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Second Opinions: How to Get Them

On a snowy day in Baltimore, I waited for my appointment with a nephrologist at Johns Hopkins University Medical Center. This kidney specialist was an MD who had a doctorate in public health. My first column in Issue 1 described how I learned I had decreased kidney function and the lessons I shared about being a patient. After that diagnosis, I was not entirely comfortable with my local nephrologist, who saw me in an initial appointment for 15 minutes, and left me with questions. I decided to seek a second opinion at one of the finest hospitals in the country.

Picture an inverted triangle. Most people are at the top of the broad base of the triangle. They are generally satisfied with the advice of their healthcare provider (physician or nurse practitioner) and follow their recommendations. If they receive medical advice that makes them uncomfortable, most will swallow their hesitation and follow the advice. They may be hesitant to object because of intimidation or deference to the healthcare provider's education and training. A small subset of the

hesitant patients will decide to obtain a second opinion. They are at the tip of the triangle.

Patients may seek second opinions for a variety of reasons:

- less than ideal communication between the patient and physician
- uncertainty about whether to follow the course of action recommended by the first physician
- at the request of an insurance company

As Dr. Eric De Van Graaf wrote, ". . . studies on the subject show that people who seek second opinions do so mainly because of a dissatisfaction with the quality of dialogue they experienced with the primary consultant. In some ways this makes it even harder for patients initiate the move to another doctor, since it signals that the doctor and the patient are not matching up well—kind of like telling your prom date that you had fun but you don't want to see her again." [1]

According to Dr. De Van Graaf, a couple of years ago CNN posted a list of 5 diagnoses that call for a second opinion: "when the diagnosis is tricky, the procedure is risky or has permanent consequences, or when there are less-invasive alternatives." These are examples:

- Heart bypass surgery
- Hysterectomy
- Pregnancy termination for fetal abnormality
- Surgery for varicose veins
- Treatments for brain tumors

Finding a second opinion physician

In some cases, patients ask their own healthcare providers for the name of another provider to use as a second opinion. The thinking behind this approach is that the provider is familiar with providers in the area and can direct them to the right person. Other patients may fear that their own provider will be offended by this request and interpret it as a lack of confidence.

Here is a way to ask your own provider for a referral for a second opinion: “I know you have recommended that I have X (operation, treatment, medication). I need to feel comfortable with the treatment I am receiving and would like to get a second opinion so I can achieve that goal. Who would you recommend I see? Whose opinion do you respect?”

When you don’t want to ask your provider for a name, do your research. Look at the specialists who are covered by your healthcare plan. Look for ones who are board certified. Use your networks to find nurses who work in the hospital where the specialists practice. Nurses have insider knowledge about the quality of healthcare providers. They observe the providers in action, at their best and worst, and recognize who are the best providers.

Once you have identified a nurse who works on a nursing unit with the type of specialist you need, ask the nurse who she or he would recommend you see for a particular problem. One of the easiest lines to use is, “If it were your mother, who would you recommend?” You may use the same approach of networking to talk to other physicians you may use or know.

There are some hospitals that offer second opinions on a routine basis as a service. Johns Hopkins is one such place. I chose not to ask my local nephrologist for a referral because I was already familiar with the idea that Johns Hopkins is a center of excellence. I asked one of my husband’s Johns Hopkins physicians for names of nephrologists she would recommend. As it turned out, none of them were covered by our medical insurance plan and I would need to pay out of pocket for my visit. The patient appointment office asked me to obtain copies of my medical records, scan them and email them. After they received my records, they assigned the physician to see me.

My appointment at Johns Hopkins took place about 6 weeks after I made the request. The physician who saw me had carefully reviewed by medical records and test results. He asked

me questions as part of a detailed history. While he acknowledged that I had some mild decrease in kidney function, he did not think the results were alarming and were in fact stable. He believed that the mild decrease was probably caused by a dose of Fleets Phosphosoda (no longer on the market) used before a colonoscopy I had 11 years ago. He explained to me in clear terms why I need not be concerned, and if I wanted to, I could have a sophisticated test with dye to look at my kidneys, but it would not change anything. I came away from the appointment with the impression that he was underwhelmed with my lab results, did not expect that I would ever end up on renal dialysis (my big fear), and that I should carry on with my life as usual.

My experience with this second opinion showed me the difference between a local nephrologist who spent 15 minutes with me during my initial visit, and an expert at a teaching hospital who reviewed my records beforehand, and then spent 45 minutes with me. I felt I received a much more thorough review of my medical condition and a sounder analysis of my kidneys.

I realize doing what I did - paying out of pocket for a second opinion at a facility 3 hours from my home - may be difficult for others, and therefore, I recommend the approach outlined above of doing some research both on the internet as well as with local healthcare providers. Your peace of mind is essential. You must be comfortable with the communication between you and your healthcare providers.

[1]http://www.kevinmd.com/blog/2010/11/hesitate-seek-medical-opinion.html

About the Author

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The Hospitalist

Over the past two decades, there has been a growing trend for the care of the hospitalized patient to be assumed by physicians who care only for patients in the inpatient setting, and who do not have an outpatient medical practice. These physicians have come to be known as “hospitalists”, and their area of practice as “hospital medicine”. Hospitalists are a departure from the old style of practice, in which the primary care physician (PCP) cared for their seriously ill patients in the hospital while still maintaining a busy outpatient practice. Because of the increasing complexity of modern medicine, and due to a variety of economic pressures, the trend now is for physicians in primary care specialties to focus their practice on either outpatient or inpatient care, but not both.

