

Creativity In Geriatric Care

**The National Geriatric
Interest Group**
Publication
Volume 10 | April 2023





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

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**National Geriatrics
Interest Group**



@NGIG1415

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Editors-in-chief



Mary Wood
MD Candidate 2024
University of British Columbia

Mary is a third year medical student at UBC. She began volunteering with Dementia and Alzheimer's patients back in highschool and has had a long standing interest in Geriatric Medicine. She has been involved in the UBC Geriatric Interest Group since her first year of medical school and has been the Co-Chair for the past 2 years. Through this role she hopes to increase medical student exposure to the field of Geriatric Medicine. She is hoping to complete a residency in Internal Medicine and ultimately work in Geriatric Care.



Shailee Siddhpuria
MD Candidate 2023
University of British Columbia

Shailee is a fourth year medical student at UBC. Her interest in Geriatrics began with volunteering for the Hospital Elder Life Program - working to prevent Delirium in hospital. She has been an active member of GERAS' Delirium Research Group in Hamilton, ON, completing various research projects within the field. She will be starting residency in Family Medicine at the University of Toronto, where she hopes to continue providing care to older adults.



Hayden Nix
MD Candidate 2023
Western University

Hayden is a fourth-year medical student at Western University. His experiences volunteering in long-term care homes prior to and during medical school make him passionate about caring for older adults. Throughout medical school, he has been involved in a variety of projects exploring ethical issues in clinical trials involving people living with dementia and hopes to pursue a career as a geriatrician-researcher.



Letter from the NGIG Co-chairs



Bernice is a fourth-year medical student at the University of Toronto. Her enthusiasm towards Geriatric Medicine stems from her fond memories of volunteering at a senior home, working as a Cantonese medical translator for older adults, and through taking care of her own grandma. This passion was further strengthened during COVID-19. In her second year of acting as Co-Chair, she is excited to continue to trailblaze opportunities focused on increasing medical education in Geriatric Medicine, mitigating senior social isolation, and leveraging allied health professionals to provide holistic care to older adults.



Trina Gartke is a third-year medical student at the University of Alberta, and this is her third year involved with the National Geriatrics Interest Group. Volunteering with seniors for over 9 years, she has developed a passion for caring for the elderly population. She hopes to be involved in positive transformative change in seniors' preventative healthcare during her career to help better meet the needs of Canada's aging population.

Dear Readers,

It is with great pleasure that we share with you the 10th Edition of the National Geriatrics Interest Group's (NGIG) Annual Publication! Our publication is a celebration of the beautiful articles, artwork, and photographs of medical and allied health professional students as well as residents across Canada that align with this year's theme: Creativity in Care.

As we emerge from a COVID-19-ridden society, we are faced with ongoing concerns of how to provide optimal care to older adults with comorbid medical, psychiatric, and social needs that were exacerbated by the pandemic. Nevertheless, the Geriatrics community has stepped up to this challenge, and we are continually amazed by their response to the needs of older adults by offering both traditional and non-traditional approaches to holistic geriatric care. Thus, this issue hopes to showcase the ways in which students and the larger Geriatrics community have "creatively" provided care to older adults in recent years to improve their wellbeing and health outcomes.

The NGIG is a national student-run organization that is supported by the Canadian Geriatric Society (CGS). Our organization's main goal is to promote educational, advocacy, research, and mentorship opportunities in geriatric care amongst all medical schools across Canada. This year, our NGIG executives as well as local Geriatric Interest Groups' (GIG) leads went above and beyond to expand our organization's vision. We successfully organized, executed, and transitioned our annual NGIG Student Day to an in-person event after two years of being virtual due to COVID-19 restrictions. We shared the work of two student researchers across all our social media platforms to highlight their wonderful research in the field of Geriatric Medicine. We were able to expand the resources and educational opportunities available for students interested in the subspecialties of Geriatric Psychiatry and Care of the Elderly. We continue to have ongoing success awarding our annual J.L. Student Leadership and Research Awards to medical students that demonstrate exceptional leadership and merit towards caring for older adults. Finally, we were able to expand the reach of NGIG's support to all Quebec medical schools, as well as Memorial University.

