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Avoid Medical Errors Magazine

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Patricia Iyer
MSN RN LNCC

Cataract Surgery – The Easy Way

In November 2011, I had cataract surgery on my left eye. I returned to the hospital a month later to have the other eye operated on. It was an entirely different experience.

My husband and I got up at 4:30 AM to make it to the hospital waiting room at the very early time of 6:15 AM. "You'll be his first patient", I was told. We immediately noticed the woman who shuffled in with a walker and her husband. Her eyelids were cherry red. We also noticed the young mother and her baby, who looked to be about 2 months old. The *baby* was the eye patient. The mother and grandmother of the baby anxiously watched as the child was taken away for surgery. In fact, I watched *every* patient taken away for surgery while I waited in the holding room.

As he did last time, my surgeon again checked the dot pasted over my eye to be operated on, and wrote his initials on my forehead to mark the spot. I noticed that he politely greeted the staff, and that they responded to him with pleasantries. (It is very important for your doctor to get along with the staff.)

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When the cheerful anesthesiologist stood at the bottom of my stretcher, he shot off a series of rapid fire questions. I could tell he asked the same questions over and over – "Any medical problems, do you smoke, do you drink?" Then he said, "I promise you will feel no pain and no awareness of what is happening." "Oh, really?" I told him. "I felt pain last time." He looked puzzled. "You did? There is no knife or needle." I told him I don't know what caused the pain but I did feel pain at the end and asked the doctor for pain relievers, which he would not give to me. Then the anesthesiologist looked uncomfortable and reminded me I would not have to have cataract surgery again as both eyes would have been operated on.

The patient with the cherry red eyelids went off to the operating room before I did, and I suspect her surgery was more involved than mine; she had the same surgeon I did. When the nurse anesthetist and operating room nurse came to get me, the nurse anesthetist immediately gave me a full 3 cc syringe of Versed (sedation) as she was wheeling my stretcher down the hall to the operating room. That seemed to be the height of efficiency. But then we waited and waited in the operating room for my surgeon to finish up with the cherry red eyelids lady. I floated in a pleasant Versed-induced haze, dimly aware of the voices of the operating room nurse and nurse anesthetist. At one point, one of them said, "She's asleep." "No, I am not, I can hear everything you are saying." It got quiet then.

While still waiting for the surgeon, I developed the hiccoughs. "My surgeon is not going to like this", I told them. I imagined him trying to operate on my eye while I was hiccoughing. Ever the helpful patient, I remembered that Thorazine can be given for hiccoughs and asked the nurse anesthetist if she had any. "No, we don't have anything like that here." The next thing I knew, I woke up. My wrists were tied to the stretcher (me, in wrist restraints!) The surgeon said, "I'm taking the clamps and mask off. We're done." Wow! I got to sleep through the surgery.

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The nurse anesthetist told me she gave me Fentanyl, a fast acting pain reliever. Fentanyl took away awareness of surgery. I saw the first surgery taking place; I did not need to see the second one too. My curiosity was satisfied. My husband helped me walk to the car, as Fentanyl made it hard for me to walk a straight line. Fentanyl also made me see double cars on the highway headed home. Fentanyl allowed me to take a nap when I got home. Fentanyl is now my new best friend.

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.

Killer Cure

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. You will learn vital information to keep you safe. In this program, Elizabeth:

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- discusses how communication issues harm patients, and why you need to be the CEO of your own health care.
- stresses why it is important for you to know what questions to ask about your healthcare options and offers examples of the questions.

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ACL Injuries

Anterior Cruciate Ligament Injury (ACLI) is most often a result of low-velocity, noncontact, deceleration injuries and contact injuries with a twisting component. Contact sports also may produce injury to the anterior cruciate ligament (ACL) secondary to twisting, stress caused by outward movement of the knee, or the leg being hyperextended (straightened too far) directly related to contact or collision.
The importance of the ACL has been emphasized in athletes who require stability in running, cutting, and kicking. The ACL-deficient knee has also been linked to an increased rate of degenerative changes and meniscal injuries. For these reasons, approximately 60,000-75,000 ACL reconstructions are performed annually in the United States.

The ACL is composed of connective tissue that attaches the femur to the tibia. The ACL is composed of two groups, the anterior (in the front) and posterior (in the back of the knee) bands. During bending the knee, the anterior band is tight while the posterior is loose; during extension, the posterior band is tight, while the anterior band is loose.

Frequency

An estimated 200,000 ACL-related injuries occur annually in the United States, with approximately 95,000 ACL ruptures. Approximately 100,000 ACL reconstructions

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are performed each year. The incidence of ACL injury is higher in people who participate in high-risk sports such as basketball, football, skiing, and soccer. More females are injured than males.

History

Most ACL injuries may be diagnosed through a careful history emphasizing mechanism of injury coupled with a good physical examination. A previous ligament injury may be the cause of instability. An audible pop often accompanies this injury, which often occurs while changing direction, cutting, or landing from a jump (usually a hyperextension/pivot combination). Within a few hours, the knee becomes swollen. Athletes usually are unable to return to play because of pain, swelling, and instability or giving way of the knee. High energy traumatic injuries are often associated with other ligamentous and meniscal injuries.

Physical

The standard of care requires the physician to do an organized, systematic physical examination when examining the joints. Immediately after the acute injury, the physical examination may be very limited due to apprehension and guarding by the patient. The basic examination should include the following:

- The doctor should begin with inspection, looking for any accumulation of fluid (effusion) or bony abnormality. An immediate fluid collection indicates significant joint trauma. In the absence of bony trauma, an immediate effusion is believed to have a 72% correlation with an ACL injury of some degree.
- The doctor will assess the patient's range of motion (ROM), especially looking for lack of complete extension, secondary to a possible meniscus tear or associated loose fragment.
- The doctor will palpate the bony structures may suggest an associated tibial plateau fracture.

