

Magazica



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Health

Hope, Happiness

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Smoke Alarm:
Why Back-to-
School Anxiety
Goes Off Before
There Is a Fire

Saving Lives
Before Symptoms
Strike

The Importance of
Rest Days in Your
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Nature's
Unlabelled Aisle:
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Blue Light Glasses:
Fact or Fiction for
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*David Messika-
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The Toll Booth
and the Meter:
What Canning
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Interview

*With
a global
leader in
valvular
heart disease*

Dr. David Messika-Zeitoun



Dr. David Messika-Zeitoun is a global leader in valvular heart disease, combining scientific precision with deeply human care. Through early detection, mobile screening, and innovative treatment, he is helping bring life-saving heart care closer to the people who need it most. In this conversation, he shares a vision for cardiology that is more accessible, proactive, and personal.



Saving Lives Before Symptoms Strike:

How Dr. David Messika-Zeitoun Is Transforming Heart Valve Care in Canada

Magazica: Hello, everyone. Welcome, and welcome back. Today, we are having a conversation with Dr. David Messika-Zeitoun.

Dr. David has spent his career helping people protect the one thing we all depend on every second of our lives: our heart. As a cardiologist at the University of Ottawa Heart Institute and Director of the Center for Valvular Heart Disease, he has dedicated decades to understanding how heart valves work, why they

fail, and how early detection can save lives. His work has shaped new ways of diagnosing heart disease, expanded access to care through mobile screening, and inspired teams across Canada and beyond.

David Messika-Zeitoun: Good afternoon. Thank you for having me.

Magazica: To begin, let's go back to the start of your journey.

Was there a moment early in your life or training that made you realize that cardiology—and especially heart valve disease—was where you were meant to be?

David Messika-Zeitoun: It's exactly as you said. It was a staged career process. I was quite sure, since I high school, that I wanted to do medicine. Health, research, and science were my passion.

After high school, I did my medical school, and my career was shaped mostly by the people I met. When I was a medical student, I loved every specialty I was exposed to. After that, you meet a few people who influence your choices and guide you in one direction instead of another. That's why mentoring is so important.

The first mentor I met was Alec Vahanian. I should mention that I'm originally from France. I was born and trained in Paris until 2018, when I joined Ottawa thanks to Dr Thierry Mesana. I met Alec Vahanian in Paris as a young resident. He taught me a lot about clinical work, empathy, and how to take care of patients. He also passed on his passion for valvular heart disease. He is one of the worldwide experts in the field.

That was the clinical aspect of my training. And in 1999, I was at my first big international conference. I went to listen to someone speaking about mitral regurgitation, one of the valvular heart diseases. His name is Maurice Enriquez-Sarano. When I saw him talking, I said, "I have to go and work with that guy."

He's originally from France, was working at Mayo Clinic, and was also a close friend of Alec Vahanian. I gave up security—I had a position in Paris—and I said, "I need to go." I spent two years at Mayo with him.

Both shaped my career. Alec was more clinical, Maurice more research-focused. I'm indebted to them, and I'm still in very close contact with both; they are my friends now. That path led me from medicine to cardiology, to valvular heart disease, and to research.

Magazica: Fantastic. Let's continue with a very holistic angle: what the heart teaches us about life. Most of us think the heart is simply a pump—a biological pump. You have spent decades studying its subtleties. What has the heart taught you about resilience, fragility, or even human nature?

David Messika-Zeitoun: After decades of research, I haven't found a soul in the heart—not yet. If you take a step back, all organs are critical. You may think that without the heart as a pump you will die, but the same is true for the brain, the kidneys or the lungs. If you remove certain organs, you're in trouble.

What I've learned from medicine is that life is short. Something can happen in one minute and change your life forever. It could be the heart; it could be your brain. It gives you humility and perspective on the fact that we should enjoy what we have.

Easy to say, more complex to do—and I'm certainly not doing that, I can guarantee you—but when you face difficulties, it could be worse,

and if you're in good health, you can fix it.

Magazica: Cardiology can feel intimidating to everyday people who are not from the medical field. When you meet someone scared—for example, a patient who feels overwhelmed—how do you explain heart valve disease in a way that brings clarity, or maybe even comfort?

David Messika-Zeitoun: First, what is valvular heart disease? It's very simple. The heart is a pump even if it has many more functions than just being a pump, and inside the heart you have doors that direct the flow. Valves are those doors. They open when needed and close when needed. They can malfunction as a defect of opening, which we call stenosis, or a defect of closing, which we call regurgitation.

I tell patients that yes, the valves are malfunctioning, and yes, they may need an intervention. It could be surgery or a less invasive option that we have now. But we can fix it.

What is very encouraging—and I hope reassuring for patients—is that even though an intervention may be needed, in most cases we can fix the problem at relatively low risk. It's different from some other diseases where the cure is very limited.

If you think about Alzheimer's, when you make that kind of diagnosis, you have nothing significant to offer for now. For heart valve disease, we have options. It is indeed an intervention, but we can fix it.

Magazica: So, in fixing, as you say, we have



options to repair heart valves. What is the power or leverage we have with early detection? And in this regard, I want to draw your attention to the mobile screening program you started, which brings heart health directly to communities. What inspired this idea? First, let's talk about the leverage we, as everyday people, have by being conscious of early detection. Then we will go to the mobile clinic.

David Messika-Zeitoun: The preamble is that heart valve disease can cause symptoms, but they are very vague. It could be shortness of breath, chest pain, dizziness—very vague, nonspecific symptoms. And especially shortness of breath is often attributed to aging. People think, “I’m short of breath because I am old.”

So, the symptoms that can lead to diagnosis of valvular heart disease are nonspecific, which makes the diagnosis complicated. The second part is that awareness of the disease among the population is very low. Everybody is aware of heart attacks, strokes, cancer—but valvular heart disease, nobody knows what that is, despite it being very frequent.

The third component is that too many patients with valvular heart disease are diagnosed very late in the course of the disease, already with heart failure or serious consequences. As a result, when an intervention is needed, the risk is higher, and patients may live with long-term consequences.

The fact that patients with valvular heart disease are underdiagnosed, undertreated, and referred late made us ask: how can we improve detection and provide better outcomes?

We decided to go into the community and do a small point-of-care echocardiogram (POCUS). It's an ultrasound of the heart that gives you a diagnosis of whether you have significant valvular heart disease or not. It doesn't provide quantification; it's very basic. But it's a very good screening tool, to tell if someone has valvular heart disease.

“

In the vast majority of cases, we can fix heart valve disease – and at relatively low risk

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We went to community places and started in 2023, screening participants—people over 65 who were interested in having their heart screened for valvular heart disease. We do other things as well, but the focus is valvular heart disease.

The good thing is that when we detect a valvular abnormality, we take care of it. When a valvular heart disease is detected, participants are automatically referred to the Ottawa Heart Institute's Center for Valvular Heart Disease. They are seen by one of our cardiologists and receive a formal echocardiogram. We then have a formal diagnosis and can tell the patient what stage of valvular heart disease they have.

If they need an intervention, we refer them. But most do not need an immediate intervention—that's the purpose of screening. They are closely monitored so we don't miss the moment when intervention is needed, and we perform it at exactly the best timing.

Magazica: Fantastic. Now, let's come to the mobile clinic concept. For every concept, as I am from HR, I believe there is the idea and then the execution. Execution comes later. First, please give us the backstory. How did you come up with the idea that we need a mobile clinic for heart valve detection or monitoring? How was the idea conceived? What was the motivation and the drive behind it?

