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Alarm Fatigue

Alarm fatigue refers to a situation that occurs when nursing staff become too overloaded to hear and respond to clinical alarms coming from medical equipment. This is a frightening thought because the kinds of alarms I am talking about warn of blocked IV lines or irregular heartbeats. Increasingly, technology has resulted in improved ways to monitor patients, and manufacturers have built in alarms to warn the staff of a problem.

Alarms create a constant din in the background. On a 15-bed unit at Johns Hopkins Hospital in Baltimore, staff documented an average of 942 alarms per day — about 1 critical alarm every 90 seconds.

I recall when my father was in the ICU, he thought the alarms represented fire trucks, and could not understand why there were so many fires in the blocks around the hospital.

I asked one of my colleagues, a critical care nurse, to explain the ICU environment. She

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said, “There are days when every red alarm is ringing on all 16 patients in the unit and probably 80% or more are erroneous or just too sensitive to minute or intermittent changes. Many alarms reset on their own, as long as the event doesn't continue. Others stay ringing until a human resets them. A cardiac monitor lead comes off; an IV pump detects an air bubble; 3 patients’ call bells are ringing simultaneously; phones are ringing; a patient on a ventilator coughs; people are calling out to each other; the doorbell to the electric doors of the ICU rings and rings; and a tube feeding pump detects a clog.

“It’s a cacophony of dings and beeps and buzzes. Chronic loud constant noises like that can really begin to fade out of our awareness after a while. If alarms ring all day long, no one pays attention to them after 4-5 hours. We begin to tune into only the 'important' ones and tune out the minor ones.”

Technology, however, relies on humans to hear, interpret, and respond to alarms. Many times alarms are false and do not signify anything. Sometimes alarms are annoying, and the nurses turn them off. Sometimes the alarm is turned off because the patient is being taken off the equipment temporarily and the nurse forgets to turn it back on. Sometimes the nurse incorrectly programs a complicated piece of medical equipment. And sometimes the volume is turned down, or the nurse is at a spot on the nursing unit where she cannot hear the alarm.

I realize this is a frightening subject. My critical care nursing colleague had mixed feelings about the suggestions I will give you at the end of this column. She said, "I do appreciate when a family member comes to tell me an alarm is ringing. Believe me, I know that it’s important to diagnose the cause of any alarm. But if family members became frantic and went to look for staff every time an alarm went off, we

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nurses would never be able to accomplish any of our regular work.

"I think that staff need to be very attentive to how alarms are set, and alarms MUST be adjusted for each individual patient's parameters. Many alarm systems default to the 'textbook' alarm values when shut off and need to be individualized for every new patient. And, also, families must be assured that while monitoring systems are sensitive and cause many false alarm readings, the staff know how to recognize these subtle sounds. The last thing I'd want a family to think is that the patient's life is at the mercy of those who are only within earshot. But I do know that many important events are missed because staff is tuning out what they should be rushing in to fix.

"If I were a lay person reading your column, I would be scared out of my wits knowing that the nurses relied on family to help warn whenever an alarm went off. It's a double-edged sword. It can be a blessing as well as a disaster to involve families in the alarm features of all of our technological equipment. However, if an alarm were ringing that no one heard but the family, I would hope they would get help!

"We, as nurses, need to be aware of our patients' needs and any equipment that could be alarming. If we can't keep up with our alarms, then we need to ask for help, or re-think the alarm limit settings and change them, or identify the assignment as problematic because the patient's equipment really is alarming for a true medical reason. I think that it may be frightening to have visitors think that they need to participate actively in the monitoring process by taking action every time an alarm rings. It could instill fear that the staff is not capable. I know—sometimes they are not! What a quandary!"

What can you do as a family member?

1. Ask the nurse to explain the equipment and what it is doing.

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2. Ask the nurse to identify the equipment: "This is the cardiac monitor; this is the IV pump; this is the feeding pump; this is the pulse oximeter", and so on.
3. Ask the nurse to explain the alarms to you.
4. Ask what you can do as a family member to get help when an alarm goes off and what words you should say. For example, it is better to say, "My father's IV pump alarm is going off" than it is to say, "A piece of machinery next to my dad is alarming."
5. Ask for an explanation of the alarms that signify serious, life-threatening changes. Ask the nurse to explain which alarms warn of a life-threatening problem and which ones denote a situation that just needs a bit of attention. There are also lights that correspond to these alarms.
6. Remember that it is better to run into the hall to ask for help than it is to not speak up and watch an avoidable problem develop.

About The Author

Patricia Iyer MSN RN LNCC is President of Avoid Medical Errors. She has 24 years of experience assisting medical malpractice attorneys. She earned her master's degree in nursing from University of Pennsylvania. She has coauthored, edited, or written over 125 books, articles, case studies, online courses, or chapters.

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Father of Fitness, Jack LaLanne

On Sunday, January 23, 2011 an American icon passed away.

Francois Henri "Jack" LaLanne was 96, born in 1914, the same year as my mother. When I heard the news of his death, my mind and heart filled with memories of growing up watching him on TV as my mother religiously followed his exercises. Jack (a nickname from his brother) always had an inspirational message to go along with his exercise regimen - and a song at the end of every program! (My mother passed away in November of 2009 after four years of living with Alzheimer's disease.)

Jack LaLanne's program was my own first exposure both to exercise and to motivational speaking. I believe he really made a difference in getting women to start exercising for their health. He's been called "the godfather of fitness" and the "first fitness superhero." He

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was an evangelist for eating fresh, healthy foods and keeping physically active.

LaLanne published numerous books on fitness and hosted his fitness television shows between 1951 and 1985. In 1936, at age 21, he opened one of the nation's first fitness gyms in Oakland, California, which became a prototype for dozens of similar gyms using his name. His encouragement for the women watching his shows to join one of his gyms was ground-breaking.