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- The doctor will palpate the joint lines to evaluate a possible associated meniscus tear.
- The doctor will palpate over the collateral ligaments to find any possible injury (sprain) of these structures. Up to 50% of ACL ruptures have associated meniscal injuries; acute injuries are likely to have injuries of the MCL (medial collateral ligament) and meniscus.

Ligamentous laxity may be difficult to detect in the acute situation. The Lachman test is the most sensitive test for acute ACL rupture. Since the Lachman test must be performed when the patient is relaxed, it is often better to conduct this test prior to manipulating the painful knee.

Lab and Imaging Studies

MRI has a sensitivity of 90-98% for ACL tears. MRI also may identify bone bruising, which is present in approximately 90% of ACL injuries.

Treatment

If you have an ACL injury, most likely the physician will advise you to go through range of motion (ROM) exercises before any type of surgery would be done. Performance of ROM helps reduce the amount of effusion and regain motion and strength. Generally, the recommendation is that surgical intervention be delayed at least 3 weeks following injury to prevent the complication of scar tissue forming within the joint.

Rehabilitation follows surgery. The use of knee braces remains a highly controversial topic. Braces are well accepted by patients, but most biomechanical studies do not support their use. Studies have shown that functional bracing can limit movement of the tibia. Furthermore, most braces have been found to decrease the reaction time of the hamstring muscles.

Other Treatment

Non-operative treatment may be considered in elderly patients or in less active athletes who may not be participating in any pivoting type of

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sports (e.g.: running, cycling). The goal is to obtain a full ROM and strength compared with the uninjured knee. This modality of treatment requires modification of activity levels and avoidance of physically demanding occupations. Arthroscopy may also be considered for persons who are poor candidates for reconstruction but have a mechanical block to ROM. The goal of this procedure is to debride the remaining stump to increase motion. Patients with significant arthritis are also thought to be poor candidates unless they are experiencing recurrent instability.

Complications

The current failure rate for ACL reconstruction is approximately 8%. The 3 major categories of failure in an ACL reconstruction are (1) scar tissue (arthrofibrosis due to inflammation of the synovium and fat pad), (2) pain that limits motion, and (3) recurrent instability, secondary to significant looseness in the reconstructed ligament. These factors may be related to the surgical procedure (e.g.: incorrectly positioned tibial or femoral tunnels or misplaced hardware).

Other complications include patella fractures and patella-tendon ruptures. Reflex sympathetic dystrophy, postoperative infection, and neurovascular complications are rare (each accounting for less than 1% of complications). The rate of postoperative deep venous thrombosis (blood clots) is approximately 0.12%.

Prognosis

Patients treated with surgical reconstruction of the ACL have long-term success rates of 82-95%. Recurrent instability and graft failure is seen in approximately 8% of patients. Knee scores of those treated non-operatively have fair/poor results up to 50% of the time. As many as 40% of patients treated non-operatively have no episodes of giving way. Patients with ACL ruptures, even after successful reconstruction, are at risk for scarring. The goal of surgery is to stabilize the

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knee, decrease the chance of future meniscal injury, and delay the arthritic process.

Medical Legal Considerations

Medical legal issues from ACL injury and graft replacement generally arise from complications during surgery. Initial misdiagnosis of ACL injury also can be a source of potential litigation. This can be avoided when the physician obtains a complete history from you. The mechanism of injury for ACL tear is fairly consistent. A thorough physical examination helps the physician confirm the diagnosis, and an MRI identifies additional possible injuries to other ligaments or cartilage.

Potential for a lawsuit arising from improper physical therapy also exists. If the therapist is too aggressive in rehabilitation exercises and rupture of the ACL graft occurs, some patients might consider litigation. See www.amfs.com for details of our services.

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Suzanne Holman, MEd

Food! Glorious Food! Part 5 - Dinner

Here are some creative ideas for making healthy dinners. These are some of the things I generally choose: chicken, mahi mahi, shrimp, very lean ground beef or salmon. I generally prepare all of these about the same way, in my non-stick skillet. I have a medium size and large one. I choose a spice that sounds good to me and I sprinkle that on the topside after putting the meat on a heated skillet.

Spice Hunter has some great seasonings that are all salt free. Blackened Steak seasoning is one that's great on chicken. Thai seasoning is great and Steak and Chop Grill and Broil. I could be a spokesman for the company because I love so many of these and I really like that they don't have salt. You can add as much of the spices as you want and not worry that you are adding too much salt.

So many spices fill their jars with salt because it's the cheapest thing they can add. Also, when you get garlic powder make sure that is what you get. Don't get garlic salt because you want to control the amount of salt. Quality garlic powder adds some good fresh garlic flavor to your cooking.

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Replace any table salt that you use with sea salt to eliminate the aluminum used to process regular table salt to make it flow better. It's still questionable whether aluminum plays an important role in the development of Alzheimer's. Scientists do know that the neural tangles that are associated with Alzheimer's disease contain aluminum. That makes aluminum suspicious and it is better to avoid it.

After putting the chicken in the pan, I sprinkle the seasonings on the first side and then when I turn it on the second side, I sprinkle again. That way you don't really have to season the chicken before you put it in the skillet. This avoids the mess of working with the raw chicken on another plate. After both sides are browned, I cover with a lid that allows the steam to escape to complete the cooking. I lower the heat a little. Do not put a tight lid on because you are going to get more of a steamed effect with your meat, letting the juices flow out of them and creating a totally different taste.

