ORTHODOX JEWISH NURSES ASSOCIATION

THE OJNA JOURNAL

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Welcome to The OJNA Journal

The history of Jewish nurses goes back millennia. One of the earliest mentions of Jewish nurses is that of Shifra and Puah, midwives who helped Jewish women when their people were enslaved in Egypt. Not only were the midwives caregivers, but they were patient advocates as well. Although ordered by Pharaoh to kill all newborn males upon birth, the midwives argued that Jewish women were so skilled at delivering their babies, they gave birth before the midwives made it to the bedside. Commentaries say that for the act of saving these children, God blessed Shifra and Puah (code names for Yocheved and Miriam) with dynasties of Kohanim and Leviim, priests and Levites, who served in the Temple.

History is dotted with Jewish nurses who joined the profession, from Lillian Wald who revolutionized public health nursing and home health care, to the Hadassah nurses who modeled their health care after Wald's and helped introduce a health care system in what became the State of Israel. Jewish nurses also served in the Spanish Civil War and in the two World Wars. However, nursing as a profession was not valued in Jewish circles in the 1800s and early 1900s. Nursing schools were largely Catholic, which included mandatory Bible class, and there was low admittance of Jewish students. Furthermore, the schedules of nursing schools made it difficult for women to marry, prompting them to have to choose between a career and a family.

However, times have changed. Not only has it become easier for Jewish men and women to enter the nursing profession in nonsectarian programs, but we also have Jewish nursing schools which cater to the Orthodox population in terms of holiday scheduling, cultural sensitivity to numerous medical and nursing issues, and overall flexibility for the men and women who have families to tend to.

With the flood of Orthodox Jewish nurses entering the field, the need for an organizing body to assist these nurses as they begin their careers, advise them on professional issues, and help with social support and networking was realized. The Orthodox Jewish Nurses Association (OJNA) was founded by Rivka Pomerantz, BSN, RN, IBCLC. In its nine years of existence, OJNA, a nonprofit, has hosted several conferences attended by hundreds of frum nurses, organized networking dinners and educational events around the nation, and grown to include over 1,700 members on its Facebook forum.

OJNA also recognizes the increased number of male nurses entering the profession. According to the U.S. Census Bureau of 2016, only nine percent of nurses are male. We value each of the male nurses in the OJNA, and we believe Orthodox male nurses provide unique knowledge and insight which continue to advance our mission.

OJNA is now moving forward to continue to provide resources for Orthodox nurses, to educate them and increase their professional development, and to help its nurses advocate on the individual, community, and even national level. The OJNA Journal is one step we are taking to maintain our dedication to education, advocacy, and community.

You will find articles on trends in nursing, policy updates and guidelines, and relevant nursing research. We will also include creative pieces, such as nurses' perspectives and experiences, poetry, and prose. In Torah and Nursing, you will find a column on halacha in medicine and nursing. Finally, we will have community-related news and views — member achievements, book recommendations, and OJNA updates.

For our first issue we are broaching the issues surrounded complicated pregnancy, childbirth, and unexpected outcomes. When living in communities with high birth rates, it is important for us as nurses and community members to be aware of the possibilities for when things go wrong. Many of us will cross paths with men, women, and infants who have experienced traumatic events related to pregnancy and birth. These conversations are hard to have, and the topics are not frequently discussed. OJNA wishes to change that, and we hope we have done so skillfully, accurately, and with sensitivity.

We look forward to your involvement in our journal, whether you are reading or writing. We invite you to engage with us, to send us submissions, letters to the editors, or letters to your fellow nurses. Keep us updated on your professional journey so others can share in your celebration, whether you have obtained a certification, advanced your degree, or have been awarded an honor.

For submissions or feedback, please email us at OjnaJournal@gmail.com

Best,
Blima Marcus,
DNP, RN, OCN
President, OJNA
Editor, The OJNA Journal

OJNA LEADERSHIP

Mission:

The mission of The OJNA Journal is to

- Provide timely news and research updates
- Relay evidence-based research
- Publicize OJNA programs and upcoming events

All advertising is subject to the approval of OJNA.

OJNA Mission Statement:

The Orthodox Jewish Nurses Association seeks to provide a forum to discuss professional issues related to Orthodox Jewish nurses, arrange social and educational events, and to serve the special needs of its members. We strive to promote professionalism, education, career advancement, and be a voice for the Orthodox Jewish nurses across the world.

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A Message From the Founder

Rivka Pomerantz, BSN, RN, IBCLC

Some of you know that I am the founder of the Orthodox Jewish Nurses Association (OJNA). You have been involved for years and watched the organization grow and evolve. For others, this is your first exposure to the OJNA and I am a stranger. Please let's not be strangers any longer.

My main goal with starting this association was to forge connections between Orthodox Jewish nurses. In early 2008, when I was a new graduate with barely any nursing experience, I started connecting with people online on various websites and message boards. I even encouraged people to join by sending them Godiva chocolates in the mail!

Ten years later, our Facebook forum boasts nearly 1,700 members. We've hosted several nursing conferences and networking dinners, and with the assistance of prior board members, the OJNA has been incorporated as a non-profit organization since 2016.

As you can see, we're growing in numbers and growing professionally. Hashem has helped the right people flow through the proverbial doors of OJNA, bringing more benefits and professionalism to the organization. Continue making those connections, because connections are what brought us here today, to The OJNA Journal. I want to express my extreme gratitude to the many contributors to the OJNA along this journey. Thank you for your encouragement, your commitment, and your kindness.

As Jews, we know the power of the written word. Our sages teach us: אותיות מחכימות, letters make one wise. Please take the time to read, learn from, and enjoy this inaugural issue of The OJNA Journal. Keep coming back for more because you make us who we are.

Let's continue to grow, together.

THIS ISSUE AT A GLANCE:

"If the AMA's singular goal was to increase access to care, they should be delighted with the legislative and professional strides APRNs and PAs are making." page 4

"Couples armed with realistic expectations about the stages of labor, typical and common atypical presentations, as well as the options available to them and their providers in these scenarios tend to have better outcomes and are more satisfied when reflecting on their experiences." page 10

"WHILE GENERALLY WE FOLLOW THE MAJORITY [HALACHIC] OPINION, WHEN ONE HEARS THE RULING FROM THE MOUTH OF ITS ORIGINATOR IT GIVES THE INQUIRER THE RIGHT TO RELY ON IT REGARDLESS OF WHETHER OR NOT OTHERS AGREE." page 9

"There is growing knowledge that the medicalization of labor and birth can negatively impact a woman's experience of this normal and positive life event." page 6

"THOROUGH PREPARATION FOR THE DELIVERY OF A BABY IS CRUCIAL IN MAXIMIZING THE GOLDEN HOUR AND ACHIEVING OPTIMAL OUTCOMES." page 8

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Docs Vs. Nurses: All Out War?

Batsheva L. Bane, BSN, RN

The American Medical Association (AMA) continues to battle all non-physician practitioners, in an effort to endorse physicians as the only competent medical practitioners. In a recent policy meeting on November 13, the AMA voted on Resolution 214 to oppose the "inappropriate scope of practice expansion of non-physician healthcare practitioners" through organization and implementation of a national opposition strategy, legislative efforts, and public education [1]. With the adoption of this resolution, the AMA is setting further stakes in the continued conflict against all Advanced Practice Nurses (APRNs) and physician assistants (PAs).

