
AME
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Patient Safety: Anesthesiologists and Colonoscopies

This month I went to see a gastroenterologist (Doctor A) because I am due for a colonoscopy. I had a colonoscopy done 4 years ago by a different doctor (Doctor B), and one closer to home. Doctor A wanted to know why I had not returned to Doctor B for this new one. I explained Doctor B and I had not clicked.

This is what happened, and it is a good lesson for what not to say or do to a patient.

Anesthesiologist present at colonoscopy – a request

Four years ago, when I met with Doctor B in his office, I said I wanted an anesthesiologist to be present during my test. (The theory behind having the anesthesiologist present is that this person permits the gastroenterologist to concentrate on the procedure without having to stop to administer more medication to the patient. A colonoscopy is an uncomfortable test for people who have to endure it while awake.)

He said I would have an anesthesiologist. The test would be performed in his office on a Thursday. Then I got a call that the test was being moved to a Friday and would be at the hospital. “Yes, there would be an anesthesiologist there,” the secretary told me.

We’ll take care of you if you have a cardiac arrest

When I showed up at the hospital on that Friday, I waited for the anesthesiologist to come by my stretcher. No one came. I asked the holding room nurse when I would see the anesthesiologist. She told me, “Oh, you won’t have an anesthesiologist. The doctor gives his own drugs.” When I looked concerned, she asked me why I wanted an anesthesiologist there. I told her I thought it was safer. She replied, “Oh, don’t worry. If you arrest, we have a button on the wall to get the code team. The whole hospital will come running.” At that point, the thought of arresting had not entered my mind. If I had not been fully prepped for the procedure, I would have gotten off the stretcher and gone home.

“He gives his own drugs” translated into the OR nurse injecting me with something that took away awareness (thankfully).

Dr. A looked amused when I told him this story. I said, “I know what the nurse said was technically correct. I had just written an article about rapid response teams. I have been a nurse for 40 years. I used to teach CPR. But it just hit me wrong in the state I was in.” He disputed whether it was safer to have an anesthesiologist there and said for years he gave his own anesthesia with no respiratory complications. After he started using an anesthesiologist, he had 3 respiratory complications but he was not saying there was a correlation. He assured me I would have an anesthesiologist for the procedure.

Legal nurse consultant revealed

But the awkward moment came when he asked me my occupation: “Nurse.” “Where do you work? “I have my own business helping personal injury attorneys.”

"Oh, you are one of THOSE nurses," he quickly said (I am not sure what that meant, but the implication was that it was not good. Many doctors are leery of the medical malpractice legal system and those who work in it.) I replied, "And I won't ask you if you do expert witness work." He said, "Oh, I've been asked plenty of times. I have helped the insurance carrier point them in the right direction, but I don't take the case." I said, "Some doctors love expert work and some avoid it."

I did notice after that I got letter perfect care, a full informed consent, and careful instructions for my prep.

Patient Advocate Lessons Learned

If I had the experience today that I had four years ago, I would have handled it differently. I felt betrayed that my specific request for an anesthesiologist was ignored. Furthermore, while I realized the nurse was trying to reassure me about the safety of the colonoscopy experience, her choice of words was very upsetting. The combination of the two factors close together set me on edge.

Several people who have heard this story asked me why I did not leave without having the procedure done. The unpleasant experience of the bowel preparation would have needed to be repeated if I had the procedure done at a different time. And while I wanted an anesthesiologist there, I knew the procedure could have been done with the doctor giving me anesthesia. My sense of trust in both the doctor and the hospital was affected. What I would have done today is to write a letter to the doctor to discuss the scheduling glitch and to express concern that my wishes were not followed. I also would have told the nurse that her comment about what would happen if I arrested made me even more nervous about being there. I know she was trying to make me feel safer. It had the opposite effect.

If your healthcare providers do not respect your wishes, it puts you in an awkward position. You have to decide if what you are asking is reasonable, and if it is, what are your choices. This is not an easy decision.

As it was, I got through the experience without problems, no complications from either the procedure or the medication. When I got the letter from Doctor A's office reminding me it was time for another colonoscopy, I knew I was not going to return to him. My decision took money out of his pocket, and placed it in Doctor B's pocket. There is some satisfaction in that. Sometimes switching doctors is all you can do, but for me, this was enough for now.

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.

Inner Circle Interview

Kay Rice speaks about Mind Body Medicine.

Kay Rice is skilled in understanding Aruvedic medicine, or the mind body connection. In this interview, she shares practical suggestions for harnessing the power of your mind to help in your healing process and to increase your enjoyment of life.

Get this interview at http://tinyurl.com/cekhu6t

Pain Management

Despite over 30 years of research advancing the field of pain management, little research has trickled down to the doctor who is not a pain specialist and deals with patients in pain. Most physicians still do not understand that chronic pain is a disease, not merely the symptom of a disease. This results in frequent and generally avoidable patient suffering in acute care, emergency, inpatient and office medical practice.

We have known from research into pain over the past 25-30 years that the longer pain goes untreated or undertreated, the more the pain becomes hard-wired into the central nervous system. As example, the failure to refer patients with reflex sympathetic dystrophy in a timely manner means that the opportunity (RSD) for early, effective intervention will have passed. In this specific type of case, orthopedic surgeons are the specialists most often confronted with RSD. They are often the least equipped to diagnose RSD and refer patients for aggressive, early treatment. Cost-containment, as well as treatment-delaying tactics of insurance companies also often leads to poor outcomes. Treatable acute pain will develop into chronic pain, potentially causing additional and life-changing physical injury.

Medical Legal Considerations

To date, there have been only a few precedent-setting cases in which truly gross negligence was committed by physicians who ignored the suffering of terminal cancer patients. Never the less, lack of awareness regarding the management of pain is widespread, particularly for doctors treating those people in chronic severe pain, but also, still for cancer patients to some degree.

Pain Management became something of a mini-growth industry in the 1990s. This happened while allowable payments for anesthesia, surgery and other fields came under assault in the 1990s by both government and insurance companies. Many physicians who have not completed appropriate post-graduate training in pain management began to practice in the field. Few understand how to carefully balance the biological, psychological and social needs of the patient that the vast majority of chronic pain suffers require. Poor outcomes are the logical result of pain management treatment by untrained or undertrained practitioners.

