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Aspiration and Risks of Anesthesia

I woke up from a routine colonoscopy with coughing and not being able to speak. What went wrong?

The gastroenterologist told me I started coughing during the procedure. I inhaled some saliva into my lungs.

Aspiration is the entry of food, liquid, saliva, or stomach contents into the lung. The seriousness of this event can range from minor to a chemical pneumonia to death. Food particles that block the airways can cause suffocation. The people who are at risk for aspiration include people receiving anesthesia, those on ventilators, people with drug overdoses, strokes, traumatic brain injuries, and alcohol intoxication. These individuals have decreased gag reflexes, and are therefore at risk for getting substances into their lungs.

Aspiration can occur during a choking episode or vomiting. Since the stomach contents are acidic, a chemical pneumonia occurs. Bacteria

normally reside in the mouth and nose. Aspiration of saliva can lead to a bacterial pneumonia.

What can you do to prevent aspiration?

1. Take your time chewing and swallowing. Don't cram food into your mouth. The recommendation to chew each bite 25 times is a good one for preventing aspiration, as well as for savoring food.
2. If you are feeding someone, don't rapidly shovel food into his mouth.
3. Look for signs of food remaining in the mouth after swallowing or leaking from the person's mouth or nose. This may mean she has ineffective swallowing.
4. Notice if someone coughs a lot or seems to choke on food. This is also a warning sign of ineffective swallowing.
5. Listen for a wet or gurgly voice after swallowing. Food may still be in the mouth.
6. Turn a person who is vomiting on her side to reduce the risk of aspiration.
7. Carefully adhere to any orders to not eat or drink after a particular time before having anesthesia.
8. Look for signs of aspiration pneumonia: coughing, fever, fatigue, chills, chest pain, foul smelling mucous, shortness of breath, noisy breathing, or feeling faint or like he is not getting enough air.
9. Contact a healthcare provider if these symptoms are present. The sooner you get treatment, the better your chances of recovery.

My gastroenterologist started me on Levaquin, an antibiotic. It took about a week for the coughing to disappear and my voice to return to normal. My next colonoscopy is in 5 years. My doctor and I both agreed we were glad it was not sooner.

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.

Carpal Tunnel and Other Tunnel, Tendon and Inflammatory Syndromes

There are many wrist and hand symptoms related to the multiple tunnels that tendons, nerves, and blood vessels pass through. Wherever there is a “crease” in one’s wrist, palm, or fingers on the flexor/volar side, there is a tunnel that these structures must pass through. These tunnels are usually soft tissue bands that keep the tendons from bowstringing as they pass from forearm to fingers, as we use our hands to grasp and function.

Carpal Tunnel Syndrome (CTS)

Carpal Tunnel Syndrome is a condition well known to almost everyone who works with their hands. It represents a compression or relative tightness or compression of the median nerve as it passes through a “tunnel” as it enters on the flexor side of the palm. Nerves are very sensitive to any stimulation. When there is any tightness, swelling, or inflammation of tendons or joints, or with fractures adjacent to the wrist tunnel, we will see symptoms first in the median nerve, as it is the most sensitive tissue.

The median nerve or “carpal tunnel nerve”, provides motor muscle function to only the

muscle of the thumb, allowing the thumb to pinch the little finger with power and strength. The nerve's primary function is sensation on the side of the hand to the thumb, index, long finger, and commonly half of the ring finger, but never the fifth finger. The diagnosis is usually made by a physical examination.

In a mild case, the treatment is usually relatively simple, consisting of avoiding the aggravating problem, resting the wrist, splinting the wrist, and using anti-inflammatory medications to decrease swelling. It is common to need a diuretic "water" pill to reduce swelling that is in the hand and wrist. The need can be demonstrated by an inability to remove the ring from the finger early in the morning, when it is otherwise loose at the day's end.

Other tunnel problems, including De Quervain's tendonitis in the wrist area at the base of the thumb

Tendonitis means an inflammation and irritation of a tendon. On the radial (thumb side) of the wrist near the end of the radius, a group of tendons that extend and abduct (that is, bring the thumb into a spread-wide position) pass through a tunnel. This tunnel is comprised of a fibrous type tissue that keeps these tendons both in their functional proper alignment and from inefficiently bow-stringing. This inflammation and irritation can cause pain and localized swelling, limiting the tendons' function.

The physician's exam for De Quervain's tendonitis is relatively straightforward. The physician puts the thumb through the range of motion or places the thumb in the palm with the remaining fingers holding that thumb in the palm and bending the wrist toward the ulna or outside. This action puts stress on the De Quervain's tunnel. This will cause pain in response to this motion.

Sometimes splinting is helpful in decreasing the irritation; sometimes a local cortisone injection solves the problem. Repeat cortisone injections are generally avoided, as cortisone not only decreases inflammation but can

weaken the tendon tissue itself, particularly if it has been previously damaged.