David Messika-Zeitoun: The thought process was based on the rationale I already explained earlier: under-treatment, under-diagnosis, late referrals. We told ourselves; we have to do something to pick up patients with valvular heart disease earlier. My first thought was to go to family physicians.

So, I wondered if family physicians could screen for valvular heart disease. The issue is that they are not trained to do ultrasounds. Doing an ultrasound takes five -ten minutes of their time, and they already have very busy clinics. Also, many people also have limited access to primary care—it's a challenge everywhere. So, it might not be the right solution.

I thought, let's do it ourselves. So, we did the first pilot test. We went to community centers, booked a room, did some advertising, and started screening people coming to these centers. The idea was that we must do it

nobody will.

Magazica: For the execution part, did you start on your own, or did you build a team? Did you propose to your hospital or to the authorities that you needed a certain number of people or specific areas to cover? Just give us a glimpse of how the execution unfolded.

David Messika-Zeitoun: I went to our CEO, Dr Mesana at that time, and he responded that it was a great idea. He told me, "I cannot give you resources now, but if you show me that it works, I will help."

So, we did our pilot test without asking for any resources. We were fortunate to obtain a small grant from Ontario Health and Boehringer to start with, but we mostly used the resources we already had at the Center for Valvular Disease —our nurses, our team, and my time to go outside and begin screening.

It went very well. At the beginning, we went to easy places one day a week. After that, we went two days a week, then three days a week, and to more complex places.

We went to retirement homes, reserves, churches, mosques, underserved communities, ethnic groups —any place you can think of. I think we have been to more than 100 places in the region.

Everybody was enthusiastic. The concept is simple: we screen for cancer; we screen for many things—why not screening for heart and cardiovascular disease?

Magazica: In my childhood, I heard a story about a farmer who used to go to the mountain for water from the spring. Eventually, he dug a

canal so the water could reach his community. In the same way, if a person willing to detect their heart valve problems cannot come to you, you have to go to them.

David Messika-Zeitoun: There's a famous French quote: « Si tu ne viens pas à Lagardère, Lagardère ira à toi » "If you don't come to Lagardère, Lagardère will come to you." We haven't discussed money. I think it's important for the audience to know that the program has been funded by research money and later by the Heart Institute, but we are not charging anyone. We are paying for the screening, and we are not making any money or billing. It is a completely philanthropic program designed to help the community.

It is so rewarding to see the impact we can have on people's lives. Last month, we detected one lady who was just in Carlingwood Mall, stopping by to have her heart checked. We found a very large aneurysm (enlargement of the aorta). She was admitted right away, had surgery the next day, and is now out of the hospital. She could have died without that kind of screening.

Another benefit is that in addition to point-of-care echocardiograms to look at the valves, we also screen for cardiovascular risk factors. We check blood pressure, diabetes, cholesterol, weight, and smoking.

We also check for arrhythmia. Many people have heard about atrial fibrillation. It is very common, especially in the elderly, and is one of the major causes of stroke. We screen for atrial fibrillation with a simple device—you put

your fingers on it, and we can see if you have atrial fibrillation. If an atrial fibrillation is detected, we start blood thinners and refer the person to one of our cardiologists for management.

Magazica: Hearing this, you are working in very innovative and accessible ways to detect disease early. We have analyzed your bio and contributions, and you have been at the forefront of new imaging tools and transcatheter therapies. What recent innovation makes you feel genuinely hopeful about the future of heart care?

David Messika-Zeitoun: Transcatheter therapy has been a real revolution in the care we provide. Traditionally, fixing valvular heart disease meant open-heart surgery. Nobody wants that if it can be avoided. It is efficient but invasive. Now, for most types of valvular disease, we have options to go through the groin and replace or repair the valve without opening the chest. This has completely changed the way we understand valvular heart disease and how we fix it.

Magazica: That is the transcatheter therapy.

David Messika-Zeitoun: Exactly. It has completely changed how we think about valvular heart disease because now we have less invasive options to treat patients.

Magazica: Let us open our hearts not on the operation table, but to our beloved ones.

David Messika-Zeitoun: Exactly. And I forgot to answer one part of your question. You don't do this alone. It has truly been teamwork—with my team, my nurses, my manager, the

sonographers. Everyone believed in the project, and because everyone was on board, we could succeed. You cannot do things like this alone. I was very fortunate to have a fantastic team believing in the project and making it work. It is a lot of dedication from the team.

Magazica: Teamwork makes dream work possible. Truly. Let's go to the human side of medicine now. Behind every diagnosis, there is a person with fears, dreams, suspicion, less confidence, and of course, a family. Is there any patient story—without sharing private details—that has stayed with you and shaped how you practice medicine today?

David Messika-Zeitoun: Some of them, sure. Successes or failures—we remember them. There are some patients from my medical training who I still remember. You remember the moments when you hope you are right. Sometimes we make wrong decisions, and unfortunately that is sometimes the way how you learn. Sometimes it is hard, but you remember it. And when you make the right decision, and the patient has a good outcome and is very happy, it is very rewarding.

Magazica: You have worked around the world—trained and worked in France, then the US, and now Canada. All these countries have different cultural settings. They have common threads and their own differences. How have these cultures shaped your approach to care, teamwork, and leadership?

David Messika-Zeitoun: France and Canada are not that different in terms of healthcare systems. They are both public. There are some



differences regarding out-of-pocket costs, but both have very good public healthcare systems. What I like in Canada is the equity. Everyone can be admitted and doesn't have to sell their house to pay for an intervention.

Compared to the US, where in some specialties your treatment plan is based on the patient's insurance, it is hard to believe for someone trained in France and working in Canada. Managing based on what insurance a patient has is very frustrating for a physician. We want to provide the best care we can, with the best device and the best intervention, irrespective of insurance.

Magazica: When work gets heavy—because cardiology is emotionally demanding and physically challenging—how do you stay grounded and protect your own well-being while carrying the weight of cardiology operations and services, where the stakes are usually very high? How do you manage your own self-care?

David Messika-Zeitoun: You learn progressively with time how to protect yourself, because you're facing hard situations. You're exposed to very sad social and personal stories of patients, and when you have bad outcomes, it's also very challenging. But you learn to protect yourself.

I'm fortunate to have an outstanding team with me. Family is also very important. It's important to have support outside of work, and when you're at home, you can think about something different. You learn how to protect yourself, but from time to time, it can still be hard.

Magazica: We are almost at the end of the conversation. Last two talking points. First: building a healthier future. What are one or two habits you would suggest to our readers, listeners, and viewers?

David Messika-Zeitoun: Prevention is key. I think in Chinese medicine when you go to a physician, you only pay if you are healthy, and when you get sick, you don't pay. The philosophy is that prevention is what gives society the best impact on outcomes.

Prevention is simple: eat well, exercise, have a social life, don't be isolated, sleep. Everything you read in every health interview—but they are true. Again, easy to say, more complex to do.

Magazica: And loneliness is kind of a kill switch these days.

David Messika-Zeitoun: Loneliness is one of the diseases of our century. With the aging population, you see people 80, 90, even 100 years old relatively commonly. Our education and way of life mean that this generation is often left alone. Fifty years ago, families lived together. It doesn't happen anymore. Many are left in retirement homes, alone. Loneliness is one of the main causes of depression and dementia.

And it's so sad, because we can learn so much from the older generation. I tell my kids: how you behave with your parents—don't forget, your kids will behave the same way with you.

Magazica: Nature is a fantastic accountant in that regard. Lastly, what's your vision for the upcoming times? What do you want to do?

How do you want to evolve your mobile clinic?
What is the dream that keeps you going?