The current situation in pain management is like what happened in the field of cardiology in the 1970s when any physician performing invasive cardiology and catheterization could do so without fear of sanction or medico-legal penalty. Unnecessary illness and deaths caused by the unqualified physician eventually led to the current state, where only Board Certified Cardiologists are permitted credentialing at reputable hospitals. In my opinion, pain management needs to go in that direction as a specialty.

Editor's note: If you are dealing with severe, chronic pain, ask your primary care provider for a second opinion consultation with a pain management physician. A new perspective from a person specifically trained to handle chronic pain may improve your situation.

See www.amfs.com for details of our services.

Food! Glorious Food! Part 6

Dessert

Let's think about the dessert. How about some sliced strawberries dipped into melted chocolate? If you use the 73% chocolate, you will be well within the range of low sugar. Chocolate is a great antioxidant. Just melt it and put it into a small cup in the middle of a plate and have the sliced berries all around. I use a little shrimp fork and it makes it quite a delectable treat for being so healthy for you!

Another healthy dessert idea is something I have done for years. Buy silken tofu and put it in the blender and add about a fourth cup of some unsweetened juice. I use the ones that are called Just Cranberry or Just Pomegranate. They are 100% juice. There's no sugar added at all and the juice has an intense flavor that blends well with the tofu.

Add a small amount of Stevia and some Greek yogurt. The Greek yogurt is thicker than regular yogurt. Keep this a thick pudding consistency. The yogurt tends to blend with the tofu nicely and makes it a creamy texture. I mix it in the blender and put it into small containers. It makes a great little pudding. Or you can use it as a dip for wholegrain breadsticks. You can usually find the breadsticks in the deli section of a grocery store. I've also used tofu this way to make a dip that's similar to an onion dip. I'm still perfecting that one. I really like the fruity one better.

Meal Planning
You've read lots of different ideas for things to eat; now how can we make this easy for our planning and shopping?

First of all to keep things at a low cost, I look for sales on chicken tenders and I package them four or five to a baggie so that they are flat and lined up. That way they are easy to thaw. Sometimes I'll even just put a row of frozen tenders into the Panini maker. The chicken cooks really quickly in there with the heat coming from both the top and bottom of the Panini maker.

I purchase extra lean ground beef in quantity and make it into patties and put them in plastic bags. If you do this as soon as you get home, everything stays super fresh in the freezer. It helps to use the tray that the meat came in. Just wash it off and use it to hold the bagged-up meat in the freezer until the meat freezes. That way everything stays flat.

Once the patties are frozen, put them into a zip lock plastic bag and mark it with the date you purchased the meat and where you purchased it. Sometimes I cook some of the ground beef with onions and garlic and put it into little containers in the freezer. This combination is great for use in tacos, enchiladas, or tomato sauce. With this frozen mixture available, it is easy to put together several different meals quickly.

I usually buy frozen shrimp and mahi-mahi from a warehouse club rather than buying what they call fresh fish or shrimp unless I'm at a place where they are actually catching it. You don't know how long they've had it sitting in the refrigerated case at the grocery store. When you buy frozen, it's frozen fresh after being caught. They keep it frozen and you get a fresher product.

I love fresh vegetables and I usually keep a stock of zucchini and broccoli, as they are available most of the year at a reasonable price. I get asparagus and Brussels sprouts when they are in season. There are times that I run out of my fresh vegetables. To avoid being caught without vegetables ready to be cooked, I keep a large bag of frozen organic whole green beans in the freezer. To me, they taste as good as fresh. If you are out of fresh vegetables, you still have your frozen ones to use.

I usually buy my favorite breads when they are on sale and always keep them in the freezer. These really healthy breads can mold easily and lose their quality particularly in warm weather. Don't keep them in the refrigerator because your bread gets stale when it's just refrigerated. It's much better to freeze it.

Something else I like to keep in my freezer is a supply of vegetable beef soup. I cook it in a huge soup pot. I brown a lean cut of beef, add a couple of heads of chopped cabbage, some barley and lots of good seasoning. I get a huge can of crushed tomatoes in tomato puree from the warehouse store. There's no sugar added and it's very inexpensive. I also add a bag of mixed frozen vegetables. I add the frozen vegetables after the other parts have had a chance to cook for a while. The soup needs to cook for hours and then you pull the beef out, chop it into small pieces and mix it into the soup. Then package the soup up in freezer containers.

I save the tall rectangular feta cheese containers from Costco. They are just a perfect size to fit into my freezer door rack all lined up. They are clear so you can see what's in them. And what's really great about this particular size is that after it thaws enough to slide it out of the container, it fits into a square casserole dish. I can put it into the microwave again on my simmer setting and I'm good to go with the soup at any time. Even in the summer I think soup is great.

Hydration

Speaking of summer, we need to keep really hydrated. If you start to feel thirsty you are already partly dehydrated so drink all day. There is nothing as important for the brain as keeping it hydrated. Our brains are about 80% water. If you wait until you feel thirsty to have a drink, you are already dehydrated. It is essential to drink often throughout the day. When it is very warm or when you are perspiring, you need to be particularly careful.

Living in a dry climate like Phoenix, this is critical. People who move here and do not make it a point to drink enough water may develop kidney stones. If this is occurring, that means the brain has been severely deprived of its required hydration. To get the optimum function of the brain, it just has to have enough water.

For good hydration, it's important to have drinks that do not contain caffeine. And it's easy to choose drinks that are heavily laden with sugar. Sure, water is the best choice, but it can get monotonous. I've developed a number of drinks that do not have sugar or caffeine. These have helped me stay fully hydrated and refreshed.

I've always enjoyed the drinks in glass bottles like Snapple or Arizona Ice Tea or Fuse drinks. There's something about that really cold bottle and chilled drink that makes them special. The problem is that there are no drinks that I have found in glass bottles that are sweetened with Stevia, the only natural no-calorie sweetener. It is actually made from the Stevia plant. I wanted alternative drinks that would be healthy and still have that refreshing cold bottle!

You can brew any decaffeinated tea and pour it into recycled glass bottles. I like Good Earth decaffeinated tea because of its spicy sweet taste without having any sugar.

An alternative to the usual sweetened lemonade or lemonade made with artificial sweeteners is to put together a lemonade combination with the juice of two lemons or the little unsweetened packets of Kool-Aid lemonade I keep in my pantry. Sometimes I combine the juice of a lemon and some Kool-Aid.