Who is the AMA, what spurred this resolution, and who are they battling?

According to the United States Department of Health and Human Services, there were 624,434 physicians practicing in the United States in 2010 [2]. The AMA does not freely provide the percentage of physicians associated with the organization, and board of trustees' reports are only available to members. Yet all sources indicate a current membership rate at less than 25% of all practicing physicians in the U.S. [3].

Despite representing a minority of its overall physician constituents, the AMA is still the power player in the healthcare industry, in terms of financial wellbeing and investments on physicians' behalf. The AMA had spent $17.5 million in political contributions in 2017, while the next highest lobby sum from the health industry was a little over $2 million [4]! For comparison sake, the American Nurses Association (ANA) spent $1.2 million in lobbying efforts in 2017, and the American Association of Nurse Practitioners spent approximately $470,000.

What is the AMA lobbying for?

The AMA's official goal, per their website, is "to make healthcare more accessible to everyone", through mitigating health disparities, increasing professional satisfaction, and achieving health equity by advocating for physicians and patients [5].These self-proclaimed goals imply support for the betterment of the healthcare environment for all. Yet it seems like the underlying modus operandi is to favor physicians over all other healthcare professionals, creating a conflict of self-preservation and insecurity.

Why did the AMA vote on Resolution 214?

The AMA's vote on Resolution 214 was in response to the APRN Multistate Compact, which allows for APRN practice without supervision, collaboration, or oversight by physicians in states in which the Compact is enacted [6]. This enables expanded mobility of APRNs and increased interstate opportunities, as well as ensuring APRNs meet state practice requirements and all regulatory compliance. Thus far, only three states have enacted the Multistate Compact, and the Compact will only be implemented when ten states have enacted this legislation [7].

Resolution 214 also comes on the heels of expanded scope of practice of APRNs in the U.S. Department of Veteran Affairs (USVA). The VA's policy, as of December of 2016, allows for "APRNs to practice to the full scope of their education, training, and certification", even in states where there are restrictions limiting such practice [8].

Who is the AMA battling?

Per the National Council of State Boards of Nursing, APRNs include nurse practitioners (NPs), certified nurse anesthetists, certified nurse midwives, and clinical nurse specialists [9]. There are almost 200,000 NPs and PAs practicing in the United States in 2010 [10].

NPs and PAs contribute to overall access to care. The NP and PA role was only created in response to increased patient care needs and the associated physician shortage in the 1960s [10]. As Dr. David J. Shulkin of the VA recently noted, APRNs provide "efficient, effective, and safe primary care" that "alleviate the current access challenges" patients face [7]. Objective outcomes and patient satisfaction measures testify to the adequacy of NPs practicing in the U.S. [11].

Legislation that supports NPs and PAs often receives the support of safety foundations and other associations alike. The APRN compact for example, as well as the enhanced Nurse Licensure Compact (NLC), have received the support of the National Patient Safety Foundation (NPSF) and the American Telemedicine Association [12], further implying that these policies lend to overall patient safety and good outcomes.

If the AMA's singular goal was to increase access to care, they should be delighted with the legislative and professional strides APRNs and PAs are making. Yet they have responded to the APRN Multistate Compact defensively with the creation of Resolution 214. ANA president, Dr. Pamela F. Cipriano called the adoption of this resolution "divisive," perpetuating the "narrative that APRNs are trying to act as physicians, and are unqualified to provide timely, effective, and efficient care" [13].

Perhaps our legislative successes are threatening to the AMA, as they believe physician and NP practice are mutually exclusive. Many physicians support APRN practice, and maybe the AMA simply wants to control it, putting our scope of practice in the back pockets of physician colleagues. Without independent practice, APRN hands are tied behind the backs of individual doctors, leaving our scope of practice to their whim and fancy.

(continued on following page)

DOCS VS. NURSES: ALL OUT WAR? *(continued from previous page)*

Physicians who I have spoken with are excited about working with NPs. NPs shoulder much of the inconveniences of medical practice, such as heavy patient load, overnight call, and inadequate compensation for consultations and relatively simple procedures. Yet while individually supporting our efforts and professional investments, the policy their organization sets invests in legislation to set strict boundaries for our practice.

Controlling much?

Dr. Cipriano concluded her statement by inviting leaders of the AMA to collaborate on measures to increase overall access to care [14]. Nurses and NPs alike seek to collaborate with physicians to increase overall access to care. We all have roles in healthcare, of which there exists dire needs, most notably in closing the health disparity relative to race and ethnicities. Until we have perfected, or improved, our healthcare landscape, let's work together to close the gaps and decrease morbidity and mortality.

Until then, we'll just be playing defense in this one-sided war.

References

[1] American Medical Association House of Delegates. (2017). Report of reference committee B. Retrieved from https://www.ama-assn.org/sites/default/files/media-browser/public/hod/i17-refcommb-annotated.pdf

[2] Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. (2014). The number of practicing primary care physicians in the United States. Retrieved from https://www.ahrq.gov/research/findings/factsheets/primary/pcwork1/index.html

[3] Graham, J. (2016). 'Like a slap in the face': Doctors no longer feel the nation's largest doctors group represent their interests. Business Insider. Retrieved from http://www.businessinsider.com/doctors-american-medical-association-2016-12

[4] Center for Responsive Politics. (2017). Health professionals industry profile: Summary, 2017. Retrieved from https://www.opensecrets.org/lobby/indusclient.php?id=H01

[5] American Medical Association. (2018). About us: Our vision. Retrieved from https://www.ama-assn.org/about/our-vision

[6] National Council of State Board of Nursing. (2015a). Advanced practice registered nurse compact. Retrieved from https://www.ncsbn.org/APRN_Compact_Final_050415.pdf

[7] National Council of State Board of Nursing. (2015b). APRN compact. Retrieved from https://www.ncsbn.org/aprn-compact.htm

[8] U.S. Department of Veterans Affairs. (2016). VA Grants full practice authority to advance practice registered nurses. Retrieved from https://www.va.gov/opa/pressrel/pressrelease.cfm?id=2847

[9] National Council of State Board of Nursing. (n.d.). APRNs in the U.S. Retrieved from https://www.ncsbn.org/aprn.htm

[10] Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. (2014a). The number of nurse practitioners and physician assistants practicing primary care in the United States. Retrieved from https://www.ahrq.gov/research/findings/factsheets/primary/pcwork1/index.html

[11] Stanik-Hutt, J., Newhouse, R. P., White, K. M., Johantgen, M., Bass, E. B., Zangaro, G., Wilson, R., Fountain, L.., Steinwachs, D. M., Heindel, L., Weiner, J. P. (2013). The quality and effectiveness of care provided by nurse practitioners. The journal of nurse practitioners, 9(8), 492-500. doi: https://doi.org/10.1016/j.nurpra.2013.07.004

[12] Market Wired. (2015). Enhanced nurse licensure compact (NLC) and APRN compact receive support of the American Telemedicine Foundation and National Patient Safety Foundation. Retrieved from http://www.marketwired.com/press-release/enhanced-nurse-licensure-compact-nlc-aprn-compact-receive-support-american-telemedicine-2067595.htm

[13] Byrd, V., & McClendon, S. (2017). American nurses association responds to resolution 214 amendment presented to American medical association (11/17/17). American Nurses Association. Retrieved from http://www.nursingworld.org/FunctionalMenuCategories/MediaResources/PressReleases/ANA-Responds-to-AMA-Resolution-214-Amendment.html

[14] Japsen, B. (2014). Nurses say AMA launching 'turf war' over direct access to patient care. Forbes. Retrieved from https://www.forbes.com/sites/brucejapsen/2017/11/20/nurses-say-ama-launching-turf-war-over-direct-patient-access/#7454684f1168

Perinatal Palliative Care: A Proposed Model

Sara L. Abraham, BSN, RNC-OB

Background

When expectant parents learn that their unborn child has congenital abnormalities that are non-compatible with life, they deserve the same option for palliative and hospice care that one would have when caring for any dying family member. After getting their unborn child's diagnoses, many women have said they felt uncomfortable talking about it with their providers or with family and friends. Traditionally, the medical and mental health treatment a family will get is multidisciplinary, but not interdisciplinary.

