

Mind and Body for Patients and Health Professionals

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Two articles in this issue of the *WMJ* continue to explore the relationship of attitude and behavior on the well-being of patients and clinicians. The world has come a long way from the time when all mothers admonished their children to not get wet or get a chill or the result would be a cold or, my mother at least, would confirm that any illness would be proof that we had been too stressed or worried or working too hard. The article by Maxwell and colleagues¹ seems to reinforce some aspects of this theory. My mother would feel vindicated.

The increasing literature on mind-body relationships has moved from observational studies to a wide array of epidemiologic and prospective studies that are describing and confirming relationships between a variety of mental states and physical illness. I remember hearing a study 30 years ago when a colleague reported on the relationship of stress to the development of genital herpes and possible immunologic mediators and wondering to myself if this was going to change everything about how we approach physical and mental health.² It certainly did. HIV and the immunology of the human response to it created an enormous and transformative world of research that continues today. Recent work in biomics and the relationship between internal viral and bacterial populations on human health connects what have always been considered “behavioral” diseases such as obesity and genetic disease (eg diabetes) to environmental factors.³ The boundary between “good” and “bad” virology and microbiology is getting fuzzier by the year. The environment in which we live and which lives on and within us is more tightly connected to

everything else, both mind and body.

Building on previous work that looked at possible interventions to decrease the development of acute respiratory infections, Maxwell and colleagues found that there is a strong and

positive relationship between problematic mental health and getting a cold. While this would not be a surprise to my mother, we have good science, good measures, and important results that could be translated into better prevention if we are able to work with patients. It makes a stronger case for including preventive mental health programs in primary care.

The article by Luchterhand and colleagues⁴ offers one of those preventive approaches by describing a mindfulness program for primary care clinicians and the diffusion of that program into health teams and clinics, and even patients. A relatively small investment of time and funds produced a motivated group of leaders who went back to their home environments and began changing those environments for everyone. Mindfulness and meditation have been proven to be beneficial for individuals, but can that change a work environment for everyone?

This study shows that such changes are possible and positive. If such training can bring results to clinical environments, one would hope one day to see the benefits brought to

other high-stress, high-risk professions. Just as we see lots of busy young professionals walking or biking with their yoga mats, it would be good to see groups of construction workers or police officers sitting in meditation before

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beginning their risky and busy days. While that is not likely to be seen soon, the program that Luchterhand and colleagues describe should be offered to a wide variety of workers and work environments. If we believe in something for which there is a proven health benefit, then we should feel obliged to bring it to everyone who would benefit. Health professionals work hard in a stressful environment, but so do many others in society.

Handoffs and Testing Prevailing Beliefs

Rentea and her colleagues⁵ give recommendations that, if followed, have enormous potential to improve patient safety and patient comfort during hospital admissions for surgery. Resident work rules have made hospital care seem more like relay races and—for all involved—the baton must not be dropped. Their tips can be summarized in 3 categories: communication, documentation, and supervision. No patient or family in crisis wants to see unfamiliar faces and people who seem not to know about important

issues coming into their room in the middle of the night. Following Rentea's checklist minimizes the likelihood that that will happen.

Finally, in an attempt to describe the incidence of IV contrast-related nephropathy, Arayan and colleagues⁶ use data on patients who underwent procedures prior to the general use of prophylactic measures. They found a small number of patients (9/193 [4.7%]) who developed a rise in creatinine after the procedures, each of whom had other reasons for that rise. The discussion in the article is very helpful, both in understanding the relevance for

their study and to highlight the continuing controversy about the true incidence of contrast-induced nephropathy—that controversy will continue, short of well-done randomized control trials that are unlikely to happen. Without them, given that US medicine believes in general that doing more is better than doing less, prophylactic measures will continue.

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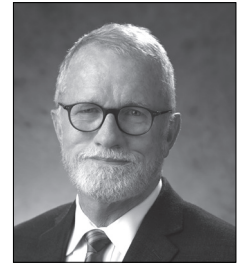
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