David Messika-Zeitoun: Regarding the mobile program, my hope is to have the opportunity to screen even more patients, one million now that our program has matured and is called 1 Million Canadian Heart. More participants, and different things that we can screen. For now, we screen for cardiovascular risk factors, the heart, and arrhythmia, but we can add many other things. I'm very interested in adding the kidney function as a screening tool.

I'm also interested in assessing the real impact we have—what kind of impact the screening has on mid- and long-term outcomes.

For now, we go into the community with our nurses and sonographers, carrying everything in the back of their car. It's challenging, especially in winter, carrying equipment in the snow. Thanks to a generous donor family, Kathleen Grimes and her husband Ersin Ozerdinc.

We are in the process of having our own transportation vehicle. My hope is that it will be the first one, running around the region screening for cardiovascular disease. My dream is to have hundreds of vehicles like that across Canada, providing screening, making early diagnosis, and improving outcomes.

Magazica: And your take on AI? How are you going to incorporate artificial intelligence into your work?



David Messika-Zeitoun: AI can help in a lot of different ways. For example, interpretation of echo images can be done by AI. But I think you still need people on the bus—connecting with patients, explaining why we're doing the program, explaining the findings. We can have robots, but I prefer to keep humans for now. AI can also help us find the best locations to have the most impact on screening. There's a lot AI can do for us, but I still like human connections.

Magazica: Thank you very much, Dr. David. Thank you for your time and for sharing your wisdom and experience with our readers and viewers.

David Messika-Zeitoun: Thank you.

Dr. Messika-Zeitoun is a non-invasive cardiologist specialized in echocardiography and valvular heart disease. He has a special interest in imaging and new transcatheter therapies. Dr. Messika-Zeitoun is leading the Centre for Valvular Heart Disease.



Nature's Unlabelled Aisle:

What Late-Summer Foraging Asks of You Before You Eat Anything

Prepared By
Suman Dhar
Editor-in-Chief

Coming is the time when the trail behind the subdivision will smell like warm dust and will crush goldenrod. The blackberries will go soft. Something will get to the elderberries first.

At the foot of a white birch, a cluster of pale mushrooms has come up overnight after Tuesday's rain. You crouch. You take out your phone because that is what people do now.

The app thinks for a moment and hands you a name with a percentage beside it. The percentage is the interesting part.

Nature's Unlabelled Aisle

Picture the late-summer bush as a grocery store where a thorough vandal has peeled off every label. Most of what is on the shelves is inert - bitter, stringy, not worth the walk home. A few things are superb. A very few will put you in hospital.

Nothing on the shelf volunteers which is which, and there is no shortcut. Public Health Ontario, reviewing the evidence on foraged mushrooms, puts it flatly: there are no simple tests for whether a mushroom is poisonous. The folk methods people still swap - the tarnished silver spoon, the idea that anything the squirrels nibble must be fine, the faith that boiling sorts it out - appear in that same document under the heading of myths.

Cooking is not a reset button either. The toxins behind the worst outcomes come through the pan intact.

Takeaway: The wild is not badly labelled - it is unlabelled, and no kitchen trick relabels it.





The Doppelgänger Problem

So people reach for the phone, which is reasonable, and which is where the second problem starts. A 2023 study tested four popular identification apps on sixteen plant species photographed at several growth stages. They got the genus right 76% of the time and the species right 58%.

The number that matters is a different one. Of eleven potentially toxic species in that study, five were labelled as something edible by at least one app. Those researchers were working in the American Midwest, not Canada, but the botany does not respect the border, and their conclusion was blunt: apps cannot currently be used to decide that a plant is safe to eat.

The other doppelgänger is geographic. Public Health Ontario notes that species growing here can closely resemble genuinely good food from somewhere else - a poisonous Ontario mushroom passing for the paddy straw mushroom of Southeast Asia, or an orange Amanita passing for the Caesar's mushroom of southern Europe. Bringing a lifetime of accurate knowledge from another country is not a mistake. It is simply knowledge of a different aisle.

Takeaway: Confidence travels with you; the mushrooms do not.

A Language, Not a List

Long before anyone drafted an evidence brief, people were eating well from this landscape without a poison centre on speed dial. The temptation is to package that as "ancient wisdom" and strip-mine it for tips. That instinct is the problem, not the solution.

Indigenous harvesting knowledge in Canada is not one body of lore. It belongs to hundreds of distinct nations; it is specific to particular territories and seasons, and much of it is taught the way a language is taught - in person, over years, by people accountable for what you do with it. A tip is a single word. This is grammar.

The health literature points the same way. A scoping review of Indigenous food sovereignty initiatives across Canada found harvesting work consistently bound up with knowledge transmission, community leadership and cultural connection rather than technique alone - and documented the other half of the story too: that government restrictions on hunting, fishing and harvesting have themselves limited access to these food systems.

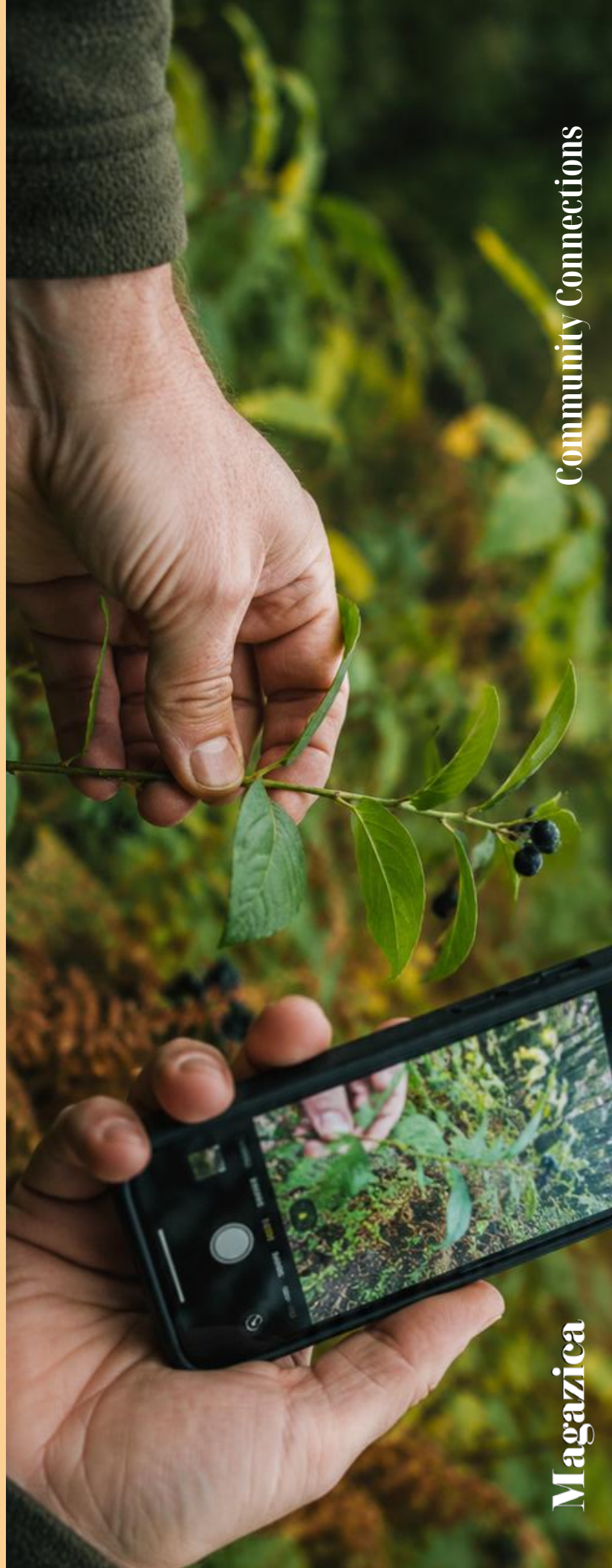
So, what a non-Indigenous reader can borrow is not a plant list. It is the shape of the thing: learn from a person, in a place, over time - and support Indigenous-led food work rather than treating it as a free resource.