Proposal

The Children's Hospital of Philadelphia has developed a Perinatal Palliative Care and Bereavement Program to provide continuity of care for families from diagnosis to the postpartum and postmortem periods. This interdisciplinary palliative care program includes obstetrician-gynecologists (OB/GYNs), neonatologists, anesthesiologists, pastoral care, psychiatry and psychology, social work, and child life specialists. Together with these specialties, the parents develop a therapeutic birthing plan long before admission to the labor floor. This kind of advanced planning provides a safe space for open discussion and emotional processing. Like cognitive-behavioral exposure techniques, this process reduces anxiety and emotional distress. Additionally, patients have said that consistent care and support for specific spiritual or religious customs increased satisfaction, so establishing and documenting wishes in advance can greatly improve care. Focusing on normal pregnancy factors throughout, like ultrasound photos and doppler heart tones, also help maintain a woman's emotional well-being. Child life specialists meet with siblings early on to take them through therapeutic play and to assess the family's individual needs. They noted it was important to make sure to tell a child that the baby's death is not their fault, and that their parents will be okay. After delivery, it is important to commemorate the baby's life, however short, by doing normal parenting activities, like holding, touching, dressing, and bathing the baby. Parents should have photos and footprints to take home.

Implications for Nurses

Advanced planning, compassion, and collaboration between doctors, nurses, and the psychosocial team are critical components of providing family center bereavement care. Advanced practitioners, like OB/GYNs, nurse practitioners, and midwives, need to appropriately counsel patients at diagnosis so that they can make informed decisions, and to provide the necessary referrals to other services. Labor and delivery and postpartum nurses are in the best place to advocate for patient needs during and after delivery. Nurses should advocate within their institutions to initiate similar protocols. Nursing leadership should assist with the development of interdisciplinary teams to assist families during this difficult time and ensure best outcomes for families and children.

References

[1] Cole, J. C. M., Moldenhauer, J. S., Jones, T. B., Shaughnessy, E. A., Zarrin, H. E., Coursey, A. L., & Munson, D. A. (2017). A proposed model for perinatal palliative care. Journal of Obstetric, Gynecologic, & Neonatal Nursing, 46(6), 904-911.

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RESEARCH RECAP

Tobi Ash, MBA, BSN, RN & Blima Marcus, DNP, RN, OCN

Medicaid Expansion and Infant Mortality in the United States

In 2013, the American College of Obstetricians and Gynecologists (ACOG) published a report on the anticipated benefits of Medicaid expansion through the Affordable Care Act. The report stated that uninsured women experience more adverse outcomes and that access to health care would result in improved maternal and infant health. In 2014, 31 states and the District of Columbia chose Medicaid expansion.

A study published in the January 2018 edition of the American Journal of Public Health examined infant mortality rates in the United States between 2010 and 2016. The overall infant mortality rate dropped from 6.7 deaths to 5.9 deaths per 1,000 births from 2010 to 2016. However, this decline was not evenly distributed. In the states that opted for Medicaid expansion, infant mortality dropped by more than 50%, with the greatest reduction of deaths in the African American community. Alarmingly, in the states that refused expansion, infant mortality rates crept up.

The authors of this study acknowledged the need to further assess other factors that may have played a role in the declining rate. These may include access to health care prior to pregnancy, earlier and better prenatal care, and healthier pregnancies and births.

The Association of Women's Health, Obstetric, and Neonatal Nurses (AWHONN) believes that access to comprehensive quality healthcare for women and infants is a basic human right. Their position statement published in 2017 reiterates that nursing is is one of the most trusted professions and nurses "play an invaluable role in leading and supporting efforts to increase access to care for all women." With the Healthy People 2020 objective of a 10% decrease in the overall national infant mortality rate, it appears that Medicaid expansion and access to health care has worked to reduce infant mortality rates and reduce health disparities in our diverse communities.

References

[1] Association of Women's Health, Obstetric, and Neonatal Nurses. (2017). Access to health care, position statement of the Association Women's Health, Obstetric, and Neonatal Nurses. Journal of Obstetric, Gynecologic, and Neonatal Nursing, 46, 114-116. 2017. http://www.jognn.org/article/S0884-2175(16)30424-5/pdf

[2] Bhatt, C. B., & Beck-Sagu., C. M. (2018). Medicaid expansion and infantmortality in the United States. American journal of public health, (0), e1-e3.

[3] Committee on Health Care for Underserved Women, & American College of Obstetricians and Gynecologists. (2013). Benefits to women of Medicaid expansion through the Affordable Care Act. Committee Opinion No. 552. ObstetGynecol, 121, 223-225.

[4] U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. (2018). Maternal, infant, and child health: Healthy People 2020 objectives. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-

New Guidelines on Labor and Childbirth Experiences

For more than 60 years, a laboring woman had to follow the "Friedman Curve" that determined progress as 1 cm dilation per hour. Any woman that deviated from this was hurried along with medical interventions of oxytocin drugs or C-section. A new report issued this February by the World Health Organization, titled "Intrapartum Care for a Positive Childbirth Experience," challenges this practice. One of the most important recommendations from the report is that as long as the mother and baby were faring well, a long and slow labor should no longer be considered dangerous.

This report has 56 evidence based clinical and non-clinical recommendations for care of the intrapartum and immediate postpartum women. There is growing knowledge that the medicalization of labor and birth can negatively impact a woman's experience of this normal and positive life event.

This paper emphasized that far too many women suffer physically and psychologically while in labor or delivering their babies. There are cultures that mandate specific behaviors during labor or delivery. This report emphasizes that women should not be left alone, yelled at, slapped or demeaned in any way during their birth experience. They have the right to choose what pain relief they want and when. They have a right to privacy and confidentiality. They have a right to have the companion of their choice to accompany them. They have the right to choose the best birth position for them.

These human rights based guidelines, as well as a woman centered approach, can ensure that women have a safe birth environment that also allows them to have a sense of control, personal achievement, and a positive life changing experience.

References

[1] World Health Organization. (2018). Intrapartum care for a positive childbirth experience. Retrieved from http://www.who.int/reproductivehealth/publications/intrapartum-care-guidelines/en/

An Ethical Perspective on Providing Evidence-Based Care

Is it ethical to provide nursing care which is not evidence-based? A new article attempts to clarify how evidence-based nursing care and ethics are related. It is well established that evidence-based practice (EBP) enhances patient outcomes as well as practitioner satisfaction. It is also known that EBP is not practiced as widely as it could and should be. The Institute of Medicine has set a goal that by 2020, 90% of clinical decisions should be based on timely evidence [1].

What does ethics have to do with evidence?

