ACCESS Health

Men and Andropause

By: Barbara A. Anderson; Ch. 4: Cultural Scripts and Men's Reproductive Health; p. 44-45.

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Disabled men must find ways to express their masculinity while facing stigmatizing disabilities. Illness and disability, as indications of weakness and vulnerability, "can reduce a man's status in masculine hierarchies, shift his power relations with women, and raise his self doubts about masculinity" (Charmaz, 1995, p. 268). Although many disabilities do not physically prevent an active sexual and re productive life, social messages about incapacity may discourage men from exploring their potential. The effects of shame and denial surrounding disabilities and sexuality can even begin with birth. Although most doctors discuss issues of diminished fertility with the parents of children with cystic fibrosis, they are not comfortable with this discussion. They report ***embarrassment, insufficient time,*** **difficulty in finding the right time, and insufficient training** as barriers to family education (Sawyer, Tully & Colin, 2001). If the community, family and sexual partner all share responsibility in enabling the disabled man to express his sexuality, then health care providers need specific training in content and counselling.

Men, like women, experience a climacteric in mid-life as part of healthy aging. Some researchers prefer the term ANDROPAUSE to describe the gradual decline in testosterone levels in middle-aged men. Indicators on ANDROPAUSE may be physical and/or emotional, such as decreased beard growth, muscle, and bone mass, and increased body fat, mood swings, depression, and ED (Mayo Clinic, 2003a). Male menopause may hinder many of the

Inside this issue:

core performances of masculinity – strength, confidence, and virility. Conversely, in most cultures men gain stature and status with age. Decision-making power and social influence may reach their peak as a man enters the period of ANDROPAUSE.

Health education messages targeted toward aging men need to focus on prevention and screening for chronic illness, mental health strategies for maximizing the quality of life and sexual expression and the active continuation in social and productive activities. Approached need to be tailored to the needs of men as shaped by culture, resources and positioning in the life course (Collumbien & Hawkes, 2000; Forrest, 2001; Hawkes & Hart, 2000). The willingness of men to share responsibility for successful aging is crucial. For many aging men, like their female counterparts, the ***second half*** offers relief from family responsibilities and the opportunity to explore new directions and interests

Benefits Available to People With Disabilities After Age 65

At age 65 the Ontario Disability Support Program terminates and is replaced by Federal and Provincial Government income plans. These plans are not designed exclusively for people with disabilities but are being described in that context only. The Income Plans are:

- Canada Pension Plan: If the person with a disability has worked in the past then he may be eligible to the Canada Pension plan. The amount of pension benefit will be determined by the amount of contributions made and length of time over which contributions were made. However, most people with disabilities will not have worked and therefore will not be eligible.

- Old Age Security (OAS): The OAS is a Federal Government program which is limited by the total annual income that is received. The income amounts are reviewed four times per year and are adjusted based on the Consumers Price Index (CPI). Individuals with income above a certain lever ($66,377 2009 amount) will begin to have their OAS payments clawed back at the rate of 15% of the excess. In September 2012, a single person with no other income can

receive up to a maximum of $544.98 per month. The maximum amount will be reduced based on other income received by the person, however, Registered Disability Savings Plan withdrawals are not considered income for this purpose.

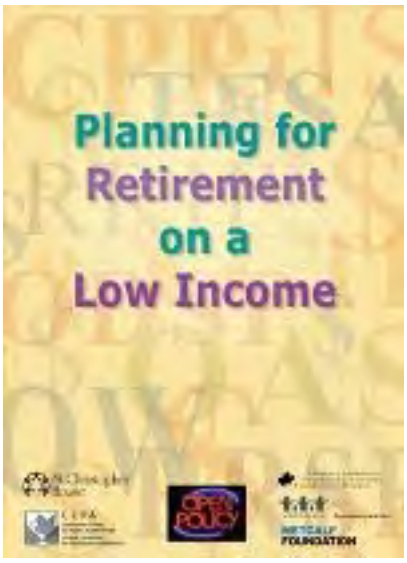
- Guaranteed Income Supplement (GIS): The GIS is also a Federal Government program available to low income individuals over the age of 65. It is in addition to the OAS and is designed to Atop up@ the earnings of seniors in Canada. It too increases based on the CPI and is reduced by formula based on the additional income. A single person with no income other than the OAS would be entitled to $738.96 per month in September 2012.

  EXAMPLE: Single person with no other income would receive:

Old Age Security	$544.98
Guaranteed Income Supp.	$738.96
Total Monthly	$1283.94

- Guaranteed Annual Income System: (Ontario Only) In addition to the OAS and the GIS, the Province of Ontario has instituted the GAINS program. The intent is to increase the minimum income for senior residents of Ontario to specific levels. The Guaranteed Minimum Income amount for a single person is $1366.94. The application of the GAINS program for a single senior in Ontario results in:

Old Age Security	$544.98
Guaranteed Income Supp.	738.96
GAINS	83.00
Total Monthly	$1366.94



Additional Benefits:

- Ontario Drug Benefit: People over the age of 65 are covered under the ODB for many prescription drugs. The covered drugs are listed in the Ontario Government=s Formulary. Drugs that are not listed may be covered based on a case by case examination by the director of the program under the Exceptional Access Program. If the person=s income is greater than $16,018 per year then a $100 deductible applies. If the person=s income is less than $16,018 then a $2.00 per prescription may apply. People receiving OAS, GIS and GAINS funding as of September 2012 receive $16,403 per year and so would not qualify for the $2.00 per prescription amount.

