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Near Fatal Patient Controlled Analgesia Pump Incident

Guest post by Matt Whitman

Amanda Abbiehl and I share a similar story. Both of us were on patient-controlled analgesia (PCA) pumps to manage our pain.

However, the difference is that, by the grace of God, an observant nurse who just happened to walk by my room when I stopped breathing, called a “Code Blue”, and that ultimately saved my life. I would have been just another statistic if it wasn’t for that nurse. Unfortunately, Amanda was not so lucky.

What are the odds of a nurse putting her head into a patient’s room just as that patient is experiencing respiratory depression? Slim. What are the odds of that same nurse putting her head into the patient’s room after she had just checked on him 15 minutes before? Almost none. Yet, that is what happened to me and I ask why.

The injury

My story begins in 1990, when I was a state trooper. My squad car was struck by a car driven by a drunk driver. Although the accident left me close to being a quadriplegic, I went through 6 months of physical rehabilitation and returned to work. Although my doctors told me that I would always have trouble with my neck, I was able to function at my job despite the pain. I was even named a district Trooper of the Year in 2001 and prior to that in 1994 received a statewide traffic safety award for arresting the most drunken drivers per capita.

But, despite being recognized again in 2003, as Trooper of the Year for in Bridgman, MI, my neck injury increasingly gave me problems. In December 2002, the neurologist who read my MRI told me that I shouldn't be a trooper anymore. He said, if I get hit again, I'd be a quadriplegic. In January of 2003, I met with Indianapolis neurosurgeon Dr. Henry Feuer, who was (and I believe still is) a consultant for the Indianapolis 500 and the National Football League. Dr. Feuer told me that my condition had worsened and that my neck looked like that of a retired football player with arthritis, bone spurs and spinal fluid unable to circulate effectively. Dr. Feuer gave me two pieces of bad news. The first was that I needed surgery. The second confirmed that I couldn't be a state trooper any more.

The surgery

So, I underwent neck surgery that year at Methodist Hospital in Indianapolis. Because of the pain that I was in, I was on a morphine pump after my surgery. The night after my surgery, a nurse had just checked on me and then continued to check on other patients on the very large hospital floor. Another patient she was caring for needed something. Although it was on her cart, she decided to go to the supply room and restock her cart. Fortunately for me, her path to the supply room led her passed my room.

The rescue

So, even though she had just checked on me 15 minutes earlier, she just so happened to be

passing my room when she noticed I was not breathing and called a “Code Blue”. She would tell me later while she was crying that she did not know what made her walk past my room. While she continued to sob she told me that she had never seen anyone live after they had coded.

I remember feeling warm, calm and in a better place. There was a point where I had to decide if I wanted to fight back and live or stay dead and remain in that warm pleasant place. I chose to fight and recall being jolted back, I remember doctors over me, bright lights, and someone holding my hand. Miraculously, I survived. The doctors told me that 96% of Code Blue patients die; only 4% live. I remember later on that morning that I was somewhat of a spectacle for the student nurses. They would come into my room and stare at me to see the patient who had cheated death.

I had been without oxygen for 6 minutes. At 7 minutes, I was told, I would have been brain dead, if not dead permanently. I died at 4:11AM, and for many years after I would wake at 4:11 in the morning remembering what happened to me.

I was never electronically monitored. There was nothing that would have indicated to a nurse that I was about to experience respiratory depression and almost die. I was 39-years-old and in terrific health. I was not a high risk patient. Why? Had my PCA pump been integrated with a capnography machine, the pump would have shut off and alerted my nurse that I was not breathing. Instead, I am alive today because my nurse, who had just checked on me 15 minutes earlier, just happened to be passing by my room when she didn’t have to. I say to Brian and Cindy Abbiehl – My deepest condolences. Know that your daughter died peacefully. Know that that she was not in any pain or under any stress.

I say to all hospitals that care about their patients’ safety and welfare — electronically monitor ALL your patients, not just the ones at

high risk. A human life is too valuable for you not to. All hospitals need a technological safety net for their patients. All nurses and caregivers need that safety net too.

This blog post was shared by the Physician-Patient Alliance for Health & Safety.
About Physician-Patient Alliance for Health & Safety: Physician-Patient Alliance for Health & Safety is an advocacy group devoted to improving patient health and safety. Follow PPAHS on Facebook (www.facebook.com/ppahs) and on Twitter (twitter.com/mikeppahs). The PPAHS website is www.ppahs.org

PPAHS is currently developing a checklist targeting PCA pump use. For more on this initiative, please see this ASC Review article: http://wp.me/p1JikT-8O

Reducing Cardiac Risks

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

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- how to find a doctor for a second opinion

For more information visit:
http://tinyurl.com/6mbljhx

Is LASIK Surgery Right For You?

Almost every American from eighteen to eighty years of age has heard enough about LASIK to understand on a basic level what it is and how it works. On average approximately 1,000,000 LASIK procedures are performed annually in the United States. The vast majority of these procedures are successful, but unwanted side effects and less than optimal results can occur in a small percentage of patients. Below is a discussion of the essential elements in the pre-operative evaluation of a patient being considered for LASIK.

