among these projects is that Team Optimize researchers strive to create the most effective health care systems, programs and approaches to caring for caregivers and patients with complex (i.e. mental, physical, cognitive and social) conditions to enable them to effectively re-integrate into community settings.

Kristina Marie Kokorelias is a PhD Candidate in the Rehabilitation Sciences Institute at the University of Toronto's Faculty of Medicine. She is a member of the Family Research Group at the University of Toronto and Team Optimize at KITE-Toronto Rehabilitation Institute. Her primary research interest is to understand how family caregivers use services to support their caregiving role across the disease trajectory. Kristina has a specific focus in optimizing life in the community for persons with dementia/Alzheimer's disease and their family caregivers.

Shawna Cronin is a doctoral candidate at the Institute of Health Policy, Management, and Evaluation (IHPME) at the University of Toronto. She is a trainee member of Team Optimize at KITE-Toronto Rehabilitation Institute. Shawna's thesis work examines the availability of primary care and other health and community services for persons living with dementia. More generally, her research interests include primary care quality, health and rehabilitation service utilization for neurological conditions, and quantitative and mixed methods approaches to health services research. Prior to beginning her doctoral studies, Shawna worked clinically as an occupational therapist in long-term-care and primary care settings.

As the population ages, health care providers will be increasingly confronted with frail adult patients who have very diverse and complex social and physical needs. Rehabilitation medicine aims to enhance and restore functional ability and quality of life to those with physical and/or mental impairments or disabilities. Rehabilitation provides a set of guiding principles to shape a model of service provision for supporting people with frailty and their family caregivers in the community. The system of rehabilitative care is not optimized for people with complex conditions nor does it take into account their personal (e.g. cognitive impairment and social) vulnerabilities.

Given the difficulties accessing services for people with frailty, Team Optimize sought to better understand how frailty is addressed in rehabilitation programs by conducting a literature review. We identified a few issues, particularly that the term frailty is defined in various different ways in research studies. Sometimes it was used as an adjective to describe a population, sometimes as a variable that has been operationalized, and sometimes both. In addition, though "rehabilitation" itself is a broad term that can encompass cognitive, arts-based, and community-based approaches to helping improve function, it most often conjures up images of parallel bars in physical therapy gyms. In research, it is crucial to clearly define concepts in order to build on an existing literature base, and eventually implement the evidence into practice. Thus, we had several team discussions to decide which definitions are relevant to the frailty knowledge base. A scoping review is a type of literature review that has a broad focus, and is often used to clarify working definitions, conceptual boundaries, and to understand a "map" of the existing evidence (3). Given the perceived disorganization, the aim of our scoping review was to explore how frailty is operationalised in the context of rehabilitation intervention trials, for adults aged 18 years or older. A protocol for this review was published last year (4). Our scoping review addresses questions about the characteristics of frail individuals included in rehabilitation trials, the types of rehabilitation interventions used among those identified as frail, and commonly reported outcome measures related to frailty. To adhere to broad definitions of rehabilitation and frailty, our literature search cast a wide net and identified thousands of articles, which were then systematically screened for rehabilitation interventions for people with frailty. This approach was made possible by the size of our team.

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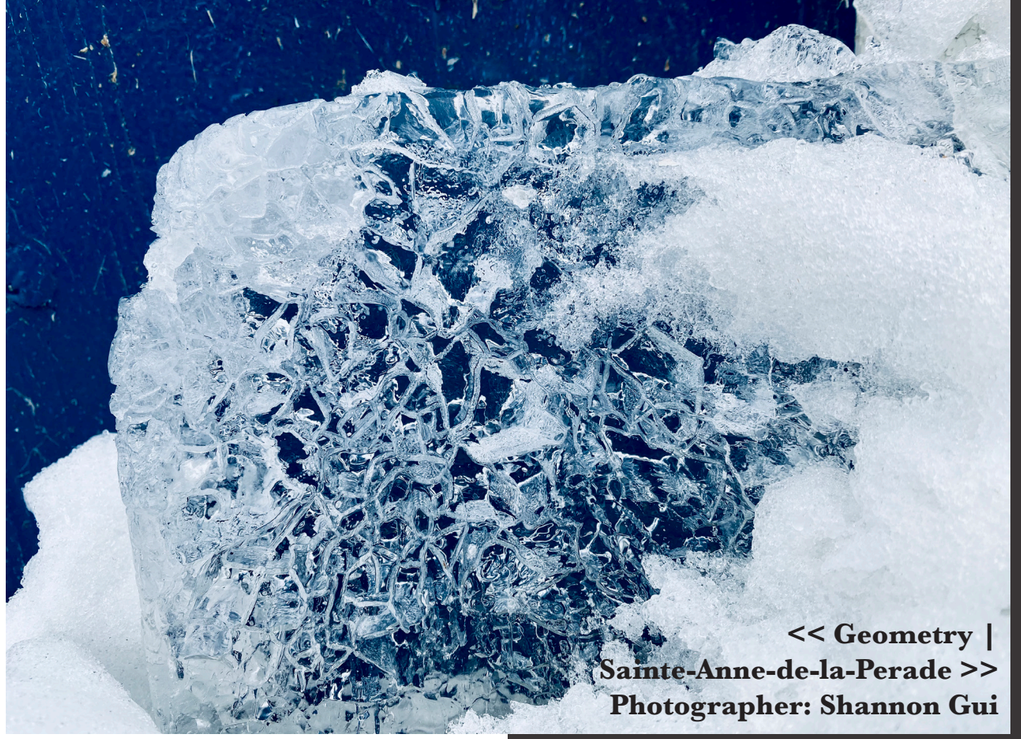

<< Geometry | Sainte-Anne-de-la-Perade >>
Photographer: Shannon Gui

Findings from our work suggest that the current system of rehabilitative care is not optimized for people with frailty nor does it take into account their personal vulnerabilities. Preliminary analysis has identified gaps in the literature to be addressed by future rehabilitation research for frail adults. This made us question the definition of frailty, and consider how the term is applied in the research literature as well as in clinical settings. We also considered our results in the context of cognitive disabilities and how these related to frailty. Finally, the role of caregivers in frailty interventions will be explored within our scoping review; as we considered that persons with frailty often have compromised independence due to severe cognitive or functional impairments, which leads to a reliance on family caregivers.

Conducting research within a large and diverse team can present challenges with achieving consensus on decisions, however, the interdisciplinary expertise in health research has resulted in a product that is relevant and broadly applicable to many sectors of the health system. Given the findings of this review, we expect that additional research is needed to develop, evaluate and implement rehabilitation interventions which also support caregivers in their efforts to care for individuals with frailty. Our results will help guide future Team Optimize research endeavours aimed at supporting rehabilitation for frail older adults that aim to help maintain function and their caregivers.

The full review is expected to be published this year.

To learn more about Team Optimize and KITE Toronto Rehab Institute, please visit: https://www.kite-uhn.com/team/optimize

Acknowledgements:
We would like to thank the support of all our Scoping Review Team Members for reviewing this article; Katherine S. McGilton (Team Optimize Lead), Susan Jaglal, Jill I. Cameron, Parvin Eftekhar, Sarah E.P Munce Shirin Vellani, Tracey J.F. Colella, Pia Kontos, Alisa Grigorovich, Andrea Furlan and Nancy M. Salbach.

Dementia Education Training: Informing A Memory Care Model

Samantha A. Rossi, MD Candidate 2022, University of Toronto
Julia A. Mirotta, Nursing Candidate 2020, University of Toronto

In Canada, the proportion of long-term care residents with dementia has been growing steadily since 2010, with 64% now affected by these diseases (Canadian Institute for Health Information, 2018 as cited in 1). The World Health Organization (WHO) recognizes dementia as a global public health challenge and has called upon countries to commit to providing high quality care and services for people with dementia, as well as to prioritize and improve the training and development of the dementia-related workforce (WHO, 2013 as cited in 1). As interns with the Ontario Centres for Learning, Research and Innovation in Long-Term Care (CLRI) at Baycrest during the summer of 2019, we set out to review the literature on dementia education training programs worldwide in order to inform the creation of a Memory Care Model at Baycrest. The goal of this piece is to report on those findings and to describe how dementia care training programs should be designed to improve the quality of life for both patients living with dementia and healthcare workers (2).