- Assistive Devices Program: The ADP is a Provincial Government program that assists in the purchase of equipment. Devices covered by the program are intended to enable people with physical disabilities to increase their independence through access to assistive devices responsive to their individual needs. The program continues after age 65 and generally covers 75% of the cost of the acquisition of the device. Items like mobility devices, respiratory products and hearing aids are covered. For Seniors, the program will also cover 100% of the cost of Oxygen required for respiration.

- Property Tax Relief for Low Income Persons With Disabilities: If a disabled low income person, senior or otherwise, is faced with increases in his property taxes resulting from Assessment Reforms, municipalities are required to defer or cancel the increase or provide other relief.

- Attendant Outreach Program and Self Managed Attendant Services: The Ministry of Health continues its attendant care programs to help people with disabilities live independently at home after age 65.

Powers of Attorney: Frequently Asked Questions

How is a power of attorney for personal care or property properly executed?

A valid power of attorney must name the person you have chosen to act on your behalf, must be signed and dated by yourself, and must be signed and dated by two witnesses who saw you signing the document. The two witnesses **cannot include**:

- Your spouse, partner, child, or some one you treat as your child;
- The person you are naming as your attorney or their spouse or partner;
- Anyone under 18 years of age; or
- Anyone who is incapable of making their own property or personal care decisions.

Power of Attorney for Personal Care

Who can I name as my attorney? For a power of attorney for personal care, you can name almost anyone as your attorney, including a family member or a personal friend. However, it is extremely important that you choose someone you **trust**.

Who cannot be my attorney for personal care? You cannot name someone as your attorney if they are paid to give you health care or residential, social, training or support services, unless the person is also your spouse, partner or relative. As well, those under the age of 16 and those who are mentally incapable themselves cannot be named as your attorney.

When does a power of attorney for personal care take effect? A power of attorney for personal care only takes effect if you become mentally incapable of making your own personal care decisions. In other words, the attorney **cannot** make personal care decisions for you until you have been found to be mentally incapable.

For treatment decisions, the health practitioner proposing the treatment must decide if you are capable of making the required decision.

For decisions about admission to a long-term care home or personal assistance services in a long-term care home, an “evaluator” must determine whether you are capable of making the required decision.. Evaluators are nurses, doctors, occupational therapists, physiotherapists, psychologists, some social workers, speech language therapists, audiologists or anyone else prescribed by regulation.

If the decision is about shelter, clothing, hygiene or safety, it will be up to your attorney to decide whether you are mentally incapable of making the required decision unless you say otherwise in your power of attorney for personal care. Therefore, if you want a different person to make this decision, you can name someone else in your power of attorney to confirm that you are mentally incapable. The person does not have to be a health professional or anyone with any specific training. It could be a specific person (your Aunt Martha) or a class of persons (your family physician).

If you state in your power of attorney for personal care that you want your mental incapacity confirmed but do not specify by who, it will be confirmed by a “capacity assessor”. A capacity assessor is someone who is specially trained and approved to determine mental capacity.

Can I dispute a finding of incapacity? If you are found to be incapable of making a decision about your capacity respecting health treatment admission to a long-term care home or personal assistance services in a long-term care home, but you disagree with that finding, you can apply to the Consent and Capacity Board to review the finding of incapacity. If the finding of incapacity is not in one of these three areas, there is no review process set out in the law.

When does my power of attorney end? Your power of attorney ends when:

- You die;
- Your attorney dies, becomes incapable, or resigns (however, this can be prevented if you name more than one attorney or if you name a substitute attorney);
- A court appoints a guardian of the person for you;

- You sign a new power of attorney for personal care while you are still mentally capable; or

You revoke the power of attorney while you are still mentally capable.

Power of Attorney for Property

Who can I name as my attorney? The only legal requirement when choosing an attorney for property is that he or she is 18 years of age or older. However, when choosing your attorney, you should pay careful consideration to many factors, including whether the person you choose is trustworthy and whether they are good at handling money.

When does a continuing power of attorney for property take effect? A continuing power of attorney for property takes effect immediately upon being signed and witnessed, unless otherwise stated in the document. However, if you want it to take effect **only** after you have become mentally incapable of managing your finances, you must make this clear in the document. It is up to the individual making the power of attorney whether they want their attorney to be able to help them now or only after becoming mentally incapable.