Patients are typically at least eighteen years old and suffer from nearsightedness (myopia), farsightedness (hyperopia), and/or astigmatism. Their eyeglass prescription must be stable prior to surgery. The generally accepted guideline for stability is a change of 0.75 or less in any component of the prescription over the last year. So, if one year ago a patient wore –2.00 glasses and today she is using –2.75 or less her prescription is considered stable. Conversely, a prescription that changed from –4.00 twelve months ago to –5.00 today is not considered stable. A patient with such a prescription should be rechecked in the future for stability of her prescription.

Surgical Requirements, Contra-Indications and Process

A patient's eyes need to be healthy to undergo LASIK surgery. What exactly does this mean? A recent case of conjunctivitis (inflammation) from wearing contact lenses overnight will need to clear up before surgery. More serious issues such as the degenerative corneal disease of keratoconus, which affects about 1 in 2,000 people, make patients ineligible for surgery. Lesser conditions, such as the presence of dry eyes, pinguecula (excessive growth of tissue on the white part of the eye), or pterygiums (growth of the white part of the eye onto the cornea) do not necessarily make patients ineligible for LASIK surgery. Some patients with retinal conditions; mild, well-controlled glaucoma; and other ocular abnormalities may need to be evaluated by another ophthalmologist and cleared for surgery. In any case, the general ocular health and specifically the health of the patient's cornea, the part of the eye contact lenses rest on and LASIK surgery is performed on, will be thoroughly tested prior to surgery.

Measurements of the size, curvature, and thickness of the cornea, the pupil size in dim lighting, the intraocular pressure, and the ideal eyeglass prescription will be taken. A dilated examination will be performed to check for the presence of cataracts, retinal and other disorders, and to confirm the patient's optimal eyeglass prescription. Scans are often done to assess if a patient would benefit from so called "custom" treatment. Such treatments evaluate the patient's prescription in a way that goes beyond an eyeglass or contact lens prescription. In some cases custom treatment can offer patients better quantitative and qualitative vision than so called traditional LASIK. Patients should be aware that a period of abstinence from soft contact lenses is required prior to surgery to ensure the most accurate measurements are obtained.

A listing of any medical problems, medications, and allergies a patient has is obtained. Some medical conditions, such as diabetes, can affect how a person responds to LASIK, how quickly she heals, and how likely the patient is

to suffer prolonged side effects from the procedure. The same holds true for certain medications, including anti-depressive and antihistamine medicines. Any unusual healing tendencies are noted, such as a history of keloids, that is, excessive scar formation after injury or surgery. Finally, a thorough discussion of the patient's expectations and her understanding of the risks and benefits of the procedure is undertaken.

Improvements in diagnostic equipment, such as more advanced corneal topography systems, and safer and more sophisticated lasers have greatly reduced the incidence of poor outcomes in patients. Permanent, bothersome glare and halos are much less likely to occur after LASIK treatment today compared to such treatments ten years ago. Femtosecond lasers to create the flaps in LASIK surgery offer an added level of safety and predictability compared to earlier generations of mechanical devices (microkeratomes) that were used in flap creation. Finally, newer medications, such as Restasis, have aided in controlling dry eyes and inflammation post operatively in patients, improving patient comfort and outcomes.

A thorough pre operative assessment, meticulous surgical technique, and careful monitoring of patients post operatively go a long way towards maximizing patient outcomes and satisfaction.

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

Spread the word. Who do you know who would enjoy reading Avoid Medical Errors Magazine? Encourage them to sign up at www.avoidmedicalerrors.com. Share the news on Facebook, Twitter, and LinkedIn.

How to Speak Up When Hospital Care Goes Wrong

In an earlier column, I suggested that you speak up when something just doesn't seem to be going right with the medical care you are receiving. But how do you do that?

Start by understanding two key points. First, it is okay for you to ask questions and expect to get answers that you can understand about what is happening to you. It's your life.

Second, big national organizations urge you to speak up. They believe that it is the right thing for you to do—and that your life may depend on your doing so. In other words, you are in good company if you ask questions when something seems to be going wrong.

For example, The Joint Commission accredits 18,000 hospitals and health care programs in the U.S. It has published more than 15 brochures in a series called "Speak Up." They have titles like, "Help Avoid Mistakes in Your Surgery."

Other brochures in this series have titles such as, "Help Avoid Mistakes with Your Medicines,"

"Help Prevent Medical Test Mistakes," and "Understanding Your Doctors and Other Caregivers."

You can find these brochures online at http://www.jointcommission.org/speakup.aspx. Or, search on [Joint Commission Speak Up].

Think about this situation for a moment. Staff members of The Joint Commission spend their working lives checking behind the scenes in hospitals to check on the quality of care provided. And *they* are advising *you* to watch out for yourself and speak up.