I often add unsweetened juice for more flavor and nutrients. For Black Currant Lemonade I use the juice of two lemons or one packet Kool-Aid lemonade, 10 drops of liquid Stevia, two quarts of water, and half a cup of unsweetened Black Currant juice. You can use any pure, unsweetened fruit juice. These are usually available at natural foods stores.

Fill recycled glass drink bottles and refrigerate. Enjoy a wonderfully chilled, refreshing and healthy beverage!

It is so important when your time is limited to have a plan for your shopping and cooking. When you have the food available it can really keep you on track, giving your brain the fuel it needs to be fully functional for a lifetime.

With this cooking system I don't feel the need to go out to eat because there's always something that's easy enough to prepare. It's kind of a rhythm for me that could work for a lot of people. Just take the time to think ahead and it can really save so much time and money in the long run. The result is much healthier meals for less than the cost of having fast food that has very little nutritional value.

It’s very easy to think, “Oh, I don’t have anything in the house. I don’t want to go to the store to buy anything.” Then you end up just picking up fast food or going to a restaurant and eating things that maybe aren’t really the best for you.

If you have something that you know is there, it’s so easy to say, “Okay. I’m just going to pull this out and this out and I’m going to have a great meal.”

Choose something from the meal options that I’ve shared that appeals to you and try adding it to your meals this week. Happy, healthy eating to you!

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

Reducing Risks in Same Day Surgery

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

What you will learn

Patricia Lewis is an RN and legal nurse consultant. She shares information from the perspective of being a risk manager and a nurse who is thoroughly familiar with the risks of same day surgery.

Invest in your safety or that of a loved one: http://www.avoidmedicalerrors.com/store/same-day-surgery-risks/

Make Sure Tests and Treatments Are Meant for You

Tom, age 45, was in the hospital hooked up to an IV line. The fluid going into his vein contained antibiotics to treat an abdominal infection. It was his second day in the hospital and he was feeling much better. The extreme pain that he'd had in his belly was completely gone, but he knew he had to keep getting the antibiotics for a while longer.

He looked up when an orderly entered the room, pushing a wheelchair.

"Okay, buddy," the orderly said cheerfully, "In you go."

Tom was a little perplexed.

"Where are we going?"

"Down to x-ray. Way in the basement in the other building. I call it the dungeon sometimes, it's so gloomy looking. They try to cheer it up by painting the walls bright colors, but it's still a dungeon to me."

"Okay, but why are we going there?"

"They want you to have a test."

"What kind of test?"

"Just says here to take you to x-ray. They know all about it. They'll take good care of you. You don't have to worry about a thing."

Reluctantly, Tom folded his newspaper and got into the wheelchair. The orderly greeted other employees enthusiastically as he navigated a series of long corridors and two different elevators.

Tom was getting more and more concerned as the journey continued. His doctor hadn't said anything about any more tests. And he was feeling much better. Why did he need another test?

Finally, they arrived and the orderly said, "Now, don't you worry. When they're finished, they'll call up and you'll get me or somebody else to come take you back to your room."

Tom wasn't worried about getting back to his room. He was worried about the test.

The x-ray technician started preparing to inject something into Tom's IV.

"Hold on there!" Tom said, alarmed. "What are you doing?"

"This is a contrast dye. It will help the doctor see what's going on in there."

"I don't want this. I don't know what this test is or what it is for. My doctor didn't say anything about getting another test. I think this is a mistake."

"Oh, they don't always tell you what they're doing. It's a standard test."

"Do not put that dye into my arm. Stop right there. I want to know what this test is called, what it is for, and who authorized it. Don't come near me with that needle until you can tell me these things."

The x-ray tech sighed, put down the needle, and went to make the call.

He came back a few minutes later and said, "Oops! This test isn't for you after all. You're not supposed to have this test. I'll call Transport and have them come pick you up. You can wait right here until they come."

Tom's experience is not unusual. Tests and even treatments are sometimes given to the wrong patients in busy hospitals. How can you protect yourself?

- Ask your doctors to tell you the names of any new tests or treatments they order for you.
- Make sure you know what dates and times these are scheduled for.
- Ask the purpose of each test or treatment. It is reasonable for you to know what will be done to your body.
- When someone comes to take you for a test or to give you a treatment, ask them to show you the order that has your name on it. Read the order carefully. Sometimes hospital employees accidentally mix up patients with similar names. If the order is signed by a doctor you don't recognize, that's a red flag.
- If someone attempts to deliver a test or treatment you weren't expecting, it's reasonable to refuse to have it until you know that your doctor ordered it.

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.

What's My Line? Who Does What in a Nursing Home? Part 2

In a previous column, I identified the ancillary staff in a nursing home and specifically stated that across the board, none of them may perform hands-on care for the residents. The one exception task is feeding, and that may occur only if the office/ancillary worker received specific training by the facility.

So who does all the physical care of our elderly loved ones in a nursing home? The majority of care is given by the nursing assistants. They can be called aides, caregivers, C.N.A.'s (Certified Nursing Assistants), or care nurses. Whatever you call them, they are the backbone of any nursing facility. Whether the facility is for rehabilitation and therapy, assisted living, long-term care, or hospice, it generally falls to the nursing assistants to provide daily, sometimes hourly care.

It used to be that if you wanted to work in a hospital or long-term care facility, you got yourself hired and the facility taught you everything you needed to know in an orientation or training program. If you passed, then you could work for them. Now, aides must learn their skills from an accredited institution and be certified through comprehensive clinical and paper and pencil tests. The certification must be renewed each year through attendance at a required number of continuing education courses, usually 12, and proof of attendance must be submitted annually. Our facility offers these courses free of charge. Employers require a copy of the updated certification before hiring. Some nursing homes will only hire those with at least six months to two years previous experience in the field. There are others who are part of larger corporations owning multiple facilities who run an accredited training program to "grow their own staff." In this case, the prior experience requirement is usually waived.