In order give a valid continuing power of attorney for property, you must be at least 18 years old and mentally capable. Mental capacity for the purpose of giving a continuing power of attorney for property means you must:

- Know what you are giving your attorney the authority to do;
- Know what property you have and its approximate value;
- Know that your attorney is required to account for the decisions they make about your property;
- Understand that if your attorney does not manage your property well, its value may decrease;
- Understand that there is always a chance that your attorney could misuse their authority; and
- Know that as long as you are mentally capable, you can revoke the power of attorney.

When does my continuing power of attorney for property end?

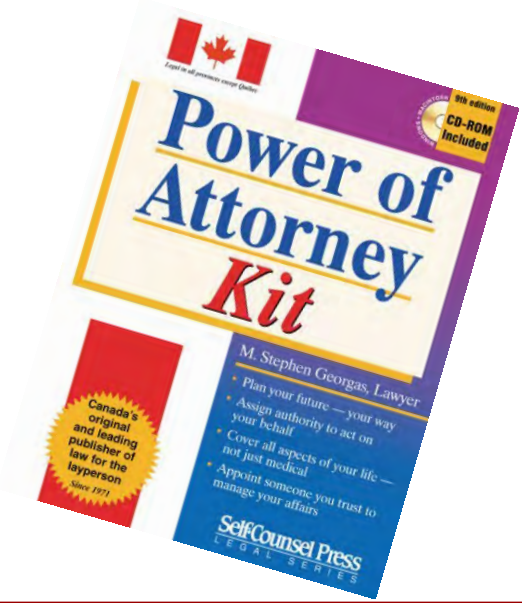
Your continuing power of attorney ends when:

- Your attorney dies, becomes mentally incapable, or resigns (however, this can be prevented if you name more than one attorney or if you name a substitute attorney);
- A court appoints a guardian of the property for you;
- You sign a new continuing power of attorney for property while you are still mentally capable;
- You revoke the power of attorney while you are still mentally capable; or

You die.

What is a general power of attorney for property? The *Power of Attorney Act* states that a general power of attorney for property is a legal document that lets your attorney manage your finances and property **only while you are mentally capable**. For example, your attorney can act for you in financial and bank-related dealings, by signing cheques, and buying or selling real estate and consumer goods.

This type of power of attorney is usually used in business or for short-term temporary reasons (e.g., if you are going on an extended vacation). If you become mentally incapable of managing your property or finances, the general power of attorney for property ends, and your attorney can no longer act on your behalf.



The Ontario Personal Support Worker Registry Becomes a Reality

© **http://www.ocsa.on.ca/userfiles/Ontario%20PSW%20Registry%20Public%20Report.pdf**

On June 14th, in a statement to the Legislative Assembly yesterday, Minister of Health and Long-Term Care, Deb Matthews, announced the launch of the Ontario Personal Support Worker Registry. In her statement, Minister Matthews acknowledged the care personal support workers or PSWs provide daily for some of Ontario's most vulnerable populations, such as seniors and people with chronic illnesses and disabilities. The establishment of the Registry was announced by Minister Matthews in May 2011, as a "registry of personal support workers that will better recognize the work they do for Ontarians, while helping to better meet the needs of the people they care for."

The Ontario Community Support Association (OCSA) was contracted to lead the development and implementation of the Registry. In addition a Steering Committee made up of various stakeholders, including front-line PSWs, employer and advocacy groups, unions and educational associations have been providing expert opinion and guidance to the process.

The Registry was officially launched on June 1, 2012 and the initial phase will focus on those working in the home-care sector. PSWs and those employed to provide personal support services can now apply to be part of the Registry by going to www.pswregistry.org and filling out an online application form. Paper applications are also available for download online or from employers and can be mailed, faxed or dropped off at the Registry's office. There is no cost to PSWs to register.

Registration will be mandatory for all PSWs currently employed by publicly-funded employers within the home-care sector. As well, in the future, these employers will be required to hire only PSWs that are on the Registry. Publicly funded employers are those receiving funding from the Ministry of Health and Long-Term Care, the Local Health Integration Networks or the Community Care Access Centres.

Ontario
Ministry of
HEALTH AND
LONG-TERM CARE

The Toronto Declaration on Bridging Knowledge, Policy and Practice in Aging and Disability

http://www.marchofdimes.ca/dimes/images/emails/FICCDAT/Toronto_Declaration.pdf

The 2011 World Report on Disability, produced jointly by the World Health Organization (WHO) and the World Bank, estimates that there are over one billion people with disabilities in the world today, of whom nearly 200 million experience significant difficulties.

At the same time, in almost every country, the proportion of people aged over 60 years is growing faster than any other age group, forecast to reach 1.5 billion by 2050, according to the Global Health and Aging Report, also released in 2011 by WHO in partnership with United States National Institute on Aging. This means that in the years ahead disability will be an even greater concern to developed and developing nations due to aging populations, higher risk of disability in older people, as well as the global increase in chronic health conditions, such as diabetes, cardiovascular disease, cancer and mental health disorders. Taken together, the dual phenomena of global aging and increased longevity for individuals with disabilities represent significant advances in public health and education.