There are many advantages to this trend of dedicated hospitalists, including that the hospitalized patient will be under the care of a physician who remains in the hospital throughout the day and is very experienced in the care of acutely ill hospitalized patients. There are also a few disadvantages, the main one having to do with the changing of providers between the outpatient and inpatient setting. This discontinuity of care is also a significant source of medical-legal risk in hospital medicine.

The hospitalist's role is primarily one of overseeing the patient's care during the hospitalization of the patient. This role includes admitting, diagnosing, and treating the patient, calling in specialists when necessary, and discharging the patient back to the PCP at the end of the stay. In a sense, they assume the role of the primary care physician while the patient is in the hospital. Hospitalists typically work as a member of a hospitalist or a multispecialty medical group, and during a hospital stay the patient will sometimes be cared for by more than one of the hospitalists in the group.

When most hospital care was provided or coordinated by a patient's primary care physician, that physician typically was already acquainted with the patient and would know the patient's medical and personal history well. The PCP would also have ready access to the outpatient medical records, since these were kept in that PCP's office.

Much of the risk of medical errors or negligence for hospitalists has to do with the transitions of care between the hospitalist and the primary care physician, when vital information necessary for effective care can be lost. Similar risks can also arise in transitions of care to or from another hospitalist or specialist during a hospital stay itself. When a new and unfamiliar hospitalist physician assumes the care of a patient entering the hospital, there is much catching up to do for that physician to become familiar with the patient's medical history and preferences for care.

Although much of this information can be obtained from the initial history and physical exam and through subsequent discussions with the patient and others during the hospital stay, the hospitalist does not have the prior relationship or knowledge of the patient that the PCP has. Much important information may be difficult for the hospitalist to obtain. In addition, when the patient is discharged from

the hospital, the hospitalist will generally not be the physician seeing that patient in follow up in the office, the nursing facility, or the home. Important information from the hospital stay may be missing in these settings.

The standard of care for a hospitalist requires that the hospitalist make every effort to obtain important past medical information if it is not readily available at the time of admission. It also requires that information vital to a patient's care be communicated to other clinicians who will be caring for the patient during the hospitalization and after discharge from the hospital.

Listed below are some of the care transitions facing the hospitalist and the responsibilities that go along with them:

Admission of the patient to the hospital
The hospitalist needs to communicate and exchange important information with the ED physician, and as soon as possible with the primary care physician, or other physicians who have previously cared for the patient and whose care may have a bearing on the current illness and care of the patient.

During the hospital stay
The hospitalist must coordinate the overall care of the patient, while engaging specialists as needed. The specialists are typically responsible for care of the patient within their area of expertise, while the hospitalist must keep the "big picture" in mind.

There is sometimes a transfer of the care of a patient during a hospital stay, especially a prolonged one, from one hospitalist to another hospitalist within the same group. Important information regarding care of the patient must be communicated in this transition.

Discharge from the hospital
The hospital ensure appropriate follow up, including appointments with the primary care or other clinicians, and treatments or tests that are necessary after discharge.

The hospitalist also follows up on any pending results of tests done during the hospital stay.

Some hospitalist groups create policies outlining the expectations of its members regarding communication with primary care and other physicians during the stay, to help ensure the safest and smoothest transitions of care into and out of the hospital. But even if such a policy does not exist, it is generally accepted within the hospital medicine community that excellent communication with other physicians involved in the care of the patient, especially the primary care physician, is an essential part of the role of a hospitalist.

Medical-Legal Considerations

Transitions to different doctors providing care in the inpatient and outpatient settings are now becoming the norm, and if not managed well these transitions can lead to inadequate care or follow up for the patient. Failure to exchange vital clinical information with other physicians involved in the ongoing care of the hospitalized patient places that patient at risk of harm, and opens the hospitalist to accusations of negligence.

About the Author

This article was written by an AMFS physician. For more than two decades, AMFS has offered the most comprehensive network of Board Certified, medical and related experts in all recognized specialties, nationwide. AMFS experts have assisted in more than 10,000 medical-legal matters and provided testimony in areas of medical negligence, personal injury, product liability, hospital/managed care negligence, criminal matters and toxic torts. AMFS takes the guesswork and legwork out of medical expert selection and provides a valuable consultative resource in the form of experienced staff, medical directors and attorneys.