Nursing assistants must perform any task that the patient/resident cannot do for themselves with a few invasive exceptions. Aides prepare residents for breakfast with toileting or incontinence care, a quick wash-up, repositioning in bed or transferring them to a chair to eat. Nursing assistants help with dressing and grooming, bathing, other morning rituals, bedtime preparation, toileting, feeding, and transportation from one activity/location to another. For those who are physically challenged by disease, condition, trauma, or age and are totally dependent on another for every aspect of care and daily necessary activities, the nursing assistant will perform all tasks related to activities of daily living (ADL's). Aides provide fresh water and ice each shift (usually every eight hours), and keep resident's personal belongings and the room as organized and safe as the resident will allow them. The aide must perform all these tasks while honoring the resident's dignity, privacy, and personal preferences.

At our facility, aides ask each resident before lunch and dinner for meal preferences from the daily selections and get any changes to the dietary department to facilitate a timely substitution. A good nursing assistant is the eyes and ears of the nursing staff because they spend the most time with the residents. Where I work, aides have permanent assignments and they get to know every nuance of choice, ability and performance level of each person assigned to them. Part of their job is to immediately notify the licensed nurse of any change in skin condition, mental attitude, or physical/cognitive ability. The nursing assistant is usually the one who tells the nurse that "Mrs. Brown felt warm this morning, or Mr. Jones needed me to help him more than usual with dressing today." Frequently, when a monthly or quarterly skill evaluation of a resident is due, the licensed nurse will go to the assigned aide for each shift for input on any changes that may have been noted.

Some residents/patients have special equipment and appliances for short or extended periods of time. These residents may have an appliance to assist with urine or fecal elimination. A Foley catheter or urostomy bag drains urine from the bladder. Aides may perform Foley care and empty a urine drainage bag, but not insert a catheter if it comes out. For residents with a colostomy for fecal elimination, aides may empty the bag and/or change it, but aides may not cut or measure the stoma covering attached to the skin in a two-part ostomy set up. Residents who are unable to take nourishment by mouth may have a tube inserted into the stomach called a "peg" tube. In our facility, an aide may put the pump running the tube on "hold" while care is being given, but not turn it off.

Nursing assistants may not perform any tracheostomy care or care related to intravenous (IV) or central catheter sites. A nursing assistant may not give a medication, injection, change a dressing, or perform an invasive test on a resident. They must defer all questions regarding care regimen, medication, or information on the resident's chart to the licensed nurse.

At my facility, the staffing ratio is generally as follows: on day shift, one aide for 8-10 residents; for second shift, one aide for 15-18 residents, and on night shift, one aide for 18-20 residents. When an aide call in sick too late to replace her, the remaining aides have to take more patients.

The licensed nurse may be a licensed practical nurse (LPN) or a registered nurse (RN). The supervisor is usually an RN, but either may be a charge nurse. LPN's may perform all aspects of care including giving medications and treatments, except an admission assessment (RN only). They can become IV certified and give medications through peripheral lines but not the first dose of any medication via IV, or infuse blood or blood products. Either nurse may speak to family members, the physician, consultants, take orders or lab results over the phone and take off orders from a written physician order. We usually staff one charge nurse for 20-30 residents around the clock.

A unit manager, usually an RN, is responsible for the smooth running of the activity and care on a unit (19 to 30 beds). This nurse prepares the unit paperwork (census and condition) and resident care plans (plan of care) and participates in the quarterly care conferences for each resident.

The director of nursing (DON) is the chief nursing officer in the facility and must be an RN. He or she is usually assisted by an assistant director of nursing (ADON) who is in charge in the absence of the DON. Their jobs are not usually hands-on care but comprised of policy formation, oversight, reports, meetings, discipline, education, hiring interviews, and more times than not, a lot of stress.

I hope this internal look at nursing home employees gives a clearer insight to all.

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.

Order Bullying in Healthcare: How it Harms Patients at

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Bullying in Health Care: How it Harms Patients

This program is an interview between Pat Iyer, President of Avoid Medical Errors, Dr. Alan Rosenstein, and Beth Boynton MSN RN. When you purchase this program, you will receive the interview in audio form, transcript and 6 bonuses.

What you will learn

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.

Emotional Freedom "Tapping" Technique: What It Is, Why It's Helpful

Modern medicine does not know the cause for many diseases. Medication is often offered to help symptoms. Most of us know that while medication is often helpful to reducing symptoms of illness or pain, it is not usually treating the cause.

There is a downside to using medication just to treat symptoms. Medication also comes with side effects that are often treated with additional medication. The more medication you are taking, the more likely you are to risk additional symptoms and medical errors.

What else can you do?

Since we know that most disease and illness is either caused or made worse by stress, addressing stress can help reduce symptoms. There is a simple acupressure approach called the Emotional Freedom Technique (EFT) that is proven to help reduce pain and other symptoms of illness with no side effects.

EFT works on the same principle as acupuncture. In addition to its circulation system and the nerve system, your body has a meridian system. Meridians have been charted and used in Chinese medicine for over 5000 years. Each meridian is connected to various parts of the body. An acupuncturist uses tiny needles to stimulate the appropriate meridian for relief of pain and symptoms. EFT allows you to stimulate meridians without the use of needles.

A Stanford engineer named Gary Craig discovered that if you stimulate the junctions of the meridians by tapping you can often get relief. Just tapping the acupressure points relaxes the body. That relaxation helps to reduce stress and pain from being too tense.

When you also tap on the points, while focusing on a specific pain, area of the body, thought, or emotion, the results can be even more powerful and direct.

The tapping process is simple. I have outlined the steps below.

The Emotional Freedom Technique (EFT)
There are four parts to the EFT technique –

- Identify the <u>specific</u> symptoms of the issue and its intensity,
- Set up the issue,
- Tap on the acupressure points,
- Integrate the resolution.

There are two factors that are vital to your success with the technique, being <u>specific</u> about the issue and staying <u>focused</u> on the symptoms throughout the process.

Step 1 - Identify the specific issue
For example, you may have sharp pain in the right shoulder, shakiness in the abdomen, fear of making a mistake in (a specific situation), anger at (a specific person) for saying (a specific words). Assign a number on a scale of 0 (low)-10 (high) indicating the intensity level you feel.

Step 2 - Set up the issue
While tapping on the edge of your palm on either hand, (where you would chop a karate board), say (aloud if possible), *"Even though I have this (<u>name the specific issue</u>), I deeply*

and completely accept myself." Repeat the phrase 3 times.