I'll keep a couple of the extra cooked chicken breasts and use them on a green salad or in a sandwich or in a whole wheat wrap. That way you've got quite a few meals from just one cooking and you don't have the mess. And you have something that's wholly natural rather than one of those little frozen meals that have nothing in them except for a few noodles, little specks of broccoli and tiny pieces of chicken. They're not very healthy; Those meals have preservatives in them.

With the shrimp, I do something a little different. I like it with garlic for shrimp scampi. I usually add a little butter and chop some fresh garlic into it. Then after the garlic is partly cooked, I add the shrimp. Once the shrimp is cooked, I'll then add my vegetables to the skillet after I've cooked them in the microwave just enough to be tender. It's very important that you don't overcook the vegetables and lose all the good minerals. The drained vegetables pick up the taste of the garlic and it just really tastes excellent that way. It makes the vegetables more special than just serving

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them plain. Brussels sprouts are my favorite vegetable cooked this way. They combine really well with the garlic and shrimp.

Some of my meals consist of a half plate of veggies and a medium size serving of some protein. When I was basically vegetarian, I used to make up a big batch of a 12-bean mixture and I would use it in a lot of different ways. You can be creative. If you are a vegetarian, you can still do a lot of different things with the beans.

I do cook rice sometimes and I love the varieties put out by Lundberg Rice Company. They all take about an hour to cook so you need to plan ahead. I cook a full recipe of four to six servings in the microwave. I use a very large casserole because it can boil over. I use part of the rice for that meal and I keep the rest in the refrigerator or in the freezer. It reheats beautifully. What I usually do to reheat it is to add it to the skillet with whatever I'm cooking. It makes just a delicious meal that way.

Next month: Dessert ideas

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

The Role of Your Advocate in the Hospital

In an earlier column, I suggested that you bring someone with you to the hospital who can watch out for you when you can't watch out for yourself.

Why would you need an advocate? Consider what Dr. Jerald Winakur wrote in the journal *Health Affairs* a few years ago:

"Three years ago, my father, a longtime heart patient, had trouble breathing and complained of chest pain. He was admitted into the hospital with congestive heart failure. This is the hospital in which I have made rounds almost every day for the past three decades. The CEO is my friend and patient. My father's physician is one of my young associates, well-trained and eager. I was confident that my father would receive the best medical care he could get in America today."

He continued: "Yet, I would not leave him alone in his hospital room. During the day, if I or my brother or mother could not be there, I had a hired sitter by his bed. . . . It is almost a miracle that any elderly patient gets out of the hospital today relatively unscathed."

The same could easily be said of younger patients as well.

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Advocates can help ensure that you get the correct tests and treatments — the ones your doctor ordered. They can raise the alarm if something seems to be going wrong but no one appears to be taking the problem seriously enough. They can take notes and help make sure that the right hand knows what the left hand is doing.

It is best if you can choose a handful of people to help you. Ideally, they can arrange among themselves for one of them to be with you all of the time that the hospital allows you to have visitors. Depending on your situation, you may or may not be able to have someone stay with you overnight.

It's best if you choose people who can be polite but assertive and who are good with details. Perhaps you dearly love someone who is very dramatic and entertaining—but who gets bored after 10 minutes if he isn't the center of attention. He is probably not the best choice. You will need to rest at times. It will not help you if your advocate is noisy or disruptive.

If you know that you will be going into the hospital, talk with your doctor and the hospital. Explain that you would like your advocates to be able to get information about your care.

Ask what paperwork you need to provide so that your request is honored. You may need to sign a form called a HIPAA release or waiver. HIPAA (Health Insurance Portability and Accountability Act of 1996) is intended to protect the privacy of your medical information.

Sometimes, doctors and nurses say that HIPAA prevents them from talking with your family or friends about your medical condition. That statement is not accurate in this situation.

For more information, see “A Patient’s Guide to the HIPAA Privacy Rule: When Health Care Providers May Communicate about You with Your Family, Friends, or Others Involved In Your Care,” at: http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/consumer_ffg.pdf.

Following are five steps an advocate can take:

- Write down questions, concerns or observations in a notebook. Then, whenever the doctor or nurse comes in,

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it will be easy to remember what to ask or tell them.

- Write down all of the doctors' orders in your notebook. These may include orders for medicines, tests, and for other care. Look at the patient's chart regularly and have someone explain what it says. Then, when anyone comes in to administer medicine or a test, you can check your notebook to confirm that it's what the doctor ordered.
- Follow up with the doctors or the hospital staff about any unmet needs or open questions. For example, it's common for people to be malnourished in the hospital. This problem can delay healing, contribute to delirium, and increase the risk of dying. If friends or family members see that a patient isn't eating, they can raise this issue. They can ask for a nutritionist's evaluation.
- Help the patient manage being in the hospital. Make sure that the call button is in reach. Talk or read to him. Simply be a comforting silent presence.
- Observe how the patient is doing and call for help if he suddenly seems worse.

Two books that offer more information about what problems to watch out for are:

- "Protect Yourself in the Hospital" by Thomas A. Sharon
- "How to Survive Your Hospital Stay" by Gail van Kanegan and Michael Boyette

Editor’s note: Expect suspicion when you ask to see the patient’s medical record. Healthcare professionals do not readily share this information, and many worry that you have a medical malpractice suit in mind. Expect that someone will sit with you while you read a paper chart. This is done to offer explanations and to also make sure you do not write on or remove paper from the record.

Electronic charting, which is moving more rapidly into hospitals, makes reviewing the record difficult. There may not be a paper copy of the chart at all, or it is printed on demand.