However, along with these positive trends come new challenges for the 21st century. These include: strains on pension and social security systems; preparing health providers and societies to meet the needs of populations aging with and aging into disability; preventing and managing age and disability associated secondary conditions and chronic diseases; designing sustainable policies to support healthy aging and community-living as well as long-term and palliative care; and developing disability and age-friendly services and settings.

Bridging the fields of aging and disability research, policy, and practice is critical for meeting these challenges. All of us aspire to healthy aging, regardless of the presence of age-related impairments or disabling conditions. The experience of growing older with a disability and growing older into a disability may differ – in part because of the different dynamics of ageism and ableism and the differences in economic and social conditions that result – but these life course trajectories present similar challenges and opportunities.

In this document we seek common ground, in terms of the modern conception of active aging and of disability, defined as difficulty in functioning at the body, person or societal levels experienced by an individual with a health condition in interaction with the person's physical, social and attitudinal environment. Moreover, we firmly believe that, despite the distinctions between aging and disability created by professionals, academics, advocacy NGOs, public policies and government agencies, the time has come to emphasize similarities in experiences and needed supports, services and policies rather than focusing on differences. Distinctions between early and late onset of disability are to a large extent a reflection of policy issues – with various utilities across nations – but they do provide a picture of the parameters of practice and research that can inform bridging and consequences of this distinction.

Based on the findings of the GOWD and larger FICCD AT meetings, we assert that:

- **National and international bridging of aging and disability knowledge, policy and practice must be actively promoted.** Aging with and aging into disability are global population trends. Cross-national and international collaborations can support effective and efficient knowledge development and transfer, implementation of best practices, and facilitate information exchange among and empowerment of persons with disabilities and their families.

- **Bridging is composed of several activities which must occur simultaneously, at multiple levels of knowledge development, policy and practice, and include disability and aging stakeholder groups.** The scope of required bridging activities is broad, including the analysis of public policies, interdisciplinary research, the development of professional best practices, and coalition building across advocacy groups and among individual stakeholders. Older adults and people with disabilities and their families must be meaningfully included in bridging activities in recognition of their rights to self-determination and social inclusion.

- **Building effective bridges across aging and disability knowledge, policy and practice requires interdisciplinary collaboration and engagement with national and international decision-makers.** Development of effective models of bridging and successful bridging practices requires engagement of

- professional and citizen stakeholders bringing together relevant knowledge and experience. Decision leaders must engage knowledge brokers to pursue program and policy changes that support bridging activities.

- **Connecting the field of aging and disability will require development of a clear model of bridging.** Research at all levels will support the science of bridging as it develops. However, research must give immediate and persistent attention to the pace of bridging to assure that it aligns with the needs of the person aging with disability in order for them to negotiate and make life choices, navigate support and service systems, and engage in opportunities for full inclusion and participation in society.

- **Bridging requires developing a common terminology and knowledge base.** Tasks include activities of dissemination, coordination, assessment, empowerment, service delivery, management, financing and policy. Technologies include various Information Technologies, assessment instruments and guidelines. Bridging practices should be catalogued and incorporated to open-access repositories for use by aging and disability networks.

Therefore we identify the following priority areas for bridging aging and disability knowledge, policies, and practice:

- **Health and well-being:** Improved access to healthcare services; improved diagnosis and treatment of secondary conditions and diseases; care coordination; health literacy; health promotion and wellness; prevention of age-related chronic conditions; prevention of abuse and neglect; reduction in pre-mature mortality and training of health professionals in aging and disability.

- **Inclusion, participation and community:** Accessible societies, including age and disability friendly communities, removal of barriers of any kind: architectural, cultural, legislative. Impact and implications of aging and disability on civic and community engagement, and the role of technology and universal design in fostering inclusion, participation and knowledge management.

- **Long-term supports and services:** Support for families and caregivers, training and education of direct support professionals; self-determination, access, availability, and affordability of supports and services; ethical issue related to non- discrimination, such as in palliative care, end of life issues.

- **Income security:** Employment, retirement security, asset development; accommodation and accessibility in the work setting; value of non-paid social and community contributions.

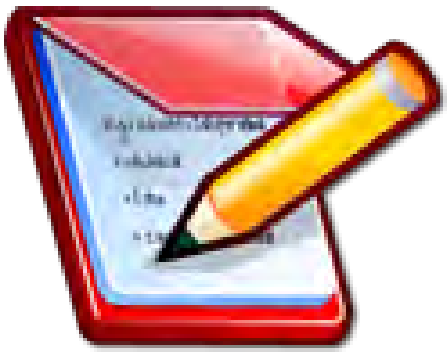
- **Science of bridging:** Research on bridging aging and disability and on ways to transfer this knowledge locally, nationally, and internationally to policy development.

We therefore recommend that:

1. An international agenda for bridging aging and disability be formally developed through the involvement of researchers, practice professionals, policy-makers, older adults, persons with disabilities and their families.