This publication, along with the wonderful work done by NGIG, would not be possible without the backings of many individuals and organizations. For starters, we would like to thank CGS for their ongoing support throughout these years, Dr. Tricia Woo for her valued guidance to our NGIG team, and RGIG for the numerous collaborations. Finally, we would like to say an enormous thank you to our NGIG co-Editors in Chief: Shailee Siddhpuria, Mary Wood, and Hayden Nix. This publication was created through their tireless efforts this past year!

We are honoured to present Creativity in Care. We hope you enjoy the read!

Sincerely,

Bernice Ho and Trina Gartke
NGIG Co-Chairs 2022-2023

"I am old, not crazy, don't worry": a South Asian family's journey with Alzheimer's disease.

Navjot Gill, Ph.D. Student, Public Health (Aging, Health and Wellbeing)
University of Waterloo, Waterloo, ON

Amrit held his grandfather's hand as the doctor delivered a diagnosis of Alzheimer's disease. The doctor handed him a folder containing information about the diagnosis and next steps. Tej, Amrit's grandfather and the family patriarch, laughed when Amrit translated that he had Alzheimer's disease. Tej said that he was getting old, not crazy, and that forgetting things is a normal part of aging. He walked out of the office, with Amrit in tow, muttering about how doctors tend to exaggerate things. Amrit was worried. He had heard about Alzheimer's disease and its impact on families. He decided to discuss it with his parents, maybe they could better explain it to Tej. He kept the folder to himself as Tej could not read, write, or speak English.

That night, as his dad got ready to leave for work and his mother returned from her shift, Amrit told them about what the doctor said and handed them the folder. His parents barely glanced at the folder and told him not to worry; people forget things as they age. It is just "a memory thing," they said.

However, as time passed, the disease took its toll. One day, while eating dinner, Tej told Amrit that he wanted to 'go home.' Amrit tried to explain that they were home, but Tej did not understand. He begged Amrit to take him home until they were both brought to tears. Another day, Tej asked for breakfast for the third time, yelling that no one cared for him. Another day, Tej walked out the front door. Thankfully, the lady a few houses down could speak Tej's language and brought him home. Amrit and his parents wondered what would have happened if the lady had not been outside. Tej could not read, write or speak English.

The family wondered if this was more than "a memory thing," but Tej was their father, and they would take care of him. Amrit looked up recreation programs to keep Tej engaged, but programs included Bingo or reminiscing about the rock and roll era. Tej was an immigrant from India. Tej could not read, write or speak English.

When relatives asked about Tej, Amrit's parents would lie and say it was old age. They told Amrit not to talk about family matters to relatives, keeping Tej's diagnosis a secret. They did not want people to call Tej crazy or mad. As the disease progressed, Amrit and his family struggled to provide Tej with the care he needed. They did not know about care partner burnout, wandering, 'sundowning' or personal expressions. What about nursing homes they wondered, but what would the society say? Amrit's parents said we don't leave our elders in nursing homes. The thought did cross their minds when Tej tried to leave or hurt one of them, but how would he survive there. No one spoke his language, provided his food, or understood his culture. Whom would Tej talk to? Tej could not read, write or speak English.

What if Tej and his family had access to resources in their language, awareness and access to culturally appropriate services and ethnically inclusive nursing homes? Maybe their journey wouldn't be shadowed by stigma and obstacles.

About the Author ~

Navjot Gill (she/her) is a Ph.D. student in the Public Health program specializing in Aging, Health and Wellbeing at the University of Waterloo. Her research focus is the experience of individuals living with dementia, awareness of community support services and ageing-in-place. She completed a Master of Science degree from Western University in the Health and Rehabilitation Sciences program in Physical Therapy. Her thesis explored the health-seeking behaviour of community-dwelling older adults related to dimensions of wellness and the implications of health-seeking behaviour for ageing-in-place. Navjot is a physiotherapist by training.