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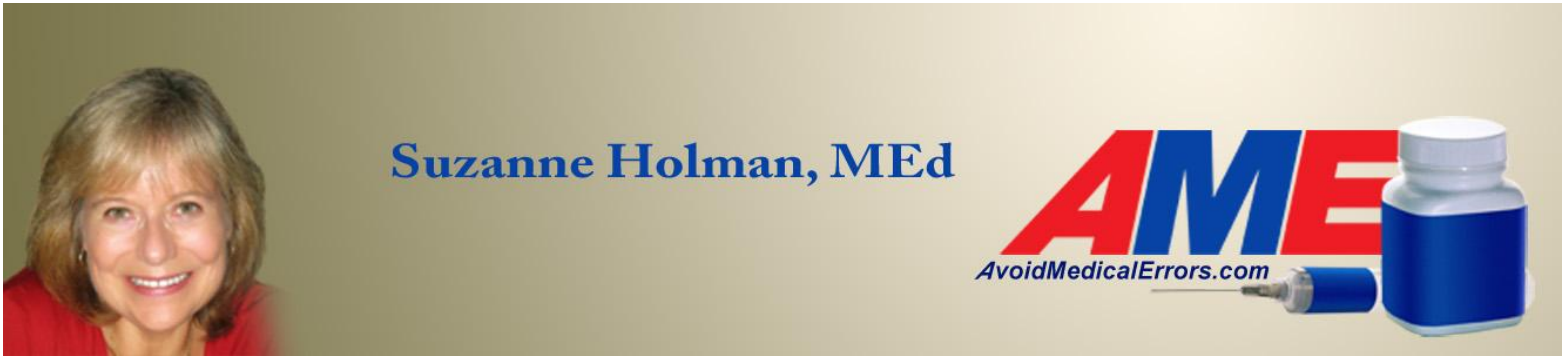

Food! Glorious Food! Part 2

The best diet for the support of the brain is one that is low in calories. Calorie restriction is associated with longevity. Dr. Daniel Amen talks about the "Dinosaur Syndrome", referring to their very small brains and large bodies. The truth is that when we are carrying excess fat, our brains tend to be less effective.

Your diet should be high in the Omega-3 fatty acids found in fish, fish oil, walnuts, and avocados. A dietary deficiency showing up very frequently in Alzheimer's patients is the lack of the Omega-3 oils. Omega-3 fatty acids are known to reduce inflammation that causes disease in the body and brain. One study showed that DHA supplementations significantly decreased the number of reference memory errors and working memory errors in male rats and in young rats.

Antioxidants are critical in fighting inflammation that is detrimental to your brain health. High quality antioxidant foods and vegetables, according to the U.S. Department of Agriculture are prunes, raisins, blueberries, blackberries, cranberries, strawberries, spinach raspberries, brussel sprouts, plums, broccoli,

beets, oranges, red grapes, red bell peppers, cherries and kiwis. All of these very colorful fruits and vegetables are rich in antioxidants. It's best to briefly cook your vegetables in as little water as possible to avoid loss of nutrients.

Choose foods that are closest to nature. The less processed food and extra chemicals that you put into your body the better off you are going to be. Choose whole grains and avoid sugars and white flour.

It's also important to monitor your blood pressure. Your blood feeds your brain nutrients. Your goal is to keep your arteries clear and flowing to improve the flow of nutrients to the brain. Reducing your high blood pressure to normal can improve cognitive function; it can slow Alzheimer's progression substantially. Choose foods that are low in salt to help with blood pressure or kidney problems.

Diabetes is also a risk factor for your brain health. Type II Diabetes, the kind associated with being overweight, increases the risk of Alzheimer's. It's thought this is from the increase in inflammation or from aging of the arteries. Also, too much of the insulin hormone in the brain can stimulate beta amyloidal build up. In fact, some people are now giving Alzheimer's disease the name Type III Diabetes.

As with all chronic disease, Alzheimer's disease results from the interaction of genetic, environmental, and lifestyle factors over many years, causing changes in brain structure and function.

Other diseases are decreasing and Alzheimer's is on the rise. The brain is really the last frontier in medicine. In the past 20 years, there have been huge strides in understanding how the brain really works. New technology allows us to study the functions in the brain more closely. In the early 1900's, a German physician, Alois Alzheimer, identified a collection of brain cell abnormalities. This led to the naming of the disease Alzheimer's.

Nearly a century later, scientists have found that people who have what is called the Apo E 4 gene have a high risk for Alzheimer's disease. Not all people who carry the Apo E 4 gene develop Alzheimer's disease, especially among those who have created a gene-supportive environment with a healthy lifestyle. And not all people with Alzheimer's disease have the Apo E 4 genotype. People with the Apo E 4 gene who eat a diet high in fats have a very high cholesterol level. Extremely high levels of LDL (bad) cholesterol cause high levels of inflammation in the blood vessels, including those in the brain. It's not surprising that there is a connection between Alzheimer's disease and one's diet.

If you enjoy Indian food, that is great because turmeric is an excellent way to combat the inflammation in the body and brain. Turmeric is found in a lot of Indian foods and is also available in capsule form.

More important than anything else is plenty of water! Your brain is primarily water. If you are starting to feel thirsty, you are already dehydrated and your brain is not functioning at an optimal level.

If you are not following some of these suggestions at this time, choose just one area where you can make a change to do something in a healthier way. If you continue to make small changes, over time you will find that your brain health and energy will be reaching new heights.