2. Public and private funders provide financial support for research and scholarship that advances the science of bridging aging and disability knowledge, practice and policies.

3. Health and social policy-makers incorporate bridging and knowledge transfer as key strategies in policy planning for building a society where all citizens can fully participate including persons with disabilities of all ages.



Antibiotic Resistance

There is an increasing concern around the world that organisms like bacteria, viruses, fungi and parasites are becoming resistant to the drugs used to fight them. An example of this is the increasing resistance to antibiotics used to treat bacterial infections. When this occurs, it can mean there are fewer effective antibiotics available to prevent and treat infections and infectious diseases, making treatment more difficult.

Until the 1940s, when antibiotic drugs were discovered, people with infections like tuberculosis, pneumonia and sexually transmitted infections often died because the available treatments were not very effective. With the discovery of new drugs, the ability to fight diseases improved dramatically. However, since then, some germs have become resistant to these drugs.

Antimicrobial resistancehappens when a drug is no longer effective in killing or stopping the growth of particular microorganisms, like bacteria. The term *antimicrobial* refers to both natural and synthetic substances like antibiotics and disinfectants, which can kill or block the reproduction of microorganisms.

The causes of antibiotic resistance: A major cause of resistance is believed to be the overuse or inappropriate use of drugs like antibiotics in preventing or treating infections in people, animals and plants. Germs constantly adapt to their environment and have the ability to take on the characteristics of other germs. When antibiotics are used inappropriately, the weak bacteria are killed, while the stronger, more resistant ones survive and multiply. Germs that develop resistance to one antibiotic have the ability to develop resistance to another antibiotic. This is called cross-resistance.

Links have also been made between giving drugs to animals and the development of resistance in humans. Drugs are often given to food-producing animals to promote growth and to treat and prevent infections in the agri-food industry. Products are also sprayed on fruit trees to prevent or control disease. Drug-resistant organisms can then be transferred to humans in meat, milk, fruit or drinking water, adding to the resistance

problem. An example of this is drug-resistant *Salmonella*, which can be transferred from animals to humans through the food chain.

Other factors that can cause resistance include an incorrect diagnosis that results in the inappropriate drug being prescribed, prescription of an antibiotic when the infection is caused by a virus, or not taking a prescribed antibiotic according to the healthcare professional's instructions (for example, not taking all of a prescription for the total amount of time required).

You can be exposed to drug-resistant germs in the same way you get other infections, through:

- contaminated food, water or soil
- unsafe sexual practices
- contact with infected people or animals
- contact with contaminated environmental surfaces
- during treatment in a clinic or hospital
- Drug-resistant germs can also enter Canada through imported food or international travel.

Safe use of antibiotics: Proper diagnosis is the first step in the effective treatment of any infection. Visit your doctor for a proper assessment. Be aware that antibiotics are not effective against all infections caused by micro-organisms, for example antibiotics are not effective against viruses, like cold or flu. Also, specific germs can be treated more effectively with drugs that are targeted to them. This often requires a laboratory test.

Take medication as directed by your doctor or pharmacist. Do not stop taking prescribed medication part way through the course of treatment (unless you are having a serious adverse reaction) without first discussing it with your doctor. Even if you feel better, use the entire course of prescribed medication as directed to make sure that all of the germs are destroyed.

- Do not share prescription drugs with anyone else or take drugs prescribed to anyone else. Taking an inappropriate drug makes the resistance problem worse.

- Do not flush out-of-date or unused medication down the toilet, pour it down the sink, or put it in the garbage. If you do, this medication will end up in the water table, which could increase the drug resistance problem. Instead, check to see if your pharmacy has a drug recycling program that disposes of unused drugs in an environmentally safe manner. If your area does not have such a program, take the drugs to your municipal waste disposal depot for proper disposal.

Reduce your risk: You can help prevent and reduce drug resistance by taking the following steps:

- Wash your hands frequently with soap and water for at least 20 seconds. Alcohol-based hand cleansers are useful when soap and water are not available. In most cases antibacterial soap is not necessary for safe, effective hand hygiene.
- Make sure you and your family are vaccinated and keep all vaccinations up to date.
- Store, handle and prepare food safely. When preparing food, be sure to wash cutting boards and knives with detergent and water. Use bleach on surfaces where you have handled raw meat. Thoroughly wash all fruits and vegetables that will be eaten raw.
- If you use well water, have it tested regularly.
- Encourage farmers to give antibiotics to their animals only when needed.

The Government of Canada's role: The Government of Canada develops policies to address the antibiotic resistance issue and leads other activities, including research, surveillance and education. Health Canada and the Public Health Agency of Canada work with other government departments and agencies in Canada and abroad to bring science and policy together. They provide financial support to a number of initiatives, like research on antibiotic resistance and the Canadian Integrated Program for Antimicrobial Resistance Surveillance (CIPARS). The CIPARS annual reports are available on the Public Health Agency of Canada's website. The Government of Canada also works to reduce risk that chemicals may pose to Canadians and the environment.

