The Newsletter of the
26th Annual Geriatric Medicine
Refresher Day

Volume 1 Issue 1

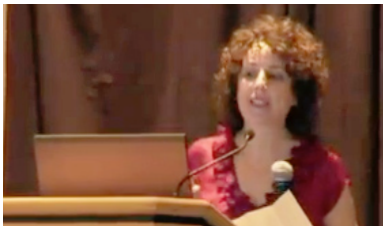
A Life Well Lived – Current Issues at the End-of-Life

On May 2, 2012, more than 500 people gathered at the London Convention Centre to hear about the latest developments in geriatric medicine. The special focus of this year's conference was "*A Life Well Lived – Current Issues at the End-of-Life*." Experts highlighted both clinical experience and research findings, sharing practical tips and new knowledge.

The morning keynote address featured Professor Meredith Levine and students from her journalism class who completed a remarkable series on dying in Canada (see article below). In the afternoon, Dr. Mark Nowaczynski shared his experiences as a family doctor who provides home-based medical care for frail and marginalized seniors, and a social documentarian who often photographs his patients. (For more information about Nowaczynski and his work, visit www.nfb.ca/film/house-calls and www.seniorshousecalls.ca/)

This newsletter provides a glimpse at some of the presentations made on May 2, 2012 and provides links to full video interviews.

GO! To get a flavour of the conference, click here for a short overview.



We Talked about Dying and Four Million People Listened: The story of a unique partnership between a UWO graduate journalism class and the CBC

Meredith Levine, a professor at Western University's graduate program in journalism, was concerned that news coverage was becoming more superficial. That's why she wanted to design a course that would force journalism students to spend time understanding and reporting in depth on unreported stories. Her choice? The dying process in Canada. "Few things matter more than how we die," says Levine. "It cuts across class, age, race – we all care about it."

Under her guidance, 16 journalism students interviewed patients, caregivers, health professionals and others. The resulting stories explored everything from palliative care for children and dying at home, to multicultural experiences of death and legal debates about 'pulling the plug.' During the presentation at the Geriatric Medicine Refresher Day, Levine and several students shared their experiences and some of the lessons they learned. "We researched hard and were rigorous in our approach," says Levine. "But we used our hearts too, not just our minds."

Levine's initial research about the topic surprised her. She learned that just 2% of the contents of nursing textbooks deal with end-of-life care, and that only 7% of medical schools offer a full course on dying. "We were on our own, muddling through!"

Among the comments from students shared during the presentation:

"I didn't think twice about the consequences of immersing myself in an environment of death. Palliative care? Yeah, I can handle that. Grieving families? I don't cry that easily anyway. I had no idea that in the middle of the course my mom would announce quite casually that she had an inoperable brain aneurysm. But as I continued my research on the good death from the Chinese-Canadian perspective, it helped."

"I've always been awkward about death. I grieve in my own way, I just don't show it. Part of me hoped I wouldn't deal with dying people, but I wanted to... Most of the time, I was just praying and hoping that I wouldn't mess it up. And I didn't."

"I did a lot of research for this project exploring how married couples fare when one spouse dies. Something I learned about in my research is a condition called broken heart syndrome, a sudden deterioration of the squeezing ability of the heart that's brought on by stress, especially the death of a loved one... a lot of times in the media we look at things very clinically. We talk about people dying in a car crash

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Amer Burhan, assistant professor of Geriatric Psychiatry at the University of Toronto, wants to dispel the myths surrounding electroconvulsive therapy (ECT).

ECT has received a lot of negative publicity in the past. Films such as *One Flew over the Cuckoo's Nest* depicted it as a barbaric form of punishment. In reality, however, ECT is one of the most effective therapies we have for treating depression, says Burhan.

In his presentation for Geriatric Refresher Day, Burhan points out that patients are rigorously screened before undergoing ECT in order to avoid complications. "When you select it for the right person and do it under the right circumstances with good medical screening," says Burhan, "you will get the benefit of ECT with very little side effects."

The elderly, in particular, stand to benefit from ECT treatment. Burhan explains that as we get older we become more susceptible to depression, but less tolerant of anti-depressant medications. "The nice surprise here is that the elderly benefit from ECT with up to 95% efficacy. There is actually a correlation between being older and getting better with ECT."

Fortunately, ECT treatment is widely available in Southwestern Ontario. Burhan hopes his colleagues will take note. "I think many people don't know that it continues to be practiced, that it's a viable option to treat depression," he says. "People do not have to think of it as a treatment of the past."