If you are uncomfortable saying you accept yourself, you can say “I want to accept myself” or “I’m OK” or some other variation. The point here is that YOU are not the issue. Once the issue is resolved you will still be here. Think about it - You cannot be anything that changes. You were a baby, child, adolescent, adult. Your body, thinking, emotions and situations changed continuously through all those stages of your life and you are still you. You are the being that moved through all those changes. You have a feeling, thought, behavior; you are not those things.

Step 3 - Tap on the Points

Stay focused on the issue by using a word or two to remind yourself “this (thought, feeling, situation)” while tapping the top of the head (baby soft spot area), eyebrow (near the nose), side of the eye, under the eye (all eye points are on the orbital bone), under the nose, in the chin groove, on the collar bone, and on the side of the body (about 2 inches below the armpit). The intensity of the issue is often reduced or may be gone just tapping the face and body points. If not, go on to tap the finger points (the side of the finger on the cuticle facing toward you) the thumb, first finger, middle finger, baby finger. Use either hand - either side of the body. Reassess your intensity level.

Often the original symptom is gone and another issue or symptom may appear, or you may find that the pain moved to another location. Keep doing the tapping process with whatever thoughts, feelings, sensations or memories appear until the overall intensity is low or gone.

Step 4 - Integrate the Resolution

This part of the process activates the left and right brain to integrate the change. Using four fingers, tap in the groove on the back of your hand between the knuckles of the ring finger and baby finger while you do these movements: Close your eyes, open your eyes, without moving your head - look down hard to the left and right, roll your eyes clockwise and counterclockwise, hum briefly, count to 5 and hum briefly again. Reassess your intensity level.

You can see a video demonstrating these steps at http://tinyurl.com/2qg2mb.

Note

EFT is not a substitute for appropriate medical treatment. Always check with your practitioner before discontinuing your medication.

Summary

When you are experiencing stress and symptoms of pain or illness that might have stress or emotional causes, EFT can provide some relief. This simple acupressure tapping technique requires no prescription and has no side effects. It is a safe tool that you can use any time to calm your body and ease your mind, a tool that is as close as your fingertips.

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.

Medical Errors in the ER

Why are there emergency department medical errors? What can you do to reduce your risk of harm from emergency department “mistakes”? No one is perfect, including ER doctors. There’s not a physician alive who hasn’t failed to diagnose a patient or given the wrong treatment. Even TV’s Dr. Gregory House takes a dozen shots at a diagnosis before finally getting it right. (I would lose my job if it took me that many tries on a routine basis!)

Emergency physicians, unlike other medical specialists, actively manage the care of multiple patients who are present at the same time. We may be also managing patients who have been admitted and are waiting in the department for a bed to open on a hospital floor. No other group of physicians has to handle a dozen or more patients simultaneously.

Frequently we are faced with managing more than one patient with the same last name; more commonly, we have different patients with similar presentations and complaints who may ultimately have entirely different diagnoses.

One 60-year-old patient with chest pain and shortness of breath may have cardiac problems, while another patient similarly aged may have pneumonia or a lung problem. Any physician managing both such patients at the same time is working at a disadvantage.

Errors may occur when a physician is obliged to provide care for too many patients at the same time. No matter how many patients we have, we ER physicians continue to see patients as they present.

Nursing staff may fail to advise us of a change in the condition of a patient; something we should know “right away” may be information that doesn’t reach us. This is often for the same reason: the staff have too many patients.

What else contributes to errors? Patient non-compliance is a top offender. Patients complain when they don’t get better even though they neither take the medication we prescribe nor follow our treatment instructions. I clearly recall a patient I saw with an eye injury who complained about his failure to improve even though he didn’t even fill the prescription for drops I wrote!

He brings to mind another “pet peeve” – the patient who complains about the length of time for treatment knowing that we asked for a urine specimen that hasn’t been provided. Believe it or not, no one really wants to handle your pee. We order tests because we need them.

Patients withhold or fail to divulge information they should know is important. It’s *your* job to tell us the names of the pills you take – not their color. One patient with an STD complained about the lack of diagnosis when he failed to reveal his sexual orientation; something entirely pertinent, which any reasonable adult should have known.

We also may miss a diagnosis when the patient presents so early in the course of the ailment there are few, if any, clues to the diagnosis. It may be very difficult to diagnose a patient with measles during the three to four days of symptoms before the rash occurs.

Often, perceived errors are not errors at all. Not every patient's disease can be cured; not every course of antibiotics will kill the germs. A bad result does not mean there was a medical error.

Some ailments defy diagnosis; I recall a patient whose diagnosis eluded several specialists. Somehow, he expected an ER doctor to diagnose him at 2 a.m. He came with unrealistic expectations, and left disappointed.

Some private practitioners, for whatever reason, try to bolster their standing with patients by putting down the emergency physicians. More than once I've heard stories of patients with minor ailments, properly diagnosed, being told by their family doctor, "Thank God you came to see me when you did! That ER doctor really screwed up!"

Attorneys are often prone to accept a "malpractice" case simply because they see "damages" (and thus, potential recovery) as large … and they *then* attempt to see if anything medical was done incorrectly.

No doctor, nor group of doctors, is perfect. Emergency physicians, by and large, are a pretty good group. Not everything labeled as a "medical error" really is a medical error.

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.

Number One Cause of Disability in Women — Depression: Part 2

To understand and recognize depression and the symptoms associated with it, the following is a self-assessment. Read through the list and check the items you agree with.

I am sad almost all of the time.

I have difficulty finding the energy to do even the simplest things.

I have lost interest in most of the things I used to enjoy.

I just want to sleep all the time and have difficulty getting out of bed to face the day. Or I am restless and find it difficult to sleep.

I have lost my desire to eat; I have no appetite.

I have lost interest in sexual intimacy.

I am not able to focus or concentrate like I used to.

I forget things and find it difficult to make even simple decisions.

I am irritable and frustrated with everyone and everything.

I have no desire to socialize; I avoid social functions.

I don't feel up to talking or emailing people.

I feel achy and have physical pains that won't go away.

I have constant anxiety and fear, but I can't pinpoint why.

Nothing makes me happy, and I feel like there isn't much point in living.

I worry about things that rarely bothered me before.

I feel bad about myself and don't like what I see in the mirror.

I find myself thinking about death a lot and wishing I could end my sadness.