Methods

We searched for literature published in MEDLINE between January 2009 and April 2019 that evaluated the effectiveness of dementia training interventions using a range of outcome measures. Titles and abstracts of 115 articles were identified and reviewed. After applying inclusion criteria, 19 relevant articles were included (Figure 1). Descriptive methods were used to summarize and synthesize key themes. We identified three high-quality systematic reviews published in the United Kingdom, two by Surr et al. (2017, 2019) and one by Nolan (2008). Of the 16 studies wherein an intervention was implemented, 12 studies employed quantitative methods, one study used qualitative methods, and two studies used a blend of both.

Our assessment of the quality of evidence from the studies reviewed was relatively low. Most studies measured self-reported or staff-centred outcomes, with few studies evaluating clinical outcomes. The majority of the studies lacked a control group, did not randomize participants, and did not control for confounding variables. This body of literature was impacted by short follow-up periods, which impacted our ability to ascertain whether improvements in outcome measures were maintained over the long-term. We also identified a need to replicate successful training programs using rigorous, well-controlled methods, since few high-quality studies were identified.

Six of the fifteen studies were deemed rigorous based on the criteria that they were either a) randomized controlled trials and/or b) longitudinal interventions with a follow-up period and employed appropriate staff and patient-centred outcome measures. Using information extracted from the studies and the systematic reviews, we developed recommendations for a dementia education training program, detailing parameters such as curriculum themes, approaches to delivery, training length, frequency and time frame, and preferred ways of learning.

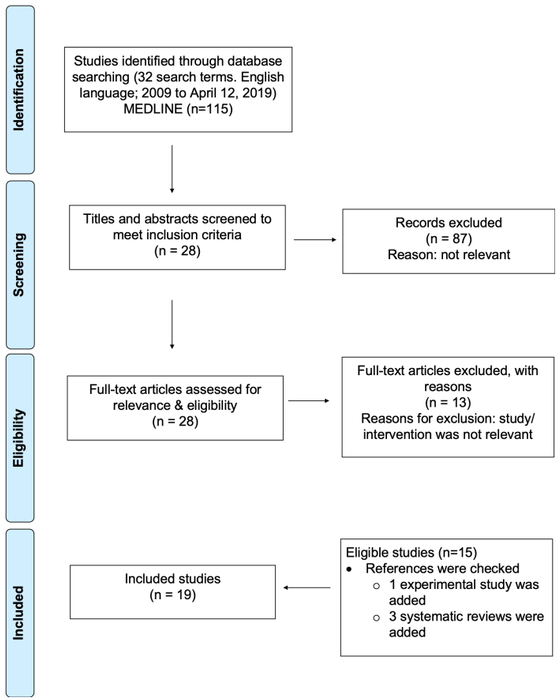

Figure 1. Flow Chart of Literature Review Selection Process

Results

Overall, the literature suggests that effective training should be tailored to learners, delivered longitudinally by an experienced facilitator, and embedded within a supportive organisational culture. Interactive learning activities, including role-play, case-studies, reflections and debriefing, were found to be particularly useful in helping staff apply learning to practice (Figure 2). In contrast, didactic learning, online modules, and text-based modalities were viewed as unhelpful by staff (3).

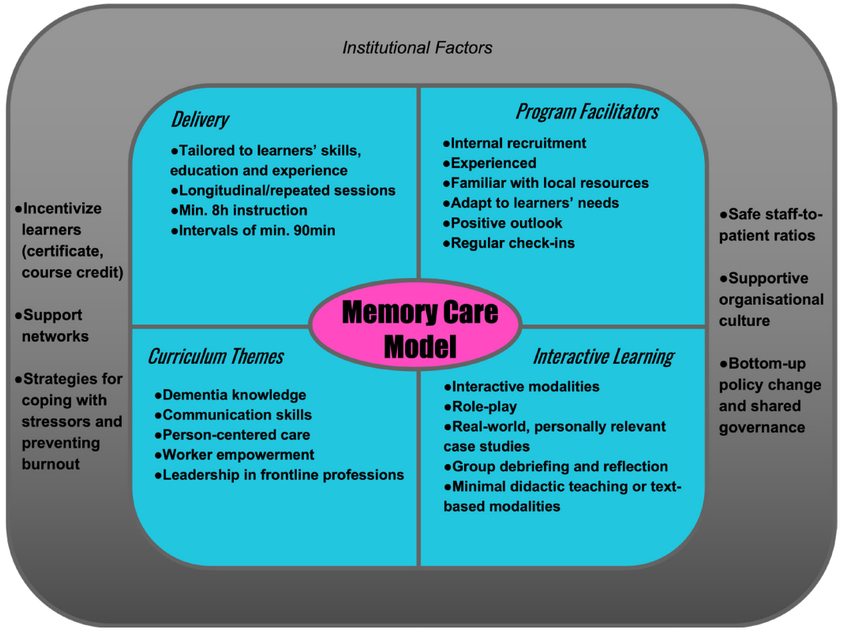

Figure 2. Memory Care Model: Core Elements of a Dementia Care Training Program

Curriculum themes centred on disease knowledge, communication skills for interacting with persons with dementia, person-centred care, leadership, and worker empowerment. While all themes identified are important, promoting worker empowerment and leadership within frontline professions is often overlooked in clinical practice and as such, seminal to informing a dementia care education model that supports both patient and worker outcomes. Future training programs should promote the development of staff support networks and provide strategies for coping with stressors and feelings of burnout. It is crucial that administrative leadership not only take part in, but also support staff-led initiatives to create an institution-wide culture shift. Staff views communicated across the literature suggest that an "us vs. them" culture ensues without such participation from leadership (4), which demonstrates the importance of a shared governance model of interprofessional collaboration.

Barriers to Implementation: Cost has been identified as one of the most significant barriers to implementing a dementia education program because of its widespread effect on resource allocation, program longevity, number of sessions, and compensation for staff who deliver the program, as well as those who complete the course/certification (5).

Barriers to Application in Professional Practice: A memory care educational program that can sustain long-term institutional practice changes needs to target permanent staff (6). Surr et al. purported that lack of time and inadequate staffing were commonly reported barriers to implementing dementia-care principles into practice and specifically, impacted the ability to deliver person-centred care (7). As such, high staffing turnover, low program attendance rates, and temporary staff will detract from program effectiveness. To increase attendance rates in permanent staff, programs should be delivered during months of the year with low staff vacation rates (8). Furthermore, training that is not tailored to the professional experience and skill level of the staff may impact its application into practice (7). However, the literature has also demonstrated the importance of facilitating an interdisciplinary learning environment regardless of skill background (9). As such, finding a balanced delivery method that is both tailored to the learners' skill levels and suited to the group's professional skill level is necessary for successful program delivery. Lastly, organizational readiness should be taken into account when planning for implementation, since institutional factors and turnover in staffing can impact educational program dissemination (4,5).

Takeaways

We identified several key takeaways from our review of the literature that are critical to the design of a dementia education program. Institutions should empower in-house staff to lead dementia education program sessions for learners (7). It is important to select champions who are experienced, have a positive outlook, and that can adapt to learner needs (7). Additionally, it is beneficial to train proactive leaders who know where and how to access additional dementia care resources (3). Trainers should provide mentorship, regular check-ins, and guide learners while they master course teachings (4).

Learning sessions should focus on exploration of real-world cases and facilitate role-play to promote application into professional practice (3, 7). Didactic teaching and text-based modalities should be supplemented by interactive learning that is memorable and relatable to learners (3, 7). Curriculum designers should deliver training sessions over a minimum duration of 90 minutes to improve staff attitudes regarding dementia care (7), as well as designate specific learning spaces for training (3). Furthermore, programs should provide the tools, time, and space for group debriefing and reflection to reduce work-related stress and associated burnout (7). It is equally important that the learners be motivated to participate in and complete a dementia education program; one effective way to do this is to incentivize participation with a course credit or certification program (10).

Finally, it is important for those implementing dementia education into their institution's continuing education efforts to consider the balance between realistic expectations and idealistic provision of best care (1). Curriculum designers must be mindful of the unique challenges of the health care institution in which they work, optimize resource use, and determine what is ultimately feasible in terms of program implementation while prioritizing patient care.