This is a video tip on being a patient advocate for a family member: http://youtu.be/xTTpYFKhVTQ

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This is a blog post of what to do if a person suddenly becomes worse: http://tinyurl.com/3zyw6v7

About the Author

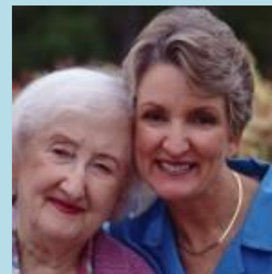
Elizabeth L. Bewley is President & CEO of Pario Health Institute and the author of Killer Cure: Why health care is the second leading cause of death in America and how to ensure that it's not yours. She is also the author of a weekly newspaper column called "The Good Patient." To tell Elizabeth your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

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.

Did you know that a person over 65 years old goes on average to the doctor 8 times a year and thus has more opportunities for medical errors?

Your parents can participate in their doctor appointments to get more information and make informed decisions. Just view http://tinyurl.com/d7vnwyl and join Alicia VanBuskirk RN in discussing challenges of caring for elderly parents.



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Sarah Jean Fisher
MSN, RN-BC, BA

What's My Line? Who Does What in a Nursing Home? Part 1

Some of you may recall a game show of the 1950s entitled "What's My Line", where celebrity contestants would try to determine a guest's occupation through several rounds of questions requiring only a yes or no answer. As a child, a very young child I might add, I enjoyed the celebrities working as a team. They tried to come up with discerning questions that would eliminate non-related lines of questioning and bring one of them to the point where they could make a confident guess of the contestant's occupation. This was great fun to pass the time on a Tuesday night. But it is not what you want to do in a nursing home when you are seeking someone who can take care of your loved one's pain, or clean up an incontinence episode. Yet, by appearance, you can't always know what a nursing home or rehab facility's employee job description includes.

Today, nursing homes across the country work diligently to achieve security protocols of name tags and/or specific uniform or style of dress to differentiate the appearance of the employees

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by their job descriptions. This article is the first of two which will attempt to provide the reader with several methods of job distinction and identification in a nursing home. At the same time, I hope to share with you the scope and practice of work for each type of employee you may find at a nursing or rehabilitation center so you may know who you can or shouldn't ask for specific assistance.

Some but not all nursing homes use picture IDs for identification and security. The facility where I currently work requires all staff to wear a picture ID above the waist at all times. It is bar-coded to only permit access to locked areas as their job description entitles them and also gives access to the elevators. For example, a housekeeper's badge will not allow her access to a medication room or a charge nurse cannot enter the records office. Staff using a time clock must swipe their badge to "clock in and out". Employees must swipe a badge to enter from the employees' entrance, and if they enter from the main entrance, security will not pass an employee who does not have a badge unless a supervisor comes to the door to confirm ID and current employment. All visitors must sign a guest book and wear a visitor badge received at the entrance.

Almost all facilities require staff to wear some type of uniform. In my facility, the **dietary staff** wears black pants, a white knit golf shirt with the facility's logo on it, and special non-skid black shoes. You may observe the dietary employees delivering trucks with meal trays, standing behind a steam table taking orders from nursing staff to prepare plates with meal choices for residents, or cleaning up the dining room after a meal. They also deliver snack trays to each nurse's station twice a day. They may not feed a resident or take a food request from a resident. These tasks can only be done by nursing staff. Dietary employees may not help transfer a resident, assist one to walk, or even help them get to a standing position. They do not deliver food items to a resident's room; they are strictly no hands-on employees as far as residents are concerned.

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Our **laundry and housekeeping department employees** wear black pants with a grey golf shirt with the facility's logo on it and sneakers. The laundry employees deliver incontinence and linen supplies to each unit at the end of a shift for the next shift. The female housekeepers keep the lobby, offices, resident rooms, nursing units, and bath/shower rooms clean. The male housekeeping employees maintain the floors throughout the buildings and empty the large trash and soiled linen containers on each unit. The laundry and housekeeping staff also are not permitted to transfer a resident, assist one to walk, or even help them to a standing position. They are encouraged to speak cordially with our residents as they move throughout the building performing their tasks but they, also, are no hands-on employees as far as the residents are concerned. Before entering a resident's room, they must knock, identify themselves and the reason for being there, and wait for a reply of permission before entering the room.

The **maintenance department staff members** wear dark blue work pants or jumpsuit for painting, repairing, and replacing equipment. They must knock on the door identifying themselves, and await a permission reply before entering a resident's room. They also do not perform any hands-on care for our residents.

The administrator, assistant administrator, admission department, business office, payroll, social service and human resource staff wear office attire. They are encouraged to verbally interact with the residents as they move throughout the building during work, but have no hands-on credentials to physically assist residents. They may not feed a resident unless they have participated in a feeding training course given at the facility.

These are the nursing home/rehab facility employees who provide services and accommodations for your loved one on a no hands-on basis. Next month, you will learn more about the medical and rehab staff who

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perform the daily care needs and provide medications and treatments for residents at a nursing home or rehabilitation center.

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

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 SFJ94@comcast.net.

Instant Stress Busters

Ever wonder how to reduce or release stress? Aila Accad will provide a way of thinking about stress that will help you instantly reduce your stress and think more clearly when tension rises. Use emotional freedom techniques such as senses, memories and images to reduce stress.

This program will give you more insight on various stress reducing tips! http://tinyurl.com/7fzuxxe

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Aila Accad RN, MSN

Coordinating Care Reduces Medical Errors

The more medical diagnoses or conditions you have and the more complex medications you are taking, the more risk you have for medical error. Just taking two medications can increase the risk for dangerous complications or side effects. As you multiply the number of conditions and medications that need to be balanced, the risk rises.

The average 65-year-old, for example, is taking 5-6 medications a day, not counting vitamins and other supplements. As health care becomes more specialized, the more likely it is that these drugs are being prescribed by multiple practitioners. The burden of clear and accurate communication between all of these caregivers is on you, the patient.