The Desktop Guide to Complementary and Alternative Medicine: An Evidence-based Approach

© By Edzard Ernst, Max H. Pittler, Clare Stevinson, and Adrian White, eds. London, UK: Harcourt Publishers, Ltd., 2001; 459 pp

Alternative medicine is a growing influence in health care today. More and more people are utilizing both traditional (conventional) medicine and some combination of alternative treatments in their search for better health and wellness. Unfortunately, many physicians have relatively little knowledge or experience with the various forms of alternative medicine that are practiced. Whether they plan to recommend alternative therapies to their patients or you cringe when their patients admit to taking herbs, every physician should have at least a basic understanding of the types of treatments that are being used and their potential interactions with our more traditional therapies.

This book serves as a very useful guide to the various types of alternative medicine that are available to the public. The editors of this desktop guide are physicians and scientists from the United Kingdom and United States who have taken on the task of attempting to bring the light of science to bear on the widely disparate practices of alternative medicine providers.

There is increasing scientific study of these previously unscientific methods of diagnosis and treatment. Some therapies have clinical merit, while many apparently do not. The authors review the relevant literature in the same way that a peer-reviewed journal would, assessing the scientific strengths and weaknesses of the various studies that have been published on the benefits of alternative medical therapies.

The book is organized not as a definitive textbook, but as a quick reference guide, with sections devoted to the diagnostic processes, the specific types of alternative therapies, and several common diagnostic groups for which various alternative therapies might be used. For example, if patients asked their physicians about how the herbs they were taking might interact with the medications they were about to prescribe, physicians could first go to the section on “Therapies,” and look up “Herbalism,” then go to the section “Herbal and Non-Herbal Medicine” and look up each type of herbal product the patient was taking.

There are also chapters discussing the legal and cultural influences on the practice of alternative medicine in Europe, Canada, and the United States The final two chapters deal with safety concerns and economic issues. While many consumers of alternative medical treatments may assume that such interventions are inherently safe, this assumption is false, and one of the chapters deals with the many potential problems associated with alternative therapies, not the least of which is their almost completely unregulated and unsupervised status, particularly in the United States.

Section two gives a brief review of the various forms of diagnostic procedures that are utilized by alternative medicine practitioners, such as chiropractic, kinesiology, reflexology, and others. The premise behind the diagnostic method is explored briefly, and the scientific basis, including any relevant research, is discussed. Essentially, all of the diagnostic methods reviewed were found to have little or no scientific validity.

Section three is a compilation of various forms of therapies, including chiropractic manipulation, relaxation training, aromatherapy, homeopathy, biofeedback, and others. Each form of therapy is analyzed with respect to its origins, the concepts behind the development of the therapy, the types of disorders that are commonly treated with it, the course of treatment, the clinical evidence for and against effectiveness, risks, adverse effects, and, finally, a risk/benefit analysis. Some of the therapies discussed, such as biofeedback and progressive muscle relaxation, are commonly utilized in the United States by psychologists and psychiatrists for the management of psychosomatic complaints, such as anxiety, insomnia, and chronic pain, and it is not entirely clear why these are considered alternative therapies. The authors review the relevant literature regarding each method of treatment and issue a conclusion based on the potential benefit, as supported by literature, and the likelihood of side effects or complications.

Section four is a listing of some commonly used herbal and “natural” products. For each product, a summary is given of the sources, constituents, presumed pharmacologic action, types of disorders commonly treated, clinical evidence for and against the effectiveness of the therapy, adverse effects and potential medication interactions, and a final risk/benefit analysis.

Section five presents a discussion of common disorders that may be treated by alternative therapies and a review of relevant trials addressing the effectiveness of the various forms of alternative therapy that are in common use for that disorder. For example, in the case of congestive heart failure, several herbs are commonly used (not counting digitalis), such as garlic, ginger, and parsley. It turns out that hawthorn and Terminalia actually do have significant benefits for mild-to-moderate congestive heart failure, as supported by randomized, placebo-controlled trials.

There is some risk in using these herbs without medical supervision. For instance, hawthorn in high doses is said to cause hypotension and arrhythmias, and may have interactions with prescribed medications such as nitrates and cardiac glycosides. Other supplements may have benefits with relatively little risk.

The Desktop Guide also comes with a CD-ROM that is a searchable version of the text. You can read the text page by page, skip through the text using the table of contents, or search for specific topics with the electronic index.

Overall, *The Desktop Guide* succeeds in its goal of being a quick reference manual for the busy physician who needs to get an overview of the types of alternative therapies in common use, the conditions for which they are used, and the issues relating to patients' decisions to seek out alternative forms of treatment. It is easy to read, constructively organized, and holds up a reasonably high expectation for the scientific validity of these forms of therapy.