If one considers the principles of biomedical ethics, it becomes more apparent. Respect for autonomy means engaging patients in their decision making and ensuring that they have the information and support needed to make those decisions. If a patient does not receive full consent or is not informed on their health options, they are not able to adequately make clinical decisions.

Nonmaleficence is the fundamental cornerstone which instructs healthcare providers to do no harm. Maintaining client safety may involve doing nothing, or finding new evidence to improve patient care. Sometimes, providing care that is not evidence-based is harmful and thereby unethical.

Beneficence, to do good, instructs providers to ensure that the care they provide results in good outcomes. Providers must consider the patient's preferences (autonomy) together with recommended EBP to ensure best practice.

The fourth principle involves justice. That all people are created equally and should be treated as such is another foundation of nursing practice. Cleary-Holdforth argues that nurses must remain concerned with issues which may compromise justice. This includes disparities in health care, unequal distribution of resources, and subpar quality of care [2].

Implications for Nurses

The author concludes by affirming that care provided to patients that is not evidence-based is failing to provide best outcomes and is therefore unethical. Barriers to implementing EBP may include institutional pushback, language barriers, working in underserved institutions where resources are limited, staff burnout and high nurse-patient ratios, and lack of support from nursing leadership.

The author acknowledges that nurses must maintain autonomy in their practice, must possess the motivation and knowledge to implement EBP, and must work on institutional or legislative barriers which prevent them from practicing using best available science.

Nurses must remain advocates for their profession and for their patients. Nurses must remain informed on best practice, join committees at their institutions, and lobby for policies which reflect the ethical foundations of our practice.

References

[1] Olsen, L., Aisner, D., & McGinnis, J. M. (2007). The Learning Healthcare System: workshop summary (Institute Of Medicine roundtable on evidence-based medicine).

[2] Cleary-Holdforth, J. (2017). Evidence-Based Practice: An Ethical Perspective. Worldviews on Evidence-Based Nursing, 14(6), 429-431.

Epigenetics of Smoking: How Cigarette Smoke Induced Genetic Changes to Human Bronchial Cells, and Why Do We Care?

Epigenetic changes to our DNA are responsible for expressing or silencing genes, including cell growth or preprogrammed cell death. It is also responsible for the development of malignancies, and many of these changes are caused by our own actions or inactions - what we eat, how we sleep, and our environmental habits. Cigarette smoking has long been known to cause cancer, but a recent study reproduced how cigarette smoke actually triggered malignant changes.

Researchers exposed human endothelial bronchial cells (HEBCs) to a steady stream of cigarette smoke condensate (CSC) and found that over time the HEBCs underwent significant change. These methylation changes (inactivation of tumor suppressor genes) made the cells more susceptible to oncogenic triggers, thus inducing uncontrolled cell growth. Furthermore, the CSC-exposed cells began growing tumors in mice three months after injection, while the control cells did not.

However, this study, as well as others, have found that within several weeks of smoking cessation, the adverse effects are partially reversible. While it is not known exactly how much damage remains, the benefits of smoking cessation are considerable and nearly immediate.

Nurses are in a direct position to help patients and community members learn the risks of smoking and the immediate benefits of smoking cessation. Nurses need to be aware of resources they can direct patients to if they express interest in smoking cessation programs or nicotine replacement therapy. The Centers for Disease Control and Prevention (CDC) is one evidence-based source for healthcare providers. SmokeFree.gov contains extensive options for smoking cessation including text messaging programs, and separate resources and programs for teenagers, pregnant women, and veterans.

References

[1] Tsaprouni, L. G., Yang, T. P., Bell, J., Dick, K. J., Kanoni, S., Nisbet, J., ... & Buil, A. (2014). Cigarette smoking reduces DNA methylation levels at multiple genomic loci but the effect is partially reversible upon cessation. Epigenetics, 9(10), 1382-1396.

[2] Vaz, M., Hwang, S. Y., Kagiampakis, I., Phallen, J., Patil, A., O'Hagan, H. M., ... & Easwaran, H. P. (2017). Chronic cigarette smoke-induced epigenomic changes precede sensitization of bronchial epithelial cells to single-step transformation by KRAS mutations. Cancer cell, 32(3), 360-376.

The Golden Hour: Best Practices in Neonatal Management

Anna Pearl Rivkin BSN, RNC-NIC

The Golden Hour

The golden hour is a term commonly used in emergency medicine. It refers to the critical first hour following a trauma. Effective and prompt treatment during this time are invaluable toward achieving positive outcomes and reducing morbidity and mortality. The neonatal community has similarly adopted the term. This describes the value of the first hour after birth when stabilization of a newborn and associated activities will have a powerful impact on the baby's immediate and long-term outcomes outcomes [1].

Guidelines for Full-term/Healthy Neonates

In healthy, full-term infants, three practices during the golden hour promote adaptation for the neonate to extrauterine life and improve bonding between the mother and baby: (1) delayed cord clamping, (2) skin-to-skin contact between mother and baby, and (3) breastfeeding. Delayed cord clamping after birth is essentially a transfusion of blood from the placenta to the newborn. This transfusion has been shown to increase red blood cell volume and improve circulation in the newborn. The benefits of delayed cord clamping are identifiable even up to 6 months later with infants having higher iron levels than infants who did not. Skin-to-skin contact is extremely beneficial in maintaining thermoregulation and promotion of breastfeeding thereby reducing hypoglycemia. Skin-to-skin contact and early breastfeeding are also paramount in establishing mother and baby bonding. Assessments for healthy, full term infants may be conducted while the baby is skin-to-skin and further nursing interventions are delayed until after the golden hour [2].

Guidelines for Premature/Unstable Neonates

When caring for premature or unstable term babies, the ideal practices during the golden hour focus on swift, gentle, and effective measures of stabilization [3]. Delayed cord clamping is recommended in certain scenarios for premature infant [4], but skin-to-skin and breastfeeding must be deferred until the baby is medically stable and developmentally ready. Several protocols have been developed to ensure stabilization of the unstable neonate to promote best outcomes.

Neonatal Resuscitation Program & S.T.A.B.L.E Neonatal Educational Program

The Neonatal Resuscitation Program (NRP) and the S.T.A.B.L.E (Sugar, Temperature, Airway, Blood Pressure, Lab Work, and Emotional Support) neonatal educational program are two programs developed to maximize efficiency and success during an infant's golden hour. NRP primarily addresses airway, breathing, and circulation (ABCs) and is used to ensure all babies are efficiently resuscitated utilizing the least-invasive support required [5]. Oxygen should be cautiously administered to target the saturation level expected for each minute of life. These measures prevent long-term damage to the lungs, chronic lung disease, retinopathy of prematurity [3] and bronchopulmonary dysplasia [4].

The S.T.A.B.L.E. neonatal educational program design by Kristine Karlsen, similarly addresses the vital components of neonatal resuscitation, but additionally focuses on the entire medical picture to stabilize sick infants for transport [6]. For example, stable temperatures prevent cold stress, hypoglycemia, respiratory distress and hypoxia, impaired blood pressures and inadequate cerebral blood flow [3]. Many measures have been established to combat hypothermia including maintaining a high temperature in the delivery room, using pre-warmed blankets, quickly removing wet towels, placing a hat on the infant, placing the infant into a pre-heated and humidified incubator, using a thermal mattress, wrapping in plastic, and using humidified oxygen and gas [3, 4].