I sometimes think about how I might end it all.

If you or someone you care about can check several items, I encourage you to make an appointment with your doctor to discuss the items you checked on this list. You deserve to feel better. Don't wait. Take the first step.

Why? Today recovery is more a probability than a possibility. In the past, many people with severe clinical depression felt like there wasn't any hope of reclaiming a full or productive life. And each time I speak to an audience about "living in recovery" from four severe bouts of clinical depression, they are astonished to learn that there exists recovery from major depression. They are literally awed to learn that the cheerful, successful, well "put together" woman standing before them was in a psychotic state some eleven years earlier. They are even more surprised to learn that between depressive episodes I went back to school, completed my master's degree, left my job teaching at a college, and opened my own training company. Yes, recovery from clinical depression is not only possible, it is probable.

When I was first diagnosed with clinical depression, I asked myself-- "Why me?" In trying to understand my diagnosis, I researched information and turned that question into, "Why not me?" With increased knowledge, newly formed perceptions concerning clinical depression crumble the wall of ignorance. Yet the majority of the general population is ignorant when it comes to major depression. Lack of knowledge spawns ignorance. Ignorance generates fear, and fear leads to stereotyping and stigma. The time has come to recognize clinical depression as a treatable illness. It is an illness that no longer has to be hidden or ignored by one out of four women challenged by depression today.

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 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.

Reducing Risks in Nursing Home Care

Sean Doolan Esq. has developed expertise in representing the victims of nursing home and assisted living malpractice. He shares his lessons learned in this interview, and provides specific information you can use to advocate for a loved one in the nursing home.

Visit http://www.avoidmedicalerrors.com/store/reducing-risks-in-nursing-home-care for more information.

Kathleen Cunningham CMLC

Vaccines for Cancer: The State of Art

For decades, man has dreamed about a cure for cancer. Recent years have revealed amazing advances in the diagnosis and treatment for various cancers. Survival rates are increasing and more and more is being learned about how cancers work. Next to a cure, a vaccine for cancer may be the next best thing. Are cancer vaccines a reality? What does the future hold?

Vaccines for cancer fall into two general categories: therapeutic vaccines, which are used to treat a disease and prophylactic vaccines which would be used to prevent a disease from starting.

Two Approved Cancer Vaccines

Vaccines for some cancers are a reality. The U.S. Food and Drug Administration approved Gardasil® (also known as Cervarix®) for the prevention of certain cervical cancers. Gardasil® is said to be effective against certain types of Human Papilloma Virus (HPV). HPV is the virus that causes venereal warts. HPV is thought to be a factor in stimulating other cancers as well, such as anal, vaginal, vulvar and penile cancers. One of the types of HPV has been implicated in the development of some head and neck cancers as well as a type of throat cancer. Gardasil® may be effective in the prevention of these other cancers. Many gay males have requested vaccination with Gardasil® to prevent venereal warts and to prevent the spread of HPV to female partners.

Gardasil® is not used to treat an ongoing infection, rather it is recommended that the vaccine be given prior to someone becoming sexually active. The vaccine has its limitations, however. It is effective against only some of the types of HPV that cause cervical cancer.

The other currently approved cancer vaccine is the Hepatitis B vaccine. Long-term infection with hepatitis B is known to be associated with some liver cancers and childhood hepatocellular (liver) cancer. The hepatitis B vaccine could potentially prevent certain other liver cancers. Once the vaccine is given, the protection is thought to be permanent. Studies have shown that the effectiveness of the hepatitis B vaccine is still present after as many as 25 years.

Research into Other Vaccines

What else is in the works? There are several hundred clinical trials which are concentrating on tumor viruses. *Cancercare* literature states, "The hope is that the vaccines can be used alone or in combination with other treatments that already exist to fight advanced disease and reduce the risk of recurrence."

A vaccine is being studied targeting Prostatic Specific Antigen (PSA), which is often found elevated in the blood of men suffering from prostate cancer. The vaccine is called GVAX® and is also being investigated regarding effectiveness for pancreatic cancer and leukemia. GVAX® apparently works by stimulating the body's production of a substance known as granulocyte-macrophage colony stimulating factor (GM-CSF). GM-CSF is said to increase the ability of the immune system to fight cancer.

A vaccine called Oncophage® is being studied in hopes of treating kidney cancer and some skin cancers. The vaccine itself is made from the tumor of the individual patient, so each patient would then have his own specific vaccine made just for him.

A drug called ImMucin™ is undergoing clinical trials in Israel. The drug is made synthetically from the MUC1 protein. The researchers believe that MUC1 is associated with approximately 90% of solid tumors and even some non-solid tumors. Apparently, MUC1 is only thought to be found on cancer cells and not on healthy cells.(1)

Also being studied is a drug called Hiltonol® which is said to be an "immunological stimulant" or immunomodulator. Hiltonol® is apparently showing promise as a treatment to help increase the effectiveness of therapeutic cancer vaccines.

Research on other viruses and vaccines is also ongoing all over the world. The hepatitis C virus is thought to be associated with liver cancer. The Epstein-Barr virus is thought to be involved with certain lymphomas and nasopharyngeal cancers. The Kaposi sarcoma-associated herpes virus (also known as human herpes virus) is associated with Kaposi's sarcoma, a common malignancy among people with HIV/AIDS. The Human T-cell lymphotropic virus Type I is thought to be involved in adult T-cell leukemia and some lymphomas.

Vaccine possibilities are being investigated for some cancers which are not caused by viruses, but by bacteria or parasites. For example, Helicobacter pylori has been implicated in stomach cancer and one type of lymphoma. A parasite known as a schistosome has been linked to bladder cancer and liver flukes (also a parasite) has been related to cholangiocarcinoma, a type of liver cancer.

