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Patricia Iyer
MSN RN LNCC



Cataract Surgery: Under the Knife

The waiting

Two days ago at this time I was waiting to be called into the same day surgery area of a major eye hospital in a major city. (In Issue 7, I described the experience of being diagnosed with cataracts.) I checked out my paperwork and saw I had a diagnosis of senile nucleus stenosis. While I understood this was an age-related cataract, I was not too fond of the senile part. I filled in some forms, giving the same information I had supplied before

surgery. On the anesthesia form, I was asked: “Do you have any concerns you want to discuss with the anesthesiologist?” I wrote, “Don’t want to see knife coming at my eye.”

The TV was on in the waiting room, tuned to a food channel. It was 1:30 PM. Having not eaten since midnight, I watched the chefs prepare simmered chicken, garlic mashed potatoes, and cranberry juice cocktails. My mouth watered.

Part of my brain was tuned to being a patient, and part of it was watching everything going on around me, from a patient safety perspective. Here are some memorable moments.

The holding room

I was brought into the holding area about 2:15 PM, invited to take off my jacket and leave on a tee shirt, and to remove my shoes. All other clothes stayed on. I placed a patient gown (opening to the back but not tied) and an OR hat on my head. The nurse hooked me up to a cardiac monitor, placed a pulse oximeter clip on my finger, and began examining my right arm for veins. She tapped and slapped and manipulated my arm for long moments in a concerted effort to find the right vein.

Meanwhile, I was thinking positive thoughts, like, "You will find a vein on the first try and not strike my nerve." We discussed the fact that the anesthesiologist liked the right arm to be used for medication if the doctor was working on the left eye. Otherwise, they would crowd each other.

When I told her blood was usually drawn from my left "antecubital" (inner elbow) vein, I inadvertently revealed I was a nurse. This led to a discussion of how the nurse admired medical surgical nurses (the kind I am)

because of the ability to multitask the care of 10 patients. She became an ICU nurse right out of nursing school and when she was pulled to a med surg floor, she had a hard time. (I always admired ICU nurses because of their knowledge.)

The holding room nurse, noting the coldness of the room, offered me a warmed blanket. I gratefully accepted it, telling her the last time I had one of these was when I delivered my first child 35 years before. She gave me eye drops three times, which gradually reduced my vision, and I realized she was dilating the pupil.

The anesthesiologist came in, looked in my mouth, listened to my lungs, and told me I would get sedation during the surgery. I pressed him for the name, and he said it was Versed, which can wipe out memory of the surgery. He told me I could get Morphine or Fentanyl during the procedure if I was uncomfortable, but that was not common. I did not see him again.

Next, I saw my surgeon checking my chart. He is a man of few words. He confirmed my left eye was going to be operated on. I told him I had been thinking of drawing an arrow on my cheek and pointing up to my left eye. He laughed, touched my shoulder and said, "We have many ways to verify the correct side." I did not think it was the right time to tell him there are two wrong site/wrong patient surgeries per day in the United States. After he left, I shared this statistic with my husband, who is not a medical person, and he advised me to not think about that.

The woman in the holding room next to me had undergone surgery that morning in a different location for a malignant tumor in her eye. She was being prepared for plastic surgery at this hospital. The anesthesiologist spent about 5 times more time with her than with me, and I was very happy to be in my stretcher and not in hers.

The nurse anesthetist bounced in. She had a cheerful, friendly personality. I brought up the

subject of seeing the knife coming at my eye and she told me she could make sure that did not happen. She made me feel comfortable, and reassured that she understood my concerns. As I was being wheeled into the operating room, about 3:15 PM, she was pulled away to help with a different room and I received a different nurse anesthetist.

My stretcher became the operating room table. My OR nurse introduced himself, and put another warm blanket on, which was positioned so my hands were tucked against my body. I asked him if these were my restraints, and he quickly denied it. Then a roll of tape appeared and the nurse taped my head to the stretcher. I told him I felt like I was on a board with a cervical collar after a car accident. He was probably wondering when I would stop making observations about what he was doing. Many of the things that were done to be in the OR occurred without explanation or forewarning, which I would have preferred receiving.

The nurse anesthetist told me her name, which was an unusual one, and I said I had never met anyone with that name before. “Most people haven’t”, she told me. The nurse anesthetist gave me Versed 2 mg. I could feel the warmth begin to spread in my blood, and announced, “Ah, the Versed!”

The surgeon arrived – again without saying anything – and put a numbing gel on my eye. Then, he placed a thing on my face. It was like a Batman mask. It covered my forehead, eyes and cheeks. It had a sticky backing on it, and it was pressed onto my face to make it adhere. I was tempted to say that this dressing was not for the claustrophobics but I felt I had volunteered enough observations. The dressing blocked my vision of what was occurring.

The surgery

Imagine lying on your back in a dark cave looking up. You can see a hole at the top of the cave. It is partially blocked by something. There are vivid red, green and blue colors in

the cave. I watched the top of the cave, dutifully tilted my chin upward when instructed, and then the cave became cloudy. (This must have been when the lens in my eye was being broken up and suctioned out. I heard a suction sound.) Then a clear round object floated into the cave. It looked like a jelly fish. I noticed it come and go a few times before it disappeared from view. This was the new lens. The end of the procedure involved the surgeon pressing on my eye in a way that really hurt. I called out for Morphine or Fentanyl, but he said, “I am almost done.” I wasn’t too happy about not getting pain medication.

The Batman mask was ripped off my face. That hurt! The tape was pulled off my forehead. That hurt too. The pain was temporary, though. The surgeon placed a clear plastic eye shield on my face. The clearness was a surprise, and eliminate the problems with losing peripheral vision that result from an opaque shield.

The recovery room

Food! Yes! In rapid fire, the nurse listed what I

could have: “peanut butter crackers, vanilla crackers, salmon crackers . . .” – “Wait, salmon crackers?” She repeated, “Cinnamon crackers.” We agreed there would not be much of a market for salmon crackers. My husband entered with half of a tuna fish sandwich, which he purchased on the ground floor of the hospital while I was in the operating room. He had enough time to get downstairs, buy the sandwich, eat half himself, and return upstairs while I was in the operating room. He barely got the chance to see the surgeon, who assured him all went well.

That day, on the way home, I had a vague sense something had been done to my eye, but there was no pain. There has not been pain since. I created a medication administration record to keep track of the postoperative eye drops, and am resting my eyes periodically.

The difference in vision is remarkable. My new lens is so clear that light looks almost blue, compared to the almost yellow from my right eye. I can use the computer without needing

glasses, which I have not been able to do for years. In a month I will have cataract surgery on the other eye. I informed my surgeon yesterday that I liked my new eye a lot. He didn't say anything but he smiled.

About the Author

Patricia Iyer MSN RN LNCC is coeditor of the newly released 4th Edition of *Nursing Malpractice*, available at www.patiyer.com. She is President of Avoid Medical Errors, LLC.



Diagnosing Infectious Disease

Infectious diseases are among the most common conditions for which patients seek medical care, and potentially the most serious. Fortunately, since the discovery of penicillin over 70 years ago, antibiotics have made the treatment of serious infections highly successful. Nevertheless, physicians and advanced practitioners such as nurse practitioners and physicians assistants must use caution in administering antimicrobial medications, both to ensure effectiveness and to prevent side effects. Careful prescribing will

help minimize the legal risks resulting from antibiotic treatment.

Diagnosis and Treatment

The first question to ask when addressing any presumed infectious illness should be, "Is it an infection"? Many illnesses, such as systemic lupus erythematosus and sarcoidosis, mimic infection but do not benefit from antibiotics.