Surgery can be necessary if symptoms are not resolved with the above “conservative” treatments. Surgery is usually low risk but extra tendons are sometimes found. If all of the tendons, which sometimes can vary from as few as 3 to as many as 9 or 10 strands, are not freed from the tunnel, it can leave an imperfect result. This condition and the number of tendons that are within the tunnel demonstrate the great variety of anatomy in humans. A surgeon will take this into account as he explores the tendons in the De Quervain’s tunnel.

People also sometimes experience trigger fingers, in which the tendons passing usually on the side of the hand from forearm to fingers must pass through multiple flexor tunnels. If those tendons have been bruised or become swollen, the thumb or the finger can catch into a flexed position and can only be “triggered” or forced into an open position.

Treatment is similar to what is described above, including decreasing swelling, using anti-inflammatory medications, considering a steroid injection, and if ineffective, surgical release of the tunnel to allow it to heal in a loosened, less bent position.

Ganglions

This is a herniation of either the lining of a joint or of the synovial lining sheath of a tendon. It is usually caused by an over-production of synovial joint fluid that has the usual function of nourishing the joint or a tendon. It can also result from an injury where the tissue has been torn recently or in the past, and has weakened the lining sheath.

Ganglion cysts appear as a lump, sometimes thought to be a “tumor” or a growth by the patient, but are commonly just a harmless nuisance. They often resolve by themselves. If they cause symptoms, they can generally be treated with using a needle to pull out the fluid. A physician does this with or without a cortisone injection. However, many times they

will recur inspite of treatment. Surgery is sometimes offered. Surgery results in a scar from the surgery. Surgery itself does not guarantee against recurrence.

Arthritis

Fracture arthritis is related to imperfectly healed fractured bones. (Perfection is sometimes impossible to achieve when there are multiple fragments.) People also get degenerative arthritis, which could be described as “wear and tear” over time (that is, the aging process of a joint). Other arthritic conditions include rheumatoid or systemic arthritis, which will require specific diagnosis and treatment. Degenerative arthritis at the base of the thumb is common, as it is the most mobile joint of the body. Bone spurring and thickening of the joints and the fingers are common as one ages and is an arthritic condition. Commonly, people with arthritis in their hands will state that they have worked hard all their life and that is the cause of degenerative arthritis, but this is not necessarily true. Arthritis can be degenerative in nature, in people who have never over used or abused their joints.

Medical-Legal Considerations

Because of the potential for severe limitation, chronic pain and disabilities, healthcare providers must be aware of the potentially serious risks and complications. The medical conditions described in this article have both minor and serious consequences. Timely diagnosis and treatment is essential. The outcome is worse if treatment is delayed or improperly performed. A good knowledge of these conditions, with proper and timely treatment, can result in successful resolution of many of these issues, and avoid serious adverse outcomes and potential medical legal issues. See www.amfs.com for details of our services.

Do Your Medical Test Results Mean What They Say?

Amber, age 26, lay in the emergency room. She couldn't move her arms. Her mind repeatedly blanked out for several minutes at a time. She was extremely dizzy. Her stomach hurt so much that she hadn't had anything to eat or drink for many hours.

The doctor said, "I think you're just dehydrated."

They put an IV in her arm and hung a bag of dextrose solution—sugar water—to drip into her vein. Shortly after the bag of sugar water had emptied, a technician showed up to draw blood. He explained, "The doctor wants to see if you have diabetes."

Amber looked at him in confusion. At the moment, she was able to speak, and she said, "That's going to read high in sugar from the IV bag of dextrose I just got."

The technician replied, "It's OK. I'm drawing blood from your other arm."

Amber's mother was at her bedside. Her jaw dropped, and she protested, "The fluid that goes into that vein travels throughout the body!"

The technician shrugged and finished drawing Amber's blood.

Hours later, the doctor came in and said, "Your blood sugar level is high. I think you're diabetic." He sent her home with a glucose test meter and test strips, and told her to test her blood sugar level regularly.

Amber's own doctor later told her that she did not have diabetes. Her trip to the emergency room had nothing to do with blood sugar. She was sent home from the ER with no treatment for a brain infection that could have killed her.

What went wrong with her medical test? No one connected the dots. The doctor may have ordered the blood test before the IV line went in. The lab may have been backed up and so didn't get to Amber until after she had roughly a quart of sugar water put into her veins. Or perhaps the doctor ordered the blood test after ordering the dextrose drip, while he was thinking about something else.

This busy doctor may have read the report out of context. He may not have been thinking about what else was going on with Amber at the time. He might review dozens or hundreds of medical test results in one shift in the ER. He probably has a routine to quickly scan for the marks that show an abnormality. Prescribe treatment to deal with that problem. Move on to the next test result.

Research published in the journal *Quality & Safety in Health Care* showed that even in office visits, mistakes in medical tests are common. An article in the *New York Times* called "Testing Mistakes at the Family Doctor," which summarizes that study, reported many kinds of problems. The doctor sometimes orders the wrong test. The lab sometimes performs the test incorrectly. The lab might even do the wrong test (even if the correct one

was ordered). Thus, the results of the tests can be meaningless.