Conclusion

In summary, a dementia training program for staff in the long-term care setting should be developed using interactive approaches to learning, and with special focus on dementia knowledge, communication skills, person-centered care, worker empowerment, and leadership within professions. Barriers to implementation center around cost and its impact on resources, program delivery and financial incentives for program completion. Translation of program learning goals into professional practice may be impacted by staff attendance and turnover, and poor tailoring of programs to learner needs. Our findings are limited by the lack of high-quality evidence. Rigorous, controlled studies that measure clinical outcomes should be conducted to inform the development of dementia care models.

Samantha Rossi is a second-year medical student at the University of Toronto with an undergraduate degree in Arts & Science and a Masters in Health & Aging, both completed at McMaster University. Her clinical interests include successful aging, rehabilitation medicine, palliative care, music and health, and best practices in geriatrics. **Julia Mirotta** is in the final year of her Bachelor of Science in Nursing at the University of Toronto and plans to pursue a career in healthy aging through public health, primary healthcare and community outreach. She also attained a MSc in Human Health & Nutritional Sciences and a BSc in Biomedical Sciences at the University of Guelph. Samantha and Julia completed this project under the supervision of Dr. David Conn, MD and Dr. Faith Boutcher, RN, PhD.

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<< Colours | Halifax >>
Photographer: Shannon Gui
McMaster University | MD Class of 2021

Shannon Gui is a second year medical student at McMaster University. Art has always been an indispensible part of her life, and it keeps her grounded through a demanding clerkship.

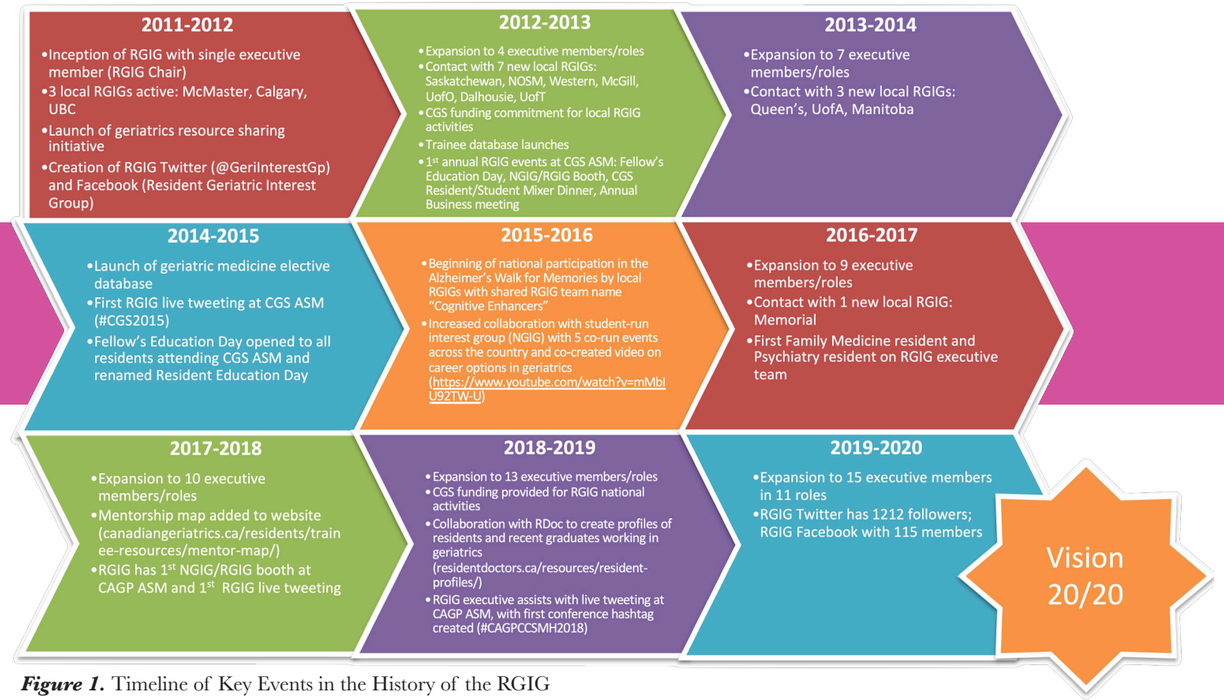

Figure 1. Timeline of Key Events in the History of the RGIG

HISTORY OF THE RESIDENT GERIATRIC INTEREST GROUP: A 2020 LOOK BACK

Amanda Canfield, MD, PGY3 Psychiatry, McMaster University
Andrew Perrella, MD, PGY1 Internal Medicine, McMaster University

The Resident Geriatric Interest Group (RGIG) is a well-established network of Canadian resident physicians with special interest in seniors' care. It is a nation-wide organization run by residents for residents, with an overarching goal of connecting like-minded trainees in order to support local and national initiatives related to geriatrics. Annually, the RGIG's executive team spearheads national-level initiatives and supports local Geriatrics Interest Group (GIG) events held at various residency training sites across the country.

The RGIG was initially created in 2011, running as a pilot project in its first year with a single executive member (1). Since its inauguration the RGIG executive team has worked tirelessly to foster a spirit of education, advocacy and collaboration in the field of geriatrics in Canada. Through these efforts, the RGIG has experienced rapid growth amongst its network of residents and alumni over the past decade. Currently, there are eleven executive positions held by fifteen resident physicians training across three medical specialties (Internal Medicine, Family Medicine, and Psychiatry). Local representation at the postgraduate level has also grown; at the time of this writing, seven universities had a local RGIG presence compared to three schools in the 2011-2012 year (1).

This piece serves to provide a summary of the key changes to and achievements of the RGIG since its inception. The hope is that this will allow for both a spirit of celebration of the RGIG's successes as well as a reflection to consider as the evolution of the group continues into the new decade.

In its pilot year, the RGIG was under the direction of Dr. Jocelyn Chase, who was a Geriatric Medicine Fellow at the University of British Columbia at the time (1). The mission statement was created during this year and remains unchanged today (1,2). The goals of the RGIG remain as follows: provide mentorship support to junior trainees from staff and Geriatric Medicine fellows; create networking opportunities for Canadian trainees interested in Geriatrics; and share resources amongst resident physicians (1,2). More recently, the RGIG has expanded its objectives to also include coordination and support of interprofessional and inter-organizational education and collaboration as well as advocacy in the field of Geriatrics (2).

MISSION STATEMENT

"Canada needs more Geriatric friendly clinicians! RGIG connects trainees from across Canada to facilitate networking and mentoring, while supporting Geriatric themed projects at local and national levels."

Key achievements in the RGIG's first year included: obtaining local membership amongst residents at three universities (see Figure 1); gaining 39 resident and faculty members within the RGIG's social media accounts; and approval of official financial funding from the Canadian Geriatrics Society (CGS) available to support local RGIGs in their initiatives (1). The CGS conference in 2012 was also the site of many firsts for the RGIG. It was the first time that the RGIG collaborated with the National Geriatrics Interest Group (NGIG; a medical student-run interest group) to run a recruitment booth, which aimed to raise awareness of the RGIG/NGIG and their initiatives as well as expand membership (1). Secondly, the RGIG held its 1st Annual Business Meeting, a forum for discussion related to achievements and challenges of the year as well as construction of a plan for the next (1). In addition, the RGIG and NGIG - with the support of the CGS - ran a Resident and Student Dinner which included live entertainment, a keynote speaker, and networking amongst trainees and staff (1). Finally, the RGIG planned its first "Fellow's Education Day" with the CGS Education Committee to create a supplemental educational program for Geriatric Medicine fellows (1). The NGIG/RGIG booth, Annual Business Meeting, and Resident/Trainee Dinner remain a staple of the RGIG's presence each year at the CGS conference. Similarly, since 2015, the Education Day has evolved into a "Resident Education Day" - open to all resident physicians in attendance at the CGS conference (3).