Burnham thinks that events like Geriatric Refresher Day, which bring together professionals in all fields of geriatric care, are becoming increasingly important. "More and more people are reaching the age of 65 and above and all these challenges on the system require a big network of collaboration."

GO! To view Dr. Amer Burhan's *Electroconvulsive Therapy in the Elderly* interview click here.

Medications used for Symptom Control in Palliative Care – *Luis Viana*

Pharmacist Luis Viana has been working with elderly people living in long-term care homes for the past 13 years. "I truly believe that while we can't add days to our patients' lives, we can add life to their days," he says.

When it comes to end-of-life care, Viana says he's seen situations where patients and their families suffered unnecessarily. "I know medications aren't the whole answer, but they certainly help. If we use the right medications at the right time in the right way, we can make the process more comfortable for the patient and more pleasant for the family."

When choosing medication for geriatric care patients, health care professionals need to go beyond the medical textbook, says Viana. Doctors must recognize what is unique in every patient's situation and tailor their treatment to the patient's particular needs. "There is no one size fits all solution in these matters," he says.

Accurate assessment and diagnosis of patients is an important first step in the process. When accurate assessments are available, doctors can isolate the underlying cause of a symptom, and use medicines that attack the cause directly. When one approach doesn't work, it's important to ask why and then consider another approach, perhaps a drug with a different mechanism.

While Viana sincerely believes that a pain-free death is possible, he warns that it may not always be desirable. Patients have different pain thresholds, and some may be willing to tolerate a little pain if it means they can be more alert for a family visit.

In his presentation Viana emphasized the importance of health care professionals knowing what resources are available for patients at the end-of-life. "Some of the recommended medications used with palliative patients are not covered by government plans," he says. "We do have programs to ensure that cost is not an issue, but you have to know where to look."

On a personal note, he adds: "When my father was deemed palliative before he passed away last year, we couldn't believe how many 'angels' appeared. When we needed something, help was there. That's how it should be."

GO! To view Luis Viana's *Medications used for Symptom Control in Palliative Care* interview click here.

"For someone who has lived through WWII, the hospital fire alarm might sound like an air raid siren, and trigger a painful flashback," says Professor Sandra Hobson. "We need to learn to recognize and remove such triggers when treating patients who have experienced traumatic events."

Hobson works in the School of Occupational Therapy at Western University, and studies the relationship between Post Traumatic Stress Disorder and dementia. She was collecting the occupational biographies of elderly patients when she was first led to consider the connection. "I was struck by how many of our older adults have been through life experiences that we have been fortunate enough to escape—war, concentration camps, and so on. And then the light went on."

In her talk for Geriatric Refresher Day, Hobson asked audience members to recall what they were doing at the age of 14. She then read excerpts from her patient's biographies. In one, an elderly man recalled joining the resistance in occupied Holland at age 14 and being forced to hide from the Nazis in the ceiling of his parents' house. "Many of today's young medical professionals don't have parents that served in a war, so they are not alert to the possibility of PTSD."

Moreover, since health care professionals are not always aware of a patient's history, they can be ill equipped to deal with behaviours that stem from traumatic life experiences. "If staff can't deal with the behaviours," says Hobson, "they might withdraw from patients, because they feel they can't help them, and that causes a distance and a negative response in the caregiver."

Events like Geriatric Refresher Day are important, according to Hobson, because they allow healthcare professionals to exchange ideas and information. "Sadly there is still a certain ageism. People think, 'they are going to die soon anyway, what does it matter?' It matters because quality of life matters. Education is a big part of overcoming ageism."

GO! To view Professor Hobson's *The Days of Their Lives* interview click here.

Supporting Clients and Caregivers through the End-of-Life Journey: How the CCAC Can Help – *Sherry Fletcher*

The South West Community Care Access Centre gives elderly people the freedom to choose where they want to die, whether at home, hospice or hospital. Sherry Fletcher, Regional Client Services Manager, explains that her organization puts clients and their families in contact with the care services they need to end their life in comfort. "If someone wants to die in a hospital, we find palliative care beds for them," says Fletcher. "If, on the other hand, they want to die at home, we talk to them about the community support services that are available."