Jack actually invented a number of exercise machines, including leg-extension and pulley devices. He also produced his own series of videos.

I feel that Jack LaLanne's most outstanding achievement was to coach the elderly and disabled to not forgo exercise. His belief that it would enable them to enhance their strength has been confirmed by the results of research that have also shown the positive effects of physical exercise on our cognitive functioning.

He preached that anything is possible and nothing is impossible, that we should go seek out the impossible because it's never too late. He promoted hope and self-confidence, not despair and shame.

Jack LaLanne achieved lots of fame for his accomplishments and amazing body. I'd like to salute him for his influence in getting women to be more focused on their fitness rather than just on how thin or beautiful they were. He was a pioneer in this area who has made a difference in the life of every woman living today.

Thank you, Jack, for your dedication!

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About the Author

Suzanne Holman is a speaker, writer, and consultant working with professionals over 50 who are intentional about having the best life possible. Suzanne supports them with strategies for optimizing their brain, staying on course with their goals, and living with gusto. She has particular interest in supporting those who have a loved one with Alzheimer's disease - after traveling the Alzheimer's journey with her mother.

Suzanne has a master's in education specializing in counseling and has been an educator of psychology and technology. She's had extensive coach training through Thomas Leonard's Graduate School of Coaching and the University of Texas, Dallas. Suzanne is also an Emotional Intelligence Certified Coach. Contact Suzanne at http://www.suzanneholman.com

This month's Tip Sheet

28 Tips for Safe Hospital Care by Barbara Levin BSN RN ONC LNCC, Clinical Scholar, Massachusetts General Hospital

> Tip 1: Keep a folder of your loved one's or your healthcare documents. Keep copies of your medical records, including test results.

Get the full set of 28 tips by becoming a member of Avoid Medical Errors Inner Circle. See www.avoidmedicalerrors.com for details.

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A Calorie is a Calorie Is a Calorie

When I was growing up, my mother taught a diet program. She led weekly weight loss meetings in the upstairs sales training room of a Chevrolet dealership across town. Our closet was filled with food scales, recipe books, and calorie charts that she sold in her class.

I never attended a meeting and don't remember having a conversation with her about dieting, but somehow I learned the basics of healthy weight loss by the time I was 13 years old. This was fortunate because, unlike some of my friends who said they had the metabolism of a hummingbird until they were in their mid-20s, mine took a nosedive the minute I hit puberty.

I never remember eating any "diet" meals growing up, but my mother always cooked what was considered to be a healthy meal at the time: meat with one starchy vegetable and one green vegetable.

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Although the meat was often fried, the starchy vegetable cooked with butter, and the green vegetable boiled until the nutrients were all but gone, these factors didn't come into the equation at that time in our nation's health history. Yet even with our dinners of Shake and Bake pork chop, mashed potatoes, and green beans, my mother was never overweight.

Over the years, people frequently told her how lucky she was to be thin. I wish I had paid attention to how she handled this situation.

How do you respond to someone who passes something off to luck that is actually the result of a relatively simple formula? Do you smile politely and stay quiet? Do you nod in agreement and say you were indeed blessed?

Do you instead tell them the truth: that if you eat everything in moderation and maintain a consistent level of activity, a normal human body will settle into a normal healthy weight? Do you say that if they think any differently, they are only fooling themselves?

In theory, I'm a big proponent of truth, but you have to handle it responsibly because most people don't want to hear it. Clients will pay good money to find out how they are sabotaging their own efforts, but people chatting with you in the checkout line, acquaintances you run into around town, or even good friends don't particularly want to hear the truth: that unless you have a medical condition that has hijacked your normal metabolic function, you can lose weight. It's one of the few things I know of in life that is 100% guaranteed. Burn more calories than you consume, and you will lose weight.

If you have a slow metabolism, whether through a sedentary lifestyle, low muscle mass, genetic disposition or yo-yo dieting, you will drop the pounds slowly, but you will lose weight. Except for genetic disposition, these factors are totally within your control.

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The first thing you need to understand about losing weight is that it is all about calories. Aside from some types of food credited with slightly enhancing your metabolism, losing weight has very little to do with the kinds of food you eat. You can lose weight just as well eating ice cream and french fries as you can eating fish and broccoli.

Here's an example. Let's say in order to lose weight Jane needs to cut her calorie consumption down to 1,200 calories/day. She could go on my Candy Bar-Jelly Bean Diet. That's right, she could eat 5 candy bars and 12 jelly beans a day and lose one pound a week without stepping foot in a gym. That's 52 pounds a year!

It's simple math. Most manufacturers standardize their regular-sized candy bar to be around the 230 calorie mark. A gourmet jelly bean has around 4 calories. Add up 5 candy bars and 12 jelly beans, and you come in right around 1,198 calories.

Don't get me wrong. I'm not encouraging you to go on a junk food diet. That wouldn't be healthy. But I do want you to know that when it comes to losing weight, a calorie is a calorie is a calorie. You can eat anything you want and lose weight, as long as your calorie intake is less than your calorie burn rate.

Start by counting the calories going in. The U.S. government requires nutritional labels on all packaged foods. You can look up calorie counts for fresh foods online. In addition, almost every restaurant chain has nutritional information on their web site and some have it noted in their menus.

Then add up the calories you burn. Start with your Basal Metabolic Rate (BMR) which is the number of calories your body needs to keep your brain functioning, your lungs breathing and your heart beating. You can approximate this number by adding a zero to the end of your current weight. For example, a 150-pound woman would have a BMR of 1,500 calories

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per day. This would be the minimum number of calories she should consume each day to prevent her body from going into starvation mode.