A part of the U.S. Government, the Agency for Healthcare Research and Quality, also offers brochures and podcasts that you can download or use online. Find these at http://www.ahrq.gov/consumer/safety.html#errors, or search online for [AHRQ Getting Safer Care].

An example of the brochures AHRQ offers is, "Your Guide to Preventing and Treating Blood Clots." Blood clots are common side effects of hospital care, and kill five times as many people each year as breast cancer does.

What pointers should you keep in mind?
First, be as clear as possible about what alarms you. For example, "I am seeing two of everything," is more useful than, "There is something wrong with my eyes." However, if you don't know what is wrong but you suddenly feel worse, it still makes sense to raise the alarm.

Second, know who you are talking with. Dozens of people may enter your hospital room each day. You may not get the right attention if you complain only to the person who is there to pick up your menus or to take you for a medical test. It is best to raise your concerns to a nurse or doctor. It is okay to ask, "Are you a doctor?" or "Are you a nurse?" or to say, "I need to speak with the person who is in charge of my care on this shift."

Third, try to treat people who are there to help you the way you would want to be treated. Sometimes, patients or their family members

think that the best way to be heard is to shout and to be abusive. This approach rarely works. That is, if doctors and nurses hear angry attacks, they often stop thinking about the problem you are raising. Instead, they focus on your behavior.

If you are the patient, they may decide that you need to be sedated. If you are a family member, they may ask you to leave. As a result, the issue you were trying to point out may not get attention.

Fourth, ask to speak to the next person up the chain of command if necessary. For example, if you are having a problem with a nurse, ask to speak to the nurse supervisor. If a junior doctor (an intern or resident) doesn't seem to grasp the problem, ask to speak with the attending physician, who is more senior. If necessary, ask to speak to the most senior member of the hospital staff who is available. Sometimes senior staff members take turns being the administrator on call 24/7.

Fifth, when you check in, ask if the hospital has a patient ombudsman, a patient advocate, a patient relations department, or a rapid response team you can reach if you need to. Some hospitals have set up hotlines for patients and family members to call if they feel that a patient urgently needs attention that she is not getting.

Sixth, you might call your primary care doctor (from your hospital room) and ask for help dealing with the problem. Your doctor may have an easier time getting your concerns across to another doctor or nurse than you do.

Seventh, if none of these avenues work -- and one of them should -- you might try calling the hospital's risk management department from your hospital room. Ask to speak to a manager. The risk management department wants to ensure good patient care so that patients get good results and are happy with the hospital. That way, the risk of lawsuits is lower. On a related note, you might ask to

speak with a person from the quality control or quality improvement department.

By speaking up when something seems to be going wrong, you make it more likely that you will leave the hospital in good shape.

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.

Sarah Jean Fisher
MSN, RN-BC, BA

The Health Fair Volunteer

I volunteered to do a bit of community service recently performing blood pressure screening at a health fair. Understanding the importance of "giving back", I was anxious to share my knowledge related to monitoring blood pressure to the multitudes who would attend. The fair was at a neighborhood center in a part of town that I was not familiar with. I gave myself an hour to reach a destination my GPS said would take 24 minutes. Much to my chagrin, it appeared as if the total population of Philadelphia was also going to the same health fair, taking the same route, bogging down traffic on the major highway that I used and causing me to arrive just one minute before I was scheduled to begin. This was not a good start, but I did find a parking spot directly across the street, so my spirits brightened a bit. My contact exited from a wide alley, greeted me by name, and took me into the building- actually right through the building and outside to a squared yard where small tables were set up around the perimeter. I had not realized it would be an outside event and the wind was promising to make this a frustrating event, considering the multiple handouts I had prepared to give out related to stroke, heart

attack, hypertension, and healthy lifestyle. I silently breathed a word of relief that I didn't bring a story board to set up.

After finding my spot, half a table facing the sun, I set up my handouts, using stethoscope, book, and a drink as paperweights to prevent a tornado of literature from spreading over the neighborhood. I waited for all my customers to arrive…and waited…and waited. Here I was, ready to enlighten the uninformed of the neighborhood regarding the risks of high blood pressure and no one came.

Finally, after chatting for 20 minutes with the group from Alcoholics Anonymous sharing my table, up came the first lucky person. Her blood pressure was unremarkable at 110/68, but I gave her a handout on healthy lifestyle. After another 20 minutes a second young lady arrived with an equally healthy blood pressure as the first, a classic 120/70. I wondered where all the people were that the current literature claims have high blood pressure and needed this screening.

Then two young women strolled by, one holding a very small infant. They acknowledged their known family history of high blood pressure but refused to let me check it saying, "I don't want to know what it is, I might get scared." No amount of cajoling would make them consent to a BP screen. I was feeling quite ineffective. Time was creeping by and my departure hour was quickly approaching. I had not been able to educate anyone and was becoming very disappointed.