Takeaway: Knowledge that took generations to build does not download in an afternoon.

Skin, Stomach, and the Long Fuse.

Two things are worth recognizing this month, and neither requires you to eat anything.

The first is a skin reaction. Sap from giant hogweed and its relatives contains compounds that, once on skin and then hit by sunlight, produce burning, redness, and blistering - usually a day or so later, which is why people rarely connect the rash to the plant.



Discolouration can linger for months. Wash sap off promptly, keep the area covered from the sun, and see a clinician for anything blistering or extensive.

The second is a stomach reaction with a long fuse. With the most dangerous mushrooms, symptoms arrive only after a latent period - and in a Toronto case published in 2015, a woman in her fifties who picked mushrooms in a city park became unwell about twelve hours later and went on to develop liver failure. That is one case report, not a rate. But the pattern matters: with wild food, feeling fine for several hours is not reassurance, and stomach symptoms that start late deserve to be taken more seriously, not less.

Takeaway: A delay is not an all-clear; with wild food, late symptoms are the loud ones.

What Careful Actually Looks Like.

Perspective first, because alarm is its own kind of misinformation. Across five years of Ontario Poison Centre data, mushroom calls made up about 0.3% of all calls, and roughly eight in ten involved minimal or no clinical effect. Serious cases are uncommon. They are also, when they happen, extremely serious.

Careful means learning from someone who knows this place, joining a local mycological or naturalist society, and eating only what you can identify without the phone. It means treating "probably" as a no. It means never handing wild food to a child, an older adult or someone pregnant on the strength of a guess.

Conclusion: The aisle stays unlabelled - so bring a person who reads it, not an app that guesses.

Key Takeaways.

- There is no shortcut test. No spoon, no animal, no boiling method distinguishes safe from unsafe, and cooking does not neutralize the worst toxins.
- Apps are not a safety tool. In one 2023 study, several genuinely toxic species were labelled edible by at least one popular identification app.
- Knowledge is local and relational. Indigenous harvesting expertise belongs to specific nations and territories - learn from people, and support that work rather than extracting from it.

This article is for informational and educational purposes only and does not constitute medical advice. It should not be taken as a medical diagnosis or treatment. Always consult with a qualified healthcare professional for personalized medical guidance.



The Overzealous Smoke Alarm:

Why Back-to-School Anxiety Goes Off Before There Is a Fire

Prepared By
Suman Dhar
Editor-in-Chief

It is the third week of August, and your kitchen has that thick southern Ontario stickiness that makes the fridge door sweat. The supply list has been stuck to it since June. You have already bought the wrong binder.

Your nine-year-old asks, again, whether Ms. Patel will be her teacher. She asked at breakfast. She asked in the car outside Canadian Tire. She asks now with a particular flatness you have learned to recognize, the kind that means the question was never really about Ms. Patel.

Somewhere in that small body, an alarm is going off. You just cannot hear it yet.

The Overzealous Smoke Alarm.

Every child comes with a threat-detection system, and like every smoke alarm, it is deliberately badly calibrated. It is built to shriek at burnt toast, because a false alarm costs you one bad morning and a missed fire costs you everything. Evolution took that trade, and it took it on your behalf.

September is burnt toast. New room, new hallway, new bus route, new social order, new adult whose temperament is entirely unknown. The alarm cannot reliably tell a dangerous unknown from a merely unfamiliar one, so it treats them the same and sounds anyway.

What keeps it sounding is avoidance. Each time a child sidesteps the unfamiliar thing, the alarm gets what looks like proof it was right - the fire never came, so obviously the shrieking worked. Anxiety disorders are the most common mental health condition of childhood, affecting roughly one in fifteen children and adolescents worldwide, and this loop sits underneath most of them.

Takeaway: Anxiety is not a broken alarm; it is an alarm nobody ever tells the toast was fine.

The Usual Suspects, and the Quiet Ones.

Transitions are where the alarm gets loudest - the first year of school, the jump from a small building to a large one, the September a child arrives in a country whose classrooms run on unfamiliar rules. British researchers tracking children across the primary-to-secondary move found something worth clinging to: their worries generally shrank once they were actually there. Canadian evidence on this transition is thin, so hold it as a well-founded hope rather than a domestic finding.

The picture at home is less rosy. Statistics Canada followed the same young people from 2019 to 2023 and found the share rating their own mental health as fair or poor more than doubled, from 12% to 26% - self-ratings across four turbulent years, not diagnoses, and silent on why.

And the alarm is not only in the child. Parents going through their own version - new schedules, new costs, old memories of their own Grade 7 - are part of the room the child is reading.

Takeaway: The kids who go quiet in late August are often the ones doing the most work.

Bodies That Talk Before Kids Do.

Children under nine rarely announce that they feel anxious. They announce that their stomach hurts, at 7:40 a.m., on a Tuesday, with total sincerity - because it does.

In one clinical study of 128 children and adolescents with anxiety disorders, 96% reported at least one physical symptom and the average child reported six. Restlessness and stomach aches topped the list, ahead of racing heart and sweating. That was a small American treatment sample, not a Canadian survey - but it maps onto what the "Sunday-night stomach" looks like from a kitchen table.

Sleep is the other tell. In adolescents, sleep problems and anxiety travel together and appear to feed one another over time - which direction leads is genuinely unsettled, so a wrecked August sleep schedule is worth taking seriously in both directions at once.

Takeaway: Believe the stomach ache and stay curious about the week it belongs to.

The Rescue Reflex.

Here is the part nobody enjoys reading. When parents of anxious children are asked, nearly all of them report regularly changing their own behaviour to spare their child distress -



for them, driving instead of the bus, letting the sleepover go. It is close to universal, and it is love doing exactly what love does.

It is also, on average, associated with more severe symptoms rather than fewer. A meta-analysis pooling studies of accommodation and childhood anxiety found a moderate positive association on parent-reported measures. Association is not causation, and the arrow plausibly runs both ways: more anxious children pull harder for rescue.

Takeaway: Accommodation is not a mistake you made; it is a dial you can turn.

What Actually Helps, and Where to Find It.

The strongest evidence sits with cognitive behavioural therapy. A Cochrane review of 87 trials and 5,964 young people found about 49% of children in CBT no longer met criteria for their main anxiety diagnosis afterwards, against about 18% on a waiting list. The same review is honest that CBT has not clearly outperformed usual care and rates the evidence as moderate to low.

More useful for a family on a waitlist: a randomized trial of 124 children found that working with parents alone - coaching them to reduce accommodation while staying warm - did as well as putting the child in CBT. The child never met a therapist. British trials of brief parent-delivered CBT point the same way, at lower cost. Practically, that means rebuilding the sleep runway a week or two out, naming the feeling without arguing with it, choosing one small, brave thing rather than the whole hallway, and telling the school before the first bell rather than after the third absence.

If the worry is stopping a child from going to school, eating, sleeping, or seeing friends for weeks, that is the point to bring in help - not a crisis, just a conversation. Start with your family doctor or pediatrician, or call 811 where it operates in your province or territory. Ask your school board about its mental health lead; that route costs nothing and is often faster. Young people can reach Kids Help Phone any time at 1-800-668-6868 or by texting CONNECT to 686868, and anyone in Canada can call or text 9-8-8, the Suicide Crisis Helpline.

Conclusion: You are not trying to silence the alarm - you are helping a child learn, one small September morning at a time, that the toast is fine.