There are 3,500 calories in one pound. Burn 500 more calories a day than you consume, and you'll lose one pound a week. It's just that simple.

About the Author

Kimberly Stevens is an author, speaker and coach who empowers clients to break through self-imposed barriers to achieve their most important goals and dreams. In her most recent book, ***"Not Another Diet Book: How to Lose Weight When You Really Don't Want To"***, she shares her passion for health and fitness by providing readers with her unique program for healthy and sustainable weight loss. She writes frequently on topics including diet, fitness, marriage, divorce, happiness, mindset on her blog at www.kimberlystevens.com

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Two Faces of Hospital Care

Hospital care is a mixed blessing. It saves millions of lives every year, but it also kills hundreds of thousands by accident. These aren't people who die because of the illness or injury that brings them to the hospital. These are people who die because of the care they receive once they get there.

Said another way, when your doctor gallops in on his powerful stallion to save the day, sometimes you get run over by his horse.

In order to protect yourself, it is useful to understand what causes these deaths and injuries. Four of the more easily measured problems are:

- medical errors
- hospital infections
- blood clots
- adverse drug events (side effects of drugs)

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Medical Errors

About 200,000 people die each year in this country due to medical error, and one study suggested that about 87% of those deaths are preventable. Common medical errors include:

- use of outmoded tests or treatment
- error in performing an operation or a test
- failure to act when an abnormal test result shows that prompt action is needed
- failure of communication
- equipment failure

Hospital Infections

In addition to death or illness caused by medical errors, about 1.7 million people each year pick up infections while in the hospital. 99,000 die as a result. These are not old people who are so frail and sick that they are going to die anyway. They can be people who check in to the hospital to have, say, elective knee surgery. They check out via the morgue.

Hospital infections are not inevitable. Hospitals in other countries, and some in the U.S., have dramatically reduced the percentage of patients who get them.

How do people get these infections? The main method of transmission is by care providers who don't wash their hands. In fact, only about a third of hospital workers routinely wash their hands before touching patients. Doctors are not exempt. Fewer than half wash their hands if they think no one will catch them omitting this important infection control measure.

More people die from hospital-acquired infections than die from breast cancer (41,000 per year) and automobile accidents (44,000 per year) put together. Said another way, hand washing might save twice as many lives as would a miracle cure that completely eliminated breast cancer.

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Blood Clots

The third way people die from hospital care is from blood clots that form in the veins and then break off and travel to the lungs. These cause about 200,000 deaths per year after surgery or hospitalization for other treatment.

Blood clots are considered so entirely preventable that Medicare, the federal health insurance program for the elderly, often will no longer pay hospitals to treat them. The hospitals have to cover the cost themselves, since they could have prevented the problem.

Even though there are screening guidelines and effective methods for prevention, the incidence of these blood clots is increasing. Most people have no idea that they are at risk, and most people aren't screened or treated to prevent this problem when they are in the hospital.

Adverse Drug Events

The fourth common way to die from the care you are given in hospitals is from the medicine provided to you. Professionals call these problems adverse drug events. These may involve you being given:

- the wrong drug
- the wrong dosage
- a drug intended for a different patient
- a drug that interacts badly with another drug you're taking

About 106,000 people die from adverse drug events in hospitals each year. These are deaths from legal drugs, not street drugs. Some of these deaths might not have been preventable, such as those from a previously unknown severe allergy to a drug ingredient.

However, a national study mandated by the U.S. Congress concluded that 1.5 million *preventable* adverse drug events occur each year. The study went on to say that "a hospital

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patient can expect on average to be subjected to more than one medication error each day." One a day! That's a fine slogan for a vitamin; it's a disturbing one for drug errors.

Action Steps You Can Take

If you are admitted to the hospital:

- Ask to be evaluated for risk of blood clots. If you are at risk, ask your doctor how they will be prevented.
- Ask *everyone* who enters your room—doctors, nurses, clergy, family members—to wash their hands before approaching you.
- Ask your doctors to tell you what drugs and doses they have ordered. Write this information down. Verify that the drugs brought for you match this list.
- If you believe something is going wrong with your care, speak up.
- If at all possible, bring an advocate with you, someone who can watch out for you and ask questions when you cannot.

About the Author

The writer is President and 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*. The information in this article is adapted from *Killer Cure*. Feel free to visit www.killercure.net

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Constance Barrett

You the Healer:

An Introduction to Self-Healing

The basic premise of this article is that all imbalances stem from our separation from our inner selves, that part of ourselves which is connected to universal and infinite wisdom.

Inner awareness is unaffected by the pressures of the outside world. These pressures may include circumstances, the impact of other people, or the efforts we make to meet external expectations. Our inner awareness always tries to guide us on the path of happiness. This guidance may show up in many ways: unexpected opportunities, sudden insights, or dreams that offer enlightenment.

When we follow this guidance (called intuition by some), we feel good. When we don't, we don't feel so good. We may experience anxiety, guilt, anger, resentment, and a range of other negative emotions. While these emotions are

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intended to help us recognize that we've gone astray, we need to pay attention to them in order to understand these cues.

The person who is unhappy in a marriage or partnership is ignoring his inner guidance if he doesn't either work to create change within the relationship or leave it. Someone who automatically goes to her job day after day in a spirit of frustration and boredom is also suppressing the inner messages that call for change. The child who has learned to take her direction from those who are older and allegedly wiser paves the way for future unhappiness.

Untended negative emotions, like untended gardens, produce tangles of weeds. In emotional terms these are blockages. If blocked emotions accumulate, illness may result.

Asking and Receiving

Our inner guidance never stops trying to direct us. If we don't pay attention to the emotional symptoms of imbalance, our bodies will give us stronger messages in the form of physical symptoms. If these are severe enough, we have to listen, but our responses don't always put us back in balance.