Amber's experience shows that even if the right test is done, doctors can easily draw the wrong conclusion. They can go down a path that doesn't help improve the patient's health.

One problem is that test results are often less reliable than you might think they are. Your doctor may also assume that tests are right when they often aren't. Authors Michael Blastland and Andrew Dilnot wrote about this problem in their book, *The Numbers Game.* In one study, doctors were given some facts and asked to figure out how likely it was that people told that they had a given disease actually had it. Only about 8 percent of doctors did the math right. The rest, the authors say, were "hopelessly confused."

People get screening tests for conditions like diabetes all the time. Usually, only about 1 percent of the people given a screening test actually have the disease. That's one person out of 100. The other 99 people are fine.

Assume that the test is 90 percent accurate. These numbers mean that 10 percent of the 99 people who are fine will be told that they are sick. That's 9.9 people. (I'll round that number to 10 people.) As a result, the one person who is sick and 10 who aren't will all be told that they have the disease. But only one person out of those 11 actually does.

Most doctors in this case assume that 9 out of 10 people whose tests say that they have the disease actually have it.

What can you do to help make sure that your medical tests provide useful information?

- Ask for—and write down—the name of the test and what it is for (or have a friend or family member do it for you).
- Ask what might skew the results so that they don't paint an accurate picture. For

example, eating a high-fat food—say, cheesecake—shortly before having a cholesterol test will distort the results.

- Follow the pre-test instructions carefully.
- Check that all of the identifying information on the paperwork reporting the results appears as expected. For example, are your name and the name of the test correct?
- If a test shows that you have a problem, don't simply take this answer at face value. Ask how this conclusion can be confirmed.

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.

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Sarah Jean Fisher
MSN, RN-BC, BA

Is That Abuse? How to Determine if Your Loved One is Being Abused or Neglected

Scene 1
It is 9:45 AM on a Saturday morning, and you unexpectedly visit your mother in a nursing home. When you enter Mom's room, you find her in bed crying softly, still in night clothes and her linens wet with a dark brown ring marking the perimeter of the wetness of her overfull incontinence briefs. Her breakfast tray is on the over-the-bed table and has not been touched. The tea is covered; milk and juice cartons are not opened. A fork is stabbed into a whole pancake and a spoon is standing upright in the middle of a bowl of almost solidified oatmeal.

Scene 2
You arrive home for dinner to find the daily companion you have hired to attend to your father's needs watching soaps on TV in the living room. Dad is in bed, which has not been his norm for this time of day. The companion says she gave him his sleeping medication because he wouldn't stop yelling and be quiet while she was watching TV.

Scene 3
It is 6 PM and you have just arrived home after picking up your grandmother from the adult day care center. When you remove her coat you notice a large bruise on her upper arm, in a pattern resembling four fingerprints. When you ask grandma how it got there, she says it must be when they moved her into the dining room for lunch, "I was walking too slowly, they said".

The above three scenes are all examples of abuse or neglect that can be perpetrated on our elderly loved ones while they are in someone else's care. Unfortunately, some facilities and people do not have a clear definition of abuse and neglect. Abuse is the deliberate mistreatment or cause of physical, mental or emotional harm to another. It includes rough handling, harsh words or bullying. Neglect is the withholding of care, or failure to provide treatment or items necessary for their daily comfort and sustenance. It includes not providing timely incontinence care and bathing, not feeding, throwing away medication because the staff is late giving it or resident is off the floor, but signing that it was given.

Scene 1 - Meals are generally delivered by 8:30AM or earlier in long term care facilities. It is understandable that everyone may not be washed and dressed by 10 AM, but everyone should at least be changed from overnight. After meals are delivered, staff should make rounds again to ensure that everyone is eating, the food is as ordered, and those needing help to eat are getting it. Not doing so is neglect.

Scene 2 - It is acceptable to give medication to someone who is restless and moaning because of pain, but it is not OK to drug someone just so you can have quiet to watch TV. This is abuse.

Scene 3 - Those who work with the elderly know that their skin is delicate and bruises easily. If the elderly person is on a blood thinner for health reasons, this doubles her sensitivity to skin changes. Long term care staff are taught to use the palms of their hands only, no fingertips. To pull her along is

emotional abuse while insinuating that she cannot walk fast enough. It is physical abuse to pull or hold an elderly person by the arm firmly enough to leave a mark.

Sometimes, the abusers will try to cover up their deeds by saying, “She was…so I had to…”, or “I just moved him over…”, or “You can’t believe what she’s saying. She has dementia”, or “We are short-staffed today and I’m doing the best I can.” None of these are viable excuses for abuse or neglect.

Some other examples of abuse/neglect:

- staff saying things like, “You nasty old lady, no wonder your family doesn’t want you and put you here.” This is mental/emotional abuse.
- personal items missing, borrowed for another resident, or used by staff without specific consent (staff actually should never ask to use/borrow anything belonging to a resident.)
- withholding any item, pleasure or activity until the resident takes all medication. He has the right to refuse even something necessary for life/good health.
- telling the elderly to “be a good boy/girl” and cooperate with staff wishes. This is emotional abuse.
- bathing an elderly person in bed without drawing a curtain for privacy, or covering parts of the body that are not being attended to at that moment.
- violating the right to privacy is abuse. Staff should always knock, identify themselves, and ask permission to enter a room. Opening the mail of a resident is also a violation of privacy and could be considered a federal offense for tampering with mail.
- speaking in a loud or disrespectful manner, arguing with residents or guests is an assault on their dignity,

violates customer service and can be construed as abuse.