Key Takeaways.

- It is a calibration problem, not a character flaw. Children's threat systems are built to over-fire, and unfamiliarity reads as danger.
- Watch the body and the sleep. Stomach aches, restlessness, and a wrecked bedtime are often the first language anxiety speaks.
- Rescuing is the reflex worth examining. Near-universal among parents of anxious kids and linked to more severe symptoms - but it is a dial, not a diagnosis.
- Help works, and it does not always require the child. Parent-focused treatment matched child CBT in a randomized trial; start with your doctor, 811, or your school board.



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The Toll Booth and the Meter:

What Canning and Freezing Actually Cost Your Vegetables

Prepared By
Suman Dhar
Editor-in-Chief

Visualize a Saturday night in late August, and your kitchen windows have gone opaque. Outside it is still twenty-six degrees and sticky in the way only southern Ontario manages. Inside it is worse.

On the counter sits a bushel of Roma tomatoes bought at a roadside stand for a fraction of what the same tomatoes will cost you in February. Beside it, a tower of jars, a canner muttering on the back element, and one nagging thought.

Canada's vitamin D fortification strategy

Health Canada recognises that about one in five
Are you about to boil the good out of them?

The Toll Booth and the Meter.

Here is the mental model worth having. Every method of keeping food charges you in one of two currencies: a toll at the gate, or a meter that runs while you park.

Canning charges a hefty toll. The heat that makes a jar shelf-stable also destroys some of the water-soluble and oxygen-sensitive nutrients - vitamin C, the B vitamins. But once that toll is paid and the lid seals, the meter barely ticks.

There is no oxygen in a sealed jar, so those same nutrients sit remarkably stable for months. Freezing charges the opposite way. Blanching is a brief toll, so the initial loss is smaller - but the

meter keeps running in the freezer, where slow oxidation nibbles away over the season. A two-part review of the research on this concluded something most people find backwards: nutrient loss in fresh produce during ordinary storage and cooking is often larger than we assume. The crisper has a meter too, and it runs fast.

Takeaway: Preserving does not add losses to fresh produce - it swaps a fast meter for a one-time toll.

What the Heat Gives Back.

Heat is not purely a tax collector, which is the part nobody mentions. In a 2002 study, tomatoes heated at 88 °C had more measurable trans-lycopene afterwards than raw ones - roughly two and a half times as much after fifteen minutes - because cooking breaks down cell walls and frees the compound up. Total antioxidant activity rose too.

That is a laboratory measurement of what's extractable, not a demonstration that anyone got healthier, and the study is old enough now to be foundational rather than current. But it punctures a tidy myth. Your simmering pot of sauce is not only subtracting.

The steadier nutrients hardly notice any of this. Carotenoids, vitamin E, minerals and fibre come out broadly similar across fresh, frozen and canned versions of the same vegetable. In two California studies comparing eight commodities side by side, most showed no significant

difference between refrigerated and frozen storage for minerals, fibre and phenolics - and for several vitamins, the frozen samples matched or beat the fresh ones. All of this work is American; no equivalent Canadian dataset exists, though there is no obvious reason a Canadian carrot would behave differently.

Takeaway: Some nutrients are dented by heat, some are freed by it, and most are indifferent.

The Risk You're Not Worried About.

So the nutrition question, honestly, is close to settled and mildly reassuring. The question worth your attention is a different one, and it turns entirely on acidity.

Clostridium botulinum is an ordinary soil bacterium whose spores shrug off boiling water. Give it a low-acid, moist, sealed, oxygen-free environment - which is a precise description of a jar of home-canned beans - and it can produce one of the most potent toxins known. It changes nothing about how the food looks, smells, or tastes.

This is why the pH line at 4.6 matters more than any recipe. High-acid foods - most jams, pickled products, fruit - are held safe by their own acidity and a boiling water canner. Low-acid foods - beans, carrots, corn, peppers, meat, plain vegetable stock - need a pressure canner reaching about 116 °C, because boiling water alone cannot get there. Tomatoes sit awkwardly on the line: their acidity varies by variety and season, so provincial guidance is to add an acid such as lemon juice to tomato products rather than assume.

Perspective, because dread is not the goal. Across sixteen years of Canadian surveillance, 67 confirmed cases of foodborne botulism were recorded nationally - an average annual incidence of about 0.01 cases per 100,000 people - and only two of those outbreaks were traced to home-prepared foods. It is genuinely rare. It is also, when it happens, severe: seven in ten of those patients needed mechanical ventilation.

Takeaway: The jar cannot tell you it is unsafe, so the recipe has to.

A Kitchen That Keeps More.

Practically, most of what protects nutrients also protects safety. Preserve close to harvest rather than after a week of "crisper drift." Use a tested recipe from a provincial health authority or a current preserving guide, and don't improvise the acid, the pressure, or the timing. Cool jars undisturbed and label them with the date.

For the freezer, wrap tightly and keep the door closed - the meter runs on oxygen and temperature swings. And use what you froze this winter rather than the winter after; the losses are gradual, but they are real.

When in doubt, throw it out. Health Canada's guidance is blunt on this point precisely because spoiled-looking food is not the danger; normal-looking food is. Never taste-test a suspect jar, and discard anything from a container that is bulging, leaking, or unsealed.

If someone develops nausea, dizziness, headache, double or blurred vision, a dry throat, or trouble swallowing or speaking after eating home-preserved food - typically twelve to thirty-six hours later - seek care promptly and say what was eaten. Contact your family doctor or local public health unit; 811 works in most provinces and territories for advice. If breathing or swallowing is affected, that is an emergency: call 911. Risk of serious illness runs higher in people who are pregnant, children under five, adults over sixty, and anyone immunocompromised.

Conclusion: Pay the toll knowingly, watch the acid, and February will thank you.

Key Takeaways.

- *Processing is a one-time toll, not ongoing damage. Canned nutrients are stable in the sealed jar; frozen ones decline slowly; fresh produce loses more in ordinary storage than most people expect.*
- *Heat both takes and gives. Vitamin C and B vitamins take a hit, while heating tomatoes made more lycopene measurable - and minerals, fibre, and carotenoids are largely unmoved.*
- *Acidity is the whole safety story. High-acid foods can go in a boiling water canner; low-acid foods need a pressure canner, and tomatoes need added acid.*
- *Botulism is rare but serious, and invisible. Roughly two of Canada's confirmed outbreaks over sixteen years came from home-prepared food - but seven in ten patients needed a ventilator. Never taste-test a doubtful jar.*

"This article is for informational and educational purposes only and does not constitute medical advice. It should not be taken as a medical diagnosis or treatment. Always consult with a qualified healthcare professional for personalized medical guidance."



Blue Light Glasses: Fact or Fiction for Better Sleep?

Prepared By
Anthony Testa
Editor

Tech Talk



Magazica

As Canadians spend more time than ever staring at screens—with 72% clocking over 8 hours daily on digital devices—blue light glasses have become a booming \$27 million industry in Canada. But do these trendy lenses deliver on their promise of better sleep, or are they just another wellness fad? The answer, according to Canadian optometrists and emerging research, is more nuanced than a simple yes or no.

What Is Blue Light and Why Does It Matter?

Blue light is part of the visible light spectrum with wavelengths between 380 and 500 nanometers. While we get a significant amount of naturally occurring blue light from the sun—which helps regulate our circadian rhythm and boosts alertness during the day, the concern lies in artificial sources. LED screens on computers, smartphones, tablets, and televisions emit concentrated blue light that can disrupt our natural sleep-wake cycle.