About the Author

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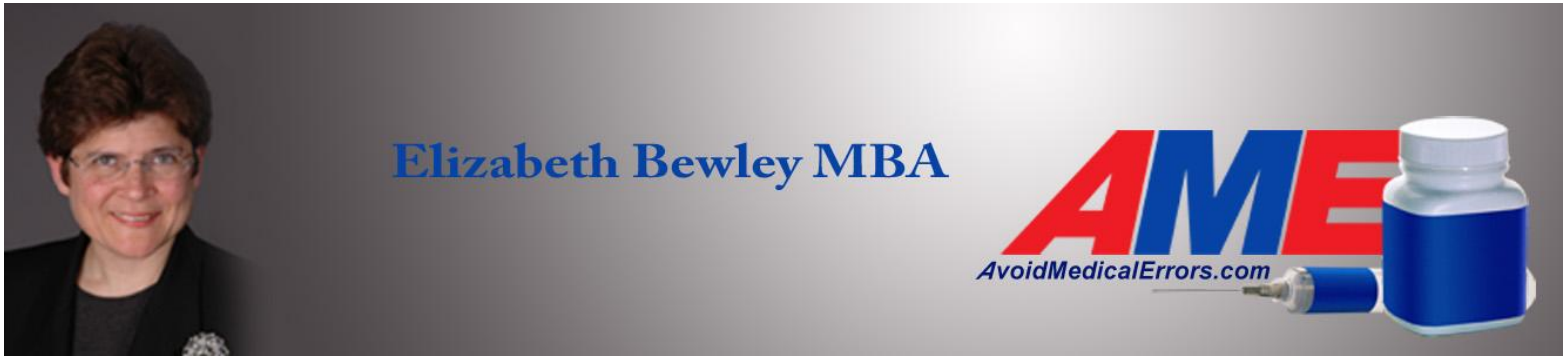

Does it Make Sense to Consider a Move to Assisted Living?

Frequently, we talk about medical errors related to treatments people are given. This article talks about another type of medical error—not recognizing the risks in declining necessary care.

In 1999, Mildred and her husband George moved into a CCRC (Continuing Care Retirement Community) that I'll call Pine Lakes. CCRCs offer a range of living options. People typically can live in apartments, in assisted living, or in skilled nursing.

Mildred and George, both in their late 70's, were still able to handle every detail of their lives. Like most people entering Pine Lakes, they moved into an independent living apartment. Mildred loved it, particularly the sun porch opening onto a greenbelt. She spent hours there, soothed by the sights and sounds of nature. "I'm never giving up this apartment!" she repeatedly warned anyone who would listen.

As the years went by, both she and George started to have trouble managing their

finances, their meals, and other activities. Mildred started to have frequent falls. Often, though, she refused to see the on-site doctor. She was afraid that if the medical staff thought she needed more attention, they would suggest a move to assisted living.

“Over my dead body!” she declared.

One night in 2008, their daughter Carol’s phone rang around 9:30 p.m. Caller I.D. showed that the call was coming from Pine Lakes, but not from her parents’ apartment. Before she even picked up the phone, she felt a sense of dread.

Mildred had fallen and broken her hip. When she got out of the hospital after surgery, she and George were moved into a room together in the skilled nursing unit. George could not be left on his own.

They never went back to the apartment again. Devastated that Mildred had been injured, George was often distraught. For months, he imagined that Mildred was going to die suddenly. In reality, she was out of danger after a few weeks. Even as Mildred got better, George declined rapidly and died the following year.

It has been three years since Mildred, now 90, broke her hip. She recovered remarkably well. She loves going for walks on the grounds of Pine Lakes, something she is able to do by herself. She doesn’t use a cane or a walker. She doesn’t need an aide to go with her.

However, Mildred is still living in the skilled nursing unit. She is no more impaired than some of the people in assisted living. If she were in assisted living, she would have more space, more privacy, and a more home-like setting. It would also cost about half as much.

But everyone agreed after George died that it would be too hard for Mildred to make another move. She would have to relearn everything—how to find her room, how to get outside, where meals are, who the staff are, and so forth. The professionals warned that such a move would disorient Mildred and push her into

rapid decline. Instead, she will spend the rest of her life housed with people who are so impaired that she doesn't even have anyone to talk with.

Carol is haunted by thoughts of what might have been. Mildred had lost 20% of her body weight by the time she fell and broke her hip. Did she fall because she was faint from poor nutrition and from not eating?

If she and George had moved to assisted living, they would have had three supervised meals a day. In the skilled nursing unit, with three meals a day, Mildred rapidly regained the weight she had lost. In assisted living, could she have avoided the fall that broke her hip? In three years in the skilled nursing unit, she hasn't had any falls at all.

Could she and George have lived out their lives in a more comfortable setting with four times the space of their room in the skilled nursing unit, at half the cost? Could they have had 80% of the benefits of independent living, with less risk? Did Mildred, by trying so hard to preserve the life she loved, put in motion a chain of events that cost her that life?

Mildred's situation highlights an important point people face in managing their health care. Often, people compare the plusses of one choice to the minuses of another. In Mildred's case, the benefit of staying in their apartment was that she got to live in a setting she loved. The downside to moving was that she would have to give up the apartment.

She did not consider the potential risk of that first choice: that she and George might abruptly lose the apartment—and be injured, devastated, and distraught—and spend the rest of their lives in the skilled nursing unit, because of a medical crisis resulting from their inability to take proper care of themselves.

"It is a lesson for us all," Carol said.

People may increase their chances of living the lives they want if they understand clearly both sides of the equation—benefits and risks—

when they decide to accept or to reject health care tests, treatments, or housing options.