- restraining a resident in a long term care facility without a good reason and a doctor's order is considered abuse. Restraints include securing a resident to a chair so she can't rise; prohibiting a resident from being able to touch or have access to any part of her body; placing side rails on a bed and using restrictive vests and mitts.

Most long term care facilities and adult day care centers have social workers on staff to address resident and family concerns, and an Ombudsman from the state who oversees the facility. Their contact information should be posted prominently near the lobby, elevator or stairs. On the computer, you may search under "abuse" or your local department of health. Don't wait and let your loved one be a victim. If you have any concerns, act right away.

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.

Reiki: What it is and how it works

Reiki is a complementary treatment modality that can improve healing. Reiki is the life force that flows through all living things.

Stresses of everyday living create blockages and imbalances in the body. Since Reiki reaches all levels of existence, it provides the environment for unification and balance to take place on all levels of the person. Reiki provides support for restoring physical, mental, emotional and spiritual balance in a way that optimizes health and healing.

A Reiki treatment or practice is a simple technique that allows your body to attune through connection with the palms of the practitioner's hands. Reiki is totally safe and can be felt as an increased sense of oneness and harmony. Reiki practitioners assist people in moving to a more integrated level of health.

Reiki supports consciousness and conscious health. It is a complementary healing modality and a cooperative process between client, practitioner and the universe.

How does it work?

Reiki is multi-dimensional. It provides the environment for healing the source of a

problem at the level of its origin, be it body, mind, emotion or spirit. Reiki attunes the person to his or her own natural state of balance. Balance provides the environment for health and healing to occur.

The Reiki practitioner is not doing anything to the person; rather a practioner allows Reiki to be present so realignment and rebalancing can occur. All healing is self-healing. When the environment is optimized the person's own healing mechanisms engage. Reiki is completely non-invasive. For this reason, Reiki is perfectly safe and has no negative side effects.

Reiki is not a religion, and there is nothing you must believe in order to learn and use it. In fact, it is not dependent on belief at all and will work whether you believe in it or not. Nor does it have to be directed by the practitioner.

Reiki is not a substitute for medical and other health care treatments; rather it can compliment, support and enhance other treatment modalities.

What are the benefits?

Reiki is being used at many hospitals throughout the world. It is used during surgery, in the emergency room and in departments of oncology, pediatrics, neonatology, labor & delivery, and rehabilitation. Benefits include:

- Reduces stress and promotes relaxation
- Decreases pain
- Assists the body in eliminating toxins
- Balances energy flow throughout the body
- Brings comfort and peace to those who are terminally ill
- Promotes health and well being
- Enhances and accelerates the normal healing processes of the body

How is Reiki learned?

Reiki is taught and attunements are passed directly to students by a qualified Reiki Master (Teacher). It is taught in three consecutive

levels called degrees, consisting of workshops of varying lengths and times. First Degree Reiki is used for self-healing and providing Reiki to another person who is physically present with the practitioner. Second Degree Reiki is used to provide Reiki when the other person is at a distance. Third Degree Reiki is the Master Level, which is reserved for those who want to dedicate themselves to teaching Reiki.

How to find a Reiki Practitioner

While many healthcare professionals can be Reiki practitioners, a person does not need to have any special background or credentials to learn Reiki. Often, Reiki practitioners are also trained in other complementary methods, as acupuncture, massage therapy, herbal remedies, and yoga. You can inquire through people who practice these modalities, wellness or holistic health centers or a local health food store. You can also search online or network through word of mouth.

You will want a practitioner who uses Reiki regularly for her own self-healing and has been trained by a Reiki Master to do at least First Degree Reiki.

What Reiki is NOT

- Reiki is not a religion.
- Reiki is not a substitute for seeking or receiving medical treatment
- Reiki is not a substitute for taking effective necessary and prescribed medication

Reiki is a safe complementary treatment that can support your health and healing along with other traditional and non-traditional healing approaches. It is used in many hospitals and has no unwanted side effects.

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.

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Ever Wonder About Us?

Ever wonder about us – the ER doctors? We are generally a decent group of people. We have gripes and groans, just like everyone else. But, we're unusually satisfied with what we do. Most of our job stress does not come from seeing patients; not at all.

We are always in a fishbowl. If your family doctor does something awkward or if you decide you don't like him for whatever reason – real or imagined – you simply don't go back. You can't write to his boss, because he's his boss. Not so for us.