Dr. Mahnia Madan, a Vancouver-based optometrist, explains: "At night, when the sun sets, the blue light in the environment goes down and tells our bodies that it's time to rest. And in the morning when we wake up with blue light in the environment, it triggers our body to be alert". The problem arises when evening screen exposure mimics daylight, suppressing melatonin production—the hormone that signals our bodies it's time to sleep.

The Sleep Connection: What Canadian Research Shows

The scientific evidence linking blue light glasses to improved sleep is promising but not definitive. A study conducted by researchers at



Université de Montréal found preliminary evidence that blue-light filtering glasses can significantly improve sleep disturbances. The study highlighted the impact of blue light on sleep and emphasized the importance of preventive measures.

One of the most compelling Canadian studies examined permanent night-shift workers at a Canada Post distribution centre in Quebec City. Researchers found that workers who wore blue-blocking glasses before and during their commute home slept, on average, 32 to 34 minutes longer per day and showed improved sleep efficiency. Morning sunlight exposure was maintaining their circadian clocks on a daytime rhythm, and blocking blue light helped correct this disruption.

However, Dr. Melissa Yuen, a Toronto optometrist, offers a note of caution: "There still isn't any great deal of scientific evidence that [blue light glasses] protect us from computer vision syndrome or any harmful kind of light from the computer".

Do They Work for Everyone?

While blue light glasses may benefit certain groups, particularly those with significant evening screen exposure or shift workers, their effectiveness for the general population remains uncertain. The 2023 Health Canada stance on blue light glasses suggests they can help with symptoms but should not be viewed as a cure-all.

The Canadian sleep clinic Sleep Therapeutics notes that overexposure to blue light before bedtime can not only lead to trouble falling

asleep but may decrease overall sleep quality by suppressing melatonin production. Yet experts like Madan recommend simpler solutions: "A blue light filter in itself isn't going to make a big difference. It's more important that patients wear the correct prescription so that they're able to see clearly on the computer".

Beyond the Glasses: Better Sleep Practices

Canadian optometrists universally recommend the 20-20-20 rule: every 20 minutes of screen time, look at something 20 feet away for 20 seconds. This exercise relaxes eye muscles and reduces digital eye strain, which remains a primary concern regardless of blue light filtering. Health Canada also suggests taking regular breaks from screens, blinking often to hydrate the eyes, and optimizing computer ergonomics.

Sleep on It

So, are blue light glasses a bedtime hero or just a stylish screen-time sidekick? Maybe a bit of both. They may help some people—especially shift workers or anyone scrolling deep into the evening—but they work best alongside the classic sleep-friendly habits: dim the screens, take breaks, and give your eyes a rest before bed. In other words, the glasses might help, but your best sleep strategy still starts with powering down before you nod off.



Eye Health Screenings: Getting Kids Ready for the Classroom

Prepared By
Anthony Testa
Editor

As Canadian families prepare for the return to school, one essential health check often gets overlooked: the comprehensive eye exam. With research showing that up to 80% of a child's learning is gained through their eyes, ensuring clear vision is a critical step toward academic success. Yet a recent national survey revealed that 45% of school-aged children in Canada are not receiving annual eye exams as recommended.

Why Vision Matters for Learning

Vision is fundamental to almost everything children do in the classroom, from reading the blackboard to participating in group activities and social interactions. Undetected vision problems can be easily mistaken for learning difficulties, attention issues, or behavioral challenges. Children often assume everyone sees the way they do and rarely complain

about their eyesight, which means problems can persist without identification during key developmental periods. As Dr. Shaina Nensi, President of the Ontario Association of Optometrists, explains, parents are often surprised to learn that vision problems can be mistaken for behavioral or learning difficulties.

Recommended Eye Exam Schedule

The Canadian Association of Optometrists recommends the following schedule for comprehensive eye exams:

- Infants and Toddlers (6 to 9 months): First eye examination
- Preschool Children (2 to 5 years): At least one examination
- School-Age Children (6 to 19 years): Annual examinations

For children without family history of eye problems and no immediate vision concerns, an eye exam before school entry at around 3.5 years of age is recommended, followed by exams annually once in school.

Common Vision Problems in Children

The most frequent issues are often the easiest to correct with a simple pair of glasses: nearsightedness (trouble seeing distance), farsightedness (difficulty seeing close up), and astigmatism (blurred or distorted vision at all distances). Myopia rates in Canadian children have increased significantly in recent years, with one in three children with myopia previously undiagnosed. Other conditions include amblyopia (lazy eye) and strabismus (eye misalignment), both of which can be treated effectively when caught early but become more difficult to correct if left undiagnosed past age eight.

Warning Signs for Parents

While physical signs can include an eye that wanders, parents should also watch for behavioral clues such as squinting, sitting too close to the TV, rubbing eyes frequently, complaining of headaches or tired eyes, and avoiding reading or close work. Irritability, short attention span, or visible frustration with tasks can also indicate an underlying vision issue.

Programs and Coverage Across Canada

Eye exams for children are covered by provincial health plans across Canada. In Ontario, annual eye exams are covered by OHIP for anyone 19 years and younger. Several provinces offer the Eye See...Eye Learn™ program, providing kindergarten students with a free pair of eyeglasses if needed. This initiative is available in Alberta, Manitoba, and Ontario, helping remove financial barriers to proper vision care for young learners.

Protecting Your Child's Eyes

Beyond the eye exam, parents can promote healthy vision by encouraging at least two hours of outdoor play daily, as studies show this can help slow the progression of nearsightedness. Following the 20-20-20 rule—every 20 minutes, taking a 20-second break to look at something 20 feet away—can help reduce digital eye strain from screen use. Sunglasses and hats outdoors, along with proper eye protection during sports, round out a comprehensive approach to eye health.

Seeing Students Start Strong

A comprehensive eye exam is one of the most important items on a child's back-to-school checklist.

With nearly one in four school-aged children having a vision problem, early detection and treatment are key to catching issues before they impact learning, making the eye exam a non-negotiable part of school readiness.





Pet Health in the Dog Days of Summer: Preventing Paw Burns and Heatstroke

Prepared By
Anthony Testa
Editor

As summer temperatures rise across Canada, from the humid streets of Toronto to the sunbaked trails of Alberta, our pets face serious health risks. The "dog days of summer" are more than just a saying—they mark a time when veterinarians see an increase in preventable emergencies. With Canadian summers getting hotter, it's essential for pet owners to be aware of the two most common seasonal threats: paw pad burns and heatstroke. Dr. Emily Durbin, a community veterinarian with the Windsor-Essex Humane Society, points out, "we had kind of a cool spring... this means that our pets haven't had time to acclimate to this weather and they are always wearing fur coats."

The Hidden Danger Beneath Our Feet: Burnt Paws

While we may think of heatstroke as the main summer hazard, burnt paws are one of the most common and overlooked injuries. On a sunny 27°C Day, asphalt can reach a scorching 50°C. At 32°C, it can hit 62°C—enough to cause second-degree burns in under 60 seconds.

Canadian veterinarians recommend the five-second touch test: place the back of your hand on the pavement. If you can't hold it there comfortably for five to seven seconds, it's too hot for your dog's paws. "We forget that they're very unique in that their paw pads are touching the ground as they walk," explains Dr. Rebecca Jackson, an instructor at the University of Calgary's faculty of veterinary medicine. "Black pavement in particular can attract a lot of heat and can cause burn injuries to those paw pads."

Protection and Treatment Options:

- **Dog Booties:** Products like Canadian-made Goo-eez boots provide essential protection.
- **Paw Balms:** Waxes like Musher's Secret create a breathable barrier against heat.
- **First Aid:** If a burn occurs, cool the paws in water for 20-30 minutes and consult a vet if blistering or infection develops.