About the Author

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Customer Service: A Two Way Street in Long Term Care

Customer service is the process by which a business ensures those who seek to purchase their product or service are satisfied with the purchase, how it functions, and are pleased to return to the business again. The old adage says, “The customer is always right.” It may not always be technically true, but businesses that treat customers as if it were, are the ones who usually end up with satisfied customers making fewer complaints and frequent

purchases in the long run. Those who are always friendly, respectful, helpful, sincere and honest to customers will find that customers will return to them and refer them again and again. The customer should perceive that the organization has exceeded all their expectations and values them for seeking its services.

It is the same concept with those who take care of our elders in a long term care facility. As a customer who places a beloved parent in

a long term care facility, you want to be assured that your parent always receives the best care, and that you both are treated appropriately – you want good customer service. As a conscientious consumer, you will want the company to value you.

Johnson (1) identified the ten deadly sins of customer service, which can set the stage for an unhappy patient or family. Examples of how these sins contribute to the roots of a malpractice suit are included:

1. "I don't know." The nurse is unable to answer the patient's questions and does not make an effort to obtain the information.

2. "I don't care." Nurses are indifferent about their jobs and the patients.

3. "I can't be bothered." Ignoring the patient's requests for help or attention creates a negative impression that is hard to overcome.

4. "I do not like you." Nonverbal and verbal messages can clearly communicate this message to a patient or family. Avoidance of the patient worsens the situation.

5. "I know it all." Failing to listen to the patient increases frustration and impairs communication. Overconfidence can lead to errors.

6. “You do not know anything." Negating the experiences of patients can lead to disasters. Patients are often finely attuned to their bodies and know when something is wrong.

7. "We do not want your kind here." Making negative assumptions based on appearance, color, age, class or educational level can lead to dissatisfaction and the development of hostility. Nurses may rush through their interactions with the patient and therefore miss important information or make errors.

8. "Do not come back." Every organization needs the return of satisfied customers. Consumers usually have a choice of providers,

and spread the word of their unhappiness to other potential consumers of health care.

9. "I'm right and you are wrong." Arguing with a patient or family fuels the anger and sense of helplessness that many persons feel when their ability to control their situation is removed.

10. "Hurry up and wait." Many patients resent long waits for attention. Waiting for someone to answer a call bell sends a message that their needs are not important.

An eleventh sin is emerging with the increasing use of non-English speaking healthcare professionals. Healthcare workers speaking to each other in a language that excludes the patient may engender feelings of insecurity or anger.

What kinds of things fall under the umbrella of good customer service in long term care? Here are a few.

Respect/Courtesy You and your loved one should always be treated with courteous respect. Even if your loved one suffers from dementia, the staff's behavior should not be based on how inappropriate your loved one's words or actions may be. Callers should not be left on hold for long periods of time. Visitors should not be told, "I can't do that now, I'm in the middle of something." Also, you can help to establish that atmosphere of courtesy by treating staff with courtesy. The staff members are professionals being paid for a professional service, and that they are not servants to be bullied, demanded or ridiculed.

Friendliness Staff at the nursing home should be friendly, welcoming, and pleased to see you visit. You should not feel like they groan, make ugly faces, or run away when they see you coming. It does not mean that you must be buddies. It is generally not wise to cross the professional barrier with a client and/or family. Remember the golden rule: treat others as you want to be treated.

Trust You should be able to trust that your loved one is getting the best care that can be

provided whether a family member is present or not. You should be comfortable in the belief that staff are attentive, caring, and looking out for your relative's best interests, and not the fastest way to complete a task. An example would be when Mom becomes agitated, insisting she must go out to work. Instead of arguing that Mom is 94 and doesn't work anymore, a clever caregiver could suggest that, "Today is your day off, remember? Now, let's go see what activity is going on in the parlor."

Punctuality Phone calls should be returned with reasonable promptness, by both parties. If you promise to accompany Mom to an appointment, you should arrive as promised, and the staff should have Mom ready on time.

Honesty You should not feel you have to question whether an employee is telling you the truth to any questions you may ask and any promises they make. Sometimes the answers to family questions are not good news. In some cases, it is the physician who should give test results or new diagnoses to the family. A family who receives good customer service from the nursing staff will often go back to the nurses with questions and concerns at a turning point in Mom's condition, because they know the staff will be honest. Customer service requires that the truth will be delivered with sensitivity and compassion, in words that the family will be able to understand. You should not have to worry that staff will steal your loved one's possessions. But, minimize risks by keeping valuables at home.

Helpfulness There is a certain amount of information about a facility that every employee should know to answer general visitor questions. The visitor should not be left standing there when an employee is not able to assist her with a specific answer or directions. The helpful employee will give an answer and then ask if there is anything else the visitor needs. Good customer service means going the extra mile saying, "I don't know that answer, but let's go to Mrs. XXXX. She may be able to help with that."

Listen Good customer service means really listening when family or Mom is speaking. Staff should not always assume they know what a patient wants by her habits or words only. Body language, volume, tone, proximity, gestures, and eye contact can change the message being sent verbally. When the speaker's words conflict with body language and tone, the listener will end up confused and unsure of what to think or how to feel. We tend to believe body language, though. If Mom says she is fine, but is breathing irregularly, grimacing or fidgeting in her seat, she may really be in pain. But she may be following her stoic 70-year habit of denying her own needs. Listening means to consider all forms of communication.

Non-judgmental Good customer service means not being biased or prejudiced in any category. Supportive staff are not critical or controlling and they rise above retaliation in any form. A successful employee will apologize, correct, prevent a reoccurrence, and get feedback.