Patient complaints to the hospital are taken very seriously, even when the absurdity of the complaint should be readily obvious: the narcotics addict complaining about our decision to withhold prescribing narcotics; the patient complaining about the wait for a specialist (like we could do something about that). Why didn't we find the ulcer the gastroenterologist saw right away on his endoscopy? (We don't do endoscopy…)

We frequently hear complaints about waiting times. Sometimes these are complaints from patients who took a long time to give us a required urine sample but somehow, they

determined it was *our fault* they had an extended ER visit.

Multiply 3 patients/hour times 2000 working hours a year…you get a large number of patients. Nobody is 100% correct all the time. We hear about almost every wrong diagnosis, and from every patient who doesn't like our bedside manner.

It's not just from hospital administration we hear complaints.The family doctor (who wasn't available) complains about our admitting "his" patient to another physician. (This results in loss of revenue for the family doctor.) We hear about every HMO patient we deem too ill to go home that the family doctor didn't want to admit…deciding, without seeing the patient in the ER, that he or she was "safe" to send home. We don't hear about it when we save their asses by insisting on admission for a patient later found to actually have the serious condition we suspected.

We hear complaints from on-call consultant specialists we call who don't want to come to the hospital. We hear complaints from specialists who wanted to come but we didn't call them. (The former group of specialists have enough money; the latter do not.)

We hear complaints from the nursing staff about everything you could imagine. Often these complaints are filtered through the ER Director, who may or may not be a generator of insincere complaints himself.

I guess people have to deal with complaints with any job, but we seem to deal with more complaints from more sources than most.

We are often pressured to see more patients per hour – meaning, generate more money per hour – by whoever pays our salaries. Usually, we are paid "hourly" or on an annual salary – paid the same if we generate a lot of money or a little. Sometimes that's a good thing; we're not financially pressured to do procedures or suturing that is not needed.

Who hires us? Often we are hired by a "third party," a company that contracts with hospitals

to provide physician staffing and management (ER Director). This company is interested in profit. They try to pay as little as possible to staff the ER and get maximum reimbursement. They are paid either by the hospital, or by billing the patients, or both.

Hospitals want the most qualified physicians providing the best care. They want enough doctors on duty at any given time to ensure there is no patient waiting for a physician to be free. They also want the cheapest possible price.

The truth is the hospital – or contract group – can have any two of the following: quality care; short wait times; low cost. They can't have all three.

One of the biggest stressors for us – ER doctors – is that we have "shift work." Working night shifts is very disruptive to home life, and physically difficult. Most of us don't mind it much when we enter the profession in our twenties. After twenty or thirty years it becomes a drag.

We are paid well, but not commensurate with our training and the degree of responsibility and stress that we endure. Any specialist whose practice includes "procedures" makes more than we do, with less stress and shorter hours. We earn less than radiologists and anesthesiologists and more than pathologists (all are hospital-based physicians).

We have a high degree of "burnout," with most ER doctors finding easier (though rarely as lucrative) work in other specialties by our fifties. ER duty is not as much fun as you might have imagined.

If only we had the life depicted on TV for our profession. Instead, we seem to always be at odds with doctors like Gregory House.

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.

Connection to a Stranger

"The life I touch for good or ill will touch another life, and that in turn another, until who knows where the trembling stops or in what far place my touch will be felt."

--Frederick Buechner

During the past week I found myself in London for business and then took time for a weekend holiday in Paris. As I embarked on a new city touring, I marveled at the history and the detail mankind put into buildings centuries ago. I became enchanted by the differences and the similarities in the people I met. I made it a point to engage in friendly conversation with others who had a twinkle in their eye or a smile on their face.

I sat next to a middle-aged woman from Japan riding to the airport in a van full of passengers. For the first few miles we said nothing to each other. Yet my inner voice was urging me to strike up a conversation so that is exactly what I did. During our conversation we discovered numerous connections and before I knew it I was handing her one of my pocket

guides about recovery from depression. Toshi was touched by a gift from a stranger, and she immediately knew who she was going to gift the guide to in Japan.

This friendly, connecting behavior is a far cry from the woman I am when consumed by depression and anxiety - that woman wants to blend into the landscape, resist eye contact, and shut herself away from everything and everyone. I imagine there are many readers who can relate to the dramatic change in behaviors if you too are living with depression and anxiety.

Remember reaching out to others can make a big difference! My own experience with depression and anxiety stopped my world in its tracks and created a new realm of isolation and loneliness. At first, I was consumed with self-pity and self-doubt while my world became smaller and smaller as I hid from family, friends, and colleagues. I noticed I wanted my days to end but nights were even worse. My illness became my life; it was all consuming. I was allowing depression and anxiety to steal away hours that turned into days which spilled into stolen months. Looking back, I now realize I exchanged a full decade of my life by allowing my illness to take over.

No more!

Today I approach each day as an opportunity to remain in recovery even if for just that day. My personal strategies for a well day start the moment my eyes open from a good night's rest and include in this order:

- Praying for wisdom to guide me during this new day
- Reading and reflecting on three daily devotionals
- Journaling a half page
- Exercising at the gym for an hour
- Taking my medications and vitamins
- Drinking a protein shake for breakfast

Sticking to this routine kick starts my day into full gear allowing me to take whatever comes up in stride. Just last week I woke with immense anxiety. I felt its tension the moment my head lifted from my pillow. Even though I wanted to jump out of my skin and hide from the world, I stuck to my routine and by time I sat down with my protein shake much of my anxiety eased up. I no longer allow my anxiety to steal my day. So what about you—

Reflective Question: What are your strategies to take back your day?