Figure 2. Annual Resident/Trainee Dinner at CGS ASM 2013

Looking back to the goals emphasized at the end of the RGIG's pilot year highlights that many of the initial visions have since come to fruition. The first Annual Report to the CGS Executive and Education Committees stated: "Currently all members are from Internal Medicine and we hope to garner interest from Care of the Elderly programs and Psychiatry" - which is indeed a reality today (1). In the 2016-2017 year, the RGIG welcomed resident representation from both Family Medicine and Psychiatry training programs onto its executive team (4).

Continued on the next page

Other goals included maintenance of the Trainee section of the CGS website and social media presence, which have remained ongoing projects of the RGIG since its inception. The RGIG now has executive roles to represent both of these interests - VP Social Media and VP Website/Administration (2) - and its social media presence has also flourished, with currently 1212 Twitter followers and 115 members on its Facebook account.

Additionally, the RGIG envisioned in its first year ongoing expansion of trainee activities at CGS conferences (1). The RGIG has continued to have a strong presence at the CGS conference each year through the above-described events and many trainees feel a strong sense of community amongst their peers through the RGIG. The CGS conference offers an opportunity for its members to meet in person with their colleagues and friends. The RGIG has recently exceeded its expansion within the CGS conference with annual presence at the Canadian Academy of Geriatric Psychiatry (CAGP) conference since 2017. Activities at the CAGP conference include an NGIG/RGIG booth, live tweeting, and resident attendance at the CAGP's Annual Awards Dinner.

It cannot be understated that the RGIG has been incredibly fortunate to have strong mentorship throughout its growth. Dr. Tricia Woo, Associate Professor and Geriatric Medicine Residency Program Director at McMaster University, has acted as the RGIG's staff mentor since its inception. Dr. Woo has not only been a mentor to the executive teams during their terms with the RGIG, but also extends her support to their career and personal development beyond their time with the organization. She has also been known to share her love of photography within the RGIG's events and initiatives (see Figures 2 and 3). The RGIG has also been fortunate to have support from the CGS and the CAGP - both of whom demonstrate a consistent commitment to educating and mentoring trainees in the field of seniors' care. Finally, the RGIG has also been working towards enhanced collaboration with the NGIG on joint initiatives between resident and medical student groups. One of the goals, in fact, is for residents to contribute to this very publication and this article is a tribute to progress within this movement. In particular, this piece was inspired by an article on the history of the NGIG, which was written in 2017 by then-medical student and NGIG co-chair, Selynne Guo (5). Selynne is currently an Internal Medicine resident and a VP Conference of the RGIG.

Amanda Canfield is in her third year of both her psychiatry residency at McMaster University and her role as the VP Geriatric Psychiatry for the RGIG. She has developed a passion for fostering awareness amongst trainees of career options involving the care of seniors. She has interests in social media use for advocacy and education as well as the assessment and management of dementia and other general psychiatric presentations in older adults.

Andrew Perrella is a first year internal medicine resident at McMaster University as well as the current VP Social Media for the RGIG. Equal parts writer and listener, his love of stories has fueled his passion for older adult care.

Figure 3. Trainees at CGS ASM 2019

And now we arrive at the present day. It is well known that Canada is facing a shortage of geriatric specialists and the RGIG remains an avenue for promoting and nurturing a critically needed interest and passion in senior's care. The growth of the RGIG over the past decade is a testament to the passion and motivation of Canadian resident physicians who share a vision of ensuring high quality and compassionate care for all older adults. The RGIG is founded on the belief that all resident physicians, regardless of their training specialty, should receive education on the delivery of elder-friendly care. It fits that the RGIG's membership has expanded to include Internal Medicine, Family Medicine and Psychiatry residents. In the next decade, the RGIG hopes to obtain resident representation from additional medical and surgical specialties. In the coming years, the RGIG envisions many other avenues of growth, including: augmenting advocacy efforts and awareness campaigns; connecting constituents with community-based physicians who work with older adults; and incorporation of bilingual resources and opportunities in order to better reach Québécois trainees and colleagues with interest in geriatrics.

Interested in learning more about the RGIG or considering becoming involved? If so, do not hesitate to get in touch with the executive team!
Email: resgig@gmail.com
Website: https://canadiangeriatrics.ca/residents
Twitter: @GeriInterestGp

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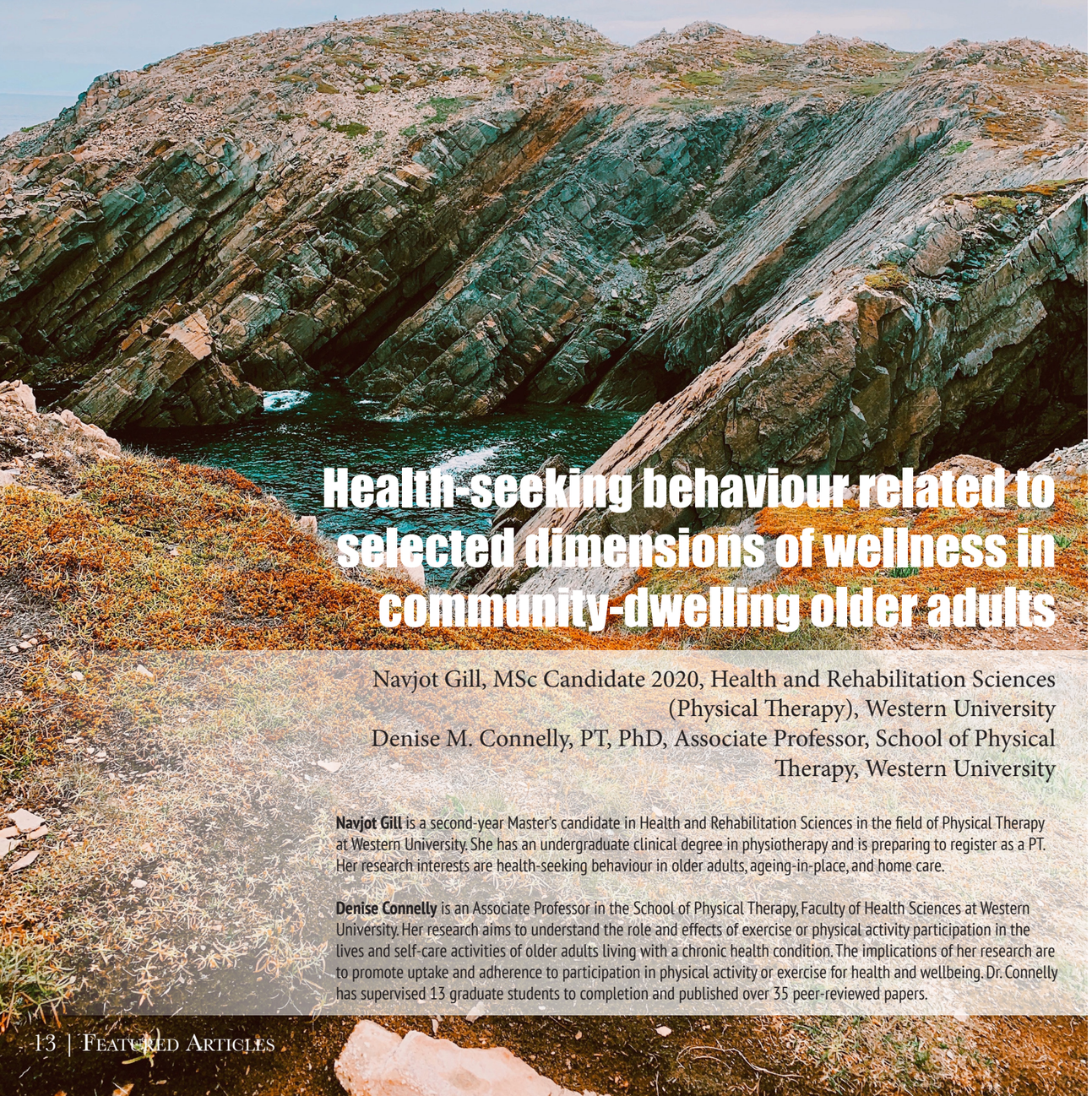
<< Bonavista, Newfoundland >>
Photographer: Haniah Shaikh
McMaster University | MD Class of 2022

Haniah is a first-year medical student at McMaster University. Her passion for geriatric health stemmed from her volunteer work in exercise rehabilitation, where she developed long-lasting friendships with the program's clients. Haniah also has a keen interest in immigrant and women's health. She was born in Saudia Arabia, spent her childhood in Ireland, and is ethnically Pakistani. Hence, she enjoys continuing to travel and exploring various cultures.