The next question to ask would be, "Should it be treated"? Certain conditions, such as chronic bronchitis and chronic cystitis (bladder infection) in the elderly, are marked by bacterial growth and low-grade inflammation. But without signs of systemic infection, treatment is often useless.

When the decision is made to treat an infection, the treatment plan should be carefully explained to the patient and family, including benefits, risks and potential side effects. These should be documented in the chart. Potential reasons for treatment failure should be discussed with the patient and documented in the record as well. An adequate plan for follow-up should be instituted.

Medical-Legal Considerations

What are the potential medicolegal risks of treating infectious diseases? These reflect the issues found in other fields of medicine: failure to diagnose, delay in treatment, undertreatment, adverse effects of treatment, etc. Unfortunately, when dealing with infection, the potential for major disability or death is often present. It is often a wise idea for a primary physician to consult with an infectious disease physician in difficult cases.

Failure to Diagnose

Failure to diagnose occurs in all areas of medicine despite major advances in

diagnostics. A physician or advanced practitioner must take a thorough history to identify any special risks for infection, such as foreign travel, animal exposure, etc., and perform a thorough physical exam. Obtaining broad cultures, particularly of blood and urine in critically ill patients, is a routine part of hospital medicine. A spinal fluid examination should be performed if there is any concern for meningitis or encephalitis.

Patients with localized infections in the chest, abdomen or pelvis generally should have imaging by computerized tomography or ultrasound. The physician should obtain a specimen to send for a culture. All significant diagnostic considerations should be documented in the medical record to indicate to a reviewer or attorney that a condition was considered, even if not ultimately treated.

Delay in Diagnosis or Treatment

Treatment delay is uncommon for infectious illnesses, as early treatment and even overtreatment tends to be the rule.

Nevertheless, if life-threatening conditions such as sepsis or meningitis or limb-threatening conditions such as necrotizing fasciitis (caused by “flesh-eating bacteria”) are significant considerations, treatment should be initiated right away, even before diagnostic tests are performed.

Treatment Guidelines

Undertreatment is also rare except with certain specific conditions such as endocarditis (heart valve infection) and osteomyelitis (bone infection). Unfortunately, many otherwise excellent physicians are not familiar with treatment guidelines for these conditions or for infections with certain bacteria like staphylococcus aureus. A relapse in such a case can have disastrous consequences.

Guidelines are now increasingly available for treating of everything from ear infections to bloodstream infections to HIV. Physicians should be aware of guidelines from national medical groups like the Centers for Disease Control and Prevention (CDC) and the

Infectious Disease Society of America (IDSA). While guidelines are neither perfect nor all-inclusive, they usually represent the consensus view of experts in the field. A physician should deviate significantly from them only after careful deliberation. Reasons for not following guidelines, such as allergies or intolerance to a certain medication or patient refusal to cooperate with the treatment plan, should be thoroughly documented in the medical record.

Finally, adverse effects can jeopardize treatment success. Side effects of antibiotics should be explored and explained to the patient and family, as well as documented in the chart. Serious drug interactions, such as that between rifampin and warfarin or between linezolid and serotonin reuptake inhibitors like fluoxetine, should be considered and avoided if possible.

Treating infectious diseases requires the same attention to detail as treating any other serious condition. A doctor or advanced practitioner must be thoughtful, thorough and

knowledgeable of the medical literature and treatment recommendations. He or she must communicate effectively with the patient and patient's family. And, to repeat, the practitioner should document everything. Close attention to these points will go a long way toward maximizing success and minimizing the medicolegal risk for the practitioner.

See www.amfs.com for details.

[Charlotte's Story: A Life Cut Short by Medical Errors](http://tinyurl.com/c6y67bl) Get details at <http://tinyurl.com/c6y67bl>

This program is an interview between Pat Iyer, President of Avoid Medical Errors and Barbara Levin. When you purchase this program, you will receive the interview in audio form, transcript and bonuses.

Barbara Levin shares her perspective about patient safety from two viewpoints: as the daughter of a woman who was a victim of medical errors, and as a registered nurse who is involved in day-to-day care in taking care of patients in the hospital. Barbara's mother was a vibrant, active woman who went into the operating room for simple same day surgery.



Untangling Charlotte's Web:

The Story of a Life Cut Short by Medical Errors

*Barbara J. Levin BSN RN ONC LNCC
Mary Ann Shea JD BS RN Patricia Iyer RN MSN LNCC*

ORDER THE DVD at

<http://www.avoidmedicalerrors.com/store/untangling-charlottes-web/>



Food! Glorious Food! Part 3

I'd like to share with you ways you can enjoy your food and choose simple methods to prepare it while also enhancing your brain health. It's fun for me to come up with new ways to make nutritious meals!

Growing up with a mom who loved to cook and encouraged me to get in the kitchen with her gave me an early love of creating great meals. Part of my college education was in nutrition,

giving me a solid background in the principles of nutrients.

After getting married and having a son and then twin daughters, I had three children under three. With the three small children, I really needed to get very efficient in getting food prepared without a lot of work. I became very good at that over the years. Later I was a single mom with children at home. I was doing graduate work and working full time as a teacher. This was more impetus to have easy meals for everyone.

Let me share with you some of the strategies I have developed over the years. These are

some typical meals I prepare that are both easy and nutritious. We are going to start by just going through the day with some of my favorites.

Nutritious breakfasts

First I'm going to share with you what I usually have for breakfast. I call it a Brain Food Popeye Green Smoothie. I think I first really got started with these after I saw Dr. Oz when he was still appearing on the Oprah show. Oprah tasted it and said it tasted like a glass of "fresh". Don't say yuck if you've never tried this! Be open and willing to listen and possibly try it.

Start with three to four cups of fresh spinach, a cup of water or unsweetened juice, and an inch square of fresh ginger. Process these on high in the blender. I then add a blend of soy and whey protein powder that is sweetened slightly with Stevia and has other nutrients in it. I also use one serving-size scoop of ground flax. Notice I said ground flax. If it's not ground, it goes right through your body without you

getting its benefit. Ground flax is a huge source of Omega-3 that is one of the main building blocks of our brain cells.

I also add to the smoothie frozen blueberries or some other type of berries like raspberries, strawberries, or blackberries. Blueberries are my favorite and have one of the best antioxidants available. You can also add other vegetables like cucumbers, zucchini or parsley.

If you have a powerful blender similar to the Vitamix, you can choose most any vegetable and be able to get it pulverized into a smooth liquid. Kale, Swiss chard, beet greens, and celery are all great in a smoothie.

Another great breakfast is yogurt with berries. I always keep on hand nonfat plain yogurt that has live cultures. Yogurt keeps in the refrigerator for quite a long time. If you don't like the non-fat unsweetened yogurt, you can add some Stevia. That is really the only healthy sweetener. You can add just a little of the Stevia to it so that it gets that sweetness and then choose some berries that you like.

Keeping frozen berries on hand is helpful so that you always have fruit ready!

I put a few of the frozen berries in the bottom of a bowl and put them in the microwave just to defrost slightly. Then spoon the yogurt over it. Or you can just leave them frozen, put some yogurt over them and the berries freeze the yogurt a little. My favorites to use are frozen cherries or raspberries. I just keep those frozen at the bottom and then on the top I add some chopped almonds or some sprinkles of wholegrain granola. This is also really great as a snack. Occasionally, I'll drizzle some of the 73% cacao type of chocolate over the top to make it extra special as a dessert.