Johnson, C. "Knock your socks off service." *Nursing Management*, pg. 16, July 1999.

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 patmedleague@gmail.com.

Resources

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Finding Meaning in Times of Chaos

In times of uncertainty and chaos in our lives we may find ourselves asking, “What is the meaning of all of this chaos?” Chaos means things are disorganized and unpredictable. In times of chaos there is turmoil and uncertainty. Indeed the only thing that is predictable in times of chaos is there will be change, usually big change.

It is true that chaos breeds creativity. In times when things are going well, your life is well organized and things are all going as planned. We tend to get into a happy routine and put ourselves and our lives on auto-pilot. Sometimes we get so comfortable that we stop growing. When this happens we eventually get bored and lethargic. It is true that if we are not growing what are we doing? That’s right! If we are not growing we are dying! And right now our economy is not growing, it is doing what? Yes – it is dying!

Look at nature. Everything has a cycle. Birth and growing, maintenance, and then dying or destruction. This is also similar to the Law of Thermodynamics. We find these cycles described in the ancient teachings from India

and other cultures of the world. Everything cycles. EVERYTHING!!

How many of you have either lost your job only to land a better one? Often the job you lost was one you hated and felt stuck in anyway. How many of you have had the experience of being in love and the relationship ended? You may have been rejected or went through a divorce only to find once you had moved on you were in a better place or with a better person. How many of you can look back on a situation or relationship that at the time it ended, it seemed like a very bad and painful experience only to realize you are now in a much better situation?

In our current economy, many of you may have been faced with or worried about losing your jobs, your homes, and your retirement savings. Or you may be concerned about whether you may EVER be able to retire after this economic disaster. I bet many of you have at least one of these concerns. What do we do? I'm going to give you some strategies:

1.) **Stop arguing with the Universe and instead, practice acceptance**. Accept situations and circumstances as they arise. Fear will **SHUT YOU DOWN**! Remember, what we resist, persists.

2.) **Manage your stress and take care of your health**. You will be more productive and able to handle situations if you have a healthy body and a lifestyle that supports health. Practice meditation. You will be more productive and more capable of doing what needs to be done in every situation and circumstance. Live in the present and remember, "I was OK yesterday; I am OK today; and I will probably be OK tomorrow.

3.) **Be flexible**. Flexibility equals resiliency. T. Harv Eker says, "How you do anything is how you do everything." In yoga I teach my students, "How you breathe is how you live your life." Breathe fully and completely. Be open, be flexible and when things aren't going the way you planned, don't resist. You may have to change plans or strategies.

If so, the more you resist the more uncomfortable it will be. Look at the trees. The flexible trees that bend with the winds of the storm are the ones that weather the storm. It's the inflexible brittle trees that snap and break during the storm. Which do you want to be?

4.) **Look for opportunities**. Remember, everything cycles. Look for opportunities. Financial gurus remind us that during these times, just like in the Great Depression, we will see the greatest transfer of wealth that we will ever experience in our lifetimes. Be open to new strategies and look for new opportunities.

Finally, know that you have the power and the choice to change and make the best of every situation. Stand up and make a declaration: "I am the champion of my future!"

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

Three Steps to Release Emotional Stress Eating

Emotional eating is a common response to stress**.** Do you find yourself reaching for comforting foods when you are stressed? You may also find that the harder you try to control emotional eating, the worse it seems to get. When you understand the forces behind emotional eating, you can see why it's so difficult to control and what works to free yourself from emotional eating habits.

Key triggers in emotional eating include early food conditioning and addictive food ingredients like sugar and salt.

The most significant factor in emotional eating is early food conditioning. Remember Pavlov's dog? Pavlov was a scientist who rang a bell right before feeding the laboratory dogs. The dogs learned to salivate as soon as they heard the bell. Our automatic responses are conditioned responses. Think about it – when a baby cries, what's the first thing we do? Feed it! And our first foods are typically formula and cereal, which contain sugar and carbs. The baby is stressed, gets fed, relaxes. As the cycle repeats, it becomes a conditioned response.

Food and beverages are also associated early in our lives with reward, punishment, family connection, celebration, mourning, and just about any emotional experience we have. You might also use food to deal with boredom or procrastination. Is it any wonder that nearly every emotion or event can trigger an eating or drinking response?

Here is a personal example: On the way home from speaking to a group, I always had the urge to get ice cream. One night I saw the pattern and wondered where this urge was created. I realized that it was directly linked to my father taking me for ice cream to celebrate whenever I performed in a recital or event at school. With self-observation, I was able to see more and more of these early emotionally triggered food connections.

Once you notice the connection between an emotion and a particular food or behavior, the next step is to interrupt the pattern and substitute a healthier satisfying behavior. Trying to force yourself to stop the behavior or criticizing yourself for having the behavior will actually reinforce it.

When you push against your emotional eating habit it stimulates what I call the "inner adolescent." That teen-aged part of us pushes back saying, *"I can do what I want"*, or *"Try and make me stop."* Instead of pushing against the conditioning, find a healthy, satisfying substitute that feels positive, relaxing or rewarding to you.