Health-seeking behaviour related to selected dimensions of wellness in community-dwelling older adults

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Denise M. Connelly, PT, PhD, Associate Professor, School of Physical Therapy, Western University

Navjot Gill is a second-year Master's candidate in Health and Rehabilitation Sciences in the field of Physical Therapy at Western University. She has an undergraduate clinical degree in physiotherapy and is preparing to register as a PT. Her research interests are health-seeking behaviour in older adults, ageing-in-place, and home care.

Denise Connelly is an Associate Professor in the School of Physical Therapy, Faculty of Health Sciences at Western University. Her research aims to understand the role and effects of exercise or physical activity participation in the lives and self-care activities of older adults living with a chronic health condition. The implications of her research are to promote uptake and adherence to participation in physical activity or exercise for health and wellbeing. Dr. Connelly has supervised 13 graduate students to completion and published over 35 peer-reviewed papers.

Introduction

Older people generally prefer to 'stay-put' in their own homes (1). According to the 2016 Canadian census, 93% of older adults over the age of 65 and 70% of those older than 85 years are living in their own homes (2). This preference for living at home is referred to in the literature as 'ageing-in-place'. Ageing-in-place is defined as "the ability to live in one's own home and community safely, independently and comfortably regardless of age, income, or ability level" (3).

Older people want choices about where and how they will live as they age (4). The home environment plays a significant role in developing and supporting personal strategies for healthy ageing (5). Ageing at home, and in the same community, is considered advantageous to healthy ageing for the sense of attachment or connection, and feelings of security and familiarity concerning both home and community (4). Ageing-in-place has been related to a sense of identity for older adults through both preserved feelings of independence and autonomy as well as sustained caring relationships and roles from having lived at home, usually, for many years (4). Previous studies with older adults in Sweden described that 'home' is a place of meaning(6). and is an important factor in self-perceived health in 'old age' (1). How older adults seek out services and resources to maintain living at home is a topic addressed by few studies to date.

Health or care-seeking behaviour has been defined as "any action undertaken by individuals who perceive themselves to have a health problem, or to be ill, for the purpose of finding an appropriate remedy" (7). The Nursing Outcomes Classification taxonomy defines health-seeking as personal actions to promote optimum wellness, recovery, and rehabilitation (8). According to Cornally and McCarthy, the definition provided by the Nursing Outcomes Classification appears to propose that health-seeking behaviour can occur with or without a health problem and covers the spectrum from a potential to an actual health problem (9). Health-seeking behaviour is the aspect of health promotion that might be aimed at preventing disease (10). Currently in the literature, health-seeking behaviour is 'measured' in terms of 'health service use'; by inference, health-seeking behaviour by older adults takes place as evidenced by the number of health services used and the demand for primary care services by this group (9).

A study conducted by Ihaji et al. stated that health-seeking behaviour was motivated by decision-making processes of elderly individuals (11). This study reported that decision-making processes of older adults were informed by community norms and expectations, that is, social expectations of behaviour appropriate for older persons, differences in rights, power in society, access to resources for older persons, health-related behaviour, education, gender, and church affiliation.

Continued on the next page

Poor health and a lack of adequate support for living at home does not have to be inevitable in old age (12). Primary health care interventions have the potential to considerably reduce consequences of decline in health with ageing and can improve quality of life for older people (13). However, according to a previous study, older adults held little belief in seeking health care for age-associated conditions because they expected that declining physical health and cognitive function comes with ageing (14). Sarkisian et al. highlighted that having lower expectations for health with ageing was independently associated ($p < 0.001$) with the belief that it is "not very important" to seek health care for age-associated conditions (14). In conclusion, these older adults were unaware of the potential benefits of seeking health care to address their age-related health problems (14). Moreover, older adults have a very low rate of use of community-support services in Canada (15). Therefore, the proposed study was designed to investigate selected factors that may influence service use by older adults – that is, to understand why there is a gap between those older adults who have a need for health services and the ample variety and number of available services for older adults to promote ageing-at-home. The gap between need and service use by community-living older adults is hypothesized to be influenced by several factors related to health-seeking behaviour of older individuals. These factors are conceptualized as a 'bridge' between older adults expressing desire for ageing-at-home and seeking the services they need to remain living in the community. The hypothesized factors include physical function, fall risk, psychosocial factors (resilience, social and spiritual well-being), and awareness of community-support services.

Theoretical Model

The proposed research is informed by the Seven Dimensions of Wellness, part of the International Council on Active Ageing (ICAA) Model, and includes physical, social, spiritual, vocational, emotional, environmental and intellectual dimensions (16). The concept of wellness aims to move the definition of health and wellbeing toward a mindset of prevention and proactive strategies as compared to 'reactive' management of illnesses and diseases (16). Active ageing is based on the philosophy that individuals can live as fully as possible within the seven dimensions of wellness (16). The wellness dimensions overlap and intersect to provide a rich framework to contextualize living through later life (16). The selected factors from the seven dimensions of wellness proposed to be related to health-seeking behaviour are physical function (i.e. physical), fall risk (i.e. environmental), and psychosocial factors (i.e. emotional, spiritual, and social). The vocational and intellectual dimensions of the model are not included due to study feasibility and the characteristics of the sample population, i.e. independent, community-dwelling older adults.

Objective

The objective of the study was to investigate the relationship among dimensions of wellbeing, including physical function, fall risk, psychosocial factors, and awareness of community-support services, with health-seeking behaviour in community-dwelling older adults.

Variables

Independent Variables related to selected dimensions of wellbeing	Dependent Variables
• Physical Function • Awareness of fall risk • Resilience • Social wellbeing • Spiritual well being • Awareness of community-support services	• Health-seeking behaviour

Hypotheses

Null Hypothesis: The scores obtained on health dimension outcomes will not predict health-seeking behaviour in community-dwelling older adults.

Alternate Hypothesis: The scores obtained on health dimension outcomes will predict health-seeking behaviour in community-dwelling older adults.

Methodology

This project used correlational study design. The sample size was calculated using the formula for minimum sample size by Green, 50+8*m where 'm' is the number of variables (50+8*6=98) (17). Study participants met the following inclusion criteria: older adults living independently at home in the city of London, ON; aged ≥ 65 years; ambulatory (with/without gait aid); and without executive function impairment. Executive function was measured using the clock drawing test (CDT) and was scored according to the criteria provided by Sunderland et al.; a cut-off score of 5 or less out of 10 indicated an impairment and the participant was not included in the study sample (18). Self-awareness of age-related factors was assessed for individual study participants using a series of self-report measures, including The Late-Life Function Instrument (i.e., physical function); Fall Efficacy Scale-International (i.e., awareness of fall risk); Connor Davidson Resilience Scale (i.e., resilience); The Duke Social Support Index (i.e.. social well-being), Spiritual Well-being Scale (i.e., spiritual well-being), Health-Seeking Behaviour Questionnaire (i.e., health-seeking behavior), and a self-generated list naming local community-support services for older adults (i.e., awareness of community-support services). Scores from the outcome measures will be analyzed using multiple linear regression analysis to determine any relationship(s).

Significance of the Study

Older adults have a very low rate of utilization of community-support services in Canada (15). A reported lack of awareness of available community support services by older adults is highlighted in the literature, and reveals a challenge to them when they are trying to determine what community-support services are available to help them (19). This study explored five health dimension variables hypothesized to be associated with a lack of service use, as measured by health-seeking behaviour. Further, awareness of available community-based services was assessed to determine any relationship between health-seeking behaviour. Findings from this study are expected to assist and/or guide the efforts of health care providers to better help older adults wishing to age-in-place at home. The present study aims to explore if self-awareness of selected age-related factors may predict health-seeking behaviour of older individuals, thereby contributing to our understanding about health-seeking behaviour of community-living older people to access community-support services to promote ageing at home.