Sleep Medicine Pearls

© By Richard B. Berry. Philadelphia, PA: Hanley & Belfus, Inc., 1999; 276 pp; $45

The increasing public awareness of the impact that sleep disorders can have on general health has amplified the need for a better understanding of sleep medicine by the medical community. *Sleep Medicine Pearls* is a welcome addition to the "pearls" series of books that serves as a concise, practical review of this rapidly developing field. This is a text that can serve as an excellent introduction for those who have little knowledge of sleep medicine, but also as a refresher for those who are already practicing sleep medicine.

The initial chapters focus on helping the reader to understand the basic principles that underlie the collection and assessment of physiologic data during sleep. This is done utilizing illustrative examples that allow the reader to identify the relationships among important variables such as eye movements, chin tone, and sleep processes.

The next few chapters focus on rules for sleep staging, the recognition and classification of respiratory events, the use of end-tidal Pco2 levels, and esophageal pressure-monitoring. These chapters provide an introduction to polysomnography, multiple sleep latency testing, and the role of these studies in the evaluation of hypersomnolence.

The main body of the book concentrates on the diagnosis and management of obstructive sleep apnea syndrome (OSAS). Here again, the author skillfully uses illustrative case histories followed by a discussion of issues relevant to each case, guiding the reader through the diagnosis and management of obstructive sleep apnea. The usual management options are discussed, including continuous positive airway pressure, weight loss in obese patients, the use of oral appliances, and uvulopalatopharyngoplasty.

Case histories help the reader to understand the basis on which these therapies are recommended, their limitations, and strategies for overcoming these limitations. In this section, the author also covers the relevance of and approaches to the treatment of nocturnal hypercapnia and oxyhemoglobin desaturations in patients who are obese or have COPD or restrictive pulmonary disease. The section ends with additional case histories of patients with OSAS complicating other conditions that result in daytime somnolence, such as narcolepsy and periodic limb movement disorder/restless legs syndrome.

The book ends with a chapter on insomnia that introduces the multifactorial nature of insomnia, details the features essential to insomnia history-taking, and presents a brief discussion of other sleep disorders that can lead to the development of insomnia, such as periodic limb movement disorder. Continuing the “pearls” format, illustrative case histories lead to discussions of psychophysiologic insomnia and reversed first-night effect, environmental sleep disorder, and sleep-state misperception. Sleep hygiene issues, biofeedback, meditation, and the roles of exercise and stimulus control therapy are also briefly discussed in this section. The menu of case discussions ends with circadian rhythm disorders and their management, and the

relationships between sleep and depression.

The 101 illustrative cases reviewed in *Sleep Medicine Pearls* shed light on the diagnosis and management of a wide spectrum of sleep disorders. The breadth of information that the author has managed to squeeze into this unique member of the "pearls" series makes this volume appealing to a wide audience as both an introductory text and a reference tool.

In Case of Emergency (ICE) Program

Toronto EMS has developed an "In Case of Emergency" information sheet that allows you to provide important medical details for paramedics and hospital staff should the need arise. These sheets are easy to read and provide critical information to healthcare providers at a time when communication may be hindered due to illness or language barriers.

It is important to keep this sheet up to date with any changes in current medical conditions or medications. The "In Case of Emergency" sheet is downloadable and printable in order for you to make as many changes as you need to keep the information current. We recommend posting the sheet somewhere handy like the front of your refrigerator.

INFORMATION SHEET
IN CASE OF EMERGENCY
CALL 911

CONTACT INFORMATION

First Name _____ **Last Name** _____

Address _____ **Apartment Number** _____

City _____ **Postal Code** ___ ___ ___ ___ ___ ___

Main Phone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ **Alt. Phone** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Health Card ___ ___ ___ ___ - ___ ___ ___ - ___ ___ ___ - ___ ___ (version code) **Birth Date** ___ ___ (day) / ___ ___ (month) / ___ ___ ___ ___ (year)

Primary Language(s) _____ **Gender** ☐ **M** ☐ **F**

☐ **Advanced Care Directive** → **On file with** _____

Emergency Contact 1 _____

Main Phone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ **Alt. Phone** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Emergency Contact 2 _____

Main Phone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___ **Alt. Phone** (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Primary Care Provider _____

Phone (___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

RELEVANT MEDICAL HISTORY

☐ **Cardiac** (angina, heart attack)	☐ **Asthma**	☐ **Cancer**
☐ **Stroke/TIA**	☐ **COPD** (emphysema, bronchitis)	☐ **Alzheimer**
☐ **Hypertension** (high blood pressure)	☐ **Seizure** (convulsions)	☐ **Dementia**
☐ **Congestive heart failure**	☐ **Diabetic IDDM/NIDDM**	☐ **Psychiatric**

Other: _____

www.torontoems.ca

MEDICATIONS

1) _____ 6) _____ 11) _____

2) _____ 7) _____ 12) _____

3) _____ 8) _____ 13) _____

4) _____ 9) _____ 14) _____

5) _____ 10) _____ 15) _____

MEDICAL ALLERGIES

☐ No Known Allergies ☐ Penicillin ☐ ASA ☐ Sulpha ☐ Codeine

Other _____

SPECIAL CONSIDERATIONS

Communicable Infection / Disease _____

Other _____

Hospital affiliation _____ → ☐ Extensive history.