Also for breakfast you could have whole grain bread. I've found that there are quite a number of breads that are totally wholegrain. You have to read the label, though, to see that there is no second ingredient of just enriched wheat flour that isn't the whole wheat. Getting the whole grain gives you the fiber and you get the full benefit of this complex carbohydrate. The

whole grains digest more slowly and keep you satisfied longer. Also, you are getting fewer actual carbohydrate grams when there is more fiber in a food. Subtract the fiber grams from the carbohydrate grams and that gives you a true count of the carbohydrate grams.

I found a great selection of breads at a store near me called Sunflower Market. I was excited to see these because they were only 50 to 60 calories per slice. They even had whole wheat cinnamon bread that is excellent. There should be similar breads at other stores. You can check around and see what you can find.

What's good to put on the wholegrain toast is Greek yogurt that is thicker than regular yogurt. It's really good for a spread or you can use just a little Neufchatel low fat cream cheese. The wholegrain bread slices are a much better choice than a bagel if you are trying to limit your calorie and carbohydrate consumption.

Try adding nuts to your cereal or yogurt or choose bread with nuts to get more Vitamin E in your diet. Vitamin E is a very good protection

against Alzheimer's. People who consume adequate vitamin E are 43% less likely to get Alzheimer's, according to studies. You can get enough vitamin E by eating just 3 ounces of nuts or seeds a day.

Next month I'll share ideas about healthy lunches.

About the Author

Suzanne has a master's degree in education specializing in counseling and has been an educator of psychology and technology. She's had extensive coach training through Thomas Leonard's Graduate School of Coaching and the University of Texas, Dallas. Suzanne is also an Emotional Intelligence Certified Coach. Contact Suzanne at www.suzanneholman.com

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Elizabeth Bewley MBA



Most Fatal Blood Clots are a Result of Hospital Care

Louise, age 38, was scheduled to have a hysterectomy. Her doctor had decided to perform the surgery to eliminate the very heavy bleeding that she had had for years with her periods. She said, “The attitude from the doctors and nurses was, ‘This is routine surgery, a walk in the park.’”

The operation went well, and Louise soon returned home. She does not recall much, if

any, discussion about possible complications or symptoms to watch out for.

She said, “One week later, I got up in the morning and had an awful pain in my shoulder when breathing. It was hard to catch my breath. I went back to the surgeon. He said, ‘What’s wrong with you is a shoulder problem. Go see an orthopedic surgeon.’”

Louise continued, “As the day went on, it got harder and harder to breathe. My friends took me to the hospital. A blood clot had gone through my heart to my lungs.”

Dr. John A. Heit of the Mayo Clinic in Minnesota notes that more than 900,000 people develop blood clots each year. Many people believe that blood clots are usually a result of long airplane flights. However, Dr. Heit reports that more than two-thirds “are related to recent hospitalization.”

Further, nearly a third of the people who get blood clots die as a result. This situation typically occurs when a blood clot breaks off and travels to the lungs, where it interferes with breathing.

As was true in Louise’s case, symptoms may not show up until the patient is home. At that point, people may let down their guard. They may assume that any risk related to being in the hospital went away when they drove out of the hospital parking lot.

Dr. Heit reports that blood clots are more common than heart attacks or strokes, and cause more deaths than either of those. He also points out that deaths from blood clots are

expected to increase because older people are at greater risk, and the population is aging.

Dr. Joseph A. Caprini at Northwestern University has developed a model to gauge a patient’s risk of getting a blood clot. It lists about two dozen risk factors and assigns points to each. Three of the risk factors are being age 40+, having surgery that lasts 45 minutes or more, and having recently fractured certain bones.

As an example, imagine a 55-year-old woman in the hospital after having surgery lasting 60 minutes to treat a broken hip. She would score 1 point for her age, 5 points for her recent broken hip, and 2 points for the 60-minute surgery, for a total of 8 points.

Of the people who score 5 or more points, 40-80 percent develop blood clots.

Additional examples of risk factors for blood clots among hospital patients are obesity and smoking. In fact, most people who land in the

hospital are at risk, so it's worth paying attention to this potential complication to safeguard your life.

Louise received emergency treatment and recovered from her blood clot. Looking back, she was disturbed that the surgeon assumed right away that her new problem had nothing to do with the operation she'd just had. This dangerous assumption could have killed her.

Five action steps can help you avoid this deadly problem:

- If you know that you are going to be hospitalized, start to check your risk for blood clots by taking the easy quiz at preventdvt.org. It is called "DVT Risk Assessor Tool." (DVT stands for Deep Vein Thrombosis, the technical term for a blood clot.)
- Print out the results and talk with your doctor about them. Factors unique to you may mean that you have more risk or less risk than the quiz suggests.
- If you are at risk, ask for a plan to prevent blood clots.

- Make sure that the plan is put into action.
- Ask what symptoms to watch for and what to do if they arise. Generally, you will need immediate medical attention.

When you know about the often-overlooked risk that blood clots present, you can be on the alert to help prevent the needless tragedies they often create.

About the Author

Elizabeth L. Bewley is President & CEO of Pario Health Institute and the author of *Killer Cure: Why health care is the second leading cause of death in America and how to ensure that it's not yours*. She is also the author of a weekly newspaper column called "The Good Patient." To tell Elizabeth your story or to ask her a question, write to: thegoodpatient@pariohealth.net

***Editor's note:** A blood clot in the lung is called a pulmonary embolus. The tissue below the*

clot dies from lack of blood and oxygen. A large clot blocking a large amount of the lung can be fatal.

There are common measures used to prevent blood clots in the legs after surgery. You may have sleeves on your legs that inflate and deflate to stimulate the circulation. You may also have support hose on your legs that the nurses are expected to remove and reapply three times a day. You might receive injections of low dose heparin, called Lovenox. The nurses should instruct you to “pump your feet” or move your foot up and down ten times every hour while awake to stimulate your circulation.

The Centers for Medicare and Medicaid Services have identified the development of blood clots in the legs after total hip surgery as a preventable medical error. They have taken a stand that the government should not have to pay for care that results in preventable complications. If Louise was recovering from hip surgery and developed her blood clot in the hospital, and even if it had been diagnosed in

time, her hospital would not have received reimbursement for the care needed to treat her blood clot.

Had Louise died, her family may have spoken to a plaintiff attorney about whether the delay in diagnosis of her blood clot constituted medical malpractice. What her doctor should have done is take a more detailed history, examined her legs for swelling or pain, and sent her for a lung scan. The diagnosis of pulmonary embolus is discussed in more detail by Dr. Rosemary McGeady in our Inner Circle interview, [Reducing Cardiac Risks](#). Get details about this program on our website in the Educational materials tab. See <http://tinyurl.com/6mbljhx>

Pat Iyer



Sarah Jean Fisher
MSN, RN-BC, BA



Assessing Pain in the Elderly

Does it hurt to grow old? The answer is an emphatic “No.” But what does hurt the elderly under our care is lack of appropriate assessment and treatment of their myriad health conditions because “they didn’t ask for pain medication.”

Caring for the elderly, whether in a private home or long term care environment, presents challenges on several levels related to successfully managing their pain. There may

be multiple conditions afflicting the elderly patient and just as many reasons why the patient does not complain of pain. Some examples are:

- trying to be stoic for the family’s sake: “Why complain, it doesn’t help anyone by being miserable?”
- saying that nothing stops the pain all the time; I’m used to it;
- fearing looking weak;
- stating “I don’t want to be doped up most of the time”;
- having communication barriers;
- having cultural barriers due to heritage;

- being affected by cognitive barriers if the elderly person in question has dementia. The dementia patient may not realize that what she is experiencing is pain;
- believing that pain is inevitable in aging;
- having fears of becoming addicted to pain medication.