Implications for Nurses

Thorough preparation for the delivery of a baby is crucial in maximizing the golden hour and achieving optimal outcomes. A baby's first hour of life can be chaotic and overwhelming especially for a premature or sick infant. Specific roles should be predesignated for all members of the interdisciplinary team who will be assisting in the resuscitation and stabilization of the infant.

Nurses play a major part of the interdisciplinary team when implementing the NRP and S.T.A.B.L.E programs during the golden hour. The most important task for the admitting nurse is to ensure all necessary supplies and equipment are working and ready for use. This will minimize delays when every second counts. A suction machine and an appropriate bag and mask should be ready for use to administer positive pressure ventilation. Appropriate preparation and a united interdisciplinary team will guarantee best practices in neonatal management and increase the probability of success during every infant's golden hour.

References

[1] Castrodale, V., & Rinehart, S. (2014). The Golden Hour. Advances in Neonatal Care,14(1), 9-14. doi:10.1097/anc.0b013e31828d0289

[2] Neczypor, J. L., & Holley, S. L. (2017). Providing Evidence-Based Care During the Golden Hour. Nursing for Women's Health,21(6), 462-472. doi:10.1016/j.nwh.2017.10.011

[3] Reynolds, R. D., Pilcher, J., Ring, A., Johnson, R., & Mckinley, P. (2009). The Golden Hour: Care of the LBW Infant During the First Hour of Life One Units Experience. Neonatal Network: The Journal of Neonatal Nursing,28(4), 211-219. doi:10.1891/0730-0832.28.4.211

[4] Sharma, D. (2017). Golden hour of neonatal life: Need of the hour. Maternal Health, Neonatology, and Perinatology,3(1). doi:10.1186/s40748-017-0057-x

[5] Weiner, G. M., Zaichkin, J., & Kattwinkel, J. (2016). Textbook of neonatal resuscitation. Elk Grove Village, IL: American Academy of Pediatrics.

[6] Karlsen, K. (2013). The S.T.A.B.L.E. Program pre-transport post-resuscitation stabilization care of sick infants: guidelines for neonatal healthcare providers: learner provider manual. Park City, UT: S.T.A.B.L.E. Program.

[7] Lambeth, T. M., Rojas, M. A., Holmes, A. P., & Dail, R. B. (2016). First Golden Hour of Life. Advances in Neonatal Care,16(4), 264-272. doi:10.1097/anc.0000000000000306

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NURSING DO'S AND DONT'S

Pregnancy Loss: A Patient's Perspective

Nechama Schofield, LMSW

When I married my high school sweetheart, I thought we had it all. I naively assumed we would enjoy each other, start a family, and everything would be perfect.

But life is not so simple.

When we decided to go off of birth control, we thought that was it, that within a few months we'd be starting our family. But a year came and went and I still wasn't pregnant. I couldn't help but think there must be something wrong with me. One month I took a test in the middle of the night. I did it in secret so I wouldn't have to crush my husband again and tell him another cycle didn't work. But I was so relieved and exhilarated when it was positive.

Each day after that I felt like a walking miracle. I talked to the baby in my belly constantly. I prayed for that little baby to keep growing every day.

Then I started spotting. I called my obstetrician and was told repeatedly that a little spotting could

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HALACHA AND NURSING

Abortions & Halacha

Rabbi Micha Cohen

Introduction

For a couple expecting a child, learning that the fetus has severe fetal anomalies is devastating. In such situations, Orthodox Jewish couples will often turn to a trusted Jewish friend in the medical profession for advice and direction. This raises a number of important halachic (pertaining to Jewish law) questions: First, is it permissible for a Jewish person to have an abortion when fetal anomalies are present, and if permitted, under what circumstances? Furthermore, is it appropriate for a medical professional to tell a patient the name of a *posek* (halachic authority) who has permitted abortions in similar situations? This article will provide a brief summary of the major halachic positions on abortion, as well as general halachic guidance in advising patients how and where to seek rabbinic counsel.

Halachic Opinions Regarding Abortions

Classic Rabbinic Sources on Abortion

The question of abortion is a serious halachic issue and requires direction from an expert *posek*.

According to the Nodah BeYehudah, Maharam Shick, Rabbi Chaim Soloveitchik, Rabbi Moshe Feinstein, and Rogachover Gaon the prohibition of abortion is *retzicha* (murder), one of the three cardinal sins. Therefore, an abortion is only permitted in circumstances where the fetus has the status of a *rodef* (a "pursuer") whose life may be terminated in order to save the pursued (i.e. the mother) [1].

However, the Toras Chesed of Lublin and Rabbi Chaim Ozer Grodzensky understand that this classification is only applicable when the woman is in active labor[2]. During the pregnancy, however, the fetus is just considered a part of the mother's body. As such, while an abortion is still a Torah prohibition, it would not constitute one of the three cardinal sins. Therefore, in certain situations these *poskim* would allow more room for leniency during the prenatal period, than according to the first approach.

The Sheilas Yaavetz, Chavos Yair, and possibly the Maharit take a more lenient approach based on the opinion of Tosfos. Tosfos seems to hold that abortion is permitted for non-life threatening maternal considerations. Contemporary *poskim* primarily base their opinions on these three approaches[3].

Contemporary Views

In 1975, Rabbi Eliezer Yehudah Waldenberg was asked by Shaare Zedek Medical Center if it is permitted to abort a fetus with Tay-Sachs disease. Rabbi Waldenberg writes that in such circumstances abortion could be permitted until the seventh month of pregnancy [4]. This position is based on the most lenient view of abortion.

Rabbi Moshe Feinstein sharply criticized Rabbi Waldenberg's position [5]. Rabbi Shlomo Zalman Auerbach [6], Rabbi Ovadia Yosef, Rabbi Shmuel Wosner, and Rabbi Yosef Shalom Elyashiv do not seem to accept Rabbi Waldenberg's permissive ruling regarding Tay-Sachs. However, they differ in situations of fetal anomalies where the fetus has little or no chance of survival for more than a few hours or days after birth.

Rabbi Shmuel Wosner in *Shevet HaLevi* discusses situations where the fetus has serious abnormalities in the brain or heart and cannot survive very long after birth. He leans toward the approach of the Toras Chesed, who views abortion as a Torah prohibition but not one of the three cardinal sins. Moreover, he argues that if, unfortunately, the fetus is a *triefah* (a human or animal with injury or bodily harm that most likely will not survive for twelve months), or a *nefel* (that cannot live for 30 days), its status is further compromised. Therefore, under these circumstances one could permit aborting the fetus in a situation where the mother is in great anguish [7]. However, it does not seem that Rabbi Moshe Feinstein would agree with this approach.

All opinions agree that if the pregnancy endangers the mother's life, the fetus may be aborted. It is not clear, however, if this permissibility is limited to physiological risks or if it extends even to psychological issues. The Levushai Mordechai considered serious psychiatric issues resulting from the pregnancy as legitimate maternal considerations. Likewise, Rabbi Feinstein viewed the risk of a nervous breakdown as a legitimate reason to abort even when such risk is not directly caused by the fetus [8].

Helping a Patient Choose Which Rabbi to Ask

As we have seen, there are differing views on abortion for fetal anomalies. Is a patient allowed to specifically seek a rabbi who is known to be lenient? Is it proper for a Jewish medical professional to provide this information? This important question touches on many issues, including the entire concept of "asking a *sheilah*" (posing a question to a halachic authority).