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<< Winter Palisade | Lake Louise >>
Photographer: Shannon Gui

Letting the Laughter In: Promoting Communication and Trust in the Geriatric Consultation

Michelle Gyenes, MSc, MD Candidate 2022, Royal College of Surgeons in Ireland

Michelle Gyenes is a medical student at the Royal College of Surgeons in Ireland, originally from Toronto, Canada. Prior to starting medical school, Michelle earned her Master's degree in Sociomedical Sciences from the Mailman School of Public Health at Columbia University. There, she studied the effects of social programs on health outcomes for older adults. Also a regular contributor to the Johns Hopkins medical humanities blog, "CLOSLER," Michelle is especially interested in creative approaches to clinical problem-solving.

The resident and I walked into the examination room, where a patient sat waiting. We introduced ourselves, each shaking the man's hand in turn. He began, "You both look so young. I'm surprised you're not scared of me", clearly referring to his skin, covered in visible growths as a result of a genetic condition called neurofibromatosis. The resident without skipping a beat, replied, "I'm a doctor – people are usually scared of me!"

The patient responded with a good laugh. Immediately put at ease, the visit began.

After completing my first year of medical school, I participated in a summer scholarship program for students interested in geriatrics at Sinai Health System in Toronto. This program provided me the opportunity to observe geriatricians and residents in a variety of care settings. One constant through almost all of my experiences in this program has been the presence of laughter.

One afternoon, during a home visit with my summer mentor and supervisor, Dr. Samir Sinha, the patient and his wife we came to see were joined by all of their children from across the region. Together, they joked about this encounter being more of a family reunion than a doctor's appointment. When shadowing another geriatrician, Dr. Barry Goldlist at the Memory Clinic, I observed him preface his cognitive testing with an anecdote about a special pen that a friend had made for him. He gave the patient the pen to use during the cognitive testing, and at the end joked amicably about needing the pen back. This natural ease turned an otherwise often stressful part of the visit into a more positive experience.

Research has demonstrated that laughter can be a powerful tool in promoting communication and trust, particularly when working with older patients. Older adults can experience ageism in a variety of contexts in their day-to-day lives, both overtly and covertly. Over time, negative age-related stereotypes can become ingrained in an individual's self-concept. Medical appointments in particular can be accompanied by a unique degree of apprehension, with concerns about one's memory, thoughts about the future, and decades of both medical history and life experience influencing the visit. Though I am early in my training, it is clear to me that using humour appropriately can help to ease the tensions often associated with a medical visit. Humour can promote effective communication and trust, ultimately benefiting both the patient and the practitioner.

Unsurprisingly, I'm not the first to come to this conclusion. The well-known adage, "Laughter is the best medicine", is thought by some to date back thousands of years. A quick literature search on Medline generated thousands of peer-reviewed articles outlining research that explores the effects of laughter on the beneficial health outcomes for older adults from laughter therapies including laughter yoga, to the introduction of clowns in nursing homes.

While the efficacy of laughter as an intervention raises interesting empirical questions, research has shown that it can be difficult to ascertain robust results. However, across all of these studies, it was also clear that laughter, when used appropriately, is not associated with risks or harms. Indeed, it can promote both psychological and physiological well-being. In applying these concepts to clinical practice, laughter can strengthen existing relationships and assist in the formation of new relationships.

I have learned so much from my experiences observing the work of geriatricians this past summer, who all have expertise in understanding the complex conditions and comorbidities often associated with older age. Each of them seems to follow the unwritten rule of incorporating the routine use of laughter in their clinical practices. While it is important to prioritize communicating empathy towards a patient's life stressors and experiences, there is room for humour in the geriatric consultation. Furthermore, what has become clear to me is that patients and providers of any age can benefit from the extra bit of human connection found in sharing a laugh.

Exercise As A Multidimensional Intervention IN FRAILTY

Scott MacKay, MD Candidate 2022, University of Calgary

Frailty is a clinical condition brought upon by age-related decline in the functioning of multiple, interrelated physiological systems (1). This condition is multifactorial, as evidenced by various measures constructed to quantify frailty (2, 3), and impacts the physical, mental, and social wellbeing of older adults who experience it. As the global prevalence of frailty continues to rise (1), finding interventions to help prevent frailty and benefit those who are considered frail is increasingly important. Exercise has been proposed as one such intervention (4), largely due to the diverse positive effects exercise can have on human physiology.

The physical consequences of frailty include decreased muscular strength, coordination, endurance, and mobility (2, 4). Conversely, exercise has been shown to aid in balance, mobility, strength, and functional ability, which reduces falls and promotes functional independence (4). The physiological basis for these benefits comes from the ability for exercise interventions to alter the development of sarcopenia, improve body composition, and down-regulate chronic inflammation in older adults (5). Exercise can also serve as an adjunct treatment for many of the chronic diseases frequently observed in this population, such as osteoarthritis, diabetes, and hypertension (5). While the relationship between exercise and physical and functional benefit has been well-established, frailty is not solely a physical condition.

Frailty has been associated with negative changes in both cognition and mood (1). The connection to cognition is related to changes in the structure and function of both neurons with high metabolic demand (e.g., hippocampal pyramidal neurons) and microglial cells, which are implicated in Alzheimer's dementia and delirium, respectively (1). A higher level of physical frailty has also been found to be associated with accelerated decline in cognition (6). Exercise programs involving aerobic and strength training have found improvements in cognition in frail older adults, including executive function, working memory, and processing speed (7). Frail individuals have also been found to report higher depression and anxiety scores than non-frail older adults (8). These mood disorders are thought to be closely related to the functional impairment, social withdrawal, and disengagement from daily activities often seen in frail individuals (8, 9). Exercise has been found to consistently enhance mood in older adults (10), though only select studies have shown exercise interventions to lead to improvements in depression, mood, overall quality of life scales in frail individuals specifically (11, 12). Research also supports the idea of group exercise programs as a mechanism of enhancing mood through providing social support for frail older adults (12).

Frailty has a social component in that these individuals are often rendered socially vulnerable through losses to social support networks, as well as the experience of loneliness (13). There is a relative paucity of literature on social frailty, however, compared to research regarding physical and mental functioning (13). The consequences of social frailty for older adults, including the deterioration of self-efficacy for social behaviors and decision-making capacity, cannot go ignored in attempts to target frailty as a whole (13). Exercise often occurs in a social context, and can provide opportunity for meaningful social interaction that facilitates improvements in cognition and mood in older adults (14, 15). These findings have not been replicated in populations of frail older adults specifically but select findings, such as exercise interventions being more effective in reducing frailty if conducted in groups (16) and providing meaningful social support for frail individuals (12), suggest a similar process may be occurring. Exercise interventions also improve both self-confidence and self-efficacy for exercise and physical activity in frail individuals (17).

The positive impact exercise can have on the physical, mental, and social functioning of frail individuals has been well-documented but the ideal format of an exercise intervention for achieving these outcomes is an ongoing debate. A systematic review from Theou et al. (17) looking at exercise in frail populations helped provide input regarding what types of interventions have been most effective in recent times. For example, longer interventions (i.e., greater than 5 months in duration) that took place three times a week were associated with greater improvements in determinants of frailty. They also found that multicomponent training (i.e., programs involving multiple types of exercise) appeared to improve functional ability to a greater degree whereas programs with solely resistance training improved physical and psychosocial determinants of frailty to a greater degree. Safety in exercise interventions for frail individuals is also an important consideration, though the Theou et al. (17) review also stated that adverse events were exceedingly rare in the literature they reviewed. Similarly, even safer low intensity exercise was found to have beneficial impacts on health outcomes for frail individuals (17). Recommendations for exercise programs specific to the needs of a frail population also include group formats to provide a social component (12, 14) and including a significant balance training component to help prevent falls (17).

Exercise programs have also been compared to other types of interventions designed for frail individuals, both in the sense of economics and effectiveness (16). Evidence surrounding the economics of exercise programs for frail adults is sparse, though a multicomponent intervention that included substantial exercise demonstrated better value than usual care (18). The effectiveness of exercise programs has been covered above, but it is important to note that a significant challenge is maintaining these effects once an intervention has ended (17). While adherence in most exercise studies for frail individuals has been adequate (17), developing strategies to help them maintain activity (e.g., motivational interviewing, building self-efficacy, reducing barriers) is important moving forward.