"Why Geriatrics" A Quatrain Poem

Why geriatrics? A field of care,
Where helping older adults is what we share.
It's more than medicine, it's dignity and grace,
And a daily commitment to a smiling face.

It's understanding what matters most in life,
Comfort, purpose, and a little less strife.
Understanding each step of the way,
Learning and sharing, every single day.

It's a calling, a passion, and so much more,
To make their world a brighter place to explore.
Researching solutions, finding new paths to tread,
To enhance the lives of older adults, now and ahead.

For in helping others, we're truly blessed,
With a life of purpose, love, and success.
So why geriatrics? Because it's where we thrive,
Bringing hope and happiness to older adults' lives.

About the Authors:

Momina Abbas is a masters student in the Health Research Methodology (HRM) program at McMaster University. She will completing a thesis project under the supervision of Dr. Alexandra Papaioannou, a geriatrician and Executive Director of the Geras Centre for Aging Research. Momina is passionate about spreading knowledge and identifying successful methods to decrease falls and fractures among older adults in long term care.

Dr. Patricia Hewston is an occupational therapist with a PhD in Rehabilitation Science. She is a research associate in the Department of Medicine and an assistant clinical professor (adjunct) in School of Rehabilitation Science at McMaster University. Her clinical research area of focus at the Geras Centre for Aging Research is to design and evaluate new models of care to keep older adults healthy and active.





'Milan, Italy'

Mary Wood MD Candidate 2024

“Is it safe to take the bus?”

How the COVID-19 pandemic impacts immigrant older adults

“

“Is the ‘society’ open,” he asked, referring to the local community centre for immigrant Punjabi seniors.

“It’s closed,” we replied.

“How about the Gurdwara?”

“No, it’s closed too.”

“Achaa”

“Is it safe to take the bus?”

”

My grandfather sat at the kitchen table with a cup of cha in his hand, his face still weary from the Indian summer. He had returned home following a trip to India, extended unexpectedly by cancelled flights and grounded planes. My parents sat across from him, explaining why it was not safe for him to take the bus.

In 1998, shortly after retiring from military service, my grandfather emigrated from Punjab, India to join my parents and me in Canada. Despite the challenges that came with immigrating as an older adult, he quickly became a part of his new community, calling it home.

The COVID-19 pandemic, however, brought new challenges to overcome. With pandemic restrictions and precautions, my grandfather found himself unable to participate in the activities and communities that nourished him. He could no longer take the bus to the public library, meet with friends at the recreation center, or attend prayers at the gurdwara. There were no events at the local seniors’ centre to look forward to and no summer festivals to experience. Public transit became unsafe, and family gatherings and celebrations ceased to exist. With winter, cold weather and icy sidewalks made it difficult to go on his daily walk around the neighbourhood and to meet with friends.

My grandfather is not alone in his experience; one third of older Canadians are immigrants. [1] They face unique barriers to health and wellbeing, particularly during the COVID-19 pandemic where pandemic restrictions have weakened the connections they once had with each other in the larger community and the activities, interests, and routines that supported their physical and mental wellbeing. [2] While all older adults are more likely to face social isolation, immigrants are particularly at risk. [2, 4-5]

Older immigrants often face significant language barriers in their new communities that not only worsen isolation, but can lead to decreased access to timely and accurate information about the pandemic. [3, 6, 7] While others have begun to rely more upon technology like video-calling and Zoom hangouts to maintain connection with others, immigrant seniors are more likely to have limited digital literacy that makes it difficult for them to do the same. [8, 9] In the winter months colder temperatures and icy, snow-covered walkways present an additional barrier. Many, like my grandfather, found themselves unable to safely go outdoors. [2, 10] Many older immigrants rely on others, including public transportation, to be mobile within their communities. [2] With the pandemic, these become an additional potential exposure to the virus.