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.

Mind Body Medicine

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

What you will learn

Kay Rice challenges assumptions about Western medicine and presents a different model of thinking. She asks us to think about your medical care in a way that will help you realize

- the basis of mind-body medicine and how that can help you
- how you can help your body fight disease
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Kathleen Cunningham CMLC

Anesthesiologist Accused of Medical Malpractice

In 20 years of working as a medical legal investigator, my toughest case involved an anesthesiologist who negligently intubated a patient for a relatively simple procedure requiring using a machine to breathe for the patient. After the anesthesiologist inserted the breathing tube, he never confirmed it was in the right place. The patient was obviously not being oxygenated and the anesthesiologist was totally unaware of her deteriorating condition because he had turned off the audible alarms on the anesthesia machine. He was "asleep at the wheel". The problem was not detected until an OR nurse walked by the monitor and alerted the anesthesiologist to the patient's condition. Too much time had passed and a healthy 65-year-old woman had loss of oxygen to her brain and associated brain injury. Her injury was devastating.

The patient had been a financial secretary for a large school district and after months in a coma and more months in rehabilitation, she was reduced to the intelligence of a 6-year-old. She has constant jerking movements, is unable to use the toilet unassisted, needs maximum assist with ambulation and has to use a sippie cup because of the jerking she is unable to

control. Tragically, after her injury, this woman was unable to answer simple questions about her own history, such as how many children she had and if her parents were living or deceased.

The biggest roadblock of the medical malpractice case was that the medical records were altered to the point that one of my experts said that they were "incompatible with human biology". If you looked at the patient's postoperative condition and then looked at the anesthesia record, things just did not add up.

The anesthesia record showed that the patient was maintaining an adequate level of oxygen during surgery. Her lowest oxygen saturation level was 93% (normal is 95-100%.) Because the medical records were so unreliable, the legal team represented her had enormous difficulty lining up an expert willing to testify to a reasonable degree of medical certainty of what we think happened. Many pages of the chart were missing and information was withheld. It was not documented until 3 months after surgery that the patient had sustained a broken tooth during the procedure. No complications were noted on the anesthesia records and the record stated that the intubation went without incident.

In the discovery phase of the lawsuit, I requested pertinent policies and procedures from the hospital and found multiple problems and discrepancies. I noticed that there was no Code Blue Sheet (resuscitation record filled out when a patient needs emergency care) in the patient's chart. (The policies and procedures spelled out specific procedures regarding documentation of codes.) The hospital was unable to produce a code sheet for our patient. The hospital staff said, "It must have gotten lost", so I requested a blank one. They were unable to provide that because they didn't even use one. The nurses were questioned under oath in front of a court reporter during a deposition. The nurses knew nothing about code sheets and testified that they had never seen one used at that hospital. The written procedures stated that all codes were to be

reviewed by a Code Blue Committee and undergo thorough review. The hospital did not even have a Code Blue Committee.

In my investigation, I found that the hospital's own website was full of lies. For example, they said that all of their anesthesiologists were board certified, when in truth, less than half held certification. The defendant anesthesiologist said he was board certified when, in fact, he was not.

I rarely request a medical licensing file in medical cases because they hardly ever have any useable information. But in this case, my gut told me that there was a sleaze factor with this particular physician and perhaps I might find something interesting. Once I received the doctor's medical licensing file, it was obvious to me that he had lied to the licensing board, saying that he was board certified. Prior to the deposition of the anesthesiologist, just to make sure I had correct information, I asked the American Board of Anesthesiology to send me a written document giving his official status just in case we needed official backup. They sent the document, which stated that the defendant was neither board certified nor board eligible. (Board eligible means that the doctor has completed requirements necessary to sit for the board certification examination.) Lying to the medical board about your credentials is a big deal. When the anesthesiologist applied for privileges at the defendant hospital, the hospital either did not double check his status or if they did know about his status and they chose to do and say nothing and continue to lie on their website. This was especially interesting in light of the claim on their website that all their anesthesiologists were board certified.

In the anesthesiologist's deposition, when the attorney representing the plaintiff asked about board certification, the defendant tried to dodge the question. We showed him and his attorneys multiple years of license applications that had "American Board of Anesthesiology" typed in under the section regarding board certification status and signed by him. His

response was that "the girls" in his office filled out the forms and he just signed them without reading them closely. It was then the attorney pulled out our smoking gun - the application for license renewal that he had WRITTEN IN HIS OWN HANDWRITING that he was board certified. We then produced our document from the American Board of Anesthesiology, proving his lie. The defense attorneys were shocked and called for an immediate recess. Needless to say, the defense team was quite unhappy with their client. The licensing file was entered into evidence. This did irreparable damage to the anesthesiologist's credibility.