In my case, I decided to take a few moments in the car or hotel room to take some deep breaths, review and acknowledge the great experience I just had. I choose to celebrate the "sweetness" of those moments now by consuming the joy directly, rather than by using ice cream as a substitute. Over time, I created a new healthy and satisfying habit to replace the old one.

Be patient and consistent. It may take a few repetitions of the new behavior to replace the old automatic reaction. Once you create a new conditioned response, it will also become

automatic. Just like when you learned to ride a bike or drive a car, you had to think about how to do it in the beginning until the actions became automatic. New habits work the same way.

To recap, here are the three steps to effectively release emotional stress eating or drinking habits.

1. **Notice your automatic emotional eating habit**. Think about when it started and the meaning the food or behavior has for you. Realize that conditioned reactions are normal. Resist the temptation to push against the old habit or criticize yourself for having it.

2. **Find a healthy substitute that feels rewarding, relaxing or gives you the satisfying feeling the original behavior gave you.**

3. **Practice using the new behavior until it becomes automatic.** Be kind, patient and encouraging to yourself if you slip up. Over time, the new habit will become automatic.

Here is one more tip that can make the change easier. Learn the "Emotional Freedom Technique" (EFT). This is a simple tapping technique that can speed up the release of old conditioned behaviors and support new healthy choices. You can find information about EFT online and view my demonstration video along with others on youtube.com.

Summary

Emotional stress eating or drinking habits are patterns formed early in life. Once you are an adult, you can observe where these habits started and choose to change them. You can create new healthy habits that are just as satisfying by using a simple three-step process along with kindness and understanding toward yourself.

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.

Theresa Healy RN

The Truth About Food Part 2

In Part I, I talked about GM (genetically modified) food. Here is a direct quote from one corporation website:

> *To meet our 2030 commitments, Monsanto has adopted a new vision for agriculture built upon three pillars. These pillars are advanced breeding, biotechnology, and improved agronomic practices. When all three components are fully integrated, we can provide the best tools and technology to farmers so that they can meet the goals of feeding, clothing, and fueling the world.*

That is quite a goal isn't it? To feed, clothe, and fuel the world? Fifty-seven percent of the global seed market is controlled and/or owned by 10 companies. These top 10 companies have also been leaders in the pesticide industry: DuPont, Monsanto, Bayer, and Dow, to name just a few.

These companies have also been buying shares in or buying outright smaller seed businesses globally. This allows one particular conglomerate to have control over most of our

seeds. Now, the point here is to let you know that behind the scenes, not being talked about, and ignored by the media, is extensive information regarding the future of and truth about the food you are eating.

On a positive note, there are many organizations working to protest against GM foods and seeds that have garnered enough support to at least be heard by some government sectors. There is still much work to be done. For a consumer, it is more of a chore than a joy trying to determine the cleanest options available. But stay informed, and see for yourself the truth about the farming, reaping, and harvesting of our food. Some authentic resources are listed below.

My biggest message here is that food plays a key role in our health. We have no idea today what the long term effects of GM foods will be on our bodies. I just know that foods containing pesticides, herbicides, and genes that make them resistant to pests and chemicals are not what God put on our planet to sustain us or the bodies we live in. I am not willing to risk my health on the unknown.

Environmental working group: EWG.org
Organic center: organic-center.org
Monsanto.com
cdc.gov/seeds

Google these keywords: the truth about Food, Monsanto Acquisitions, genetically modified foods, Monsanto and seeds.

Watch these DVDs: The Future of food; Our Daily Bread; The World according to Monsanto; Supersize me; Fat, sick and nearly dead. All are available on Netflix.

In health and gratitude,

Theresa Healy, RN, CCH, HHC
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What are people in the ER thinking?

Ever wonder what the people who work in the ER are thinking? What do they think of YOU?

Sometimes you ought to; it may impact on the type of care you get. While we – ER personnel – want to do the best job possible for everyone, there are some things that just don't help.

1. What if you're saying, "Hurry up. I've got to get out of here?" We say, "Yeah, really? Then we're guessing it wasn't such an emergency." The others here will need attention sooner because they do actually have emergent conditions.
2. "I had two beers, that's all." Commonly heard, rarely true. Why? The heavy drinkers are much more likely to get into problems that bring them to the ER. When your blood alcohol comes back to show you were legally intoxicated - twice over - we know we can't really believe anything you say, including how much you hurt. Which means, when you request pain medication, you'll get the minimum dose.
3. Why is it taking so long for you to be seen? The answer – almost universally – is that

the most seriously ill or injured patients need to be seen first. That's why the infant (whose temperature was 104.5 degrees) went right back while you're still there with the sore throat.

4. "My brother is on the Board of Directors of this hospital." Good. Go see your brother for your problem.

5. "Next time I'll go to another hospital." Boy, is it ever hard to not say, "I very much hope so!"

We sometimes get just a little chuckle when we are working full speed and know we have a full waiting room and someone decides they'll go to Elsewhere General. We know (and often tell them) they'll have a similar wait at that facility; and they're already near the head of the line here. Still want to go? OK, but on the way out, don't let the door hit you on your….

It's not very frequent that we have patients who try to impress us with their "importance" to get "better" care. Often we'll have patients who are quite insistent that we call "Dr. So-and-so" – who may or may not be on staff – to get what they want. It's not usually "better care" they are seeking.