Older immigrants are more likely than the general population to live in intergenerational households. [3, 12] While this can be a protective factor, many find themselves alone at home once children and grandchildren leave for work and school. [12] Grandparents can also often be caregivers for children while living together or not. This is essential to immigrant survival, but it can put them at risk of contracting the virus from children who have been exposed to it at school, as well as from those family members who have been exposed to it at work. [12, 13] For those who live in long-term care, the pandemic exacerbates the impact of pre-existing language and cultural barriers as well. [14] Without stable access to the people and activities that support their wellbeing, older immigrant adults are at an increased risk of experiencing both poor

physical and mental health, including elevated blood pressures and heart disease, as well as anxiety and depression. [11, 15] The pandemic and the measures that have been taken to protect us are essential but disproportionately affect those who are already vulnerable. My grandfather isn't alone in his experience, but older immigrants are not a homogenous group of people. They are diverse and have different paths of immigration, education, language abilities, cultural and religious backgrounds, family and living arrangements, as well as different degrees of integration into 'mainstream' Canadian society. [3] The need for connection, however, is universal. Maybe for now, connection looks like watching the news on TV together with a cup of warm cha on a cold winter afternoon.

By: Sharan Preet Aulakh



'Coffee'

Shailee Siddhpuria MD Candidate 2023



'Valencia, Spain'

Sarah Loughton MD Candidate 2024

About the Author

Sharan Preet Aulakh is a third-year medical student at the University of Alberta. She is interested in health equity and justice, and applying an intersectional lens to the health and wellbeing of older adults.

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"The Cogs of Time"



"The Cogs of Time"

Mackenzie Bone University of Saskatchewan, Class of 2024

Mixed media, acrylic. Completed in 2020 using some of my late grandmother and grandfather's items that were sitting out of sight in some dusty boxes in my parent's attic.

"One-forty-two"

You are the woman in room one-forty-two,
And so far, that's all I know of you

You are "Aniela" it says on your sheet,
I was asked to take vitals, but I know only doing so
would be a job incomplete

When I walk in the room, a smile shines across your
face,
Beautiful you are, put together, and full of grace

We chat about the many days gone by,
Only when I ask about your children, do I see a
twinkle in your eye

You are a mother of three; two girls and one boy,
You grew up in Poland, and then moved to Illinois

You are an immigrant, up to Canada you came,
You knew then, life would never be the same

What brought you here was surgery on your heart,
Non-English at the time, you felt so set apart

It was a difficult time in your life, you were scared and
alone,
But this motivated you to become a nurse and build a
life of your own

You are now here, with a painful UTI,
You can't believe thirty-seven years have gone by

You are hoping today, your daughter can take you
home,
As you can't bear to spend another night alone

The nurses come and go with great care,
but you feel blue and wonder "is anyone really
there?"

But you are not defeated, not you, not yet,
You will fight this infection, you don't even fret

As I sit here taking notes, I have learnt so much,
You are a kind woman, with a gentle touch

As a medical student, young and bright,
I have a heart full of passion, a desire for insight

We chat for a while, but now I'm off to the next case,
Thank you for reminding me to approach every
person with a warm embrace

You have taught me a great lesson that each patient
is unique,
to treat them with dignity, for it is their story I seek



Poem: Josephine Jakubowski

Art: Michele Zaman

About the Author

Josie Jakubowski, a second-year Medical student at Queen's University, brings a wealth of knowledge and experience to her studies. With a Master's degree from McMaster University, and extensive research experience, including work at Sunnybrook and with CanChild, a Centre for Childhood Disability Research, Josie has a passion for making a difference in the lives of others. Her love for working with older adults stems from their wisdom and rich life experiences. Josie finds inspiration in listening to their stories and the valuable advice they offer provides a unique perspective and newfound insights. Her passion for working with older adults is also deeply personal, inspired by her beloved grandmother, Aniela Jakubowski, whom she holds dear to her heart.