I'm not speaking against medical, surgical, or pharmaceutical treatments. Sometimes these interventions can alleviate both physical distress and the negative emotions that accompany them. By breaking the cycle of pain, suffering, and anxiety, we may be able to address the underlying emotional imbalance. However, if that imbalance remains unaddressed, either the old symptoms will reoccur or new ones will develop.

A neurologist recently told a friend of mine that he believes a positive attitude is essential to healing. Many members of the medical profession echo this belief. Finding a practitioner who will work with you on all levels of healing or encourage your independent pursuit of alternative methods can help you return to the path of wellness.

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In the end, no one else can interpret your inner guidance. Only you have that ability.

Your Body Wants Wellness

Your body's natural state is that of balance. When it's out of balance, every cell asks for healing. To respond to this desire is one of the most important elements of healing. A simple prayer like "Body, please help me get well" or an affirmation like "I join my body in a healing partnership" can have great results.

About The Author

C.M. Barrett does flower essence counseling for people and pets, including by email. She is the author of several email courses about health from a psychological viewpoint. She is the author of *Big Dragons Don't Cry*, a fantasy. Her web sites are http://www.adragonsguide.com and http://eftconsultations.com

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cardiopulmonary conditions or other chronic diseases.

Sarah Jean Fisher
MSN, RN-BC, BA

To Flu or Not to Flu

Are you or your parents at risk for dying from influenza? In the United States, annual epidemics of influenza typically occur during the fall or winter months, but the peak of influenza activity can occur as late as April or May. Influenza-related complications requiring urgent medical care can result from the direct effects of influenza virus infection, from complications associated with age or pregnancy, or from complications of underlying

Studies that have measured rates of a clinical outcome without a laboratory confirmation of influenza virus infection (e.g., respiratory illness requiring hospitalization during influenza season) can be difficult to interpret because of circulation of other respiratory pathogens (e.g. respiratory syncytial virus) during the same time period. However, data from the U.S. Outpatient Influenza-like Illness Surveillance Network (ILINet) demonstrate that increases in healthcare provider visits for acute respiratory

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illness with fever occur each year during the time when influenza viruses circulate.

According to the CDC *Morbidity and Mortality Weekly* of August 6, 2010, “Persons aged 85-years-old or older were 16 times more likely to die from an influenza-related illness compared with persons aged 65-69 years.” The 2009 influenza A (H1N1) is expected to “continue to occur during future winter influenza seasons in the Northern and Southern Hemispheres.” Does that mean that if you are over 85 years old, you should take the 2010 vaccine? Does it also mean that if you are 20 years younger, you don’t need to take the vaccination because you probably won’t die from the flu? What flu vaccine advice should you give your elderly parent?

There are two kinds of flu vaccines.

1. The 2010/11 trivalent flu vaccines contain A/California/7/2009 (H1N1)-like, A/Perth/16/2009 (H3N2)-like, and B/Brisbane/60/2008-like antigens. The influenza A (H1N1) vaccine virus is derived from a 2009 pandemic influenza A (H1N1) virus.
2. A newly approved trivalent inactivated vaccine (TIV), Fluzone High-Dose by Sanofi Pasteur, is an alternative vaccine recommended for persons aged 65 years or older. Persons aged 65 years or older can also receive any of the standard-dose TIV preparations. The CDC recommends that persons younger than 65 who receive inactivated influenza vaccine should also receive a standard-dose TIV preparation. You can view specific recommendations and other information at the CDC’s website http://www.cdc.gov/flu.

The CDC has found that hospitalization rates during typical influenza seasons are substantially increased for persons aged 65 years or older in comparison to younger age groups. If you or your parents have chronic

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medical problems, you may be at risk for flu-related complications. One study based on data collected during 1996-2000 from managed-care organization, estimated that people aged 65 years or older with underlying conditions that put them at risk for influenza-related complications, had 560 influenza-associated hospitalizations per 100,000 (0.5%) persons, compared with approximately 190 per 100,000 healthy persons younger than 65 years (0.1%). Persons aged 50-64 years who had underlying medical conditions were also at substantially increased risk for hospitalizations during influenza season, compared with healthy adults aged 50-64 years.

Influenza is an important contributor to the annual increase in deaths attributed to pneumonia that is observed during the winter months. During 1976-2001, an estimated yearly average of 32,651, 90% of influenza-related deaths occurred among adults aged 65 years or older, with the risk for an influenza-related death highest in the oldest age groups. Persons aged 85 years or older were 16 times more likely to die from an influenza-related illness compared with persons aged 65-69 years.

Are there medications that can reduce the severity of flu symptoms? Antiviral medications (Tamiflu, Oseltamivir, Symmetrel, Rimantadine) can be used for treatment and have demonstrated that they reduce the severity and duration of illness, particularly if used within the first 48 hours after the onset of illness. However, antiviral medications are simply adjuncts to vaccines in the prevention and control of influenza. Primary prevention through annual vaccination is the most effective and efficient prevention strategy.

Wash those hands! Handwashing reduces detectable influenza A viruses and reduces the overall incidence of respiratory diseases. However, the impact of such hygiene interventions on influenza virus transmission is not well understood, and hygienic measures

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should not be advocated as a replacement for vaccination.
Financial considerations, lack of medical coverage and fear and hatred of needles are other reasons why some elderly people do not receive the flu vaccine. It all boils down to priorities and how one considers non-health related issues in the scheme of things. I hope you make the right decision. Remember, others can be affected if you choose not to get immunized.