If you forget to communicate all the conditions for which you are being treated and the correct names and doses of medications you are taking, it is easy for errors to occur. Not only that, you can take something that seems relatively harmless like an over the counter cold remedy or aspirin[1] and suddenly find that it seriously interferes or dangerously interacts with medications you are already taking. Even certain foods can cause interactions. It can be mind boggling to try to keep all the details

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straight, especially when you are not feeling your best.

You can reduce the risk of medical complications and errors by assigning one practitioner to manage and coordinate all of the variables involved in your care. A registered professional nurse is an ideal practitioner to carry out this function, since case management and care coordination is a core role of nursing.

As health care becomes more specialized and complex, there is an increased need for care coordination and management. The Affordable Care Act attempts to address this important need by requiring health insurance plans to provide coverage for this role.

The nurse is knowledgeable about a wide variety of conditions, drug complications and interactions. Plus, he or she is able to communicate effectively with a wide range of specialists. In this way, your care can be integrated. This may even result in being able to reduce the number of medications you are taking.

I am not suggesting that you give over your power and responsibility for being aware of your conditions and medications to someone else. You always need to be aware of what you are taking and why. What I am suggesting is that you may also benefit from having a knowledgeable professional at your side. This person can oversee the various aspects of your treatment and advocate for you, when your care becomes complex.

In cases of multiple medical conditions and medications, the risk for adverse drug events, interactions and errors can be radically reduced by adding a professional care coordinator as a member of your personal healthcare team.

[1] **Editor's note**: Something that seems as innocent as aspirin can cause serious problems. My brother was recently admitted to the hospital because he took several aspirin a

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day for a few days and developed stomach bleeding.

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.

Charlotte's Story: A Life Cut Short by Medical Errors

Learn concrete strategies you can take to keep records of medical care, share information about medications, communicate with your physician, and be your own advocate.

Discover practical and essential advice about how to stay safe in the hospital from her perspective of a staff nurse.

Use this link to find out more information: http://tinyurl.com/c6y67bl

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Dean Dobkin MD

When the Doctor Becomes a Patient

Last issue did not contain an article by me. The reason it did not is a topic I think might be of interest. What is the perspective of an ER doctor about going to the ER?

I've personally been a patient in a hospital emergency department only twice in my life. Once I was admitted for a gallbladder attack (leaving three days later, without a gallbladder.) The second time I arrived in the ER by ambulance. A speeding truck pulverized my car while I was at a red light. Fortunately, the car accident caused no permanent damage. (Yes, I was wearing my seat belt.)

I have three teenager children, fraternal twins, age 17, and their older brother, 19. I brought the oldest to the ER twice. Each visit he had one or more broken bones. I brought his younger sister there one Sunday when I thought she might have broken her finger and needed an x-ray.

I bypassed the emergency department when my youngest son had a burn. I called the closest pediatric burn center and spoke with the physician director and arranged for his care without a visit to their ER.

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This brings us to the reason I could not provide an article in a timely fashion for last issue. Three days ago, I walked down the steps and tripped on my cat. He was far too trusting I would not step on him, and I'm a bit too clumsy. I did, after all, have "right of way." He ran and didn't have to give up even one of his nine lives. I landed hard on my flexed left leg two steps below him.

I can't begin to describe how much pain I had. My prior broken bones and my gallbladder pain were hangnails by comparison. My wife came to see why the cat ran from the stairs like a bullet and why a variety of unpleasant sounds came from the point of my impact. She helped me to a chair. (Did you know that the common housecat is able to run 30 mph?)

An hour after my fall, ice wasn't preventing swelling and was doing little for the pain. I could barely walk, and couldn't put weight on my left leg. An hour after that, I cleared my schedule for the next three days, calling out of work "sick" for the first time in seven years.

I did not go to an emergency department. I think most people would have gone, and I certainly had an injury serious enough to warrant a visit. So, why didn't I go? My self-assessment told me I didn't break a bone, and my working diagnosis is – and has been – either a severe sprain, or possibly a torn muscle or ligament. (Doctors are not supposed to diagnose themselves, but most of us will.)

I think what I need for diagnosis is an MRI, a test I wouldn't have in the ER. I don't think an x-ray will show anything. The emergency visit would have provided pain medication and an orthopedic referral – something I can arrange myself.

Like many of you, I feared a ten-hour visit. I considered going to the ER a little more strongly at 4 a.m., when I awoke when my pain medication wore off. My best chance of avoiding a long wait would be near that time of morning.

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I did some things that are not generally an option for the general public. I determined I didn't have a broken bone – something I'm hoping will be proven after my orthopedic visit. I am arranging an orthopedic visit on an expedited basis. This is not usually an option for non-physicians. I also know enough medicine to be able to predict that another emergency physician would have similar considerations for my diagnosis and treatment. Someone who is not an ER doctor would not be able to come to that conclusion.

Would an ER visit have decreased my chance of a medical error? Yes and no. Yes, it would have reduced my wife's anxiety, no question. I try not to reflect on how often I've seen patients seriously ill who came to the hospital only because their spouse insisted. But no, if I had gone to the ER, I would have been at risk for getting the wrong medication, the wrong treatment, or an infection transmitted by the hands of the staff. There are risks you *take* when you walk in the door of the ER, and risks you *avoid* when you walk in.

I am sitting in my pajamas – a sick day from work – with a bag of ice on my leg, waiting by the phone for a call from the orthopedist's office. My leg is elevated and my wife brought me coffee.

Next time I'll let you know how I fare.

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

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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.

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Dr. Rosemary McGeady shares her special perspective as a cardiologist who became a plaintiff's medical malpractice attorney. She teaches you:

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Carol Kivler MS CSP

Number One Cause of Disability in Women — Depression: Part 1

Imagine meeting someone at work, at the gym, or at a function and finding out that she has had clinical depression. What would your immediate reaction be? Would you think of her as negative minded? Selfish? Weak? Unintelligent? Crying out for attention? Believe it or not, these are all common reactions and misconceptions. Many of these misconceptions are due to a lack of knowledge of what depression really is.