Art by: Michele Zaman, MD Candidate 2025, Queen's University



'Tofino'

Lily Wolak MD Candidate 2024

Featured Student Researcher

Frailty Assessment and Management in Interdisciplinary Primary Care

The Canadian population is rapidly aging. In Newfoundland and Labrador, the proportion of seniors is higher than the national average, with frailty becoming an issue faced by a sizeable group of our population. Though there are many definitions, Frailty is a clinical syndrome associated with an individual's high vulnerability to internal and external stressors from a decline in physiological functioning and multisystem impairments. We currently use the Rockwood clinical frailty scale (CFS) to analyze an individual's level of frailty, but there is no set system of frailty management that is both effective and feasible. Under the supervision of Dr. Susan Mercer, the goal of this project is to determine the best model to manage the care of frail individuals once they are identified, providing higher quality of life and improved outcomes. It is likely that frailty management would be best addressed by an interdisciplinary team, so we will focus on models of frailty management in primary care with interdisciplinary teams. Models of care in other provinces have proven to be effective and feasible using collaborative clinics and connections with community supports. Many of these studies have only published findings on pilot program implementation, but the data is promising. It appears the method of frailty assessment is inconsequential if post-care assessment shows either frailty improvement or maintenance of functionality. It is probable that combining positive aspects of these models and basing our frailty management on our populations needs could provide the ideal method of frailty management for residents of Newfoundland and Labrador.



Margaret Henley

MEMORIAL UNIVERSITY MEDICINE - CLASS OF 2026

SUPERVISOR: DR. SUSAN MERCER



Featured Student Researcher

SEDENTARY BEHAVIOUR GUIDELINES FOR OLDER ADULTS: A REVIEW OF THE LITERATURE AND QUALITY APPRAISAL WITH AGREE II

Older adults spend about 80% of their time being sedentary. Sedentary behaviour refers to sitting, reclining, or lying down whilst awake and using very little energy. Long periods of sedentary time are linked with an increased risk of several long-term diseases, becoming frailer, developing disabilities, needing help with everyday activities, and early death. While there is a strong evidence that sedentary time is associated with negative health outcomes, there lacks research regarding how older adults can safely limit specific sedentary behaviours. Not all sedentary behaviours should be modified as some cognitively engaging sedentary behaviours (e.g., reading, socializing) appear to benefit health, while time spent in more passive activities may be detrimental. Therefore, the goal should not be to reduce total sedentary time, but rather identify sedentary behaviours that may be detrimental to the health of older adults.

I am currently involved in a sedentary behaviour research study surveying available sedentary time guidelines from around the world to compare the recommendations and assess the methodological quality with which the guidelines/recommendations were developed. The results of this study will be used to co-design an intervention to reduce, or break-up, sedentary behaviours associated with negative health outcomes among older adults.



AMY HUANG

McMaster Medical School Class of 2025

Supervisor: Dr. Alexandra Papaioannou (Canada Research Chair in Geriatric Medicine and Healthy Aging) Team: Dr. Isabel Rodrigues, Ellen Wang, Stephanie Sanger

About Resident Geriatric Interest Group (RGIG)

The Canadian Resident Geriatric Interest Group (RGIG) was founded in 2011 to foster Geriatric-related interest among medical trainees across Canada. RGIG has diverse representation annually, including specialties in Family Medicine, Internal Medicine, Psychiatry, Geriatric Medicine, and Geriatric Psychiatry, and comes together to support older adult-friendly education and networking for learners interested in this field.

In 2022-2023, we had 19 different residents across Canada part of the internal RGIG team, each fulfilling a vital role in expanding Geriatric-related learning for medical trainees and this was all lead in the supervision of Dr. Tricia Woo, Geriatric Medicine Staff at McMaster University and current Program Director for the University's Geriatric Medicine Residency Training Program.