Caregivers face several potential barriers to successful management of pain in elderly loved ones and clients. The caregiver:

- may not be adequately familiar with the client's condition;
- may be reluctant to use opioids fearing addiction;
- may lack the knowledge of alternative and non-medication treatment regimens or the care team may not give adequate priority to pain management;
- most importantly, the caregiver may not recognize the symptoms being displayed as pain.

What is pain? Officially, it is an unpleasant sensory and emotional experience associated with actual or potential tissue damage (1). Yet, because of its complexity, one cannot easily create a definition to satisfy or describe the sensation adequately for all situations. Regardless of the situation, pain is whatever the person experiencing it says it is. Many caregivers emphasize its importance by calling it the fifth vital sign. (The others are temperature, blood pressure, pulse and respiratory rate.)

Pain may be acute or chronic. Acute pain usually has an identifiable source, an injury from trauma or surgery and is not long lasting. The goal is pain relief with rapid onset analgesics, with availability of suitable medication for breakthrough pain.

Chronic pain is caused by one or more conditions with a longer duration, lasting six months or longer. The goal here is to achieve pain relief and maintain pain control. With chronic pain, treatment is given regularly in

anticipation of pain to preserve maximum function and quality of life at the highest level. Chronic pain can be treated with opioid and/or non-opioid drugs and should be treated around the clock. Alternative treatments such as guided imagery, pleasure foods and nutritional protocols, relaxation techniques, aroma therapy, massage, hypnosis, heat/cold packs, and immobilization have been successfully used for break-through pain.

- Mild pain is treated with Tylenol or Tylenol with Codeine. The use of Darvocet is no longer recommended for elderly people because it takes so long to go through the system; there is risk of it building up in the blood to dangerous levels.
- Moderate pain is treated with Percodan, Percocet, Lortab, Vicodin, and Oxycontin.
- Severe pain is treated with Morphine, Dilaudid, Fentanyl and Methadone. Severe chronic pain is managed by cutting nerves, implanting pain pumps,

or infusing IV pain medication. The rule of prescribing medications for the elderly is “start low, go slow”. This means start with the mild drugs and slowly increase the dose based on the effectiveness of the pain medication.

How might elderly people show that they are in pain without using words? There are several key areas to assess for pain in dementia patients, non-verbal patients or patients who do not report pain: facial expressions, body position, body movements, moaning or other sounds, changes in level of alertness, mood, appetite, or sleep; and resistance to care. The elderly may respond to the pain by yelling, moving about, or striking out at the closest person or object, a loved one or a stranger. Be sure to consider biological needs when assessing your patient/client/loved one with dementia. Check for hunger, thirst, toileting and sleep needs before giving pain medication.

State surveyors who annually evaluate nursing homes for care given, policies, staff

performance and resident satisfaction align pain management with quality of life. They assign deficiencies in care against facilities who fail to assess, treat, monitor, and document its residents' pain management regularly and thoroughly.

For more information on pain management, try the following organizations and websites: The International Association for the Study of Pain; American Geriatric Society Panel of Persistent Pain in Older Persons; John A. Hartford Centers of Geriatric Nursing Excellence; www.ngna.org; www.amda.com; www.geriatricpain.org.

A closing thought from Albert Schweitzer, "We must all die. But if I can save him from days of torture, that is what I feel is my great and ever new privilege. Pain is a more terrible lord of mankind than even death itself."

The International Association for the Study of Pain (2002).

About The Author

Sarah Jean Fisher earned a master's degree in nursing from Thomas Jefferson University with emphasis on education and has been certified in gerontology for over 13 years. She has end-of-life training certification by ELNEC (End of Life Nursing Education Consortium) and her bachelor's degree in English is from Bucknell University. Sarah Jean has been a nurse for over 18 years. Long-term care has been her only focus. She has worked as a charge nurse, shift supervisor, and has been specializing in staff development/infection control for the past 8 years. She has presented original programs at the annual National Gerontological Nursing Association (NGNA) Conference and was the founding president of the Southeast Pennsylvania Chapter of NGNA.

Sarah Jean has also worked for four years as a geriatric nursing expert witness with Med League Support Services reading and evaluating medical records for attorneys related to potential litigation. She is a widow

with 4 grown children, 11 grandchildren and her first great-grandchild. She can be reached at SJF94@comcast.net

[Challenges of Caring for Elderly Parents](#)

Get more details at <http://tinyurl.com/d7vnwyl>

This program is an interview between Pat Iyer, President of Avoid Medical Errors, and Alicia VanBuskirk. When you purchase this program, you will receive the interview in audio form, transcript and 3 bonuses.

What you will learn



Alicia VanBuskirk RN discusses challenges of caring for elderly parents. The elderly are at risk for injury from safety hazards, as well as medical errors due to their typically complex medical problems and medications regimens.

You will learn

- that the person over 65 years old goes on average to the doctor 8 times a year and thus has more opportunities for medical errors.
- concrete and practical suggestions for helping your parents communicate with their physicians (and much more).



Kaye Rice MEd CN

Why Resistance Training Belongs in Everyone's Fitness Plan

Beginning in our late 30's to early 40's the average person loses about $\frac{1}{4}$ pound of muscle every year. This means by the time we hit 80, we may have lost about $\frac{1}{2}$ of our muscle mass. The loss of muscle as we age is called "sarcopenia". Science has not proven how much of this is hardwired to the aging process and how much of this is caused by poor nutrition and lack of physical activity. Having seen many people in this age range stop

muscle loss, or even regain muscle through changing their lifestyle habits, I suspect the latter. Please read on to see how you can benefit.

Maintaining our muscle mass is essential for being healthy, vital and independent as we grow older. It keeps us strong and mobile, and tugs on bone to help our bones stay strong. A pound of muscle requires 30-50 calories per day just to maintain itself, as opposed to fat which has no calorie requirement for maintenance. Your lean body mass, or your muscle mass, is the metabolic engine in your body. Therefore the more muscle you have the

higher your metabolism and the easier it is for you to stay trim.

The best way to maintain or increase your muscle mass is through proper nutrition and strength training. The ACSM (American College of Sports Medicine) recommends doing strength training 2-3 times per week for optimal results. If you are consistent with at least twice per week you will get good gains with muscle and bone strength. Even one day a week is beneficial, although not optimal.

Here are some other benefits of strength training:

- More muscle mass means lower blood sugar, reducing your risk of Type 2 Diabetes. If you already have diabetes you can improve your blood sugar control.
- Strength training will lower your risk of developing osteoporosis and can even improve bone density. Prevent fractures by more muscle and better bone density.
- Maintaining muscle mass prevents frailty. When we lose our muscle mass as we

age and become frail, the risk of falls and loss of independence increases for the elderly population.

- Increased muscle mass improves sports performance.
- Strength training helps reduce arthritis and lower back pain.
- Strength training helps fight depression, improves sleep patterns, and increases self-confidence. You will look and feel better which will elevate your overall well-being.
- A good strength training program can turn back the clock as much as 20-25 years.

A note on nutrition

The higher quality foods you eat the better results you will get from your strength training program. The ADA currently recommends 20% of our diet should be from protein. There have been a couple of studies which have shown that for our middle age population, 20% protein is sufficient to maintain health but it is NOT sufficient to prevent muscle loss as we age. Make sure you are eating high quality foods

and getting all three nutrient groups each time you eat: carbohydrate, protein, and fat. Better nutrition equals better results.