Major depression is not an attitude. It is not a personality dysfunction. It is not a flaw in character. It is not laziness or a call for attention. It is not hurt feelings or a reaction to a bump in the road. It is not contagious. Depression is not something that can be brought on or fought off by self-will. Depression is not something to be ashamed of. And most importantly, it is not something that should be ignored. Left untreated, major depression can be life-crippling and even lead to death (by suicide). Fortunately, most women get better with treatment.

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No one wants to be depressed. So what is depression? Depression is an illness that affects the body, mood, and thoughts. About twice as many women suffer from depression as do men. Women are at an increased risk of depression if they have a family history of the condition, a chemical imbalance or changes in the brain chemistry, or another medical illness, such as a stroke, cancer, or Parkinson's disease. Depression can be described as feeling sad, blue, unhappy, miserable, or down in the dumps. Most of us feel this way at one time or another for short periods. But true clinical depression (also known as major depression) is a mood disorder in which feelings of sadness, loss, anger, or frustration interfere with everyday life for an extended period. The condition can be mild, moderate, or severe.

While researching this topic, I found some startling statistics generated by The National Institute of Mental Health. Did you know – one in four women will experience severe depression at some point in life? Or that depression is the number one cause of disability in women. How about that at least 90 percent of all cases of eating disorders occur in women, and that there is a strong relationship between eating disorders and depression. Or that depression is more common than cancer, heart disease, and diabetes combined? How about – in general, married women experience depression more than single women do, and depression is common among young mothers who stay at home full-time with small children. And the most startling – only about one-fifth of all women who suffer from depression seek treatment. Depression is at an epidemic level yet most women struggle in silence not seeking treatment. There is no better time to educate, support, and advocate for an open dialogue around this debilitating illness.

About the Author
Carol Kivler, MS, CSP, is a passionate consumer advocate, speaker, author and the founder of Courageous Recovery. She speaks to consumers, their loved ones and healthcare professionals to raise awareness, instill hope

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and combat stigma surrounding mental health diagnoses and treatments. Along with Courageous Recovery, Carol is also the founder and president of Kivler Communications, which provides executive coaching and customized workforce development training.

Carol lives in Lawrence Township, NJ and is the proud mother of three grown children and five grandchildren. She is an avid reader, life-long learner, gardener and amateur baker.

Advocating for Yourself: Patient Power

Kathleen Aston is an award-winning serial entrepreneur and expert in personal empowerment. She talks about the barriers patients face when trying to be assertive. She shares her perspective both as a patient and an expert on helping people find their confidence. She will teach you:

- Why being a patient advocate is so troubling for so many people
- The dangers of passive and aggressive patient behaviors
- How to use the power dynamics of health care in your favor
- How to build your confidence as a patient who has to speak up

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Medical Charities: "Show Me the Money"

These days, it is not uncommon for people to be inundated with requests for donations by various charities. Many of these charities involve a medical issue, such as a particular illness, disease, symptom or other medical cause. Some requests come to us in emails and the U.S. Mail. Others are phone solicitations or door-to door requests. In these days, when everyone is exercising careful spending and trying to get the most for their dollar, a wise consumer may benefit by being cautious and carefully checking out charities prior to sending a donation. Charity scams are abundant, including medical charities.

Oftentimes, when people send a check to a charity, they have no idea how that money is going to be used or how much actually goes to those in need. It might be surprising to learn that a large percentage of donated dollars often go to administrative expenses and salaries. Administrative costs include fundraising, warehousing, salaries, office space and equipment, postage, telephone campaigns and other expenses. Many phone solicitors are some of the worst offenders. You may have received solicitations for local causes from callers in far away states. Many

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of these calls are made by paid callers hired by a charity and do not originate from the charity itself. Some of these paid callers have no relationship whatsoever to the requesting charity. These callers have to be paid and that money comes out of the money we donate. If you receive a call and wish to consider donating to a charity that contacts you by phone, have them give you their name and location and check them out before you send money.

Why is this important? On June 2, 2011, *Time Magazine* reported that a charity by the legitimate-sounding name of "The National Breast Cancer Research Center" spends only 4% of its income on research. Fifty two percent of their income was spent on fundraising. So where does the other 44% of the money go? That's the problem. Luckily, the trend is moving towards increased transparency and accountability regarding the finances of charitable organizations.

The *Charlotte Observer* did an investigation of charities and found about 200 charities whose CEOs made over a million dollars a year. Do you want your money going to a whopping salary for the person in charge?

The *Arizona Republic* also did an investigation and found that charities "can legally inflate their finances by taking credit for donated goods that they never actually handle. This makes donors think the groups are large and makes the group's expenses appear lower." This goes by the term, "title transfer".

Some solicitations are made by non-existent charities or the charities may have not used the donated money for its intended or stated purpose. There have been instances of fake websites and other fraudulent practices. There has been an increase in the number of "sound-alike" and "look-alike" charities. These are charities with official sounding names, logos, official looking websites and official-looking mail solicitations, but may be of questionable quality. They attempt to ride on the coat tails

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of their better known and trusted counterparts and many people give without realizing that it is not the charity they thought it was.

A lot of wonderful work is being done because of charities and their donors, but a few rotten apples can spoil the barrel for everyone. So how do you know which ones are the bad apples? If a charity doesn't sound familiar, check it out. Don't fall for mailings which thank you in advance for a pledge you made. If you don't have a specific recollection of making the pledge, you might be in line to be scammed. Surely you have seen those jars next to the cash register in stores asking for donations, but even these have been known to be fraudulent in some cases. In these and many other cases, you must rely on your judgment.