We are proud of that our group of RGIG Presidents and Vice Presidents (VPs) were able to co-lead various initiatives for learners on a national level. Highlights from these initiatives include:

1. Creation of a mentorship database for Geriatric Medicine, Geriatric Psychiatry and Family Medicine Care of the Elderly trainees. This program pairs trainees in or interested in these field with a corresponding staff and provides career and clinical mentorship.
2. Evaluation of the effectiveness and feasibility of the RGIG Mentorship Program.
3. Collaboration with the National Geriatric Interest Group to foster interest Geriatric-related initiatives through joint events.
4. Creating relationships with local organizations to provide opportunities for trainees to educate members living in the community.

We also have the involvement of various Local RGIGs from individual universities across Canada including University of Calgary, McMaster University, McGill University, University of Alberta, Memorial University and Dalhousie University. Some prominent events held by our local RGIGs included:

1. Geriatric Skills Night (University of Calgary): An annual event that educates medical students on geriatric-related subjects, with an associated panel session involving Internal Medicine Residents, Geriatric Medicine fellows and staff Geriatricians.
2. Geriatric Staff Panel (McMaster University): A multidisciplinary discussion for medical trainees of all stages (medical students, residents of all specialties) to discuss falls with an interdisciplinary group of speakers (staff Geriatrician, Geriatric Psychiatrist and Occupational Therapist)
3. RGIG Research Fair (McGill University): An event for residents and students to meet researchers at McGill University and University of Montreal and become involved in geriatric-related research.

We are very excited to continue expand RGIG's reach across Canada. Please contact the RGIG Presidents or VPs for more information and about how to join our group!

Website: canadiangeriatrics.ca/RGIG

Written by: Manan Ahuja, PGY2, Internal Medicine, McMaster University



"Epistemic injustice in caring for people living with dementia"

Author

Hayden Nix

Photograph

Lily Wolak MD Candidate 2024

Introduction

Epistemic injustice is an umbrella term for a group of wrongs "done to someone in their capacity as a knower".(1) The primary form of epistemic injustice is testimonial injustice. According to Fricker, "a speaker suffers a testimonial injustice just if prejudice on the hearer's part causes him to give the speaker less credibility than he would otherwise have given".(1) For example, a sexist corporate executive who does not believe an employee's testimony because she is a woman inflicts testimonial justice on the employee.

There is a growing body of literature applying the concept of testimonial injustice to patients.(2,3,4,5) Crichton and colleagues argue that patients with dementia are especially vulnerable to testimonial injustice in healthcare settings because negative stereotypes about their cognitive capacities cause healthcare professionals to wrongfully underestimate their ability to act as knowers.(6) Their argument raises unexplored questions about the ethics of collateral history taking: the process of interviewing a patient's informal caregiver (commonly a spouse or adult progeny) to learn more about the patient's medical history, living situation, and ability to function.

There is a growing body of literature applying the concept of testimonial injustice to patients.(2,3,4,5) Crichton and colleagues argue that patients with dementia are especially vulnerable to testimonial injustice in healthcare settings because negative stereotypes about their cognitive capacities cause healthcare professionals to wrongfully underestimate their ability to act as knowers.(6) Their argument raises unexplored questions about the ethics of collateral history taking: the process of interviewing a patient's informal caregiver (commonly a spouse or adult progeny) to learn more about the patient's medical history, living situation, and ability to function.

In this article, I argue that taking a collateral history to diagnose or medically manage a patient with Alzheimer's disease does not constitute testimonial injustice because physicians have a duty to treat the patient's epistemic capacities as an object of inquiry, and Alzheimer's disease impairs episodic memory, and episodic memory is essential for credibility when testifying about recent events.