It doesn't take long to start getting results from your efforts! Each session should take about 30 to 45 minutes. You need to do 2-3 sets of 6-10 different exercises in order to work different muscle groups. How much weight should you use? Everyone is different, but here is a good gauge. You should be able to perform the exercise, maintaining good form, 8-12 times, but after that the weights should feel too heavy to maintain proper form in the exercise. (Good form means both the proper position for your body to target the intended muscle *and* good posture.) As soon as you cannot maintain proper form, stop. Start with lighter weights, make sure you are using good form, and then progress to heavier weights as you build muscle. Maintaining good form is essential. Remember, small consistent steps yield the best results.

As always, get clearance from your physician before starting any exercise program. If strength training is new to you, it is worth your investment to hire and work with a good personal trainer for a few sessions to make sure you are hitting all the muscle groups, and using correct form and the appropriate weights for your strength level. For more information, please visit my website www.kayrice.com .

About the Author

Kay is a Primordial Sound Meditation Instructor and Vedic Master, certified by the Chopra Center for Well-Being. Primordial Sound meditation is a mantra-based meditation process in which individuals receive personal mantras based on their birth information. If you would like more information about meditation or Primordial Sound Meditation, please contact Kay at kay@kayrice.com or visit her website at www.kayrice.com



Aila Accad RN, MSN



Preoccupation, Interruptions and Multitasking Lead to Medical Errors

According to the Institute of Medicine, an estimated 7,000 deaths in the United States yearly are due to medication errors. And, the Agency for Health Research and Quality estimates over 770,000 patients are injured each year from medication errors. An error occurs in one of every five doses of medication in the hospital.

These errors occur from a missed dose or wrong timing, inaccurate measurement, medication interactions, expiration or improper storage, confusion in medication or patient names, or incorrect route of administration. There can be errors in prescribing, transcribing an order or verbal order, misreading a label or incorrect documentation. One third of all errors are due to similar drug names.

These errors can happen at any point along the process from prescription by the healthcare provider, to dispensing by the pharmacist or to administration by a nurse, ancillary staff person or patient. When you realize all the steps in the chain of getting a medication to a particular

person, it is easy to see how vigilance and attention are essential to prevent errors.

Many studies are examining how inattention from distractions, preoccupation and multitasking contribute to medical errors. Inadequate staffing and work overload contribute to increases in interruptions and multitasking.

An Australian Health Informatics Research and Evaluation Unit reported that nurse interruptions resulted in a rise in serious medication errors. It was clear that when interruptions escalated, quality decreased. Interruptions included alarms going off, phone calls, co-worker inquiries and searching for supplies. Several studies report that information is lost during interruption. Multitasking creates a higher memory load, both contributing to medical error. They also found that most nurses accept interruptions as part of the job rather than taking steps to prevent them.

When it comes to something as detailed as preparing and delivering medications, interruptions and distractions can be dangerous and at times fatal. Providing proper medicine dosage, delivery and documentation demands full attention to detail.

Providers must not short cut the safety procedures of double checking dosage, route and patient identification. It is also important to clarify poorly written prescriptions with the provider rather than making assumptions about what might be meant. This applies to anyone who is looked at a prescription, including you.

Patients and family members can also be more vigilant and aware of the influence of distraction and interruption on their care and use of medication. Avoid talking to a nurse when he or she is preparing medications. Wait until the process is complete before asking a question or making a comment. Be assertive in checking with your provider when medication looks different than your previous dose or prescription.

You are an important co-participant in your care. Preventing medical errors from preoccupation, distraction and multitasking requires vigilance on everyone's part.

About The Author

Aila Accad, RN, MSN is an award-winning speaker, bestselling author and certified life coach, who specializes in quick ways to release stress and empower your life. A health innovator, futurist and member of the National Speakers Association, she is a popular keynote speaker and radio and television guest. Her bestselling book *Thirty-Four Instant Stress Busters: Quick Tips to De-stress Fast with no Extra Time or Money* is available at www.stressbustersbook.com. Sign up for *De-Stress Tips & News* at www.ailaspeaks.com and receive a gift, "Ten Instant Stress Busters" e-book.

Dramatically reduce stress and build an unshakable lifelong resistance to it. The damaging emotional and physical problems associated with stress may never be a problem again. Increase your mind power by switching on "hidden" receptors in your brain. These are shut off due to years of external noise and stress and even stress inducing signals from the T.V. and radio, negative thinking and poor education. Get help with feeling low, overwhelmed and anxious.

You may break free from phobias and behavioral problems such as ADHD, OCD, overeating, smoking, drugs and alcohol abuse. [Get more information.](#)



Dean Dobkin MD



How Long Should You Wait for Care in an ER?

I was shocked. I've been working in emergency rooms since 1977, and I remain shocked that I don't know the answer. How long is too long? How long should you wait before getting up and walking out of the emergency department to seek care elsewhere? A lot of considerations go into a question like this, things that weren't issues when I started in this field. There's no pat answer. It doesn't fit into a box. You can't simply come to an estimate by trying to figure

how many doctors and nurses there are, and how many patients are waiting to be seen.

A growing problem – now in almost every emergency department – is “boarding” patients. Patients are seen; the decision is made to admit the patient; and there is no bed available on the admitting unit inside the hospital. So the patient waits – is “boarded” – in the emergency department. Sometimes these patients are boarded for over a day. They require care; they've already shown themselves too sick to be discharged. The emergency staff tends to them while less acute, less severely ill patients wait in the waiting room. They use another precious resource that is growing more scarce in

modern emergency departments; they take emergency department stretchers.

The beautiful, state-of-the-art, 28-bed emergency department may have 20 people waiting to be admitted. That leaves eight beds to see new patients. Worse, there may be 25 patients in stretchers or wheelchairs in the hallway ... you get the idea. Where does that put you? Right where you are - in the waiting room. In “the good old days,” there were formulae that could be used to estimate the staffing needs of the emergency department based on the number of patients, and the average acuity. “Acuity” refers to how sick the patients are; patients who require admission are considered to have “high acuity.” They take more time.

Under “usual” circumstances, or in a more nearly ideal world, an average, reasonable competent emergency physician can see about 2.8 patients per hour. Add a physician extender – a midlevel practitioner such as a PA (physicians assistant) or nurse practitioner –

and you can increase that number by about one patient per hour, give or take. In that scenario, when the doctors and nurses are not also tending to the needs of admitted patients, an emergency department staffed by a doctor 24/7 and a PA from noon to midnight daily could reasonably see around 25,000 patients per year – not too far from the norm for a usual community hospital.

Throw into the equation that you know neither how many admitted patients there will be at any given time, nor how many beds are open in the ER. There does not exist the data to figure out how fast patients will be seen. We – emergency department personnel – know that the longer the wait times, the more there will be missed opportunities to provide medical care to those coming through our doors. That’s the last thing we want.

There is no solid evidence to show the patients who walk out are of low acuity and leave safely. In fact, the demographics of these patients often escape us; they are the “LWBS,”

the patients who Left Without Being Seen. Should you be one of them?

First, if you can't walk, you probably shouldn't try. If you're already in the treatment area, then the process has likely already started that will provide you with the care you need. Stay. It may take a long time, but if you're under evaluation and treatment, then leaving is a bad idea. If you leave after being seen because you're tired of the wait, you'll have a rude awakening when you reach the next hospital up the road. You start from scratch, in the ER, and they might not have any stretchers on which to put you in their facility. If you are able to decide whether to stay – you're not too sick to go elsewhere. First, look around and see if other patients are being called back. See if anyone is being discharged. If no one is being called back, and no one is being discharged, you're going to be there for a long, long time.