Medical charities provide a wide range of services. Some medical charities are research based, some offer support to victims, others provide education and resources.

There are many ways to check out charities. Some sources of information can be found in the "Resources" section of this article. The percentage of income that goes directly to services should be at least more than the percentage they spend on expenses and salaries.

Basically, use common sense. Trust your gut instincts. Question! Don't allow yourself to be pressured.

Tax-Exempt Charities

Many of the charities we are approached by are 501(c)(3)s. This means that they are tax-exempt, non-profit organizations officially recognized by the Internal Revenue Service. They are required to submit annual reports (IRS Form 990) to the IRS. These 990s are available for review on the IRS website.

Advice for Donors

Be suspicious if:

The charity has no website.

The charity does not give their contact information.

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The money goes to a post office box.

The charity has bogus phone numbers.

There is no mission statement.

The charity doesn't show up on charity-evaluating websites.

The charity refuses checks but will take credit cards or cash.

The charity gives its address as a home or other non-office environment.

There is no board of directors.

There is no explanation of how the organization governs itself.

The charity is hesitant to give out information about their finances.

The charity is not listed with the Better Business Bureau, Charity Navigator, the IRS, your state's attorney general's office or the American Institute of Philanthropy.

The name of the charity does not sound familiar.

You do not recall making a verbal pledge of money.

The name of the charity sounds similar, but not exactly like a charity you know.

The charity is unclear about how they are governed.

The charity is unable to answer any questions you have regarding legitimacy.

The charity gives no more than 25% of donations to providing actual services.

For medical charities specifically, be suspicious if there is no documented medical professional on the staff or board of directors. Be alert when a person of prominence is referred to only as "Dr." and does not give a title such as MD or Ph.D. Some charities are deceptive and use the term doctor to imply that the person is a medical physician, when some of these doctors have been discovered to be

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chiropractors or have other nefarious credentials.

It may be wise not to give to charities you come into contact with via a link online and not directly from their website.

A program called Charity Choices.com advisors potential donors to:

1. Check the CharityChoices.com website
2. Check the federal government's charity drive website (Combined Federal Campaign)

   (http://www.opm.gov/cfc)

3. Check the Better Business Bureau's Give.org website
4. Check the Guidestar.org website
5. Ask the charity itself to provide copies of its reports to the IRS.

Charity Navigator is also a trusted source of information regarding charities. If you can't find a charity on any of the charity evaluator websites, you can ask to see their "Letter of Determination". If they cannot produce one, be cautious.

Oftentimes, information about local charities can be difficult to find on national charity evaluation websites. If it is a non-profit, you should be able to find it on the IRS website and you can always request written information over the phone or by mail. The Better Business Bureau has regional offices where you can obtain information. If you find that a charity is included in the Combined Federal Campaign list, you can be assured that the charity has met the government's CFC criteria. CFC approved charities can be found online. Some of those criteria include: They must reveal the percentage of money spent on fundraising and administrative costs, undergo an annual audit, submit an annual report to the IRS, document the "health and human benefits" it has provided in the previous year, meet the criteria for the IRS' 501(c)(3) status, use donations for the announced purpose of the charitable

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organization, prohibit the sale or lease of its contributors, have an active and responsible list of governing body and be "truthful and non-deceptive in how it promotes itself."

As always, be careful with online credit card donations. Once your personal information is out there, it is very difficult to get back. If it falls into the wrong hands, there is a chance that you could be granting financial access to someone with criminal intent.

Scams and fraudulent practices seem to crop up in larger numbers following natural disasters or other catastrophes. Well-meaning donors see heart-wrenching scenes on television and wish to help however they can. Many people prefer to donate money to help recovery efforts and rebuilding. Following the earthquake in Haiti, many fraudulent scams were born. The same thing happened after Hurricane Katrina and similar events.

There have been frightening examples of fraud at the highest levels, even in well-known, trusted charities. United Way of America is one such instance. The United Way is an umbrella organization which involves thousands of charities. A former president and CEO of United Way used large amounts of donated money for personal gain and luxuries. Falsified records were reportedly found. He was adept at hiding his activities. He kept his position for 22 years, but resigned in 1992 following a very public scandal. The good news, however, is that the incident prompted Americans to ask more questions about the legitimacy of charities.

Many people save their decisions regarding charitable giving until the end of year. This can be helpful - it gives you the time to carefully consider exactly where you want your money to go within the confines of your budget and it allows time to leisurely check out the charities without feeling pressured or obligated.

The purpose of this article is certainly not to deter from charitable giving, but rather to help you be a well informed and confident consumer. There are thousands of legitimate

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charities and they are accomplishing amazing amounts of good for the benefit of many. Just make sure your hard-earned money goes where it is needed and is used for tangible benefit.

Resources

Charity Navigator.com

CharityChoices.com

www.guidestar.com

Better Business Bureau

The Better Business Bureau Wise Giving

Alliance

www.Give.org

American Institute of Philanthropy

Internal Revenue Service

www.medleague.com

www.libraryspot.com

Givewell.org

Federal Bureau of Investigation

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.

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Nancy Collins
PhD, RD, LD/N

Caffeine: Why You Should Avoid It

Medication side effects
Caffeine may cause more medication side effects. It interacts with medications and may increase side effects, such as:

- Irritability
- Trouble sleeping
- Possible seizures
- Possible heart rhythm changes

Anxiousness
You can become anxious. Caffeine is a stimulant that increases anxiety. It can start a panic attack.

Addiction
You can become addicted. You will keep using caffeine despite the problems it causes. You will feel you are unable to cut down. You will need more and more to get the same effect, and will experience withdrawal symptoms if you quit.