At the appointed hour, I started to pack up my handouts and an elderly woman came up to me and blurted out in one long sentence, "Can you check my blood pressure, my pills ran out and I can't see my doctor again until May 11th, I've been having bad headaches and I get dizzy when I stand up, I did stop smoking but my family won't believe me, and I know it must be high." At this point I stopped her, asked her to sit down and tell me her name. "Gerry," (changed) she said. Her blood pressure on the right arm was 200/120 and on the left it was 184/120. She was Caucasian, 63-years-old,

diabetic, skin cool and dry, respirations relatively easy and she appeared somewhat overweight for her height. I asked her when was the last time that she took medication, and she said, “Last week when they ran out and I didn’t have any money to get more.” She then showed me a bag of empty prescription bottles.

I informed her that she was in immediate danger of a stroke or heart attack and I had to call 911 to take her to an emergency room for treatment. Gerry then complained, “They’ll put me in the hospital and I don’t want to spend the summer in the hospital.” I replied, “You may not live to the summer if you don’t get this blood pressure treated immediately. Besides, they may just give you medication to bring down your blood pressure and release you after a bit.” She complained then that how would she get home, since she didn’t have a token or the $2 bus fare. I confirmed someone would take of that so she agreed to remain and wait for 911 and I made the call. I moved her to through the alley to the front of the building, seated her on a chair and checked her blood pressure again: 210/120. I wondered how she remained without symptoms.

Shortly, her best friend arrived, and asked, “What’s going on with Gerry?” Gerry acknowledged her friend and said she was waiting for an ambulance to take her to the hospital…she only wanted to go to “XXXX, I like that hospital, and my doctor works there.” I waited for the ambulance, gave a report to the crew on the symptoms that I had found and her comments regarding medication, money, physician’s visit in May. I slipped him $2 for her bus fare. I watched them help her into the ambulance. It was now one full hour after my scheduled departure.

This was an eye-opening experience for me, a person of comfortable means, to be witness to a situation where someone must make a choice…buy food, pay rent, or get medication. Yet, there are thousands of other elderly persons making this risky decision every day. I believe I had an impact on Gerry’s life

yesterday, maybe even helped her to live a little longer, a little wiser.

What you need to know about high blood pressure

High blood pressure is called the silent killer because the only way to know if your blood pressure is starting to get dangerously high is for you or your doctor to check it regularly. Normal blood pressure is 120/80 mm Hg, and a blood pressure of 120 to 138/80 to 89 is *pre-hypertension*, when damage can start to blood vessels affecting organs like the heart, brain, kidneys, and eyes. Those at high risk are people with diabetes, gout or kidney disease, or have a family history of high blood pressure. Blacks tend to develop high blood pressure earlier in life and generally, the older you get, the higher your risk for blood pressure. You cannot do anything to change your race or stop aging, but there are some things you can do to decrease your risk:

If you are overweight, lose weight.

- If you smoke, stop.
- Eat foods low in saturated and trans fats, cholesterol and salt.
- Eat more fruits, vegetables, and low-fat dairy products.
- Increase your daily physical activity.
- Take all medication the way your doctor has prescribed.
- If already at risk, buy a home blood pressure monitor and use daily between doctor visits.
- For more info, check americanheart.org or StrokeAssociation.org

I am sure that not every volunteer will experience a life changing situation like this at every event, but, for me, the promise of even the possibility of such a moment has no price, and will never be passed up.

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.

Advocating for Yourself: Patient Power

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

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

Visit http://tinyurl.com/7tbwoj6 for more information.

Compassion Fatigue and Medical Errors

Compassion fatigue is a condition that often affects caregivers, such as people caring for a loved one at home, and those in the helping professions, such as nursing, medicine, social work and so on. It is most common in people who have a high commitment to caring for others at the expense of themselves. People who are both taking care of others, plus trying to handle high stress situations are especially vulnerable to compassion fatigue.

Compassionate professionals and caregivers tend to be strong people. They are often asked to take on more than the average person would be expected to handle. Because of their compassionate nature, they tend to say yes when asked to help another, even when their own resources are low. This can lead to a loss of balance between caring for others and self-care.

Research shows that long-term exposure to people in severe pain, suffering, or trauma is often linked to compassion fatigue. Family members may be responsible for an aged parent or a child with extraordinary medical needs. Nurses and other professionals at risk work in burn units, oncology, hospice and other

areas where patients have prolonged suffering or extreme trauma.

Two factors that contribute to compassion fatigue are long-term or chronic exposure to extreme suffering and the lack of awareness or attention to the gradually increasing signs of fatigue. Additional factors in the healthcare work setting include lack of organizational support, overwhelming workload due to short staffing, and the tendency for caring professionals to tend to the needs of others to the point of ignoring their own needs. Nursing staff, for example, may be unable to take meal breaks and even find it difficult to get away to use the bathroom.

Compassion fatigue does not happen overnight; it happens over time. The strong value for serving others to the detriment of one's own health, while working under chronic stressful conditions is a formula for fatigue that contributes to medical errors.

A person who is developing compassion fatigue is often not able to see what is happening. It's a nurse manager, a coworker or someone in close relationship to the caregiver who is in the best position to identify the signs of compassion fatigue.