Asking a *Sheilah*

When there is a difference of opinion between halachic sources an individual should generally follow certain guidelines - like following the majority opinion or being stringent with a Torah prohibition and being lenient with a prohibition of rabbinic origin [9]. However, there is an option to pose the question to a competent rabbi and follow his opinion, even if his opinion is not the widely accepted view. Rabbi Moshe Feinstein in *Dibros Moshe* explains this phenomenon based on an episode recounted in the Talmud [10]. The Talmud relates that Rabbah Bar Chuna ate a certain fat (*chailev*) that other rabbis deemed to be forbidden. Rabbah Bar Chuna explained that he is permitted to eat it because he heard the ruling from the mouth of Rebbe Yochanan, but that others may not [eat it] because it is a minority opinion [11]. Rabbi Feinstein understands from this vignette an important dimension to the halachic decision-making procezss. While generally we follow the majority opinion, when one hears the ruling from the mouth of its originator it gives the inquirer the right to rely on it regardless of whether or not others agree. The Chazon Ish takes a similar approach [12].

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ABORTIONS & HALACHA

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This concept gives important direction when posing a halachic query in a serious situation. The inquirer is allowed to ask a rabbi who may rule more leniently, even if others disagree. However, as Rabbi Feinstein explained, it is only if the rabbi is of great stature and could be considered the originator of the ruling. This means that the rabbi needs to have the level of scholarship that he can defend his position on the issue.

Advising Others

Advising others poses a unique challenge. Helping a patient find the right rabbi who has the time, patience, sensitivities, halachic expertise, and medical understanding is clearly a great *mitzvah* (good deed in keeping with Jewish law). The more difficult question is if it is permitted to direct the patient to the rabbi that will give the answer "the patient wants."

There is a halachic discussion about the balance between the obligation to help others and not impeding the judicial process [13]. Similarly, when a medical professional knows various rabbinic positions on the issue, sending a patient to a particular rabbi may be in essence deciding the question for them. This is something that a medical professional is not qualified to do.

For this reason, it would seem that the decision to rely or consult a minority opinion must come from the patient. Accordingly, the role of the medical professional is to provide accurate and balanced information, not to impose a position. If in such situations most rabbis would not permit an abortion but some would, the patient should be made aware of exactly this. If with the proper information the patient chooses to take a more lenient approach, the patient should be directed to consult a rabbi of stature who can defend his position on the matter, as stipulated in the *Dibros Moshe*.

Final Thought

Often, medical practitioners become involved with couples dealing with fetal anomalies. Their commitment as Torah Jews and their professional expertise can be a great asset in navigating these difficult decisions. However, giving halachic guidance is a serious and sensitive issue. If the couple has a spiritual leader like a *rebbe* (personal rabbi) or *rosh yeshiva* (head of a jewish institution) who can responsibly direct them to which halachic authority they should consult, utilizing that connection may be very helpful. This could alleviate a medical practitioner's burden of giving advice in an area that may be outside his or her expertise [14].

References

[1] *Yabia Omer*, Even HaEzer 4:1, citing *Nodah BeYehudah* and Rogochover Gaon, *Chidushei R' Chaim HaLevi* on Rambam; *Igros Moshe*, Choshen Mishpat 2:69–71.

[2] Toras Chesed 2:42–44, *Achiezer* 3:72.

[3] Cited in Yabia Omer Ibid.

[4] *Tzitz Eliezer* 13:102; *Emek HaTeshuvah* 2:92 takes a similar position.

[5] *Igros Moshe*, Choshen Mishpat 2:69–71.

[6] *Nishmas Avraham*, Choshen Mishpat 425.

[7] *Shevet HaLevi* 9:266.

[8] *Reshumai Aharon* [Felder], Choshen Mishpat 425:4. See Dr. A. Steinberg's *Encyclopedia of Medical Halachah* for further sources.

[9] See Rem"a CM 25:2.

[10] Dibros Moshe Tractate *Shabbos* 10.

[11] *Pesachim* 51a.

[12] *Chazon Ish*, Yoreh Dei'ah 150:1.

[13] See Mishna *Avos* 1:8, *Seder HaDin*, ch. 16 for extensive discussion.

[14] A more comprehensive discussion of these issues can be found in Healing in Halacha (Mosaica Press 2016) by this author, pg. 197.

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MUSINGS

Abandoning the Ideal Birth Plan

Esther Lebovic, DNP, FNP-BC, CS

Women today are inundated with information about ideal childbirth experiences and often reminded about the body's innate ability to birth, feed, and nurture naturally. This may often lead to the mistaken assumption by primiparous prenatal patients that childbirth will be easy and follow their birthing plans. Although the literature has shown that patients with birthing plans or prenatal childbirth education are more likely to have vaginal births [1], there are mixed reviews about birth plans and their effectiveness [2]. To increase positive outcomes and patient overall satisfaction with their antenatal healthcare providers and birth experience, enhancing communication and fostering partnerships between pregnant couples and their providers is key [3].

Childbirth has been a natural, yet often life-threatening process from the beginning of time. Women labored in their homes attended by loved ones or local midwives. As modern medicine evolved and anesthesia became a viable option, childbirth became a medical issue managed in hospitals by physicians [4]. On the wings of the women's liberation movement came a renewed interest in the feminine capacity to birth a child. Women found that there were more ways than one to bring their babies into the world. Gone were the days when birthing women were sedated and childbirth was an event that happened to them. Women began to view themselves as participants in the process, making choices that reflected their understanding of the nature of reproduction and the naturalness of childbirth [3].

A recent Time magazine article titled "The Goddess Myth: How a Vision of Perfect Motherhood Hurts Moms" covered the very idea that American women hold themselves to a very high standard when it comes to birthing and parenting their children [5]. This is at least until they experience it themselves. Those interviewed expressed feelings of disappointment in themselves and their birth experiences. They had negative judgements about how they responded to the challenges, both expected and unforeseen, of childbirth as well as breastfeeding and childrearing. Many had regrets and felt shame about their unsuccessful attempts to deliver naturally, without epidural or anesthesia, or having cesarean sections. Unfortunately, many of these sentiments are expressed by Orthodox Jewish mothers as well.

Children and family are of utmost importance to Orthodox Jewish women [6]. Personal development as well as providing the very best for their offspring are strong values of their culture. This may contribute to the desire for the ideal childbirth experience for both mother and baby as well as the desire to breastfeed exclusively while simultaneously caring for other family members and working outside of the home. Culturally competent prenatal and maternity education, resources, and support would be greatly beneficial to this population especially because they tend to be multiparous.

Nurses are well positioned to support pregnant women in their quest for childbirth education and the development of oral or written birth plans [7]. Whether they are employed in outpatient women's health or obstetrics and gynecology (OB/GYN) clinics as well as inpatient labor and delivery or maternity units, nurses and advanced practice nurses such as nurse practitioners and nurse midwives can each play a role in the creation of healthcare partnerships between patients and their providers [3]. These collaborations present opportunities for prenatal and lactation education, personal and individualized birth planning, referral to appropriate resources, and postpartum follow up. This preparation is vital for patients when faced with making informed decisions based on prior contemplation and planning. Couples armed with realistic expectations about the stages of labor, typical and common atypical presentations, as well as the options available to them and their providers in these scenarios tend to have better outcomes and are more satisfied when reflecting on their experiences [1,3].