Sherry Fletcher spoke recently at Geriatric Refresher Day to spread the word about innovative new programs at CCAC, and to dispel some of the myths about what CCAC can and can't do. CCAC recently introduced the e-Shift program, which takes advantage of smart phone technology to enable direct communication between personal support workers and nurses. The specially trained PSWs are then able to provide overnight care for palliative patients. "The program allows us to provide more clients with the shift support they need," says Fletcher.

Fletcher was also eager to receive feedback from healthcare practitioners about what services are still needed. "I think it's important that we are able to hear what the clients' concerns are," says Fletcher. "In particular, there were questions about interpreter services for clients that don't speak English. It's something we will definitely reflect on."

Fletcher sees Geriatric Refresher Day as an opportunity for the CCAC to collaborate with others working in geriatric care to improve end-of-life services. "It's important that we are always working with other care providers to understand and overcome any roadblocks we are facing."

continued from page 1 *or of a heart attack, but we often don't have the chance to explore the emotional toll this can take on the individual or the family members."*

"To be honest, I found this much more difficult than I imagined. I couldn't believe how unprepared I felt or how badly I wanted to run out of the room. Knowing this about myself will be invaluable in my career.

For more information about the A Good Death project and to read the stories developed by the students, visit www.cbc.ca/news/health/features/a-good-death/index.html.

Dr. Paul Ferner, a family physician, was introduced to palliative care when he began working in the London Regional Cancer Program in 1989. He recognized early on that he had the right personality for this difficult work. "I think I have an interest in working really closely with people and I'm not afraid of dealing with the emotional issues that are raised when someone is dying. It's a really intense time and helping people work through it is a way I feel I can make a difference."

Today, Ferner works in both home palliative care and long-term care. He provides care for some 200 long-term care patients in four long-term care homes. Ferner's presentation at the Geriatric Refresher Day shed light on the unique challenges of doing palliative care in the long-term care setting. "People don't realize how much palliative care happens in nursing homes," he says. "It's a completely different population than we usually think of in palliative care."

One of the challenges for health care practitioners is learning to effectively communicate with patients and their families. Doctors need to clearly explain what to expect in the dying process. "It's important to use the 'd' word when talking to people," Ferner says. You will get families who are coping, who know what's going on, and then you get families where there is denial, anger and frustration." In his presentation, he talked about ways to deal with conflict and anger.

Ferner also made health professionals aware of the basic medications needed to control symptoms in palliative care — a narcotic, benzodiazepine for anxiety and depression, and something to control secretions. He advised that medication orders be flexible enough to allow nurses to deal with crisis situations. "If for instance you order something every four hours, the nurse's hands are tied," he says. "For pain meds, it may be better to order 'every hour as needed.'"

Ferner believes that Geriatric Care Refresher Day is a valuable opportunity for health professionals to network, share and reflect on their experiences, and spread new information.

GO! To view Dr. Ferner's, *Palliative Care* interview click here.

Dr. David Tang-Wai became fascinated with behavioural neuroscience while working as a resident at the Mayo Clinic. "I had two preceptors who were both dementia specialists and they got me interested," says Tang-Wai. "It's an area where people think they know a lot but, in reality, there's so much more to learn, discover and demystify."

Today, David Tang-Wai is a physician at University Health Network where he specializes in cognitive testing and localization. Tang-Wai spoke at Geriatric Refresher Day to explain how these techniques can be used in treating patients with dementia.

Localization enables doctors to determine exactly what part of the brain is not functioning correctly, based on the fact that each part of the brain has a specific cognitive function. For example, the front part of the brain is responsible for planning, motivation, and multi-tasking abilities, while the temporal lobe is responsible for memory, and the back part of the brain is responsible for math, writing, and physical skills. By determining which part of the brain is affected, physicians can determine what kind of dementia or brain injury is involved.

Tang-Wai gave examples from his own clinical practice of situations in which the procedure helped to identify problems. In one case, an individual with Alzheimer disease started to show difficulties with math abilities on cognitive tests. This suggested to doctors that there was a problem in the left parietal lobes in the back of the brain, and a CAT scan of that area showed that the patient had had a stroke. "You can use cognitive testing to tell you which parts of the brain to look at," says Tang-Wai. "Even when a normal neurological exam doesn't find any weakness, cognitive testing can discover an abnormality."

Tang-Wai left participants with the knowledge that simple bedside tests, combined with functional information, can lead to accurate diagnoses.

GO! To view Dr. David Tang-Wai's, *Cognitive Testing and Localization* interview click here.

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