You can come to that type of conclusion after an hour or so. You can ask the staff for a reasonable estimate of your wait to be seen.

The staff will never, ever suggest that you leave. They may, however, give you an indication whether your wait will be closer to two hours or twelve.

- Ask if the department is on “divert,” meaning they've told the local ambulance services they are too busy to accept incoming ambulance patients.
- Ask if the back is filled with patients who are “boarding.” There's no reason they shouldn't tell you.
- Ask if there are open beds for patients – like you – to be seen. You will probably already know if the ER has an “urgent care” or “fast track” side. Hospitals tend to brag about this type of service, designed for the less acute patient to be able to be seen, treated, and discharged in a relatively short amount of time.

If you're waiting to be seen in a hospital's “fast track” area, then you probably should stay. You've already been determined to be without a life-threatening ailment, and it's simply a matter of waiting your turn. Not a simple question; nor is the question, “Where do I go

from here?” That’s when it might be a good idea to have an idea before you leave of what the situation is in the other local hospitals. However, it is really difficult to get that information. If you call up another hospital’s ER to ask about wait time, they may not be able to give you an accurate answer.

One other idea: Hospitals tend to be less busy from about 2 a.m. until 8 a.m. or 9 a.m. I’m not advocating you “sit” on a true emergency until 2 a.m., but you certainly might have a shorter wait.

About the Author

Dean Dobkin, M.D., is a practicing emergency physician at the Philadelphia Veterans Affairs Medical Center. A graduate of Albany Medical College in 1976, Dr. Dobkin completed residency training in Emergency Medicine at the University of Illinois while the specialty was in its infancy. He has been certified and recertified three times, as a specialist in Emergency Medicine by the American Board of Emergency Medicine. He has experience

acting as faculty for an emergency medicine residency program, has held academic appointments at two Philadelphia medical colleges, and acted as an emergency department director at a variety of different hospital emergency departments. He has been honored by being named a Life Fellow of the American College of Emergency Physicians (ACEP), after serving with distinction for that organization. Dr. Dobkin chaired the Pennsylvania Chapter’s membership committee, represented the Chapter at the National Council, coordinated their one day seminar series, and was elected as Officer of the Board of Directors for six years. Dr. Dobkin has acted as a consultant for PEER Review organizations, the Jefferson Health System, the Commonwealth of Pennsylvania, and the United States government. Dr. Dobkin lives with his wife and family in southern New Jersey. He testifies as an expert witness in emergency medical care. Contact him through patmedleague@gmail.com.



Carol Kivler MS CSP



A Friend's Reminder to Live Life to its Fullest

“One never goes so far as when one doesn't know where one is going.” – Johann Wolfgang von Goethe

When first diagnosed with a mental health disorder, life is confusing and discouraging. If you haven't been exposed to others with a similar ailment, you are unaware of not only the symptoms but the long-term effects. Let's add in the bleak realization that these disorders are not curable – talk about being blindsided. So where does one start?

Start with gathering, studying, and analyzing information regarding your disorder. Gradually move onto finding and networking with others, who have lived with similar diagnoses. From there find your path to a way to manage your illness, which will assist you in remaining in recovery for longer periods.

What I've come to learn is that it doesn't matter what physical or mental ailment you find yourself carrying – the ultimate goal for each of us is to learn to live life to its fullest – making each day count. Even on your bleakest, most consumed days your goal is to live. How you

choose to live to get to the next day remains with you.

Recently I buried a long-ago friend. A physical illness took her life in a mere ten months. Up to that point, she was healthy and vibrant. Posters filled with pictures of her life lined the slow march up to her coffin. It was evident Jan lived life to its fullest – thanks, dear friend, for reminding me to do the same.

Reflection Question

What can do you today to live life to its fullest?

About the Author

Carol A. Kivler, MS, CSP, President of Kivler Communications, is a speaker, motivator, training consultant executive coach, and author. Her company provides customized corporate training and development, organizational development, and executive coaching to a wide range of corporations, organizations, government agencies, and school systems.

Carol delivers programs known for their intriguing learning environment, interactive exercises, and appealing materials. She has conducted more than 2,500 corporate programs and motivational speeches.

Editor's Note: We welcome Carol to our panel of authors with this first column. Pat Iyer

Magnetic Goals * Get details at <http://tinyurl.com/78cfu9f>

This program is an interview between Pat Iyer, President of Avoid Medical Errors and Cathy Demers. When you purchase this program, you will receive the interview in audio form, transcript and bonuses.

Cathy Demers discusses how you can set and magnetize your goals to achieve your objectives. She will help you define

- how to use magnetic goals to overcome obstacles and rise to the top
- what people want more of and less of
- why so many people do not set goals and how that harms them
- how you can use the power of the reticular activating system in your brain to help achieve goals
- how to take impotent goals and make them magnetically charged



Kathleen Cunningham CMLC



Plastic Surgery: The Sometimes Dangerous Search for Perfection

According to the American Society for Aesthetic Plastic Surgery, 92% of patients undergoing elective plastic surgery are women. The most popular non-surgical cosmetic procedures are Botox injection, laser hair removal, microdermabrasion, chemical peel and collagen injections. The most common surgical procedures are liposuction, breast augmentation, eyelid surgery, rhinoplasty ("nose job") and female breast reduction.

The number of plastic surgery procedures has increased in recent years. Each person who undergoes plastic surgery has her own reason for opting to have what many consider "unnecessary" surgery. For many, the reason is not so much a physical or medical reason to go under the knife, but rather a psychological one. Sometimes there is a desire to improve self-esteem, self-confidence or just a need to feel better about oneself. There is nothing wrong with that, but before submitting to surgery and the inherent risks, potential patients would be well served by doing some serious reflection to find out the real reasons behind seeking this kind of surgery.

Some patients have the surgery to please themselves and some patients do it to please someone else. Whatever the reason, prior to undergoing any elective cosmetic procedure, enter the surgery with full informed consent and awareness of the potential risks and potential cosmetic outcomes.

Celebrities offer examples of the effects of cosmetic surgery. Many people in the public eye are quite open about their surgery and absolutely love their results. However, it's the folks you don't see that you should consider as well. There have been many instances of horrible outcomes (including death) from cosmetic surgery. The number of medical malpractice suits has been increasing. Many people feel that the reason for the increased number of lawsuits is that many physicians are doing plastic surgery, but do not have sufficient training in the subtleties of plastic surgery and poor outcomes. Actual physical injury and even death can result. Many of the lawsuits claim that the surgeon failed to warn the patient

ahead of time about risks and possible outcomes.

There are many areas of controversy in plastic surgery. Younger and younger patients are asking for cosmetic procedures. This raises questions about their motivations and if psychological issues are involved. The standards of beauty that young women face can be unrealistic. If Barbie was a real life human being, she would be six feet tall with measurements of 39-18-33 and would wear a size three shoe. Young women, in particular, may feel pressure to look "perfect". Absolute perfection cannot be achieved.

Some people are "addicted" to plastic surgery. A woman listed in the Guinness Book of World Records has undergone over 100 surgeries in her quest to be a "real life Barbie". It raises issues of whether a surgeon should simply say "no" to patients requesting procedure after procedure.