Signs of compassion fatigue can include:

- Preoccupation and lack of attention to detail
- Poor concentration, focus, and judgment
- Complaining about or not wanting to come to work or about the needs of a loved one you are caring for at home
- Worrying about patients on days off
- Memory issues
- Loss of objectivity
- Emotional oversensitivity
- Emotional outbursts or mood swings
- Visible frustration or anxiety
- Avoidance or desensitization
- Weight gain
- Low energy
- Sleep deprivation
- Exhaustion

With the proper help a person can recover from compassion fatigue. The first step in recovery

is to recognize that there's a problem. The next step is to get appropriate help. Learning how to care and be compassionate, while maintaining clear boundaries is a skill most caregivers have never learned. The person will need to put in place effective daily self-care habits, recognize emotional and physical cues and learn to set limits.

Today's healthcare environment can feel overwhelming at times for professional and personal caregivers. It's important for staff to recognize that when they take on more than their share of the burden, the need for more help may not be seen. A compassionate person who is out of balance actually creates more problems. A burned out caregiver at home may need respite care, or a break, more than she realizes. (Women are more often in the caregiver role than men.)

Tips for preventing compassion fatigue

- Established daily health habits for eating regularly drinking water and taking deep breaths periodically
- Build enjoyable movement or exercise into your week.
- Create an environment and rituals for adequate sleep
- Express your emotions through art, journaling, or talking with a trusted friend
- Know your limits and don't compromise quality care by exceeding your limits.
- Notice what energizes you and what drains your energy. Let this knowledge guide your choices.
- Create opportunities for talking about difficult situations.
- Learn to recognize the signs of compassion fatigue in yourself and others.
- Seek professional counseling or guidance when needed
- Value self-care for yourself and encourage self-care in others

We cannot afford to lose our most caring and compassionate people to the risks of compassion fatigue. It's important to remember the advice we are given every time we fly in a plane. *"Put your mask on first!"* We are not told to ignore the other person. We are

only cautioned to be sure that our own resources are adequate when we reach out to help them. This is good advice in every caregiving situation.

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.

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.

Lessons for Patients

1. Obtain and read discharge instructions. Understand the way you should expect to feel after you go home.
2. Call the same day surgery center if you experience symptoms that are unexpected.
3. If you do not improve, call the surgeon's office and insist on speaking to the surgeon.

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

Good People, Bad Outcomes…What Can Happen in the ER

First, let me make it clear that the vast majority of emergency patients in this country receive excellent and professional care. The emergency department environment is not conducive to long, leisurely visits between doctors and patients. The physicians – and to a lesser extent, the nursing staff – are pressured to care for more patients in a shorter time period. If the ER happens to be exceptionally busy, well, you just "gotta work fast."

An emergency physician may care for as many as ten or twelve patients at once, each waiting for a test result, treatment response, consultant, or inpatient bed. Nurses may care for up to six.

This is a "perfect storm," the place where small but important items can be missed. Each of the dozen patients presents with a unique set of problems, a unique medical history, and an individualized response to therapy.

We are asked, "How can you keep them straight? Four middle aged men all with similar complaints, two kids with fever, a couple of 'diagnostic challenges' and the unpleasant

distraction of someone with a non-stop stream of complaints."

The answer? It can be very difficult. Our patient population is skewed. Chronically ill patients with multi-system disease taking over ten different medicines are more frequent emergency department visitors than the average, usually healthy individual. Their problems are much more complex, and treatment options vary widely. Keeping straight each patient's individual medical condition can be a daunting task, particularly while the results of extensive testing – often needed – must be incorporated into any treatment plan.

Occasionally, in the "heat of the battle," test results may be overlooked; a medication interaction may be overlooked; or a patient's prior response to therapy might not be obvious or considered.

In patients with multiple chronic problems, any small change in the balance of medications may have a great impact. A minor problem in a healthy individual can be lifethreating for someone chronically ill.

Let's look at an example. Assume our example patient has multiple chronic conditions that accompany aging and obesity – a realistic example in today's society, where people live to older ages and a greater percentage of the population is obese.

Our example patient has type 2 (adult onset) diabetes and *atherosclerosis* or hardening of the arteries. The atherosclerosis has led to a cardiac condition, renal (kidney) insufficiency, strokes, peripheral vascular disease, and a decreased resistance to infection.

The atherosclerotic cardiac disease leads to requirement for *warfarin/Coumadin,* a widely used blood-thinning pill. The patient presents after a minor scrape that led to infection on the lower leg. Note that *this* example patient has an obvious, easy-to-diagnose problem.

Part of the evaluation is a slew of lab tests, including testing the effectiveness of the

warfarin. Warfarin interacts with scores of medications/. If the doctor selects the wrong medication to add to the patient's regimen, the patient can bleed from blood that is too thin, or suffer a heart attack because the blood isn't thin enough.

A routine urinalysis might show an infection without symptoms … but because it's not directly related to the patient's presenting complaint, this can easily be overlooked. Unrecognized, a urinary infection can lead to systemic illness that can be dangerous if not deadly.