Understanding and Preventing Heatstroke

Unlike humans, dogs don't sweat through their skin. They regulate their body temperature by panting and the small sweat glands on their paw pads. This is not an effective cooling system in extreme heat. As the temperature rises, their tolerance decreases.

Brachycephalic Breeds at Higher Risk

Flat-faced (brachycephalic) breeds—like pugs, French bulldogs, and Boston terriers—are particularly vulnerable. Their shortened airways make it hard for them to pant effectively. This means they can overheat at temperatures as low as 21-22°C. The Canadian Veterinary Medical Association (CVMA) classifies these animals as "compromised" because they cannot regulate their body temperature.

Safe Practices for Hot Days:

- **Timing:** Walk dogs in the early morning or late evening when temperatures are cooler.
- **Hydration:** Always carry water and offer it frequently.
- **Never Leave Pets in Cars:** Even on a mild day, vehicle temperatures can skyrocket within minutes. The Ontario SPCA
- emphasizes the "No Hot Pets" pledge, reminding owners that leaving an animal unattended in a parked vehicle is life-threatening, even with windows cracked.

- Indoor Cooling: Ensure adequate airflow via air conditioning or fans and consider frozen treats like peanut butter-stuffed Kongs.

Recognizing and Responding to Heatstroke

If a pet's core temperature exceeds 41°C, the risk of heatstroke and multiple organ failure becomes critical. Recognizing the early signs is vital.

Signs of Heatstroke include:

- Excessive, loud panting
- Thick, sticky drool
- Muscle twitching or weakness
- Vomiting or diarrhea
- Disorientation or a dazed look

What to Do:

If you suspect heatstroke, move the pet to a cool area immediately. Use cool (not ice-cold) water and damp towels on the belly, neck, and paw pads to lower body temperature.

Ice-cold water can constrict blood vessels and trap heat internally. Allow the pet to drink small amounts of water and seek veterinary care immediately.

Conclusion

Canadian summers pose specific challenges for our pets, but vigilance and preparation can prevent tragedy. By walking on grass, avoiding peak heat hours, and staying informed about the signs of distress, we ensure our furry friends enjoy a safe and happy season.

As the adage goes, "If it's too hot for you, it's too hot for your pet." If you are ever in doubt about your pet's health during a heatwave, consult your veterinarian immediately.



The Importance of Rest Days in Your Summer Fitness Routine

Prepared By
Anthony Testa
Editor

A Canadian Perspective

As summer arrives with its long daylight hours and inviting outdoor conditions, the temptation to ramp up your fitness routine is strong. After months of shorter days and colder weather, Canadians are eager to make the most of every sunny moment. However, fitness experts across the country warn that more isn't always better, especially when the heat is on. I can attest to this. As a middle-aged man, I still workout with resistance training and cardio, but I find that two resistance training workouts a week with a blended cardio works better. Plus, I can train harder. Rest days are not a sign of weakness; they are a crucial part of any effective training program.

Why Your Workouts Don't Make You Stronger, Your Recovery Does

The most common misconception in fitness is that progress happens during the workout itself. The opposite is true. According to Matthew Lees, a Postdoctoral Fellow in the Department of Kinesiology at McMaster University, "exercise is a controlled form of stress that we impart on our system" that creates damage, especially to muscle tissue. The body then repairs this damage during recovery. This process—known as supercompensation—is what builds strength and resilience.

As Dr. G. Trevor Cottrell, Professor of Kinesiology at Sheridan College in Ontario, explains, "In order for adaptation in the muscle to take place, we need to rest that muscle to prevent further damage from being done. " Without adequate rest, you break down muscle tissue faster than it can repair itself. This can sabotage your training progress and increase your risk of injury.

Overtraining vs. Active Recovery

Canadian researchers emphasize two important concepts: the dangers of overtraining and the benefits of active recovery.

Overtraining occurs when exercise volume or intensity becomes so high that recovery becomes nearly impossible. Dr. Matthew Kwan, Assistant Professor in the Department of Family Medicine at McMaster University, notes that "at least one or two days each week should be dedicated to active rest, whereby you allow your body and your mind to recover from higher intensity training".

Active rest differs from passive rest (like sitting on the couch). Dr. Stephen Cornish, Assistant Professor at the University of Manitoba, explains that during active recovery, energy stores are replenished and muscle damage is repaired without the heavy loading of high-intensity exercise. Activities like walking, gentle yoga, swimming, or light cycling allow you to maintain momentum while promoting recovery.

Signs You Need a Rest Day

How do you know when to take a step back?

Experts identify several key warning signs:

- Persistent muscle soreness lasting more than 48 hours
- Decreased performance—workouts feeling harder than they should
- Fatigue that doesn't improve with sleep
- Loss of motivation or irritability
- Elevated resting heart rate

"Persistent tiredness, feeling 'stale' or demotivated, or an elevated heart rate at rest are all signs you should be building in active rest," says Dr. Stuart Phillips, Tier 1 Canada Research Chair at McMaster University.

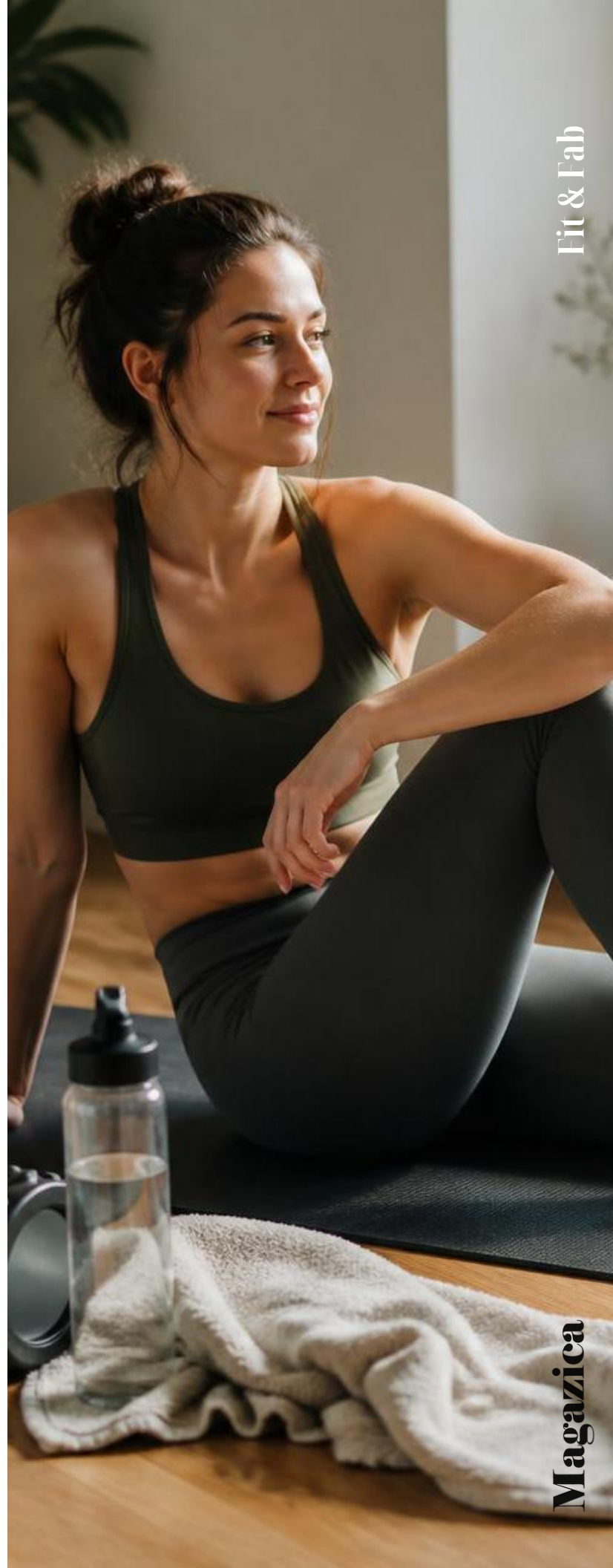
Rest and the Canadian Summer Heat

Summer heat adds another layer of urgency to rest and recovery. As fitness experts in Guelph note, "Life can be more fatiguing in the heat," and listening to your body becomes even more critical. Dehydration and heat stress can compound the physical demands of exercise, making recovery days more important than ever.