The case dragged on for four long years, with the defense delaying progress whenever possible. I believe they were hoping our client would die in the interim and they would be off the hook. I have seen that before. She lived.

The case settled for the insurance policy limits. But as a condition of settlement, we required the hospital to correct the errors on its website and to actually follow their own policies and procedures. Part of the settlement was that the hospital now requires audible alarms on anesthesia machines and monitors could not be overridden and shut off.

I believe that a lot of good can come out of a tragedy like this if you can effect actual changes in the hospital's procedures to prevent the tragedy from happening again, perhaps even saving lives. It's NOT all about money. Lawsuits can actually work to improve patient safety and make positive changes in the health care environment.

Sadly, the patient has deteriorated over the years. She needs round the clock care. Her devoted husband is caring for her. With the settlement money he was able to build a fully handicap-accessible home where they can spend the rest of their years. They are now both in their seventies. He refuses to place his wife in an institution. Respite care is provided twice a week to give her husband a much

needed break - all made possible with the settlement funds.

About the Author

Kathleen Cunningham is a Medical Investigator /Certified Medical Legal Consultant with 20 years of experience in her field. Ten of those years were spent as the full time in-house medical investigator for Gerry Spence's nationally recognized law firm in Wyoming. For several years she functioned as the in-house medical legal consultant for the law firm of Meyer and Williams in Wyoming.

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Nancy Collins
PhD, RD, LD/N

Fish Oil Supplements: Which Ones to Buy

By now, everyone has heard of the health-boosting powers of fish oil, and many people have a bottle or two of supplements at home. Before you buy the next bottle, read this to ensure that you are not wasting your money.

Is it all fish oil?
Make sure that all of the oil is really from fish, containing eicosapentaenoic acid (EPA) and docosahexaenoic acid (DHA), and not the other omega-3 fatty acid, alpha-linolenic acid (ALA) contained in flaxseed and vegetable oil, which does not seem to provide the same benefits as EPA and DHA. Many experts believe that a supplement should contain more EPA than DHA.

How much should I take?
If you already have heart disease, make sure that your supplements provides at least 1 gram (g) of fish oil/day. Healthy people who want to reduce their risk of developing heart disease should take 500 milligrams (mg)/day.

Are larger doses better?
Taking doses larger than 3 g/day can lead to spontaneous bleeding, which sometimes is deadly. Talk to your doctor before beginning a

high-dose regimen or if you are taking blood thinners. Be sure to tell your doctor you take fish oil. You may need to stop taking fish oil for a number of days before surgery or other procedures to avoid bleeding.

Concerned about overfishing?
If you are concerned about overfishing, you may want to choose a supplement that gets its omega-3 fatty acid, DHA, from algae.

Have you checked out the product online?
Before choosing a supplement, go to the company's Web site and look for a copy of the certificate of analysis (COA), which shows whether or not the supplement was tested and proven free of mercury, polychlorinated biphenyl (PCBs), dioxins, lead, arsenic, and other toxins. The COA also will state the total oxidation level of the supplement—you want one that does not have a level higher than 17 milliequivalents (mEq)/kilogram (kg). Also look for a product that was molecularly distilled, further proving that all potentially harmful contaminants are removed.

What else should I look for?
Choose a brand that is pharmaceutical grade. Also look for a supplement that is produced at a pharmaceutical good manufacturing practices (GMP) facility.

References and recommended readings
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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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Real Food is Always Better Than Fake Food

I've been challenged to write a report on the 101 Best Tips for Losing Weight. I'm well on my way, in fact I have AT LEAST 101 tips, but I thought I'd share two of them with you this month. "Real food is always better than fake food!" has practically become my signature statement. When choosing your foods, you should always ask yourself, "Did Mother Nature create this, and is it as close as possible to the way she made it and intended it to be consumed?" This question will serve you well.

This question will guide you through the food industry fads and confusing information and statements we get from other "reliable" sources that have been known to be mistaken in the past. If this were not true, we would not have been encouraged to overconsume refined carbohydrates these past few decades. And don't get me started on the Industrialized Food Industry, processed foods, and all the confusing information in the media. I mean really, "processed cheese food" – it doesn't need refrigeration and never goes bad – how can that possibly add to our health in a positive way? For how many decades was the public encouraged to use margarine made from

unhealthy Trans-Fats as a substitute for real butter? I could go on – but I won't. Instead of a "fruit roll-up" ask your kids to try a fruit "roll-down" – a banana!

Real Food is Always Better than Fake Food!
This has become my signature statement for choosing healthful and nutritious foods. Mother Nature knew what she was doing when she created our food supply! The closer you can get your food to the way Mother Nature created it, the more nourishing and healthier it will be for your body. This means whole grains, locally grown fresh fruits and vegetables in season; foods that come without packaging or bar codes, and only have one ingredient. Processed and packaged foods, foods that have ingredients that you don't recognize and can't pronounce, foods that have additives and preservatives, or have been genetically altered are not the best choices. This will also eliminate the need for substitute foods, such as diet sodas, low-fat dressings, and processed cheese food (not real cheese). Generally, they have taken something out and replaced it with something even less healthy. So, whenever you have a question about the healthiest choice, or the latest fad, remember that "Real Food is Always Better than Fake Food", and ask yourself how close to the way Mother Nature created it that food really is.