Try to manage a dozen such patients at a time. Remember, each is already taking ten or more different medicines.

Assume each patient requires half a dozen lab tests, each of which is reported at a different time by the laboratory. Each lab test gives a half dozen independent values. For example, a blood chemistry profile gives values for serum electrolytes (all four), two kidney function tests, calcium, serum albumin, and four liver functions. Even the urinalysis includes the specific gravity (density), content of sugar, protein, acetone, *leukocyte esterase* (occult white blood cells), *nitrite* (frequent by-product of metabolism from bacterial infection), and a microscopic analysis of at least four different types of cells.

Now imagine you're under time pressure, and there's a dozen patients waiting to be seen. Analyze all the data, come up with a treatment plan, arrange follow-up care or admission, and do it *fast.* Add in a couple of x-rays, an electrocardiogram, changing vital signs, the complaining lady to distract you … and here is the set up for something to be missed resulting in a "bad outcome."

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.

Instant Stress Busters

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

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Focus Hits the Bull's Eye…

"When the bull's eye becomes as big in your mind as an elephant, you are sure to hit it."

--Alejandro Jodorowsky

Through the years I have been fascinated by the Laws of Intention and Attraction, and the more I read and studied these universal laws the more I was able to manifest my desires. I've also come to learn that these universal laws are grounded in belief, expectation, motivation, and focus.

Yet when the "beasts" of depression and anxiety bring me to my knees and hold me hostage, the grounding of these universal laws evaporate into thin air as I barely hang onto life itself. What occurs from the turmoil in my emotional state of my mind is the attraction and manifestation of isolation and hopelessness--the direct opposite state of mind I long for in recovery.

However, as the adjusted medication and treatments begin to provide the "light of hope," the bull's eye of my mind is once again focused on recovery. I believe recovery is possible, I expect to recover, and I am motivated to do

what I need to do. My intention once again attracts wellness.

Those of us with mental health challenges surely know suffering. You can see it on our faces, hear it in our voices, and witness it in our actions. Although suffering is part of any illness whether physical or mental, it is what we learn from the suffering that makes all the difference in our existence moving forward.

Looking back over the struggles both my children and I endured in the grips of the "beast" called depression, I marvel at the strength and courage that became by-products of our experiences. Today my children and I embrace that strength and courage to overcome any obstacle we face in our lives.

We are well aware that for those with mental health challenges at times life can seem overwhelming and all-consuming robbing them of days, months, and even years. Yet, no one's life escapes suffering and struggles of some kind. Fortunately for us, though, the human spirit is resilient. It can bounce back to conquer another day.

This week spend some time re-evaluating your own suffering and challenges. Actively embrace the strength and courage those struggles left in their wake, and you will gladly notice that the suffering moved you from feeling overcome to forging you to become an overcomer!

At times mental health disorders can be caught in the vicious cycle of recurring episodes, but I've learned through my four bouts to keep focusing on my intention—sustained recovery. I've also come to recognize that sustained recovery takes an enormous effort on my part, which includes a combination of sleep, exercise, and nutrition as well as medication and therapy. You, too, can manifest recovery with the right intention. Give it a try!

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.

Nancy Collins
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AME
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Food Allergy or Not?

When people have unpleasant symptoms after eating something, they generally assume that it is a food allergy. In fact, only about 3% of adults and 6%-8% of children have a true food allergy. A true food allergy is an abnormal response to a food that is triggered by the immune system. Food intolerances, food poisoning, and toxic reactions often are mislabeled as allergies.

The foods that adults are most commonly allergic to are shellfish, tree nuts, fish, eggs, and peanuts. Peanut allergy is particularly dangerous, and a very sensitive person could have a reaction to 1/44,000 of a peanut kernel. The foods that children are most commonly allergic to are eggs, milk, peanuts, and fruits (particularly strawberries and tomatoes).

Food intolerance is much more common than food allergy, although the symptoms sometimes are similar. Food allergy reactions sometimes are fatal, while food intolerance reactions are uncomfortable, but cannot lead to death. For instance, lactose intolerance is not the same thing as milk allergy, nor is it as dangerous. Food allergy is not clinically proven

to lead to migraines, rheumatoid arthritis or osteoarthritis flares, tension-fatigue syndrome, or pediatric hyperactivity.

Histamine toxicity often is mistaken for food allergy. Histamine levels are high in cheeses, wines, and fish, especially tuna and mackerel. If a person eats a food containing a high amount of histamine, they can develop histamine toxicity, which has very similar symptoms to food allergy. Fish that is bacterially contaminated can contain very high levels of histamine. Histamine toxicity is dubbed “pseudoallergenic fish poisoning,” and according to the Centers for Disease Control, it accounts for more than 33% of seafood-related foodborne illnesses.

Some people have an intolerance to food additives, such as monosodium glutamate (MSG), sulfites, and food coloring. These are not immunoglobulin E (IgE)-mediated food allergies.