People with eating disorders, body image issues and Body Dysmorphic Disorder (BDD)

are especially at risk of undergoing a procedure for the wrong reasons. People with Body Dysmorphic Disorder are preoccupied with slight or even imaginary flaws. Many people approaching plastic surgery have unrealistic expectations of how they will look after the procedure. If the expectation is that the patient will appear 25 years younger, she may be setting herself up for disappointment. Depression is quite common after cosmetic surgery, perhaps because the results fell short of expectations or because she is not seeing the full benefit of the surgery soon enough.

A person considering plastic surgery should do some thorough investigation and self-searching prior to undergoing the surgery itself. In order to raise the chances of a safe and satisfactory outcome, take steps before signing on the dotted line.

Most plastic surgery procedures are done for cosmetic reasons, not to improve function or correct an abnormality. A cosmetic procedure

is still surgery and the decision to proceed should not be taken lightly.

Here are some suggestions:

- See your family doctor to make sure you are healthy enough to undergo surgery.
- Find out if the plastic surgeon is board certified in plastic surgery. This can be ascertained by checking with the American Board of Plastic Surgery and the American Board of Facial Plastic & Reconstructive Surgery. This information is available free of charge from the American Board of Medical Specialties or by calling the board directly and asking for a doctor's certification status. It is very important that you take the steps to ensure that your surgeon has had sufficient training and experience.
- What are the doctor's credentials? Where did he go to medical school? Did the doctor do a residency in plastic surgery? Most state medical board websites have this information available to the public.

- Where will the surgery be performed? Many *cosmetic* procedures are done in doctor's offices, but *actual* surgical procedures should be performed in a hospital setting just in case there are complications. If complications do arise, you will be in a hospital setting with proper monitoring and resuscitative equipment as well as having access to personnel with the skill to properly manage a complication.
- If the procedure is to be done in an office setting or small surgery center, find out ahead of time if the doctor has admitting privileges to a hospital.
- How many times has s/he performed your particular procedure? Ask the doctor.
- Ask to speak with other patients about their experiences.
- Ask to see before and after pictures of other patients.
- Ask your surgeon what type of anesthesia will be used. Will you be put to sleep? Will a local anesthetic be used or a regional block?
- Check out the anesthesia provider. Is the person providing the anesthesia an

MD anesthesiologist or a Certified Registered Nurse Anesthetist? Find out the qualifications and level of training of the anesthetist.

- How long is the recovery time?
- Will there be restrictions of any kind during your recovery period?
- How does the postoperative follow up work?
- Does the surgeon recommend a psychological evaluation prior to surgery?
- What is the expected aesthetic outcome of the procedure?
- Insist on an exhaustive explanation of risks, benefits and alternatives.

Plastic surgery is still surgery and results in some degree of trauma to the body. Do not make the decision casually. Be informed, educated and safe.

About the Author

Kathleen Cunningham is a Medical Investigator /Certified Medical Legal Consultant with 20 years of experience in her field. Ten of those

years were spent as the full time in-house medical investigator for Gerry Spence's nationally recognized law firm in Wyoming. For several years she functioned as the in-house medical legal consultant for the law firm of Meyer and Williams in Wyoming.

Editor's note: We welcome Kathleen to our panel of authors with this first column. Her column makes me think of a plane trip I took. I sat a row in front of two attractive women in their 30s. They were discussing when they should start Botox injections in their face. What struck me was not IF they should use Botox but WHEN they should. They also discussed their ideal boyfriends. He should have wide shoulders, narrow hips and long legs. I did not hear anything about morals, personality or values, such as kind, responsible, or a good provider. Be careful what you wish for. I'm just saying. . . Pat Iyer

Killer Cure by Elizabeth Bewley * Get details at <http://tinyurl.com/ch9dgch>



This program is an interview between Pat Iyer, President of Avoid Medical Errors and Elizabeth Bewley. When you purchase this program, you will receive the interview in audio form, transcript and a bonus.

What you will learn

Patient safety expert Elizabeth Bewley exposes the sources of errors in the healthcare system. Health care kills more than 600,000 people every year, the equivalent of the population of Boston.



Nancy Collins
PhD, RD, LD/N



Alcohol Abuse and Associated Health Conditions

Alcohol and weight

Alcohol should count as a “fat” in the diet, even though many alcoholic beverages are fat free, because alcohol most likely promotes fat storage, which leads to the “beer belly” effect that we have all have heard about. Alcohol contains 7 calories of energy/gram (g).

Carbohydrate and protein contain 4 calories/g, and fat contains 9 calories/g.

To calculate how many calories are in a drink, use the following equation:

Calories = fluid ounces (fl oz) of beverage x proof x 0.8 calories

Calories in common beverages

Beverage	Calories
Wine, dry red or white (4 fl oz)	85
Bloody Mary (5 fl oz)	116

Beer, regular (12 fl oz)	150
Martini (2½ fl oz)	156
Whiskey sour (4 fl oz)	164
Gin and tonic (8 fl oz)	182
Wine cooler (12 fl oz)	215
Daiquiri (4 fl oz)	222
Piña colada, no ice (4 fl oz)	228
Margarita, no ice (4 fl oz)	267

Determining how much alcohol is in your drink

The percentage of alcohol is stated as “proof.” Proof equals twice the amount of alcohol in the drink. For example, 100-proof liquor is 50% alcohol. A standard serving of alcohol delivers ½ fl oz of ethanol. One standard drink is:

- Wine: 3-4 fl oz

- Wine cooler: 10 fl oz
- Beer: 12 fl oz
- 80-proof whiskey, gin, brandy, rum, or vodka: 1½ oz

Unless you are mixing your own drinks, it is hard to determine how much ethanol each drink contains. It is important to note that a woman will absorb one third more alcohol than a man of the same size.

Alcohol and cardiovascular disease

The studies regarding the beneficial effects of alcohol on heart disease risk remain controversial. No beneficial relationship was seen in the 6,000 men who were followed for 20 years; in fact, an increased overall risk of mortality from all causes was seen in men who drank more than 22 drinks/week. In addition, men who drank more than 35 drinks/week had twice the risk of dying from stroke. Grape juice, rather than red wine, is probably a better choice for lowering blood pressure.

While it is reported that wine contains phytochemicals, which act as antioxidants, it is

important to note that alcohol itself may cause oxidative stress that may damage the liver and pancreas. Alcohol causes an increase in triglycerides. At autopsy, the heart of a person who suffered from alcoholism will weigh twice as much as a heart of a nonalcoholic. Still, some researchers recommend a moderate alcohol intake for reduction of cardiovascular disease. At any rate, it is not recommended that a man consume more than two drinks/day or a woman more than one drink/day.

Alcohol and cancer

A correlation exists between alcohol consumption and breast cancer in young women. In addition, relationships between alcohol usage and cancers of the liver, mouth, throat, esophagus, colon/rectum (especially in beer drinkers), and the lungs is documented. Once cancer has developed, alcohol appears to spur progression.

Alcohol and the elderly

Having an alcoholic drink 20 minutes before mealtime is shown to improve appetite. It also seems to improve morale, stimulate sociability,

and help with sleep. Improved staff-resident relations are reported in nursing homes that allow residents to drink a moderate amount of wine.

Alcohol and the brain

The brain shrinks in people who drink moderately or excessively. The extent of the shrinkage correlates to the amount of alcohol consumed. Alcoholics who abstain from all alcohol and eat a healthful diet can reverse some, or all, of the brain damage. However, the damage is sometimes irreversible, if the person has drunk alcohol in excessive amounts for a long time, and permanent harm to memory, vision, and learning ability may occur.