Don't Ever Eat anything That You do not Like or Truly Enjoy!
Don't waste calories by eating something you think you "should" eat, or feel guilty because you think you ate something you "shouldn't". Make the healthiest choice from the most nutritious and highest quality foods. You can skip the diet substitutes, artificial sweeteners, and any other food that you do not like, that does not genuinely satisfy you, or that you do not enjoy. We have so many delicious food options. Make your choices from high quality foods, and keep your nutrient ratios and portion in line. You should never "have to" eat anything you do not enjoy.

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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3. If you do not improve, call the surgeon's office and insist on speaking to the surgeon.

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Faye Levow
President and CEO of
Launch Pad Publishing Inc.

To Drive or Not to Drive?

(Excerpted from the upcoming book *OMG! My Parents Are Getting OLD!*)

I was very fortunate that my mom had enough sense to know when to stop driving and enjoy the luxury of “chauffeurs”. Of course, she would drive them absolutely crazy screaming to turn right when they knew it should have been left. Or to continue straight ahead at a “T” with a tree in front of them!

My grandfather had Alzheimer’s and in the early stages, when he was still driving, he would attempt to drive away before my grandmother was fully in the car, or before her door closed. Also, he got lost. My mom inherited her bad temper from him, so suggesting that he not drive never worked.

Finally, the family had a police officer go to the house and ask my grandfather to surrender his driver’s license. There were no arguments. And he never drove after that. Phew! Disaster averted.

If you are concerned about your aging parents’ driving ability “at their age,” start off by riding with them during the day. Simply observe their driving style. Do they seem comfortable behind

the wheel? Are they able to stay on their side of the road? Do they take the turns smoothly? How is their reaction time? Are they able to get to and from familiar places without getting lost?

If things are going well, ask, “How are you able to drive so well at your age?” and “Are you comfortable driving at night, too?”

On the other hand, if there are definite issues with their driving, you might want to ask, “Are you still comfortable with driving?” They could say, “Yes.” Or they might say, “I’m ok during the day, but I don’t really see that well at night.” They might be willing to agree not to drive at night for safety concerns.

If they are getting lost, you could express your concern about them getting lost. Say you know how frustrating it can be and how much easier it would be if they didn’t have to experience such frustration behind the wheel.

Have a gentle conversation about being concerned for their safety and the safety of others. You could say something like, “I would feel so terrible if you crashed and hurt yourself or someone else. Imagine if you hit a family and a child got hurt.”

It may seem a little dramatic, but you haven’t pointed any fingers. You started off with your own discomfort, and you gave them an image to consider. No one wants to be in a crash, but even beyond that, no one wants to harm a family, especially a child.

All these are ways to help your parent come to an agreement about driving. Perhaps it will be to only drive during the day (between certain hours so she is not in rush hour traffic) and to stay within a certain familiar area. Perhaps it will be not to drive at all.

It is never an easy thing, to give up one’s independence of being able to just get in the car and go. Picture it for yourself before you discuss this issue with your parent, for your day will come, too. How would you want someone to approach you about this sensitive subject?

Consider solutions for them to be able to get around, so they don't feel isolated or overly dependent or burdensome to others. If they are moving to a senior community, transportation is usually provided, and meals, too, so little shopping is required.

If they are remaining at home, it would be helpful to line up various alternatives for them to get to stores, appointments, entertainment, etc. If you are in the area, you might offer to take them shopping one day each week. Perhaps another family member or friend can take them to appointments. There are non-medical transportation companies, and caregiver agencies that will also provide a driver to drive your parent's car. My mom utilized all of these.

While discussing issues of aging is never easy, perhaps these suggestions will make this discussion a little easier for you and your parent.

About the Author

After two years of being in a crazy whirlwind of managing her mom's care, caregivers, and finances, Faye Levow knew that she had to do something with all that she had learned. Knowing that millions of people deal with similar situations on a daily basis, she decided to create the upcoming book *OMG! My Parents are Getting OLD!* scheduled for release in 2012.

A comprehensive resource book, *OMG! My Parents are Getting OLD!* weaves her story among chapters from over 50 professionals who work with seniors daily in a wide range of fields, and the lessons from nearly 70 family caregivers who have "been there."

President of Launch Pad Publishing, Faye has been writing and editing for over 30 years and coaching authors for the last seven. She has been a features writer for magazines and newspapers, a contributing author in several books, and has edited magazines, newsletters,

and numerous books in a variety of genres, including a Washington Post best-seller.

From coaching to editing to publishing, Faye Levow's passion is to help authors get their books out of their heads, and get their message, in their voice, to their audience. She specializes in going Beyond the Book™ to discuss branding, future products, and other opportunities that can bring greater success and satisfaction to an author.
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