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, and long-term care has been her only focus. She has worked as charge nurse, shift supervisor, and has been doing staff development/infection control for the past 8 years. She has presented original programs at the annual National Gerontological Nursing Association (NGNA) Conference and was the founding President of the Southeast Pennsylvania Chapter of NGNA. Sarah Jean has also worked for four years as a geriatric nurse expert with Med League Support Services reading and evaluating medical records for attorneys related to potential litigation. She is a widow with four grown children, 11 grandchildren and her first great-grandchild. She can be reached at sjf94@comcast.net

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Meditation – The Antidote for Stress

What are the Benefits of Restful Awareness or Meditation?
There are two kinds of deep rest. The first is restful sleep, in which both the body and the mind are at rest, and we have very little awareness. The second is restful awareness, a state where the body is in deep rest, but the mind is still alert. The best way to achieve the state of restful awareness and its benefits is through the daily practice of meditation. Although in Western culture we commonly think of meditation as a tool for stress management, meditation has many other benefits. Meditation enhances creativity and enlivens the natural healing and rejuvenating systems in our bodies.

What Is Stress?
We experience stress anytime we encounter an obstacle to the fulfillment of our needs or desires. Stress triggers the most primitive part of our involuntary nervous system, and our body responds with what is commonly known as the fight or flight response. Walter Cannon,

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an early 20th century American scientist, first described the fight or flight response. Its original purpose was to help us survive in threatening situations. In situations that genuinely threaten our lives, it still serves that purpose.

However, stress in our daily lives triggers an inappropriate fight or flight response. When we do not have a way to release this stress, it will eventually accumulate in our bodies and can lower our immunity and cause disease (dis-ease). Some of the results of experiencing prolonged or accumulated stress are accumulated toxins, elevated blood pressure, autoimmune diseases, heart disease, cancer, stomach ulcers, insomnia, anxiety, and depression.

What are the physiological responses of the fight or flight response?

- Increased heart rate and blood pressure
- Shallow and rapid breathing
- Sweating
- Sticky blood platelets
- Increased production of hormones by the adrenal glands: adrenaline, cortisol and glucagons
- Decrease in the production of HGH (growth hormone), insulin and sex hormones
- Suppressed immune system

What is Restful Awareness?

The state of restful awareness or meditation produces physiological responses that are the opposite of the fight or flight response. This is why meditation is often referred to as the antidote to stress. What are the physiological responses during meditation?

- Your heart rate decreases.
- Blood pressure becomes normal.
- Breathing slows and becomes more efficient.

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- You perspire less.
- Your adrenal glands produce fewer of the hormones adrenaline, glucagons, and cortisol. The last is known as the stress hormone.
- Your pituitary gland produces more growth hormones (HGH is known as the anti-aging hormone), and you produce more sex hormones.
- Your immune system is strengthened.

Meditation provides a way to release stress and eliminate toxins. When the mind settles down in a state of restful awareness, the body also settles and gets a deep level of rest. Rest is nature's way of restoring and rejuvenating the body and enlivening its self-healing systems. Meditation's benefits have been well established and accepted by the medical community. Meditation is for members of the mainstream world who are looking for tools to experience more health, well-being, and balance in their lives.

Kay Rice, M.Ed., C.N.
Exercise Physiologist, Certified Nutrition Coach, Chopra Center Certified Instructor & Vedi Master
Yoga Alliance E-RYT 200, Licensed Corporate Wellness Coach – www.KayRice.com

Kay is a Primordial Sound Meditation Instructor & 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 (PSM), please contact Kay at kay@kayrice.com or visit her website, www.kayrice.com

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Aila Accad RN, MSN

The Impact of Physical Health on Mental Acuity and Medical Errors

Mental acuity is essential for maintaining safety in medicine. Accuracy in performing specific processes and procedures is essential to safe practice. This requires continuous presence of mind.

We are not a composite of separate parts--mind, body, and spirit. All our parts work together as a whole. A clear, well-functioning mind requires physical health and stamina. One does not exist without the other. There is a high correlation between fatigue and medical errors.

The information in this article is vital. It could save someone's life. Are you a caregiver for someone else? For example, do you give your elderly parent medications or prepare a week's supply? Do you give your child medications?

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Your own state of health can put you at risk for making errors in the care of another.

Mental acuity decreases if you are tired, if you have not had breakfast, or if you are eating a diet high in sugar or salt. Stress and a high adrenaline level may seem to sharpen the mind on a short-term basis, but on a long-term basis it has a deleterious effect on the body and mind that can result in preoccupation, depression, and low energy.

To increase mental acuity and accuracy and decrease the risk of medical errors, it is essential to pay attention to your overall physical well-being. The body requires six elements to stay well: water, air, nutrition, sun, rest, and movement.

As a healthcare provider or personal caregiver, sometimes you are the last person that you think of caring for. You're taking care of your patients, your family, your children, spouse, mom, neighbors, but who takes care of you?

Do you take the time to assure that you incorporate these six elements in your daily health routine?

Unless you put yourself on the list of the people you care for, eventually your physical energy resources begin to dwindle. As physical resources are depleted, mental functioning loses the sharp edge necessary for safe practice. Think of taking care of yourself as the foundation of your mission to care for others.

Finding simple ways to habitually incorporate the six essential elements into your daily routine will keep your energy and alertness high throughout even the most strenuous days. Here are a few suggestions.

Air: Take a deep breath periodically during the day. When you have a break, take a moment to go outside and get some fresh air. This will help you to clear your mind and be more accurate.

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Water: Be sure to drink plenty of filtered water continuously and especially when you feel tired. The medical environment has high concentrations of chemical toxins. Water helps to cleanse these toxins from your system.