Alcohol and mineral loss

The dehydration caused by alcohol consumption may lead to deficiencies of magnesium, selenium, phosphorus, potassium, calcium, and zinc, if proper nutrition is ignored. A long list of health issues may result from these deficiencies, including damage to the

nervous and muscular systems and inappropriate fluid balance.

Other nutritional issues associated with alcoholism

- Failure to absorb thiamine, vitamin B₁₂, and vitamin B₆ (in addition to the destruction of existing B₆)
- Failure to activate vitamin D
- Failure of rod cells in the retina and liver cells to process vitamin A
- Expulsion of folate from storage and excretion into the urine, in addition to an inability of the intestine to retrieve any – folate deficiency is the cause of Wernicke-Korsakoff syndrome in alcoholics
- Protein-energy malnutrition
- Scurvy

Alcohol and the liver

Alcohol causes the liver to make more fatty acids, which results in fat accumulating in the liver, even after a single night of heavy drinking. Of course, if a person is not drinking heavily every night, within a few days the fat will clear out of the body. However, in heavy

drinkers, fatty liver is the first stage of liver damage.

If a person has a fatty liver for long enough, fibrous scar tissue will form, known as fibrosis. Even fibrosis is curable with abstinence and a healthy diet. However, if a person continues to drink, cirrhosis develops, which has no cure. With cirrhosis, the liver cells die and the body cannot regenerate them.

Other health conditions associated with alcohol abuse

- Ulcers
- Nonviral hepatitis
- Kidney, bladder, pancreas, and prostate damage
- Impaired immunity
- Sexual impotence in men
- Reproductive issues in both sexes
- Bone deterioration and osteoporosis
- Central nervous system damage

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About the Author

Dr. Nancy Collins, founder and executive director of RD411.com, is a registered and licensed dietitian. Dr. Collins has over twenty years of practitioner experience in clinical nutrition and consulting to the health care industry. She is nationally known as a medico-legal expert dealing with the issues of malnutrition, wound healing, and regulatory compliance and has served as an expert witness in over 400 legal matters.

Dr. Collins is a frequent speaker at medical education symposia and a prolific author. Dr. Collins is an editorial advisor to the journal

Advances in Skin and Wound Care, a contributing editor for *Ostomy-Wound Management*, and a columnist for *Today's Diet and Nutrition*. She is also the member of many medical advisory boards including the American Professional Wound Care Association, which granted her Fellow status.

Dr. Collins is a Past President of the Florida Dietetic Association and a past Chair of the Nutrition Entrepreneurs DPG. Currently, she holds the position of Delegate to the American Dietetic Association. In 2003, Dr. Collins was awarded the Dietitian of the Year Award for her longstanding contributions to the profession of nutrition. In 2009, she was awarded Nutrition Entrepreneur of the Year for her visionary projects and forward thinking.



Kimberly Stevens



Don't Just Sit There ... Do Something

Isaac Newton said it best (or least most accurately) ... "A body in motion tends to stay in motion." Ain't that the truth?

Speaking as a person who has gone to the gym regularly for most of my adult life, when the economy took a nosedive so did my workout schedule. Attempting to balance an increased workload with two small children, an impending divorce, and a second business

hard hit by the recession, my ability to fit in a trip to the gym hit a brick wall.

Prior to this time, I had been working out five days a week and was in the best "rock-hard-abs" shape of my life. But when hit with the perfect storm of life's events, I was forced to give up the system that worked for me, and I was lost.

Despite my love of exercise, I'd never felt inspired to work out at home, and while I could put together an effective exercise program using no equipment at all, I just didn't have the energy or mental motivation to do it.

The irony is that one of the things I had loved most when I was still in my pumped-up workout phase was the boundless energy it gave me the rest of the day. I could lift heavy things, run with my children on the playground and frequently took the stairs two at a time.

But the emotional drain of my divorce and increased stress just zapped my motivation, and while I knew that exercise would give me more energy, day after day I chose stress-eating over exercising.

This resulted in going from being in the best shape of my life at 40 to the worst shape of my life at 42. Had you told me that I could possibly have gotten to a point where I wouldn't work out for two years straight, I would have thought you had lost all of your marbles.

After all, I had worked out at least three times a week since I was 18. Finding a gym was the first thing I did when I moved to any new town, and I had belonged to at least 10 different gyms in my lifetime. As sick as it sounds to some, I actually love working out.

But as happens to many people, life got the better of me, and I ended up on the wrong side of the exercise continuum – the one that said zero days/week.

Ironically, while I was slowly getting into the worst shape of my life, my 70-year old father was starting to exercise for the first time in his life. He'd always been rather sedentary working in a job that required him to be on his feet for some of the day but spending the remainder of his life in his recliner.

Yet in the years when I had fallen off the workout wagon, he had actually worked his way up to walking three miles and climbing the bleachers of the nearby high school every single day. When I asked him about how he did it, he said he started by walking $\frac{1}{4}$ of a mile and worked his way up. I was so proud of him.

As for me, I never did gain the desire or discipline to work out at home, but when I was finally able to go back to the gym after a two-year break, my first weeks back were off to a similarly slow start in comparison to where I

had been. But over time, just like dear old dad, I was able to work myself back up to where I wanted to be.

We all experience life's curveballs at one time or another, and even regular exercisers can find themselves having to start over. But the most important lessons for going from sedentary to active are the same no matter what your age or exercise history.

To get off to a good start, use these five keys to increasing your exercise success:

1. **Reality Check** – be realistic about where you are now and get advice as needed. If you've never exercised in your life, get some guidance from a doctor or a personal trainer. My dad's workout was simple, but even my recommendation to get high-quality shoes was something that enabled him to continue his workouts when his joints and shins started hurting from the lack of support from his el cheapo sneakers.
2. **Motivation** – figure out what will motivate you to continue when you just don't want to. My dad had COPD (chronic obstructive pulmonary disease) and as a result had trouble breathing. With the use of a couple of medications, he was able to improve his breathing and start his walking routine. However, his real motivation for keeping it up and increasing his endurance was his desire to go to the Nascar races when they came to town. His daily 3-mile walk and bleacher climbing was actually task training for what was required on race day.
3. **Enjoyment** – pick the thing you enjoy the most. Don't force yourself to do something you don't really like to do just because some magazine said it's the latest craze. Pick the type of exercise that appeals to you most and you'll be far more likely to stick to it.
4. **Schedule** – set a schedule and don't deviate from it unless you are replacing it with another schedule. No excuses. Just accept that this is your exercise

schedule and don't even allow yourself to consider skipping it except for something very special.

5. **Planning** – create or get someone else to create a workout routine that will help you reach your goals based on where you're starting from. Don't just do whatever comes to mind or whatever few exercises you happen to know. Either use a workout routine you find in a magazine or online that's suitable for you or hire a personal trainer to create one for you that you can do on your own thereafter. Do this entire routine every time until you replace it with another updated routine. Change it up every 8 weeks or so to keep your body challenged.

About the Author

Kimberly Stevens is an author, speaker and coach who frees people from their self-imposed traps around food, money, and relationships. Her upcoming book, *You Can't Outrun a Candy Bar*, will inspire, educate and guide readers to attain healthy and sustainable weight loss once and for all. She writes frequently on topics including diet, fitness, marriage, divorce, happiness and money on her blog at www.kimberlystevens.com

Whether you've been sedentary your whole life or have fallen off the workout wagon in recent years, the only way to begin is to begin. If you follow these few guidelines, you'll begin seeing and feeling results in a matter of a few weeks. Just begin.

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