Moreover, nurses can gently guide birthing women to focus on the ulti-

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Congenital Diaphragmatic Hernia: Understanding the Diagnosis, Treatment, and Importance of Prenatal Testing

Shevi (Elisheva) Rosner, MSN, RN-C

Abstract

Congenital diaphragmatic hernia (CDH) is a relatively rare anomaly that occurs in three out of every 10,000 live births and is considered the costliest defect of the neonatal period. It is a defect in the formation of the diaphragmatic muscle that occurs during the early prenatal stage. Postnatal issues associated with CDH include pulmonary underdevelopment, severe and chronic respiratory distress, growth and feeding issues, developmental delay, and orthopedic deformities. While survival and patient outcomes have improved over the years, it is imperative that parents be informed of this diagnosis during the prenatal stage to ensure proper delivery and care of their neonate during and after surgical repair.

A Little Pathophysiology

The diaphragm is the muscle that separates the chest and abdominal cavities. It is the main muscle used in respiration. In a case of CDH, the diaphragm does not fully form during gestation. The stomach, intestines, and liver can herniate into the chest cavity which causes underdevelopment of the lungs, known as pulmonary hypoplasia. The herniation most commonly occurs on the left side of the diaphragm, but can also occur on the right side [1].

Compression of the lungs during fetal development creates many issues for a neonate. As mentioned above, pulmonary hypoplasia is the formation of a smaller lung on the affected side. This decreases airway and arterial development, thickening of the pulmonary vessels, and increases pulmonary resistance [2]. The most significant issue facing neonates with CDH is persistent pulmonary hypertension of the newborn, known as PPHN, due to the associated findings listed above. Management of PPHN will be discussed below.

Preparation for Delivery

CDH is detected on ultrasound as early as 11 weeks gestation [2]. Classic ultrasound findings include abdominal organs in the thoracic cavity, a fluid-filled abdomen, and polyhydramnios (increased amniotic fluid). Although CDH is usually an isolated finding, it can be found in association with genetic syndromes [3].

Prenatal testing is crucial. A neonate with CDH should be delivered in a hospital with an excellent NICU and pediatric surgeons who have operated on this defect. An experienced NICU with a high case volume treats at least six CDH cases per year year [3]. Prenatal testing and confirmation of the defect before delivery allows parents time to emotionally prepare for the birth and expected NICU stay.

Neonates with CDH are generally born at term (>39 weeks gestation). Upon delivery, nurses should be ready for immediate intubation. Continuous positive airway pressure (CPAP) and blow-by oxygen should not be administered as it will introduce air into the abdomen causing bowel distention and more pressure on the compressed lungs. A salem sump tube is placed to continuous low wall suction to remove all air from the abdomen [3].

Physical assessment findings include: nasal flaring and retractions, asymmetric chest expansion, scaphoid abdomen (because organs are located in the chest cavity), bowel sounds auscultated in the chest, and the heart displaced to the right side.

Managing PPHN

The diagnosis of PPHN is confirmed via echocardiogram which measures the pressures in the heart chambers and surrounding vessels. Treatment for PPHN is complex and requires respiratory support and gentle ventilation (high ventilator settings cause trauma to the already damaged lungs). Oxygenation should be provided for a target saturation level in the mid nineties nineties [3]. Inhaled nitric oxide (iNO) and sildenafil (Viagra) are used to relax and vasodilate the heart and lung muscles. Inotropes such as dopamine, milrinone, and epinephrine provide cardiovascular support and manage right-to-left shunting of blood in the atria [4]. Permissive hypercapnia is the tolerance of a carbon dioxide level of about 50-70 mmHg and is shown to improve respiratory outcomes [5].

A general nursing rule for handling neonates with PPHN is minimal intervention and stimulation of the neonate. In an effort to decrease stress on the neonate, nursing cares should be clustered and suctioning should be kept to a minimum and performed only as needed.

Neonates that are not well controlled with the above interventions are placed on extracorporeal membrane oxygenation (ECMO) to allow the heart and lungs a chance to rest prior to surgery. Some infants with severe PPHN may need to be surgically repaired while on ECMO. ECMO is performed in a level IV NICU; therefore, prenatal discussion of delivery of the neonate should include this criteria.

Surgical Repair

Once the baby is stable enough for surgery, an

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CONGENITAL DIAPHRAGMATIC HERNIA: *(continued from previous page)*

open or laparoscopic repair is done by bringing down the abdominal organs and keeping them in place with a surgical patch. Complications related to use of the patch include risk of infection and risk of reherniation requiring another surgical repair.

Postoperative care involves monitoring respiratory and cardiovascular systems, pain assessment and treatment, hydration and electrolyte management [1]. Neonates that have undergone a CDH repair will often continue to show signs of PPHN and require medical and respiratory support.

Beyond the NICU

The mortality rate is 10-35% and neonates who survive often face chronic issues after leaving the NICU. Respiratory infections, bronchitis, aspiration pneumonia, gastroesophageal reflux disease, poor feeding, oral aversion, poor growth, chest deformity, and developmental delay are concerns for survivors of CDH.

Conclusion

CDH is a rare diagnosis, yet complications at birth and during childhood are extensive [2]. Management of CDH and PPHN requires a skilled team of health care members who are knowledgeable and capable of treating the condition.Nurses should be educated about this defect and be an advocate for their fragile patients and families who receive this difficult diagnosis.

With the use of prenatal testing, parents will be prepared to deliver their neonate in an appropriate health care facility and will be emotionally prepared for the long journey ahead.

References

[1] Hartnett, K.S. (2008). Congenital diaphragmatic hernia: Advanced physiology and care concepts. Advances in Neonatal Care, 8:2, 107-115.

[2] Register, C. H., Jnah, A. J., & Newberry, D. (2016). Congenital diaphragmatic hernia: Interprofessional care of the neonate and family grounded in Swanson's theory of caring. Neonatal Network, 35(6), 381-390.

[3] Snoek, K.G. (2016). Standardized postnatal management of infants with congenital diaphragmatic hernia in Europe: The CDH EURO consortium consensus - 2015 update. Neonatology, 110: 66-74.

[4] van den Hout, L., Reiss, I., Felix, J. F., Hop, W. C. J., Lally, P. A., Lally, K. P., ... & Congenital Diaphragmatic Hernia Study Group. (2010). Risk factors for chronic lung disease and mortality in newborns with congenital diaphragmatic hernia. Neonatology, 98(4), 370-380.

[5] Guidry, C. A., Hranjec, T., Rodgers, B. M., Kane, B., & Mcgahren, E. D. (2012). Permissive hypercapnia in the management of congenital diaphragmatic hernia: Our institutional experience. Journal of the American College of Surgeons, 214(4). doi:10.1016/j.jamcollsurg.2011.12.036

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be normal and not to worry.

So for about a week, I watched the spotting and prayed for the best. Then I started cramping and the spotting got heavier. Ben and I got in the car and went straight to the emergency room. They wanted to do an ultrasound, but they insisted that Ben could not come in with me.

I needed him desperately, but I had to go through this alone. Within seconds, the tech turned the screen away and I immediately knew something was wrong. Then the doctor came in, diagnosed me with a "threatened abortion," and sent me on my way.

There are so many things the doctors and nurses could have done to help me get through this trauma. The medical staff minimized my suffering and anxiety, and made me feel stupid for caring about the tiny baby inside me. Nobody told me it was not my fault my baby died; nobody held my hand and told me it would be ok. One nurse even complained about all the blood she had to deal with while I was hemorrhaging.