Nutrition: When you get a short break or lunch, eat something nutritious, like a fresh green or spinach salad with nuts and seeds. If you tend to skip lunch, keep a supply of high-energy snacks handy to grab on the go. Include unsalted nuts, seeds, dried berries, raisins, or other dried fruits, or natural foods you like. These foods provide nutrients that can improve mood and mental acuity.

Rest: On a break, opt for taking a ten-minute power nap. If you have learned to meditate, a few moments of meditation or that short power nap will clear your mind and increase mental focus.

Movement: Exercise energizes. Taking a brisk walk when you have a break, around the halls or ideally outdoors, even for a few moments, can improve energy and clarity.

Sunshine: The body converts sun to vitamin D, another essential vitamin for healthy mental function. When the sun is shining, be sure to get about 10-15 minutes of direct exposure. Allowing your body to feel the warmth and uplifting effects of the sun has numerous benefits. Supplements can be an alternative to direct sun when getting sun is not realistic.

You can efficiently combine these activities by taking deep breaths while you walk in the sun. Finish with some raisins, seeds and nuts. These few minutes will allow you to resume your duties, feeling physically refreshed, invigorated and mentally alert. The more conscious you are of taking care of your physical health, the more mental sharpness and clarity you will notice.

Put yourself on the list of the people you care for. In fact, put yourself on the top of the list,

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because it is only through your own health, stamina and mental acuity that everyone else you care about will be better served.

About the Author
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Stress Busters, Quick tips to de-stress fast with no extra time or money" is available at www.stressbustersbook.com

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Dean Dobkin MD

Picking the Doctor

You're pretty sure it's not anything exotic. You've got a fever or a cough, and you don't want to be seen by residents and interns and medical students. You don't feel well; you just want to get better.

Talk to your doctor. If you don't have a doctor, or you're out of the area, consider the local hospitals. You don't want to go to anywhere that's tiny, unless they have a strong affiliation with a large hospital or medical center nearby.

For example, your belly hurts. It ends up being appendicitis, gallbladder disease, or diverticulitis. A hospital that has too few beds, patients, and doctors may not have a proper emergency physician to see you and may not have proper specialty surgical care available. In an unfamiliar hospital you don't know whether you'll see their best or their worst doctors.

Ask Questions

Normally, you can try to select a doctor based

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on a few different questions and qualities. Bad doctors aren't tolerated by groups of physicians. If a doctor is in a group, it's a good sign. If he practices alone, it might or might not mean anything.

Is the doctor board-certified in the field? That's an important question. It's not that all good doctors are board-certified, and all bad doctors are not, but it's one of the few objective yardsticks you can use.

Board certification in a particular field of medicine means the doctor has taken prescribed training, generally lasting 3 to 7 years, and passed a standardized, national examination. If the doctor who sees you is not board certified, you're well within your rights to ask if he's taken the boards and how many times. If he or she hasn't taken the boards, ask why not. These questions are appropriate for the ER doctor and any surgeons or specialists assigned to your case.

How do you do that? You ask, "Are you board certified?" If the ER doctor is calling someone in, ask him if the doctor is board certified. He can find out if he doesn't know.

Would you choose an accountant who wasn't certified, a lawyer who failed his bar, or a plumber who didn't have a license? Why settle for someone who can't pass the standardized examination in his chosen field of medicine?

Is it rude? It's your health and your right. You've never met the person before, and it is a question that makes sense.

While you can request a doctor who is board certified, you might not get one. You might accept the reason someone is not boarded. She might say, "I graduated last June and take the exam in September." You will decide if you can live with that. An ER doctor might say, "I have practiced in the ER for fifteen years but am not eligible to take the exam because I didn't have a residency." Lots of good doctors

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will give you that answer.

For a specialist, only the first answer above makes sense, because all specialists go through a residency. So what do you do? You can request a board-certified doctor, which you may or may not get. You can request a transfer. This can also get sticky. Often you need to know someone at the hospital to which you want to go. If the hospital advertises, though, they usually want patients. Arrangements often may be made through a "transfer center" at the receiving hospital, or through the ER doctor.

If you are at a small hospital that is a "satellite"—a feeder hospital for a larger facility—the hospital will usually require its physicians to achieve board certification. In addition, the smaller hospital is often used to transfer patients to the larger hospital.

Other Criteria for Choosing a Doctor
Talk to the doctor. Decide whether you think the doctor seems intelligent, caring, and "on the ball." It's like interviewing anyone else, except that your life or health may depend on how well you can judge. Sometimes you can seek a recommendation, but usually the staff at a hospital's emergency department is obliged to refer you to the doctor on call.

Nothing prevents you from asking the ER doctor or the staff, "Do you use that doctor? Have you or a member of your family used that doctor?" Ask the ER nurse, “Is this a doctor you trust?” Nurses who are familiar with the doctors on staff usually have well-informed opinions about their capabilities and communication skills. They have experience interacting with the physicians, are familiar with their personalities, and know whether the physicians treat the nurses as subservient or as part of the team.

Sometimes you just have no choice. You hope for the best. Possibly you'll have a family

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member who can scout for you, and you consider what else you can do. If you're being admitted, and you're not all that happy about the doctor who is admitting you, you may ask for a different doctor. Speak to the ER physician, ER nurses, or nursing supervisor to get a recommendation. Depending on your medical problem, you may also need a specialist from cardiology, surgery, neurology, pulmonary, or another field. Your attending physician will request the help of these specialists.

How does that help? Your primary doctor—the one to whom you are admitted, via the ER—may be mediocre, but if 4 or 5 doctors are on your case, chances are that there's enough combined brainpower to assure you good care.

About the Author

Dean Dobkin, M.D., is a practicing emergency physician at the Philadelphia Veterans Affairs Medical Center. 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. He has developed, directed, or served as faculty for approximately one hundred emergency medicine courses. Dr. Dobkin lives with his wife and family in southern New Jersey. He testifies as an expert witness in emergency medical care.