If your own physician can give information that you (as a prudent, intelligent layperson) may be unable to relay (we know you're not a doctor), then by all means, tell us so. We want all the pertinent information we can get.

We also often will want to call your physician to tell her about your visit; that helps provide you with the opportunity to get the best follow-up care possible. It's much better for your doctor to hear from us than to hear you went to the ER and "they ran a bunch of tests."

If you have a family member who is a physician and you'd like us to call – that's very reasonable. Usually we'd want to wait until after the test results.

6. We need the direct answer to any question.

"I quit smoking."

We'll ask when.

"Yesterday." Oh come now. We're trying to gather information. We aren't here to judge whether you smoke, or drink, or have other vices. We need to know what we need to know. Along the same lines, "No" doesn't mean "well, a few cigarettes now and then."

7. On the other hand, don't be afraid to speak up if something seems unreasonable. "Doc, I've been here 3 hours..."

"I am in pain."

If your complaint is "I can't sleep," don't expect to be at the front of the line. Nobody dies from insomnia. "The most clogged up my nose has ever been." Well, one of the times it's clogged, that's got to be the case.

8. Ask ancillary personnel about ancillary concerns. The doctor does not have the phone you can use.

9. Do not be afraid to ask the status of your care. Were the tests completed? Consultants reached? If it's been hours, ask what's going on if you don't know. If the doctor says he needs a certain test and there's a delay in getting the test, common sense should tell you there's not much more in the picture than waiting for the test. No, we don't like waiting a long time for a test result either. Yes, we sometimes *do* forget; we're not perfect. Often an ER doctor will manage the care of up to a dozen patients at once - sometimes more.

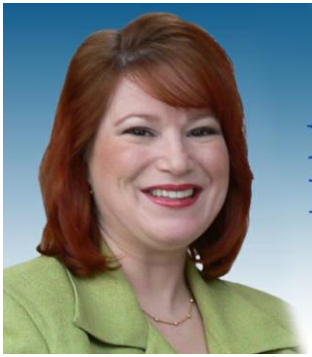
Complaints about how long you're waiting when the doctor needs a urinalysis and you don't provide one don't go very far. Questions about what did the x-ray show or the CT scan or the EKG or the testing so far - sure, don't be afraid to ask; we're happy to answer.

We are all there simply to provide care. We have compassion, but respond poorly to demands, threats, or lies. In this arena, your own ability to be reasonable will help us help you. And vice versa.

It's okay to be a squeaky wheel, but please, don't try to sound like the squeal of chalk on a chalkboard.

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.



Nancy Collins
PhD, RD, LD/N

Exercise and Heart Rate

When you begin an exercise program, it is important to understand your heart rate goals. Heart rate monitoring helps you keep track of how fast your heart is beating in a beats-per-minute (bpm) form.

Knowing how fast your heart is beating during exercise can help you to pace yourself so that you are working most effectively.

Understanding the heart rate range you are shooting for will guide you in working more or less intensely.

Calculating your target heart rate
The calculation to figure out your target heart rate *range* is:

(220−age in years)×50% or 80%

For example for a 50-year-old person:

220−50=170×.5=85 bpm

220−50=170×.8=136 bpm

Target range: 85-136 bpm

A more general table follows:

Age	Target Heart Rate Zone 50%-85%
20 years	100-170 bpm
25 years	98-166 bpm
30 years	95-162 bpm
35 years	93-157 bpm
40 years	90-153 bpm
45 years	88-149 bpm
50 years	85-145 bpm
55 years	83-140 bpm
60 years	80-136 bpm
65 years	78-132 bpm
70 years	75-128 bpm

Measuring your heart rate

Several methods are used to determine heart rate. You may find your pulse at your wrist or neck, and count how many beats you feel in a 10-second period. Multiply that number by 6 to determine your heart rate in beats/minute form.

Watches, monitors, and cardiovascular machines also are available to help you determine your heart rate with various technologies. Some monitors are very reasonably priced.

Determining if you are working effectively

Here is an easy way, and probably the best method, to tell if you are working effectively in your target heart range. You will know if you are working hard enough during exercise, if your breath is slightly impacted by exertion while trying to carry on a conversation. If your breath is shallow, you are working too hard. You should have the ability to take a deep breath while moving.

Getting started
Whether walking, biking, swimming, or performing other cardiovascular activity, start slowly with a goal of staying in the 50% bpm zone. Gradually increase time and intensity to reach the 85% bpm zone. Keep in mind that you do not need to work very hard to stay in shape.

Note: Some medications lower heart rate as a side effect. Ask your physician if you should work at a lower target heart rate.

Reference
American Heart Association. Target heart rates.

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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Bullying in Health Care: How it Harms Patients

Bullying does not occur just in the playground or corporate setting. It also happens in health care where people's lives are at stake. Bullying in the healthcare environment can have serious consequences to patient care. Beth Boynton RN and Alan Rosenstein MD share their expertise about this potentially very dangerous behavior pattern. You will learn:

- what bullying behavior takes place in health care environments
- why bullying in health care is prevalent
- how bullying in health care occurs
- how stress plays into bullying
- who are the biggest bullies
- the costs of bullying
- why bullying is tolerated
- how it harms patients, and
- what you can do about it.

-- This Inner Circle interview is available to members of the Inner Circle. Join now at www.avoidmedicalerrors.com.