Food allergy is caused by two distinct parts of the immune system. IgE is an antibody that is present in everyone’s blood. Mast cells are a type of cell found in the all human tissues, but the highest proportions are in the nose, throat, lungs, skin, and gastrointestinal tract. If a person is allergic to a food, the lymphocytes (a type of white blood cell) produces the IgE antibody specific to the allergen. The IgE is then released and attaches to the mast cells. The next time that the person eats the food, the mast cells with the IgE antibody release chemicals such as histamine.

Most food allergies are discovered within the first 2 years of life and usually persist throughout life. Cow’s milk and egg allergies may resolve with age, but nut and shellfish allergies generally do not. Allergies in adults generally do not resolve. Some individuals have a genetic predisposition to allergies.

Infantile food allergy usually is diagnosed by changing the baby’s diet and observing changes in symptoms. The recommendation for children who are genetically predisposed to allergies is to exclusively breastfeed for 2

years. However, very allergic infants can have an allergic reaction to what their mother ate if they are breastfed.

In adults, a doctor first determines if it seems plausible that a patient is having an allergic reaction to specific foods, and then confirms the diagnosis through skin tests, blood tests, or food challenges.

If you have a food allergy, take care to avoid the food. Ask questions in restaurants and insist that the waiter check with the chef if there is any doubt. If you have a peanut allergy, advise the airline when you book a flight so they will not serve peanuts on the plane. You have a right to have this request honored. Learn how to use and carry an Epi-pen to inject yourself with fast acting adrenaline. Make sure someone with you knows how to use it.

References and recommended readings

Dove L. When food bites back: is it a food allergy? Available at: http://www.recipestoday.com/articles/nutrition-and-health/when-food-bites-back-2072/.

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.

Getting Started With Meditation

Getting Started with Meditation

Only a few decades ago, Western medicine viewed the body as a machine with parts that would inevitably break down until it could no longer be repaired. Medical students were taught that random chemical reactions determined everything that happened in the body, that the mind and body were independent from each other, and our genes largely determined our health and lifespan. Today, scientific research is arriving at a radically different understanding, albeit one reached by ancient wisdom traditions thousands of years ago: The body and mind are inextricably connected in a network of energy and intelligence that is in constant, dynamic exchange with the world around us. With every breath we take, every mouthful of food we swallow, every sound we hear and every sensation we feel, our body is changing.

Furthermore, we are the only creatures on the planet that can change our biology through our thoughts and feelings. Our cells are constantly eavesdropping on our thoughts and changing along with them. If we experience a happy thought or a feeling of love, our body is directly

influenced as the messenger molecules course through the bloodstream, delivering the positive energizing effect to trillions of cells. Dark thoughts and feelings of depression suppress our immune system, leaving us vulnerable to illness. Even our everyday language reflects the underlying mind-body connection. We say things like “News of my daughter’s car accident made me sick to my stomach,” or “My heart sang when I heard that my friend was coming home.”

The Ripple Effect

Even the smallest changes in energy, such as just a few words, can lead to large-scale disruptions in the body as our thoughts and feelings can instantly trigger a stress response in our body. A physiological change known as fight-or-flight response, reveals symptoms such as an increased heart rate and blood pressure, sweating, the release of stress hormones like cortisol and adrenaline, suppressed immune functioning, and rapid breathing. Prolonged stress can make us sick and accelerate aging. Over time, the stress response can lead to high blood pressure, stomach ulcers, cancer, insomnia, depression, and autoimmune diseases.

Entering Restful Awareness

The opposite of the fight-or-flight response is the restful response, which includes restful sleep and the restful awareness experienced during meditation. When we’re in a state of restful awareness, our body rests deeply while the mind is awake, though quiet. Research has found that people who regularly experience restful awareness develop less hypertension, heart disease, anxiety and depression. They find it easier to give up life-damaging addictions to cigarettes, drugs and alcohol. People who meditate regularly also experience wide-ranging health benefits and a reversal in many of the biomarkers of aging. In short, meditation is the perfect vehicle for renewing the body, mind and spirit. By its very nature, meditation exposes your brain to a quieter state. Through repeated exposure, your brain adapts to that stillness and silence and works gently to stem the fight-or-flight stress

response. Meditation is a vital way to purify and quiet the mind, and rejuvenate the body.

Getting Started with Meditation

I usually recommend people learn a traditional meditation practice from a qualified instructor. That way, you know exactly what to do at any point in meditation and with any experience that comes along. Often, when people try to learn on their own or from a book, they learn incorrectly and soon give up in frustration because they aren't experiencing the expected benefits. When you begin to meditate regularly, you will notice thoughts and feelings that may have been building inside you are gently released. You will reach the quiet place that was always there waiting for you – the place of pure awareness. It is there that you experience peace, healing and true rejuvenation.

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For those interested, Kay Rice one of our Certified Chopra Center Instructors & Vedic Masters, offers instruction in Primordial Sound Meditation, a natural, easy practice that dates back thousands of years to India's Vedic tradition.

BY Deepak Chopra, M.D., bestselling author & Co-Founder of the Chopra Center for Wellbeing in Carlsbad, CA. 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.