Poor sleep
You can have trouble sleeping. Caffeine delays you getting to sleep, reduces sleep time, and decreases the quality of sleep.

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Heartburn
You can get heartburn. Caffeine causes an upset stomach.

Dehydration
You can become dehydrated. Caffeine is a diuretic, like a "water pill." It takes fluid out of your body.

How much caffeine is too much?

- 200 milligrams (mg) or more can cause anxiety, panic attacks, poor sleep, and other side effects in some people
- More than a cup, can, or 20-ounce (oz) bottle/day is possibly too much, if you notice symptoms or if your healthcare professional has asked you to limit your caffeine intake

Item	Caffeine Content
Drip-brewed coffee—5 fluid ounce (fl oz), about half a mug	110–150 mg
Tea—6 fl oz, 5-minute brew	20–50 mg
Iced tea—12 fl oz	22–36 mg
Mountain Dew®—20 fl oz, bottle	92 mg
Red Bull—16 fl oz, can	160 mg
Powershot—1–2 fl oz, bottle	100–125 mg
Barq's Root Beer—20 fl oz, bottle	33 mg
Milk or dark chocolate—1 oz	1–35 mg
Hot chocolate—5 fl oz	2–15 mg
Chocolate milk—8 fl oz	8 mg
Chocolate pudding—½ cup (C)	7 mg
Chocolate ice cream—½ C	2 mg

These suggestions can help you decrease your caffeine intake.

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Keep a log
Write down the coffee, tea, and soft drinks you drink for a few days. This will help you understand when and how much you drink.

Take it slowly
Decrease intake gradually over 1 or 2 weeks:

- Eliminate ½ cup (C) of coffee/tea or 1 C of pop (about two thirds of a can or one half of a 20-ounce bottle) each day

- Start eliminating the coffee, tea, and soft drinks that you drink in the afternoon or evening. This will help to restore restful sleep – you will have more energy during the day and feel less need for caffeine if you get proper sleep

Find a substitute
Have a substitute beverage instead of coffee, tea, or soft drinks.

Try drinking:

- Water
- A hot-grain beverage, such as Teecino® or Pero®
- Herbal tea
- Sugar-free lemonade or fruit drink
- A small glass of juice or milk

Stay active
Exercise or keep active during the times that you used to drink coffee, tea, and soft drinks. If you get adequate activity, you will have more energy and feel less need for caffeine.

Try these suggestions:

- Go for a walk
- Play outdoors with children or a pet
- Work in your garden or do yard work
- Clean the house
- Dance to your favorite CD

Improve your nutrition
Many people drink coffee, tea, and soft drinks instead of eating. You should eat a meal with carbohydrate and protein three times a day, such eggs and toast, a turkey sandwich, spaghetti with meat sauce, etc.

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References and recommended readings

Coffeefaq.com. Coffee and caffeine FAQ. Available at: http://coffeefaq.com/caffaq.html.

Johns Hopkins Bayview Medical Center. Information about caffeine dependence. Available at: http://www.caffeinedependence.org/caffeine_dependence.html.

Coffee Science Information Centre. Questions and answers. Available at: http://www.cosic.org/questions-and-answers.

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.

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How We Breathe Is How We Live Our Lives

These statements express a basic principle of Mind Body Integration. These ideas are explained the Ancient Wisdom teachings of Yoga and Ayurveda which are thousands of years old. Ayurveda tells us that if we have an imbalance in one area, unless we address the imbalance it will eventually show up in other areas. Conversely, if we consciously make choices to create balance in one area it will show up in other areas. We do this all of the time either consciously or unconsciously. The first step to correcting an imbalance is awareness.

How you breathe is how you live your life

Breath awareness is very important in the practice of yoga. The breath is considered the bridge between the body and the mind. If we do not take full and complete breaths, exhaling fully and completely, then our bodies will not release into our full expression of the posture. I ask my students when they notice they are struggling with a pose, not to force, but instead to bring their awareness back to their breath. Often they will notice that they are no longer breathing fully and completely. When they bring their awareness back to the breath and

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take a full inhale they will notice on a full exhale their body naturally releases more deeply into the pose. To take this idea "off the mat", I remind them if they notice during their day they are stressed or struggling, to bring their awareness to their breath. A few full and complete breaths will often release their stress, relax them and change their emotional state.

Further examples of how this may show up follow …

- Someone who is protecting his heart at an emotional level may have a posture with rounded or hunched shoulders.
- Someone who is stiff and inflexible in their body may also be inflexible in her minds, resistant to change or new ideas.
- The person who tends to hold onto things that are no longer useful to them may not only have closets crammed full of clothes she hasn't worn in years; she may tend to hold onto extra weight she does not need, or stay in relationships that are no longer serving her.
- The examples above are simple ones. At a deeper level if we hold onto negative emotions and experiences they eventually become toxic and manifest as disease in our body.
- A person with a broken heart may increase his risk for a Cardiac Accident by not addressing his feelings.
- A person who holds onto toxic emotions such as anger and resentment increases his risk for developing cancer or other diseases.

Recall the expression, "he'll bust a gut over that", referring to someone who holds onto anger and hostility? I know someone who was referred to in just that way because he held onto a lot of anger and hostility, and sure enough he did, literally, "bust a gut". He almost died when it happened. Holding onto anger and hostility, he literally imploded!

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Our outer world is a reflection of our inner world. Because of this, I frequently say that "Everything Is an Inside Job." Check out this website that was just created which will discuss just that: www.EverythingIsAnInsideJob.com.

Our thoughts and emotions frequently show up in our body or our physical environment. We are not just physical beings. Instead we are multi-dimensional beings with physical, mental and spiritual aspects. It is not unusual for our experiences on one level to influence or show up in other areas.

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.

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