A practical approach involves scheduling recovery just like you plan workouts. For many athletes, a hard day should be followed by an easy day. As Dr. Kwan puts it: "Think about your next hard work out if you get the urge to go harder in your active recovery!".

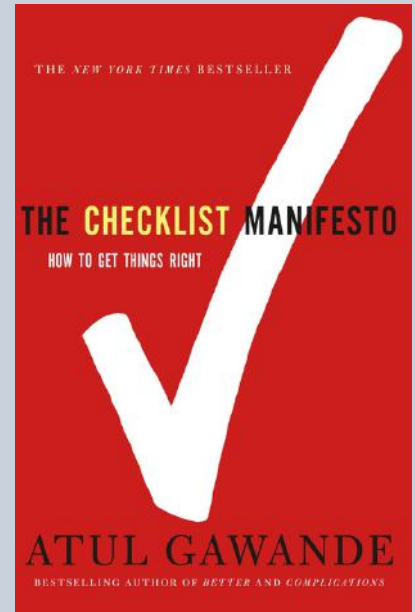
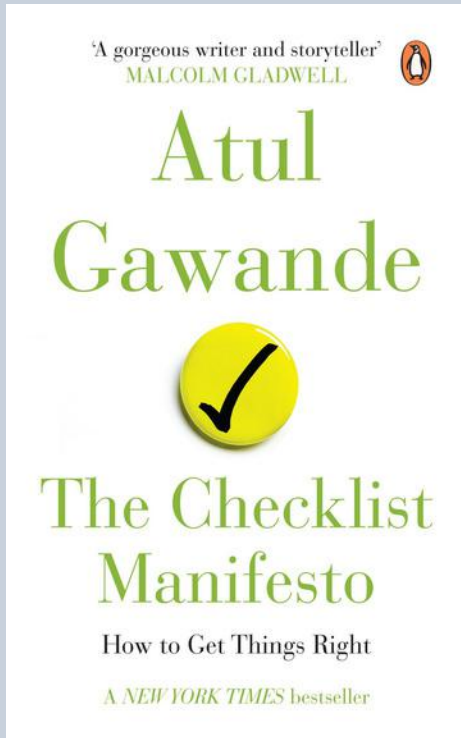
Conclusion

Whether you're a dedicated runner training for a fall marathon or someone simply trying to stay active through the summer months, rest days are non-negotiable for long-term success. Your workouts stress your body; recovery builds it back stronger. Embrace the rest day, schedule active recovery, and you'll find yourself



BOOK

Review



The Simple Device That Is Keeping People Alive During an Age of Excessive Complexity: An Analysis of Atul Gawande's "The Checklist Manifesto"

From Surgical Safety to Money Management: How Expertise Is Not Sufficient To Stop Avoidable Mistakes

Reviewed By
Suman Dhar
Editor-in-Chief

One Halloween night, a patient with a two-inch stab wound in his abdomen was brought to the operating room in San Francisco. The trauma team did all things by the book – measured his blood pressure, observed his respiration, and had the blood bank on stand-by. He appeared fine until suddenly his heart rate soared and his blood pressure dropped. As the surgeons cut him open, they witnessed an "ocean of blood" pouring from the incision site. The stab wound extended over a foot and pierced through the aorta. Everything had been done right, but there was just one small thing that they had forgotten – to inquire about the type of weapon used.

With such an opening by Atul Gawande in his book "The Checklist Manifesto: How to Get Things Right," Atul Gawande raises a very compelling thesis that in the twenty-first century, the problem is not one of ignorance but of ineptitude. As a Harvard surgeon and writer at The New Yorker, Gawande argues that while science has equipped us with "stupendous know-how," there is so much of it that we cannot use it safely and effectively.

Gawande's book will be of interest to a Canadian audience trying to navigate the increasingly complicated healthcare landscape. Gawande notes that we are fixated on "great components": great drugs, great technology, and great experts; yet there seems to be little attention paid to how all these pieces fit together. This means we live in a world where, even with all our brilliance, we forget the "stupid stuff."

The book serves as an intense "infotainment" ride by constantly leaping between the cockpit of the Boeing planes and the construction site of the enormous skyscrapers. Gawande's stories are at their most effective while dealing with the 1935 crash of the Model 299 plane, a plane so advanced that it was considered "too much airplane for one man to fly". What came to the rescue of the nearly bankrupt Boeing company was not increased pilot training but just a simple index card with "dumb stuff" like releasing brakes.

From a wellness perspective, it becomes necessary to acknowledge the skill of Gawande in breaking down the "Right Stuff" syndrome prevalent in many professions. According to him, the traditional model of the hero, which involves being a renegade who manages to make it by virtue of his audacious and cunning nature, is in fact a weakness in an era where there is a great deal of complexity involved. This new professionalism has four components – selflessness, competence, integrity, and above all, discipline.

The heart of the book explains Gawande's involvement with WHO in developing a "Safe Surgery Checklist." The developed checklist with nineteen items seems very simple, with a focus on "killer items," which can be fatal if forgotten, yet are easy to forget. It includes verification of whether the surgical team has the right patient and right surgical site, as well as administration of antibiotics up to sixty minutes before the cut.

Certainly, one would expect critics to find the checklist approach “ridiculously primitive,” and as Gawande himself reports, many surgeons were certainly upset at the idea that they needed one. But the results of the pilot study cannot be overlooked; in eight hospitals around the world, including Toronto General Hospital, the implementation of the checklist was linked to 36 percent fewer complications and 47 percent fewer deaths.

But more importantly than just checking off tasks, the evaluation of the book also takes into account the psychology of teamwork. Gawande points out the “activation effect”; the simple fact of introducing oneself by name and occupation increases the chances of speaking up when an issue arises. It is proposed to treat communication as the final “cognitive net” capturing the errors present in everyone's minds.

Another interesting part is where the author enters the financial world to show how the “cocaine brain” – a primitive reward circuit activated by money-making opportunity – drives even talented investors to cut some corners. He gives examples of investors who started using checklists in order not to forget about the “basics” when analyzing financial statements, like reading footnotes for cash flow.

The prose is informal and urgent; however, the author is very careful to note that checklists are tools that help to remember the basic facts, rather than the “comprehensive how-to guides”. The purpose of the list is to support the expertise of the specialist, not to take its place. Gawande’s personal experience of having

almost killed his patient on the table, as a result of the torn vena cava, is a perfect acknowledgment of human fallibility. As for the result, his patient survived, thanks to the extra blood stored in the blood bank thanks to the checklist.

In “The Checklist Manifesto”, Atul Gawande presents his work as a brilliant example of scientific writing which reveals the miraculous nature of the ordinary. The author asserts that it is essential for people to recognize their weaknesses and utilize an approach in order to compensate for their “inevitable human inadequacies”. For all those who want to know why something goes wrong, Gawande offers a practical manual for the vessel of life.

This review is for informational purposes only and does not constitute medical advice. Always consult with a qualified healthcare professional before making significant changes to your health or wellness routine.



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