Faye Levow
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Preventing Elderly Abuse Part 1

Elder abuse is a major problem that requires everyone's attention. It comes in several forms: financial, physical, mental/emotional, and neglect. Most people don't realize how susceptible their aging loved ones are to being abused and the fact that anyone can be an abuser. He or she can just as easily be a family member as a hired caregiver.

When imagining abuse, most people immediately think of physical abuse. Physical abuse is fairly easy to spot because you can often see bruises or scars, although some abusers hit the part of the body normally covered by clothes. There may be an increase in numbers of hospital visits. The elder also often has a fearful attitude. Sexual abuse may be less difficult to spot, but, again, an elder's behavior is a clue. He or she may seem uncomfortable, embarrassed, nervous, and anxious.

Neglect may mean that the elder is not getting fed, bathed, dressed in clean clothing, or receiving medication, for example. If she is still living at home, her home may be ill kept or

downright filthy. You may not know that this is occurring if you are living far away, which is another reason to either visit frequently, or have someone you trust look in on your aging relative on a regular basis.

If your elder does not have any assistance, he may be neglecting himself, either because he has dementia and doesn't realize he is not doing basic hygiene, is depressed, or is no longer able to perform simple functions on his own. He may also be afraid of falling in the shower, for example, so he simply avoids showers.

My mom was diabetic and did not maintain a proper diet for her condition. She also had early stage dementia, but was apparently not handling her insulin injections appropriately. At one point she was very close to a diabetic coma. Not being acquainted with this sort of thing, I had no idea what was wrong with my mom or how serious it really was. I was under the impression that her caregiver (daytime only up to this point) had experience with eldercare and was getting her nursing degree (this was lie), so she knew what was going on. Unfortunately, this wasn't true and I realized much later that I hadn't been involved enough with my mom's care. Thank goodness she already had a doctor's appointment scheduled for the next day or she might have died at that time.

Six months later, my mom had a stroke and ended up bedridden, on a feeding tube, and unable to speak. The primary caregiver had arranged for 'round-the-clock care after the blood sugar issues, but now my mom couldn't do anything for herself at all. There were plenty of opportunities for neglect or abuse. I was visiting more regularly at this point, but probably not enough to really know what was happening. It was easy to believe that everything was fine, *but I also didn't know how to recognize any problems*.

Mental/emotional abuse may come in the form of isolation, intimidation, harsh words, teasing, and other disquieting behaviors. Your elder

family member may be abnormally quiet, fearful, or nervous. When you are leaving at the end of a visit and notice your parent to be especially clingy, there may be a bigger problem beneath the surface.

I found out later that my mom's friends had tried to call and/or visit, but the caregiver was either not answering the phone, not giving anyone the messages, or telling mom's friends they couldn't see her. My mom had always been a very social person and was being completely isolated. I only found this out after she passed away. Had I known, I would never have allowed that to happen. This was a form of abuse through isolation.

With financial abuse or exploitation, you might never know that it is occurring until very late unless you are very protective of your parents' situation. Financial exploitation can be as simple as a caregiver using credit cards for personal purchases or as complex as convincing an elder to rewrite her will or create a power of attorney naming the caregiver as one who has charge of finances. There are also solicitors who may call the house and convince the elder to "invest" in a scam, pay taxes on "lottery winnings in a foreign country" or make a purchase that never shows up. If you are not keeping an eye on the finances and bills, you might be in the dark about this scam.

My mom had dementia that was not officially diagnosed and she was exploited financially of tens of thousands of dollars by a hired caregiver, so I have firsthand knowledge of how crazy this can be. I was tipped off by another caregiver that the primary caregiver was skimming money off everyone's pay. She also suggested that I check the credit reports, where I found that there were credit cards for which we were not receiving bills and bills for credit cards that I couldn't find.

I immediately re-routed all of the mail to me and started requesting a year's worth of bills from all the credit card companies. In my research of the bills, I found over $30,000 in

credit card debt that could not have been my mom's!

Because my mom was bedridden and couldn't do more than move her lips a little or make a light whisper for many months, there were many opportunities for neglect, physical abuse, and mental/emotional abuse. She had worn glasses most of her life, but somehow they were "missing" or "broken" and she was not even given the opportunity to see out of her one good eye—another form of abuse.

When I removed the exploiting caregiver and her associates and brought in qualified, licensed people, I saw my mom relax and appear much happier. As you can see, these forms of abuse may be going on and you don't even know it.

If you want to keep your elderly relative safe, you simply must be involved in their care. If you are far away, hire a geriatric care manager to be your "person on the ground." You must also be involved in your relative's finances, even if you are monitoring her accounts via the Internet and paying the bills on their behalf.

Remember, any elder may be vulnerable and runs the risk of any type of abuse. If it seems scary, you're right! Hopefully, if you have siblings, you can all get along and work together to help your aging parents with their various needs and challenges.

Part 2 will discuss what to do if you suspect elder abuse or exploitation is occurring with your aging loved one.

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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