☐ Specialty (Dialysis, neuro, etc.) _____

MOBILITY / SENSORY

☐ Dentures ☐ Visual (impairment / glasses) ☐ Hearing (impairment / aid)

☐ Mobility issues (cane / wheelchair / walker / motorized scooter / prosthetic limb)

Completed by _____ Date ___ ___ / ___ ___ / ___ ___ ___ ___
day month year

Putting Together an Emergency Preparedness Kit

Don't wait for an emergency to happen: An emergency kit contains basic supplies that your family can survive on during an emergency -- even in cases where the power is out for an extended period of time or you have no access to running water or other necessities.

Make sure your emergency kit is easy to carry -- in a duffel bag, backpack or a suitcase with wheels, for example -- and that everyone in the household knows where it is.

What to include in your emergency kit:

- *Two litres of water per person per day.* Include small bottles that can be carried easily.
- *Food that won't spoil*, liked canned goods, energy bars and dried foods. Remember to pack a manual can opener so that you can get into the food.
- A *flashlight*.
- Battery-powered or wind-up *radio*.
- Extra *batteries*.
- *First aid kit*.
- *Special needs or health-related items* such as prescription medications, infant formula or equipment for people with disabilities.
- *Extra keys* for your car and your house.
- *Cash* (especially smaller bills and change for payphones).
- Your family's *emergency plan*.

Putting Together a Home and Travel First Aid Kit

Prepared for a Medical Emergency: Almost everyone will need to use a first aid kit at some time. Take the time to prepare a kit to have available for home and travel. First aid kits may be basic or comprehensive. What you need depends on your medical training and how far you are from professional medical help. Ready-made first aid kits are commercially available from chain stores or outdoor retailers. But you can make a simple and inexpensive first aid kit yourself. Be prepared to take enough medication to last at least as long as you may be traveling (or for a few days more in case of delays). Carry your medical information with you. In case of emergencies when first aid is only the beginning of care, people should be prepared to give emergency personnel all of their current and past medical history.

Home and Travel First Aid Kits

Home first aid kits are usually used for treating these types of minor traumatic injuries:

Burns, Cuts, Abrasions (scrapes), Stings, Splinters, Sprains, Strains

First aid kits for travel need to be more comprehensive because a drug store may or may not be accessible. In addition to personal medical items, the kit should contain items to help alleviate the common symptoms of viral respiratory infections such as fever, nasal congestion, cough and sore throat.

How to Make a First Aid Kit: Try to keep your first aid kit small and simple. Stock it with multi-use items. Almost anything that provides good visibility of contents can be used for a household first aid kit.

- If your kit will be on the move, a water-resistant, drop-proof container is best.
- Inexpensive nylon bags, personal kits, fanny packs, or make-up cases serve very well.
- You do not need to spend a lot of money on a fancy "medical bag." Use re-sealable sandwich or oven bags to group and compartmentalize items.
- Put wound supplies in one bag and medications in another.

How to Use a First Aid Kit: Make sure you know how to properly use all of the items in your kit, especially the medications. Train others in your family to use the kit. You may be the one who needs first aid! Pack and use barrier items such as latex gloves to protect you from bodily fluids of others. Check the kit twice a year and replace expired medications. The National Poison Control Centre phone number in Canada is 1-800-268-9017.

Where to keep your first aid kit:

- The best place to keep your first aid kit is in the kitchen. Most family activities take place here. The bathroom has too much humidity, which shortens the shelf life of items.
- The travel kit is for true trips away from home. Keep it in a suitcase or backpack or dry bag (for example, a zip lock plastic bag), depending on the activity.
- A first aid kit for everyday use in the car should be just like the home first aid kit. For that matter, you could keep similar kits in your boat (inside a waterproof bag), travel trailer, mobile home, camper, cabin, vacation home, and wherever you spend time.

What to Put in Your Household Kit: You can buy all items for your first aid kits at a well-stocked drug store. Ask the pharmacist for help in selecting items.

A household first aid kit should include these items: Adhesive tape, Anesthetic spray (Bactine) or lotion (Calamine, Campho-Phenique) - for itching rashes and insect bites, 4" x 4" sterile gauze pads - for covering and cleaning wounds, as a soft eye patch,2", 3", and 4" Ace bandages - for wrapping sprained or strained joints, for wrapping gauze on to wounds, for wrapping on splints, adhesive bandages, safety pins, triangular bandages, exam gloves, scissors, tweezers, oral antihistamine for allergic reactions, Polysporin antibiotic cream, AND a pocket mask for CPR.

In case of a medical or trauma related emergency, a list of family member's medical history, medications, doctors, insurance company, and contact persons should be readily available.

Centre for Independent Living

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Promoting a new perspective on disability