Testimonial injustice

The concept of testimonial injustice applies to social interactions in which the object of inquiry ought to be the reliability of the information offered by a speaker. Fricker focuses on social interactions in which a speaker contributes information to the shared pool of knowledge and a hearer acquires information from it. She argues that trust in the pool of knowledge is vital for society to function. In this kind of social interaction, inflicting testimonial injustice upon a speaker by unfairly attributing low credibility to her is wrong because it objectifies her: rather than treating her as an active participant in the exchange of knowledge, the hearer treats her as an object of inquiry. It is wrong for hearers to treat speakers as objects of inquiry in this context because it denies them status as a human being with the capacity to reason: it "relegates them to the same epistemic status as a felled tree whose age one might glean from the number of rings".(1)

Dementia

Crichton and colleagues invoke the concept of testimonial injustice to shed light on a prevalent problem in psychiatry: healthcare professionals do not believe what patients tell them.(6) They argue that many healthcare professionals hold negative stereotypes about psychiatric illness, in general, that cause them to wrongly deflate patients' credibility. Further, they argue that stereotypes about the symptoms of particular psychiatric disorders, such as the cognitive impairments caused by dementia, cause healthcare professionals to "reduce the credibility of what patients report about their own experiences to an extent that constitutes epistemic injustice".(6)



Dementia is a serious and debilitating clinical syndrome characterized by the progressive deterioration of cognitive abilities and loss of independence.⁷ Crichton and colleagues argue that “[t]he main negative stereotype associated with dementia is the belief that the impairment of cognitive function is severe and global; that the person has or will rapidly and inevitably become a ‘vegetable’”.⁽⁶⁾ They argue that this stereotype is incorrect, except for patients with severe dementia, because “[t]he personality of [patients with dementia] and some cognitive functions are often well preserved”.⁽⁶⁾

In their brief article, Crichton and colleagues do not analyse whether collateral history taking for patients with dementia constitutes testimonial injustice. But it is important to assess whether collateral history taking constitutes testimonial injustice because collateral history taking seems to bear the hallmarks of testimonial injustice. When asking a third-party informal caregiver about the patient’s health status, the patient is treated as an object of inquiry, rather than an active participant in the exchange of knowledge, and this is the fundamental wrong captured by the concept of testimonial injustice. Additionally, the need for a collateral history is predicated on the notion that patients with dementia are not sufficiently credible informants about their own health. Instead of relying on patients’ credibility, healthcare professionals appeal to their informal caregivers for reliable information. Further, as many have argued, there are prevalent negative stereotypes about the cognitive capacities of patients with dementia.^(6,8,9)

The fundamental wrong

The duty of care requires physicians to promote the medical interests of patients, including their well-being. Diagnosing and managing illness are two ways of promoting patient well-being. For patients with Alzheimer’s disease, receiving a diagnosis can help them understand their illness experience and grants them access to needed treatments and supports.

Quantifying cognitive—including epistemic—

Impairments is a central component of diagnosing and managing patients with Alzheimer’s disease. The diagnostic criteria for Alzheimer’s disease include (1) “clear-cut history of worsening of cognition,” (2) “deficits [that] include impairment in learning and recall of recently learned information,” and (3) “[i]nsidious onset... over months or years”.⁽¹⁰⁾ To diagnose a patient with Alzheimer’s disease, the physician must quantify these cognitive impairments to determine whether they are impeding the patient’s ability to complete daily tasks such as cooking and managing finances.⁽¹⁰⁾ After diagnosis, quantifying changes in cognitive impairments over time allows physicians to provide needed supports. For example, as cognitive impairments worsen, patients with Alzheimer’s disease might become a danger to themselves or others (e.g., if they forget to turn the oven off after cooking). When this level of impairment is reached, the physician might need to coordinate the patient’s move into a long-term care home. Therefore, physicians must treat patients’ cognitive—and epistemic—capacities as objects of inquiry in order to diagnose and manage patients with Alzheimer’s disease.

Collateral history taking enables physicians to quantify patients’ cognitive capacities. A collateral history gives the physician a point of reference to which she can compare the patient’s testimony and allows her to hone in on the patient’s type and level of cognitive and functional impairments.