Continued on the next page

With aging populations worldwide, frailty is becoming more prevalent and with this rise comes a growing need to find effective interventions. Exercise programs, both aerobic and resistance-based, have been proposed as interventions to fight frailty since the clinical syndrome was originally being defined. The majority of research surrounding frailty and exercise has looked into physical and/or functional benefits, which are highly important for this population, but the potential for exercise to improve cognition, mood, and social wellbeing are less well known in comparison. The positive findings that do exist in all of these domains are encouraging as they demonstrate the potential for properly designed exercise programs to benefit frail and pre-frail individuals to a greater degree than previously thought. Frailty is by definition a syndrome of deficits in multiple domains but exercise programs are an effective, cost-saving intervention with the potential to build resilience in all of these domains simultaneously.

Scott MacKay is a first year medical student at the University of Calgary, where he is an executive for the Geriatrics Interest Group. His interest in geriatrics comes from both the complexity of patients and the emphasis given to patient preference and reflection in Geriatric Medicine. With a background in Kinesiology, he is especially passionate about promoting and facilitating healthy lifestyle interventions for older adults.

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<< Watercolour | Thesen Islands, Knysna, South Africa >>
Photographer: Steven Chen
McMaster University | MD Class of 2021

Steven Chen is a second year medical student at McMaster University. His camera of choice is his iPhone XR, and he hopes to show that big moments may be captured through small lenses.

Nadine Abu-Ghazaleh, MD Candidate 2020, University of Saskatchewan
Adrian Chan, MD Candidate 2020, University of Toronto

The Future of Canadian Geriatrics

The National Geriatrics Interest Group wishes to recognize the exceptional work that medical students and communities across Canada are doing to support our seniors and healthcare providers. There is no better time than now to remember that the true measure of a society is found in how it treats its most vulnerable members.

UBC Department of Medicine Retweeted

UBC Media Relations ✓
@ubcnews

'We wanted to do something': UBC students volunteer their time to fight against COVID-19. via @Ubyssey

'We wanted to do something': UBC students volunteer their time to fight ...
The initiative began with a small group of six medical students who were told that they could no longer practice in hospitals and clinics.
ubyssey.ca

SMSS
@SMSS_SK

Our community care initiatives during #COVID19 #SupportingEachother

forms.gle/aHo81ygMJQK7DZ...

Shannon Gui
@ShannonYGui

👉 bit.ly/33ABaxc
Local GIGs need your help to compile resources for seniors & caregivers!

#COVID—19 particularly impacts older adults. They're at higher risk of infection, and many live in isolation / aren't connected online while we are all #SocialDistancing.

> **NGIG** @NGIG1415 · Mar 22
> We are working with local GIGs to create a national database of community resources and opportunities to support vulnerable elders/caregivers during #COVID19, please share! @CanGeriSoc @GeriInterestGp #MedStudentTwitter
>
> bit.ly/3bfgKwf twitter.com/JennyBasran/st...

Monisha Persaud
@MonishaPersaud

CALLING ALL CANADIAN MED STUDENTS: The Student-Senior Isolation Prevention Partnership COVID Response Team is now expanding to 7 different Canadian universities. Don't see your school on this list? Dm myself, @DanielDJLee or @GeoffSem if you'd like to start a local SSIPP chapter!

Are you a health professional student looking to get involved?
Contact your local chapter.

- University of Toronto - St. George: ssippvolunteer@gmail.com
- University of Toronto - Mississauga/MAM: ssipp.mississauga@gmail.com
- Western University: ssipp.uwo@gmail.com
- University of Ottawa: ssipp.ottawa@gmail.com
- University of Manitoba: ssipp.manitoba@gmail.com
- University of Calgary: ssippcalgary@gmail.com
- McMaster University - Hamilton: MacSeniorIsolationPrevention@gmail.com
- McMaster University - Waterloo: watseniors@gmail.com
- McMaster University - Niagara: ssipp.niagara@gmail.com
- University of Saskatchewan: ssipp.usask@gmail.com
- University of Alberta: TBA
- Northern Ontario School of Medicine: ssipp.nosm@gmail.com
- University of British Columbia: TBA
- Queen's University - *Student-Run Community Support Program (SRCP): khealth.community@gmail.com

Don't have one? Reach out to us for guidance on initiating a local SSIPP chapter at your university.

RGIG
@GeriInterestGp

The elderly, currently alone in their homes, are vulnerable to loneliness and the risks of social isolation. An article written by a geriatrician gives 4 tips on how to avoid social isolation #whygeriatricswednesday

tinyurl.com/wxcrkq9

Submitted by: University of Ottawa GIG

COVID-19: 4 tips to help the elderly stay connected
The advice for the elderly, who are most at risk from coronavirus, has switched from social engagement to social...
weforum.org

Yipeng Ge 葛义朋
@yipengGe

During my cleaning frenzy over the weekend, I came across reflections that @CFMSFEMC medical students wrote up on why seniors care matters to them. These are incredibly difficult times (outbreaks of #COVID19 in nursing and retirement homes). Wanted to put these out there for you.

UAlberta Med & Dent
@UAlberta_FoMD

A group of selfless #UAlberta med students have launched Bag Half Full, an effort to help #YEG elderly and immunocompromised by delivering groceries and household items during #covid19. Two of the organizers will be on @CityNewsYEG at 6pm tonight!
Sign up: bit.ly/2vWLfbq

UM Centre on Aging
@UM_coaging

If you're in the Winnipeg area and at higher risk for the COVID-19 panademic, the Winnipeg One Neighbourhood Initiative is a new initiative to connect community members with volunteers.
Sign up online, if you're able to volunteer.
Web site: oneneighbourhood.ca

TheWrinkle
@TheWrinkle2

What happens when medical students and isolated elders connect? We're about to find out! @NGIG1415 @CanGeriSoc @CMHAWW @MacMedWRC @SchlegelVillage @WW_LHIN

Medical Students and Older Adults Connecting during COVI...
During the COVID-19 outbreak, medical students have been sent home and older adults, like all of us, are isolated. We ta...
youtube.com

Canada map by Randomhero from the Noun Project

Time Marches On

<< Forget-me-not 2 >>
Photographer: Qamar Halat

Time marches on.

The late afternoon sun streamed through the vinyl blinds,
Untouched dinner on a sectioned plate.
She sat in her favourite armchair,
Hospital green.

"You're wearing your dancing skirt again!"
She exclaimed to me, a glimmer of joy in her eyes.
I look down at my school uniform,
Should I tell her again?

"Time marches on."
She'd tell me this every time I saw her,
The joy in her eyes becomes glazed over by a lifetime of worry,
Asking me when her father would come home.

"It's been a long war."
She has been busy in the kitchen.
There wasn't always enough food to go around,
Her father would be home soon, she'd assure me.

"Who are they?"
Images of a child's birthday party on a screen.
A man is here to visit, face lined with sadness.
"Remember mom, that's Ryan and Hannah, your grandchildren."

Time marches on.

- Jennifer Payandeh
Queen's University | MD Class of 2022
Jennifer Payandeh is a second-year medical student at Queen's University, with roots in Vancouver, BC. She has volunteered extensively with geriatric patients throughout her high school and undergraduate years, which guided her career path and taught her invaluable lessons. She is interested in providing care to patients of all ages through a surgical specialty.

———

This poem was written from my experience volunteering in a long-term care home during my high school years. This was my first experience directly seeing the immense cognitive and behavioural impact dementia can have on a patient, as well as on the family members who love them. I am grateful to have been able to spend time with her and her family, and for the lessons that have stayed with me.

<< Succour >>
Photographer: Alexandra Sylvester
Western University | MD Class of 2022
Since her grandmother's passing in 2016, Alexandra has followed her passion for geriatrics through her undergraduate degree and into medical school. She has been an executive member of Schulich Medicine's Geriatrics Interest Group at Western University for two years, with plans to remain involved in clerkship and beyond. Her grandmother is with her every step of the way; Alexandra carries her in her middle name and in her heart.