Regarding the safety of cancer vaccines, the *Journal of Infusion Nursing* states, "Vaccines intended to prevent or treat cancer appear to have the safety profiles comparable to those of traditional vaccines."(2)

There is some controversy surrounding cancer vaccine development. Some scientists believe that the research is focusing on the cancers with the highest number of patients rather than the more deadly cancers. A financial incentive may account for this phenomenon.(3)

Researchers must deal with declining budgetary resources to continue their work. The researchers, however, continue to receive government funds and financial assistance through The Cancer Vaccine Acceleration Fund (CVAF) which is based at the National Cancer Institute and The Ludwig Institute for Cancer Research. CVAF provides "catalytic funding, scientific leadership and valuable clinical resources for Phase II and III Clinical Trials. It is said to be a unique model that combines a non-profit mission with investment funding best practices to maximize the impact of every dollar.(4)

Over the last decade, much has been learned about cancer, particularly about improved screening techniques, treatments and the genetic makeup of cancers. Researchers have made tremendous strides in all aspects of cancer, but the study of cancer vaccines is still in its infancy. However, the field shows a great deal of promise and it will be interesting to see what the future holds.

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4 Cancer Research Institute website

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.

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

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

• her poignant story of the series of errors that ultimately ended in her mother's death.

• how to recognize the danger signals to watch for when you or someone you love is in the hospital.

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

Invest in your safety: http://bit.ly/t9edgR

Lifestyle Changes: Tips for Breaking Unhealthy Habits

The *Encarta World English Dictionary* defines a habit as a "regularly repeated behavior pattern; an action or pattern of behavior that is repeated so often that it becomes typical of somebody, although he or she may be unaware of it." Some habits are good, but others are detrimental to our health. These tips can help you break unhealthy habits.

Change multiple bad habits
Changing more than one habit at a time traditionally is thought to cause too much stress for a person, leading to greater rates of relapse. However, a new study from the Baylor College of Medicine shows that many people do better when they break multiple habits at the same time. This is believed to hold true, because bad habits love company and tend to cluster together. A good example of this is people who say, "I only smoke when I am drinking alcohol."

Have a good reason to break a bad habit
You need a good, well-thought-out reason for wanting to break a bad habit. "I want to stop

smoking cigarettes" is not going to cut it. Instead, try, "I want to stop smoking cigarettes to reduce my risk of developing heart disease and cancer, to feel more comfortable in social situations, to save money for a vacation next summer, and to stop allowing an external factor to control how I spend my time."

Find a new way of spending your time

A habit is often a way of spending time. You will need to find a new way to fill that time before you can successfully break the habit. What if you worked on an art or craft project that you used to enjoy doing instead of watching television and snacking on work nights, or what if you started to read through that stack of books and magazines you set aside for a "later time" instead of shopping every Saturday?

Do not go it alone

You do not need to call a meeting of all of your coworkers and announce that you are giving up your 4 PM candy bar habit, but it is helpful to let a few supportive people know what you are doing, so that they can help to hold you accountable and motivate you during tough times.

Do not anticipate failure

Do not expect to fail, but accept that it might happen. Many people say, "I am sure that I am going to screw this up, but when I do, I will just try again." This is a mistake. Why are you "sure" that you are going to fail at something until you try not to? You often hear these remarks from people who are making a change that they are not personally invested in and are instead changing something about themselves for another person or group of people. Instead, it is healthier to say, "I might slip up, although I am going to try really hard not to because (list of reasons). If I do slip up, I am going to (list of actions)."

Set "want to" goals

Studies have shown that "want to" goals are much more likely to succeed than "have to" goals. Saying, "I have to start eating better" probably is not going to help. Saying, "I want to replace my potato chip and ice cream habits with more fruits and vegetables to lose weight and increase my energy" is more likely to lead to sustained lifestyle changes.

Know why you are doing something

You need to know why you are doing something in order to find an effective way to stop it. Why are you digging into the candy jar, lighting up, pouring yourself another glass of wine, or spending too much money? These habits may form because of either chronic stress or chronic boredom, among many other reasons. What the reason is will greatly impact how to best go about breaking the habit.

Pick a date to break that habit

Sometimes, you just have to jump. Some people spend so much time researching why to stop doing something, strategizing how to stop doing something, and coming up with ways to make stopping easier that they never actually get around to stopping. If this sounds familiar, you have to just specify a date to break a bad habit and do it.

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About the Author

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

Dr. Collins is a frequent speaker at medical education symposia and a prolific author. Dr. Collins is an editorial advisor to the journal *Advances in Skin and Wound Care*, a contributing editor for *Ostomy-Wound Management,* and a columnist for *Today's Diet and Nutrition*. She is also the member of many medical advisory boards including the American Professional Wound Care Association, which granted her Fellow status Dr. Collins is a Past President of the Florida Dietetic Association and a past Chair of the Nutrition Entrepreneurs DPG. Currently, she holds the position of Delegate to the American Dietetic Association. In 2003, Dr. Collins was awarded the Dietitian of the Year Award for her longstanding contributions to the profession of nutrition. In 2009, she was awarded Nutrition Entrepreneur of the Year for her visionary projects and forward thinking.

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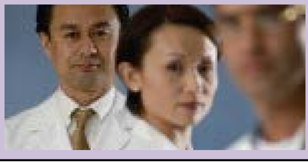

Anna Morrison BA BSN RN CLNC

7 Reasons to Make Sure You're Getting Enough Vitamin D

According to a recent study in the Archives of Internal Medicine, 75 percent of Americans do not get enough vitamin D. According to the United States Institute of Medicine, the recommended dietary allowances of vitamin D are:

1–70 years of age: 600 IU/day
71+ years of age: 800 IU/day
Pregnant/lactating: 600 IU/day

We all know that getting enough vitamin D is supposed to be good for us. Manufacturers add it to our cereal. We've been taught since childhood that we should "drink our milk for strong bones," and as we get older our healthcare providers start testing our vitamin D levels to make sure we're getting enough.

But did you know that the present-day research is so compelling that many researchers and healthcare providers are now asking whether low vitamin D levels could be a key element in many of the chronic health ailments plaguing our modern society?

Based on the latest research, here are 7 reasons to make sure you're getting enough vitamin D:

Prevention of Certain Types of Cancer - 18 to be exact. These include breast, colon, lung and pancreatic. There have been numerous research reports supporting these claims. One study discovered that patients with colon cancer who were also deficient in vitamin D were almost twice as likely to die as patients with healthy levels.

Prevention of Bone Disorders - including osteoporosis, rickets & fractures. It has been well-established that low serum vitamin D levels are associated with rickets, falls, and low bone mineral density. The good news is that one study found that people taking vitamin D supplements lowered hip fracture risk by almost 20 percent.