Fricker developed the concept of testimonial injustice to apply to social interactions in which the object of inquiry ought to be the reliability of the information provided by a speaker—not the epistemic capacities of the speaker. By contrast, the foundation of the relationship between physicians and patients with Alzheimer’s disease is such that the physician ought to treat the patient’s cognitive—including epistemic—capacities as an object of inquiry by attempting to quantify the patient’s level of cognitive impairments. Therefore, the fundamental wrong captured by the concept of testimonial injustice has diminished applicability to the relationship between patients with Alzheimer’s disease and their physicians.



Credibility and episodic memory

Classically, Alzheimer's disease has the greatest impact on episodic memory.(11) Episodic memory is "the memory system that allows an individual to consciously retrieve a previously experienced item or episode of life".(11) The impairment of episodic memory is often the first symptom to appear in patients with Alzheimer's disease, and patients' episodic memory continues to deteriorate as the disease progresses.(11)

This type of impairment calls into question the epistemic capacities of patients with Alzheimer's disease. Alzheimer's disease impairs recent episodic memory, but a physician attempting to diagnose or manage a patient with Alzheimer's disease needs to collect information about the patient's recent past experiences. The information that the physician is interested in precisely overlaps with the putative cognitive impairments of the patient. For example, episodic memory impairments might prevent a patient from accurately recalling whether he cooked dinner for himself in the past week, but the physician requires this information to determine how the patient's cognitive impairments are affecting his ability to function. The only way for a physician to confidently gather the information she requires is by taking a collateral history.

This means that attributing low credibility to patients with Alzheimer's disease when asking them about their recent experiences does not constitute testimonial injustice. To meet the criteria of testimonial injustice, the level of credibility attributed to the speaker must be lower than he deserves. But patients with Alzheimer's disease do not deserve full credibility when they testify about recent events because it is reasonable for physicians to assume that the disease has impaired his ability to accurately recall the information. Therefore, when an inconsistency arises between the testimonies of a patient with Alzheimer's disease and his informal caregiver, attributing higher credibility to the informal caregiver does not inflict testimonial injustice on the patient.

Duty to listen

One potential objection to my argument comes from a

recent article by Drożdżowicz.(12) She argues that healthcare professionals have an epistemic duty to attend to and/or solicit patients' first-person experiences because patients deserve epistemic respect. Applying her argument to collateral histories for patients with Alzheimer's disease, one might argue that epistemic respect grounds a duty to interview patients in addition to taking a collateral history from their family caregiver.

In response to this objection, I agree that physicians ought to interview patients with Alzheimer's disease in addition to taking collateral histories. However, the duty to solicit and attend to patient's subjective experiences should not be understood as grounded in epistemic respect. Rather than epistemic respect, there are more fundamental reasons to listen to and value what patients with Alzheimer's disease say. As Harcourt argues, "it is possible to... treat a patient's utterances attentively and respectfully, without... [treating them] as knowledgeable about the world".(13) As Matthews and Kennett argue, healthcare professionals ought to listen attentively to patients with advanced Alzheimer's disease because it enables healthcare professionals to "see the individual in care as a whole person, and worthy of engagement on that basis," and thereby foster their agency and well-being.(14)

Conclusion

In this article, I argued that, when diagnosing and managing a patient with Alzheimer's disease, taking a collateral history does not inflict epistemic injustice upon the patient because physicians' duty of care grounds a duty to treat the cognitive capacities of patients with Alzheimer's disease as an object of inquiry, and Alzheimer's disease impairs patients' ability to act as a knowledgeable informant about their recent experiences. However, even though physicians should not necessarily believe patients with Alzheimer's disease when they testify about recent experiences, listening to them is important because it promotes their well-being and agency. While physicians should not merely obtain collateral histories from informal caregivers when diagnosing and managing patients with Alzheimer's disease, doing so does not constitute testimonial injustice.



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Sarah Loughton MD Candidate 2024

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