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Theresa Healy RN

Theresa's Journey to Health: Part I

Back in 1990, one of my sisters started eating a funny diet she called macrobiotics. She said it was for healing cancers. Although she didn't have cancer, it was known to heal in general. After months of observing her health improve, and listening to her insist I try the diet too, I decided to give it a try.

My intention was more to prove to her that I didn't need the diet than to really learn it.

My appointment with the nutrition counselor went well, produced a 6-month commitment to her program, and a promise to be compliant and follow her instructions, despite my true intentions. When she informed me that I had a wheat and dairy allergy, I was sure I could prove her wrong. How could this be accurate? These were the foods I grew up with and was still eating.

I did not believe her, as it made no logical sense to me. An allergy? From my medical perspective, if you have an allergy to something, you manifest it with hives, difficult

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breathing, and impending death. I did not experience any of these symptoms when I ate wheat or dairy. Nevertheless, I listened intently to her instructions.

It was a daring and daunting plan, but I began the journey. I really didn't have any previous experience in cooking, and I had never heard of many of the foods I was told to eat. However, I set out to buy the tools: pressure cooker, steamer, tea diffuser, and wooden spoons, and the food: brown rice, seaweed, beans, burdock, and kale. I burned many pots before I learned how to cook the food.

Having never used a pressure cooker, I initially feared that it would explode and spray beans and grains all over the kitchen. This fear gave way to fascination with the delectable results of new flavors and tastes.

Initially, I could not imagine how I would ever be able to eliminate my favorite foods: cheese, soda, bread, and ice cream. But it was only for a few months, right? I believed this wasn't going to make any difference in my life, and I would resume my usual diet when done.

After the first few days, the real journey started. When you go into a change of diet, full board like I did, and change everything at once, you will detoxify quickly–and miserably. This I was not prepared for.

I drained mucus from every orifice of my body. I was sneezing, coughing, and just continuing to drain, drain, drain. Many coworkers would comment about my cold, and I will admit that many days I was feeling so bad, like I was having the flu: body aches, sweating, low energy, headaches and real brain fog. I wasn't sleeping well and was an emotional basket case.

Many days, I didn't want to continue. I just wanted to give up and go back to what I used to do. After all, I wasn't feeling bad before I started so why did I start this silly journey? But my sister and my nutrition counselor kept me going by cheering me on. They promised that

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this would all pass soon. They told me I was “cleaning out” and detoxifying my entire body from years of poor eating and drinking. Some days I felt like screaming because I wanted a soda so badly.

For 3 months I sneezed, coughed, pooped, slept, and drained mucus from everywhere. After 3 or 4 months the symptoms changed and suddenly I felt better! The drainage stopped, and body aches went away, and my PMS went away. I no longer suffered from bloating or gas, and did not have unbearable cramps when I would go to the bathroom. The world seemed clearer and brighter and the food began to really taste good. My skin cleared, and my energy level was better than ever. Cravings stopped, I no longer longed for a soda, and tea became my comfort food.

People started asking me what I was doing because I looked so good, my skin looked brighter, and they stated I was really losing weight! The weight loss suddenly happened and I wasn’t even aware of it until someone told me about it.

I did lose between 12-15 pounds.

Coworkers had started asking me about what I was eating, but now they were really interested in what it was because they could see a change. People would comment on my more stable and elevated moods, and my physical appearance. I was barraged with questions on a daily basis, especially when I continued to pass on the usual sugar-filled, fat-laden, chemical-filled, processed foods that are always available in the nurse’s lounge. They asked about it, but only a rare few would ever want to REALLY hear it, or taste it!

So, the 6 months came to an end, and my nutrition counselor was as excited as I was about my newfound health and wellness level. I told her I was excited because now I could go have a piece of pizza, which is the one food I still really missed. Obviously, after all this time, I still wasn’t “getting it”. She told me I could do

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that, but I wasn't going to like how I would feel after eating that pizza. She could not say what exactly would happen, but she was pretty sure it would not be pleasant.

Once again, it was she who was right. The pizza tasted so good, as I ate it. But, within 30 minutes of eating 1 piece, I began with a headache, started sneezing, had body aches, and just wanted to sleep. I was really surprised by this clear and obvious and unpleasant reaction to a food! Needless to say, I finally "got it."

My body was not happy when I ate these foods. I now knew, I would not continue to consume them.

About the Author

Theresa Healy is the founder of **Rx: Food - Let Food be Your Medicine**, and coauthor of ***11 Weeks to Discover Nutrition***. She has been a registered nurse for more than 25 years. In 1990, with the emergency of her own health challenges, she met a nutrition counselor. Using food as medicine and experiencing the benefits of eating fresh whole foods, she realized there was a void in our healthcare system's approach to health. She entered alternative and complementary medicine. Theresa is certified as a health counselor from the Institute of Integrative Nutrition and Columbia University. She also has certification as a colon hydrotherapist, and a Chelation and IV Therapy Technician. Theresa's passion continues to be of service and guiding people to be happy and healthy through food and lifestyle. She believes that health and well-being depends upon both good nutrition and healthy lifestyle. Theresa is available for company wellness programs, youth programs, group and individual counseling, and educational talks. Reach her at Theresa@theresahealy.com

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Too Sleep Impaired To Operate?

"You promised. You promised me. I cannot wait any more," the full-term pregnant woman wailed. Her obstetrician replied, "I know you have been waiting, without food, for hours. We have worked hard to get this baby for you, and it is safer to wait until tomorrow. I have been in the operating room since 3 a.m. with a difficult case. I am exhausted. This is no time for me to do more surgery and look after you and your baby. You will be my first patient tomorrow."