Reduction of Systemic Inflammation - Systemic inflammation is a negative response of the immune system and is related to auto-immune disorders, cardiovascular disease and other illnesses. A University of Missouri nutritional sciences researcher has found that vitamin D deficiency is associated with inflammation.

Reduction of Infections & Improvement of Immune Function - Vitamin D boosts your immune system. Some researchers actually believe that low vitamin D levels will emerge as the decisive element that makes some people more susceptible to serious illness with H1N1 than others.

Protection Against Multiple Sclerosis - According to the latest research, although the exact mechanism is unknown, vitamin D does appear to have a protective effect against multiple sclerosis.

Prevention of Cardiovascular Disease - Vitamin D has been shown to protect you from strokes and heart attacks. A recent study at Harvard University found that over a five year period, participants with low vitamin D had a 60 percent higher risk of stroke, heart attack, or heart failure.

Enhancement of Longevity - Finally, vitamin D helps you live longer. While the exact mechanisms have yet to be discovered, a study which followed 3,000 people over the age of 73 found those who possessed the lowest vitamin D levels had an 83 percent higher risk of mortality (death) from any cause.

Moral of the story: try to get at least 20 minutes of direct sunlight per day. If that's not possible for you, due to your work schedule or geographic location, make sure to follow your healthcare provider's recommendations for supplementation to stay on the healthy side of vitamin D statistics.

About the Guest Author
Anna Morrison, BA, BSN, RN, CLNC is the founder of The EntrepreNurse™ Group. Her work empowers nurses to leverage their clinical experience to create and sustain profitable businesses with meaningful impact. She is the author of the #1 Amazon Bestseller *5 Things They Never Told You in Nursing School*. As an in-demand speaker & nursing business consultant, Anna Morrison has helped hundreds of nursing small business owners re-connect to their passion for making a difference in the world, while improving their own lives. She has been featured in The Miami Herald, Good Morning America, Nurse.com, and RNCentral.com. Anna runs the online "I Coach Nurses" blog, where she offers dozens of free resources to fast track your business, get your multiple-streams-of-income-mojo working, and attract clients for life. You may reach Anna through icoachnurses.com.

Fast & Easy: Tips & Meal Ideas

I've been asked to share some of my recipes and tips for putting together healthy meals with balanced nutrient ratios (the right amounts of protein, carbohydrates & fats) in a hurry! Really – it is not hard to do! If you follow some of my "Top Tips" to have some of your favorite foods available then you can easily put together a delicious, healthy meal in "under 2 minutes" when it is time to eat.

Top Tip: Cook in bulk. I go shopping and have a "cook day", usually on Sunday. I may cook several chicken breasts, make turkey chili or turkey meatballs, bake some sweet potatoes or cook some brown rice all in the same afternoon. I keep some in the refrigerator and freeze the rest. Now I'm really prepared to put together a meal that is "fast & easy"!

Top Tip: If I don't want to cook, I head to the **Whole Foods Hot bar** … I can purchase some pre-cooked meats that are healthy. The price per pound for the meat isn't unreasonable especially when you consider the meat is being weighed after cooking. For example, the same chicken breast will weigh less after it has been cooked because the juices are released. I look for baked or blackened fish filets and chicken breast meats. I can purchase enough for several meals at once.

In under 2 minutes …

Fish Tacos: Blackened Tilapia (protein and a little fat) from Whole Foods Hot Bar wrapped in Organic Corn Tortillas (carbohydrate) with a little bit of Trader Joe's Wasabi Mayonnaise (fat). If you have some shredded lettuce, tomatoes or salsa – add them!

Yogurt Parfait: Greek Yogurt, 0% fat (protein) with fruit (carbohydrate) and chopped walnuts or pecans (fat).

Faux Soft Ice Cream: Low Fat Cottage Cheese (protein) and chopped frozen berries (carbohydrate). To make a soft ice cream – blend these ingredients along with a dash of vanilla extract in a mini-food processor or blender. Have a few raw almonds with it (fat) to balance the nutrient ratios.

It's A Wrap! Your meat of choice (Boar's Head Low Sodium Turkey, Chicken or Ham or Chicken Breast) and wrap it in either a low carb or whole wheat tortilla. I like to use an Ezekiel Brand Tortillas for my wrap. You can add either cheese or avocado for some fat. If you want it to taste more like a sandwich … add mustard and use cold deli meat. If you want it to be more like a quesadilla then add some salsa and heat it up!

Breakfast On the Go: Place equal parts of oatmeal and water and a small handful of frozen blueberries (or other frozen fruit) in the microwave and for 3 minutes (carbohydrate). Now you have choices for your protein and fats to balance your meal:

1. Add some nut butter, almond or peanut (fat) and protein powder (protein) and a little more water. Kids like to use Chocolate Protein Powder – I use Vanilla.

2. Have some eggs (protein & fat) & egg whites (pure protein).

3. Add Greek yogurt (protein) and chopped nuts (fat)

Recipe: Turkey Meat Balls
A recipe I prepare and one I'm asked for often is for my Turkey Meat Balls. Honestly, every time I make them the recipe is slightly different depending on how I choose to season them, but here is a "Basic Recipe" for you to start with … it will yield 24 Turkey Meatballs

2 pounds ground turkey breast meat

2-3 egg whites

4 ounces tomato paste

5 ounces Worstershire Sauce

1 cup of dry oatmeal (or cooked brown rice)

1 cup of chopped vegetables

(use any combination of the following: onions, peppers, parsley, celery or come up with your own!)

Season to taste with salt, pepper, and any combination of the following spices: thyme, Italian seasonings, Bragg's Seasoning, Rotisserie Chicken Seasoning

1. Preheat your oven to 350 degrees and spray two muffin tins with vegetable cooking spray.

2. Mix all the ingredients above together in a large bowl.

3. Use a spoon or ice cream scoop and form 24 balls (a little larger than a golf ball) and put them in the muffin tins for cooking.

4. Cook for 30-35 minutes. Remove from the oven and cool.

You can eat them right away, refrigerate them for later meals or freeze them.

Here's how I use them … to balance your meal you will need to add some fat and carbohydrate … the meatballs are mainly protein.

Top with marinara sauce and a sprinkle of cheese.

Top with mustard … and put in a wrap.

Top with bar-b-cue sauce … have some brown rice or sweet potato & steamed broccoli with them.

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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