<< ad perpetuam memoriam >>
Photographer: June Yue Dong
McMaster University, Niagara Regional Campus | MD Class of 2022

severe osteoporosis.
their reason for hospitalization
this time.
And as we go through the history,
I hear
fractured tales, only
pieces
of the past, of the present reality.
Born across the ocean,
kids, grandchildren,
heart meds, surgery,
job, now extinct,
pain, constant.
Mind, sharp as a scalpel,
cutting millions and millions and millions of
past decisions,
past encounters,
past joys,
out to answer my probing.
Can we find the core?
It is so difficult to rebuild
bone that is lost.

- Imelda Suen
University of British Columbia | MD Class of 2022
Imelda Suen is interested in providing longitudinal care and understanding the power of patient's stories. She is looking forward to more opportunities to learn from older adults in clerkship and beyond.

<< Gun Hill, Trinity, Newfoundland >>
Photographer: Haniah Shaikh

Home

Skin like porcelain,
fragile, yet strong all at once.
Arms lined with a labyrinth of blues and greens
like the grass in her yard.

In her veins, I see the rivers and streams –
that run through our land –
that fuel our roots.
In her veins, I see branches,
scattered and intertwined;
they bear our fruit
and hold me up while I play amongst the leaves.
In her veins, I see myself:
my lies and my truths –
the things I've tried restlessly to hide.

Yet as days go by she fades.
Laughter that was once a euphony,
clear as a bell,
is now laced with a cacophony of wheezes and coughs.
With each of her instrumental breaths
my heart waves goodbye as her tides die away.

Now, her skin rises and falls with its hills and valleys
lined with scars – dashes and dots.
I trace the surface of her embossed hands
and close my eyes as her story unfolds under my fingertips.

- Qamar Halat

<< Steel City >>
Photographer: Steven Chen

Cancer NYD

Rana Kamhawy, MD Candidate 2021, McMaster University

"Leave this one until the end. He's a bit complicated; we can see him together," the attending warned me while going through the patient list. I nodded enthusiastically, ready to do my due diligence with the chart review. As I walked down to the unit later that day, the distinct sound of the inpatient ward rushed over me; the beeping of machines and solemn hurry in the workstation.

I sat down and digested the story – metastatic cancer not yet diagnosed. He had been admitted for the past two months. Strange.

It was my first week of clerkship. My heart was racing as I knocked on the door. The patient to the left rattled from her sleep and shouted, "who's there?"

I smiled, turning to the patient to the right. "Harry?"

My eyes were met with a slight, old man as I pulled back the curtain. His hands were behind his head, his eyes shut. He frowned slightly as he opened his eyes.

"Good morning."

"Good morning, afternoon, whatever," he grumbled.

I kept my composure. "Hi, Harry. My name is Rana – I'm a medical student. How are you feeling today?"

He sighed. "How do you think? I've been lying in bed all day."

"I understand-"

"And the doctors are just watching me wither away."

At that moment, my attending came in, her eyes apologetic. She nodded towards me before introducing herself to Harry.

"My job is to make you feel more comfortable," she explained. She had mentioned earlier that week that the words "palliative care doctor" tend to scare people. At the end of the day, her job was to relieve their symptoms.

Continued on the next page

He watched her with distrusting eyes. “And what does that mean exactly?”

She smiled. “Well, what does that mean to you?”

He sighed. “I can’t move without feeling pain. I can’t walk to one end of the room and back without the shooting pain.” He gestured towards his legs. I nodded, already knowing he had spinal metastases. “And I’ve been really trying to keep up my activity. I know if I don’t use my body it’ll leave me faster.” He rolled up his pajama pants. I had to stop myself from visibly gasping. His thigh was just skin and bones. The diameter of his thigh was not much different from his calf. It was at that moment that I realized the extent of his disease. This was a dying man.

“Honestly, if I can get to the bathroom without feeling pain that would be half of it.”

My attending nodded. “And what would be the other half?”

His eyes welled up with tears. “Seeing my granddaughter graduate.”

“And when is that?”

“In five years.”

Silence. We both knew that he would not live past this year.

“The doctors don’t know what it is. Not yet. But when they do, I’ll be out of here. I can go home. I can go back to work.”

We listened.

“And I can get my life back.”

“I’ll be right back,” the doctor murmured as her pager sounded. “But don’t worry Harry, we’ll start you on something for the pain. I hope we can make you feel better. And we’ll check in when we can – every day while you’re here.”

“It was nice meeting you.” And she was gone.

Continued on the next page

<< On these shoulders we climb >>
Photograph of *Karma* by Do-ho Suh
Photographer: Steven Chen

It took me a moment before I followed her out of the room. Here was a man who, we knew from the charts, had been healthy his whole life. He competed in 50km bike races. He had a thriving business in a small town where his customers were his friends. He had a loving wife and childhood friends who visited him every day. And yet, there he was, dwindling.

Over the following week, I saw him every day. I saw him on his bad days, exhausted from undergoing countless tests and having numerous new physicians come by his room. I saw him with his family, laughing at the times when they were young without a care in the world. Most of all, I saw the change in his attitude. I saw him coming to terms with his health.

Improving quality of life in the face of terminal illness – this is the focus of palliative care. I knew this but struggled to come to terms with it when I saw patients like Harry. How can one's life change so drastically? How can one maintain their quality of life when their day is scheduled around imaging and tests rather than work and hobbies?

His trajectory was a sudden one, taking a turn for the worse over a short span of time. He had morphed from being physically healthy to being frail. In his words, he was "withering away." While his cancer was far past the realms of what medicine can cure, he explained to me that his connections with others and the progress that was made with his symptoms kept him feeling alive. It was a pleasure to see him light up talking to his loved ones and to be part of the small successes throughout his journey. Less pain, more mobility, more life in his eyes. He was a dying man, but his spirit was not lost.

Rana Kamhawy is a second-year medical student at McMaster University. She is passionate about working with the elderly population and empowering vulnerable populations to have a voice in healthcare. Her interests include innovation in medicine, quality improvement, and global health. In her free time Rana enjoys hiking, traveling, and journaling about her experiences.

<< Limitless | Johnston Canyon, Banff >>
Photographer: Shannon Gui

- Nails and Makeup for Equity -

Leah Rusnell, MD Candidate 2021, University of Saskatchewan

In 2016 Hilary Aadland and Mandeep Kaler, medical students at the University of Saskatchewan, developed 'Nails and Makeup for Equity'; a volunteer program in which students in the College of Medicine visit long term care homes to paint nails and apply makeup for the residents. Both students had a longstanding passion for geriatrics. Their mutual interest combined with Mandeep's personal experience with makeup and connections in the makeup industry provided the initial inspiration for the program. Furthermore, Hilary had noticed through her abundant volunteer experience with the elderly that senior loneliness was an issue requiring more attention. Nurses, recreational therapists, and other staff at these often-understaffed care homes do not always have time to provide a service like this so were delighted when Hilary and Mandeep reached out with their idea.

The residents are overjoyed with the pampering but even more so, with the conversation and connection with the student volunteers. Even male residents enjoy our nail filing services plus or minus a clear coat! Meanwhile, the students benefit from the genuine relationships built with residents, develop an understanding of the long-term care context, and gain the ability to converse effectively with an elderly population. These skills are invaluable to several potential career paths in medicine especially given the landscape of our aging Canadian demographic.

I am thrilled to have had the privilege of participating in and taking over this wonderful initiative after Mandeep and Hilary entered residency. I believe it is one that could be expanded to other medical schools in the country. The time commitment is reasonable for a busy student schedule and the experience is priceless. I encourage anyone who is interested to reach out to me about the logistics of funding, organizing, and executing a similar program at their own medical school.

Leah Rusnell is a third year medical student at the University of Saskatchewan who is the current president of Nails and Makeup for Equity and NGIG VP Care of the Elderly. She has a longstanding passion for geriatric health care stemming from a lifelong relationship with her beloved grandmother and extensive volunteer experience in long term care. She plans to integrate care for the elderly into any specialty she eventually pursues.

Special Mentions:
Dr. Hilary Aadland – PGY1 Psychiatry University of Calgary
Dr. Mandeep Kaler – PGY1 Family Medicine University of Saskatchewan

NGIG

NATIONAL GERIATRICS INTEREST GROUP EXECUTIVE TEAM

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