This is the real conversation between my wife and her obstetrician "planning" the cesarean section for our third child. A secondary benefit to this "safety" discussion was that the baby would be born on April 2nd, rather than April 1st! The year was 1978, more than 30 years ago.

The question of good surgical practice in regard to sleep deprivation and surgeon exhaustion has been around for a long time. Although objective data are nice to have, and

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may be confirmatory, they are not needed to resolve these issues. Experience, common sense, and consideration for social responsibility are all that is needed.

A recent *New England Journal of Medicine* (NEJM) article highlighted the issue of sleep-deprived surgeons. It made the point that the working hours of medical residents in their first postgraduate year are restricted to a maximum of 16 hours of continuous work followed by a minimum of 8 hours off duty. http://www.nejm.org/doi/full/10.1056/NEJMp1007901 - ref2 There are no such regulations for fully trained physicians. The risks of operating on patients when sleep-deprived can be compared to the risks of driving while intoxicated (DUI). In surgery, there is an 83% increase in the risk of complications (e.g., massive hemorrhage, organ injury, or wound failure) in patients who undergo elective daytime surgical procedures performed by attending surgeons who had less than a 6-hour opportunity for sleep during a previous on-call night.

The article recognizes that many patients would prefer to change surgeons or postpone elective surgery if they knew their surgeon was sleep-deprived. Surgeons and hospitals may lose money when procedures are cancelled. However, the authors stressed the ethical obligation of surgeons to inform their patients of the risks and the responsibilities of the hospital to enforce policies about not operating when sleep-impaired.

The recent NEJM article on this subject makes useful recommendations, but it could have gone further. The management of practice patterns is neither the sole domain of the individual surgeon nor only a matter of the profession providing advice and guidance. Speaking as a surgeon, I believe we increasingly need senior hospital management and the boards of directors of institutions to more fully face their social responsibility to act

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in the public interest. In an era when much professional behavior is shrouded in unnecessary and self-serving secrecy, it is essential for boards of directors to more fully accept that an important part of their role to society is on behalf of the community they are required to serve.

If these premises are accepted, then boards of directors, through their senior management, should establish clear and unambiguous Standard Operating Procedures (SOPs) about the rules concerning "on-call" hours and associated clinical conduct. These must cover the common eventuality of physician sleep deprivation and exhaustion in regard to continuing clinical practice in general and the needs of the operating room in particular. These conditions should form part of the contractual, and therefore legally binding, relationship between the surgeon, the institution and the patient.

Fixing the Problem

1. A surgeon who is on call for a hospital must not have on-call duty or patient clinical activity in another hospital for the total period involved.
2. A surgeon should not arrange elective surgery following a 24 hour on-call period.
3. A surgeon should not undertake elective surgery when, during the previous night, he/she has not had an appropriate period of rest (probably 6 hours - to be defined), or if, for any reason, the surgeon feels exhausted.
4. If there are circumstances in which sleep deprivation or exhaustion have occurred, and the surgeon feels the need to operate on an elective patient, the patient should be so informed. Both parties should be required to sign an informed consent document before surgery commences (as recommended in the NEJM article).

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5. A parallel set of SOPs could be developed to consider the need for urgent/emergent surgical interventions when the surgeon is sleep - deprived or exhausted.

Part of our professional responsibilities as surgeons is to make sure that we are all involved in "clinical outcome improvement". Arranging for this surgeon performance issue to be addressed at individual, professional, and institutional levels would be a step in the right direction.

Tips for a Patient

What can you do as a patient or potential patient to avoid being harmed by a fatigued surgeon? Some suggestions:

1. Call your local hospital or surgicenter's senior administrator, such as the chief operating officer, and ask for a copy of the hospital or surgicenter's SOP for on-call requirements which address sleep deprivation and physician exhaustion issues.
2. Ask your local community (political and religious) leaders to discuss these questions and to seek dialogue with local hospital leadership.
3. Call any member of your hospital board of directors who you might know for a discussion about surgeon exhaustion.
4. Ask your surgeon about "on-call" requirements, and if he or she carries out elective surgery after being "on-call."
5. If your own surgery gets "delayed" for any reason, you are entitled to know those reasons. Ask! If it seems that the surgeon may be sleep-deprived or exhausted, insist on discussing your concerns with the surgeon.
6. If necessary, use your ability to say no. Withdraw your informed consent for the surgery until your concerns have been addressed to your satisfaction. The staff cannot begin your operation without your consent. Remember there are risks

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associated with being operated on by an exhausted surgeon.

For those surgeons who are already conducting their clinical practice with these concerns in mind, there would be little to change. Others must become aware that patients and society need mandates for our protection.

Source of *New England Journal of Medicine* article: http://www.nejm.org/doi/full/10.1056/NEJMp1007901

Surgeon L. Peter Fielding, MD

Guest columnist L. Peter Fielding, MD FACS FRCS received his medical degree from the University of London (with Honors) and Advanced Surgical Training in Gastrointestinal Surgery. He is a Fellow of the American College of Surgeons. He holds or has held senior academic appointments in the role of Clinical Professor of Surgery at Yale, Rochester, U Penn and Penn State Universities.

As a clinical and academic general and colorectal surgeon, he has experience in these fields as well as advanced wound care and hyperbaric medicine. As Chief of Surgery and Surgical Residency Program Director, he has had responsibility for the general management of pre- and post-operative care in surgery.

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This month's Avoid Medical Errors Inner Circle Interview

Learn how a series of medical errors devastated a healthy woman who went into the hospital for a minor same day surgery

Hear the story from the nurse/daughter who witnessed the events

Learn how this woman's story made care safer for all patients in Joint Commission-accredited hospitals

Gain practical tips for a safer hospital stay

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