A few months later we were thrown back on the roller coaster. But the next time I saw those two little lines, I knew how terrifying it was to be pregnant. The innocence of pregnancy was gone. And again I was faced with heartbreak and disappointment when this pregnancy was also short lived.

This loss came as even more of a shock because every doctor and nurse told us (inaccurately) that it was statistically unlikely to lose two pregnancies in a row; that most women go on to have healthy pregnancies after loss. So when I became the exception to the rule, I was devastated.

After this, we went to a fertility clinic and started treatments to try to get pregnant more easily and avoid more miscarriages. The staff at the clinic were very compassionate and caring. The nurses held my hand and supported us through everything. They gently explained every treatment, test, and procedure, and cheered us on every step of the way, never complaining or losing sight of what we were going through.

And so, after years of trying, we finally welcomed our first child. We had always talked about having our kids close in age. So while we were still grieving and healing and processing what we went through to get our miraculous "rainbow baby" (a baby after a loss), we started again, not knowing how long or how much intervention it would take to have another baby.

After losing two more pregnancies, we went in for countless tests and procedures by our reproductive endocrinologist (RE), only to find out nothing was wrong and I was diagnosed as a "habitual aborter." This is the horrifically offensive medical term for a woman who has lost three or more pregnancies.

After months of tests, treatments, and monitoring, we were blessed to finally get pregnant again. But after so many losses, it was hard to feel hopeful. There were numerous scares during this pregnancy as well. In fact, the RE gave the pregnancy a very low chance of survival. He apologized for being so honest, but I was grateful that for the first time someone tried to prepare us for what could really happen.

We went home and cried, prayed, yelled, screamed, and bargained with G-d.

But this baby somehow managed to make it, and on the next ultrasound, we saw our little baby wiggling around on the screen with a perfectly healthy heartbeat.

This pregnancy was so filled with anxiety, but the healthcare team didn't understand why it was so hard for me to tell my story. The nurses never said, "I'm sorry for your loss," or "That must have been so hard," when I explained that this was my sixth pregnancy with only one live birth. They didn't seem to understand or appreciate the toll it takes on a person to go through round after round of fertility treatments and monitoring. When I said I was tired and ready to have this baby because we've been waiting for her forever, they rolled their eyes and said I wasn't even full term yet. What they didn't understand was that I had been waiting for this baby for almost two years already, and that being in the hospital triggered the memories of my previous miscarriages.

I think a lot of nurses at the hospitals that I have interacted with were so caught up in the medical stuff that they forgot they were dealing with a real person with real emotions and trauma. Many of these nurses rolled their eyes at my fear, complained when things got bloody, and were completely unsupportive. Many times they also said unhelpful things such as, "At least you know you can get pregnant," "Don't you love the child you already have?," "It wasn't a real baby," or "Why are you trying so hard?"

Healthcare providers may not always know the right thing to say, but they need to be aware of how painful it is when the wrong thing is said. Sometimes it is best to not say anything at all. Sometimes a simple, "I'm so sorry you had to experience that," or "That must be so difficult for you" is all one needs to hear.

According to the Centers for Disease Control and Prevention (CDC), about 12% of women ages 15 to 44 in the United States have difficulty getting pregnant or carrying a pregnancy to term, regardless of marital status [1]. According to Mayo Clinic, at least 10-20% of known pregnancies end in miscarriage, which is the spontaneous loss of a pregnancy before 20 weeks [2].This is a common medical occurrence, and nurses and other medical professionals should be trained to be more sensitive to women and their partners.

Women and men dealing with loss and infertility need to be treated with more respect and love. It's not an easy road, but with a little sensitivity and kindness, nurses can make the world of a difference.

References

[1] Centers for Disease Control and Prevention. (2017). Reproductive health: Infertility FAQs. Retrieved from https://www.cdc.gov/reproductivehealth/infertility/index.htm

[2] Mayo Clinic. (2016). Miscarriage: Symptoms and causes. Retrieved from https://www.mayoclinic.org/diseases-conditions/pregnancy-loss-miscarriage/symptoms-causes/syc-20354298

Nechama Schofield, LMSW, recently earned her Masters in Social Work from the College of Staten Island and is taking time off to enjoy her two beautiful children. She hopes to pursue working with women and families with fertility struggles and pregnancy loss.

ABANDONING THE IDEAL BIRTH PLAN

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mate goal of bringing a healthy child into the arms of a healthy mother. Ultimately, this outcome should be the guiding principle when faced with decisions about medical interventions, such as labor induction, progression, and augmentation, anesthesia, episiotomies, cesarean sections, and beyond. Every woman has her unique birth experience with each child she births and should not be judged by others based on their subjective experiences. Healthcare providers can support women throughout this journey into motherhood by providing education, fostering open communication, and partnering with them in the creation of healthy families.

References

[1] Afshar, Y., Wang, E. T., Mei, J., Esakoff, T. F., Pisarka, M. D., & Gregory, K. D. (2017). Childbirth education class and birth plans are associated with a vaginal delivery. BIRTH, 44(1), 29-34. https://doi.org/10.1111/birt.12263

[2] Mei, J. Y., Afshar, Y., Gregory, K. D., Kilpatrick, S. J., & Esakoff, T. F. (2016). Birth plans: What matters for birth experience satisfaction. BIRTH, 43(2), 144-150. https://doi.org/10.1111/birt.12226

[3] DeBaets, A. M. (2017). From birth plan to birth partnership: Enhancing communication in childbirth. American Journal of Obstetrics & Gynecology, 216(1), 31-33. https://doi.org/10.1016/j.ajog.2016.09.087

[4] Mennill, S. (2014). Ideal births and ideal babies: English-Canadian advice literature in the 1950s and 1960s. Canadian Bulletin of Medical History, 31(2), 25-47. https://doi.org/10.3138/cbmh.31.2.25

[5] Howorth, C. (2017). The goddess myth: How a vision of perfect motherhood hurts moms. TIME, 190(18). Retrieved from http://time.com/magazine/us/4989032/october-30th-2017-vol-190-no-18-u-s

[6] Feder, D. (2011). The Jewish roots of family values. Family Research Council Issue Brief, 1-8. Retrieved from https://downloads.frc.org/EF/EF11C13.pdf

[7] Divall, B., Spiby, H., Nolan, M., & Slade, P. (2017). Plans, preferences or going with the flow: An online exploration of women's views and experiences of birth plans. Midwifery, 54(), 29-34. https://doi.org/10.1016/j.midw.2017.07.020

Esther Lebovic, DNP, FNP-BC, CSC, is a family nurse practitioner who specializes in women's health and sexuality counseling.

Postpartum Depression: A Family Affair

Tziporah Newman, BSN, RN

Background

The postpartum period is a time when women experience many hormonal changes during and after birth. Due to fluctuating hormones women are at risk for developing mental health disorders. The most common disorder is postpartum depression (PPD), which affects 13% of postpartum women. Women can also experience "baby blues," postpartum obsessive-compulsive disorder (OCD), postpartum anxiety, postpartum post traumatic stress disorder (PTSD), and postpartum psychosis. Common symptoms associated with PPD include feelings of sadness, anxiety, mood swings, periods of crying, poor appetite, and difficulty sleeping after birth. Postpartum mental health disorders can be treated through a variety of methods including pharmacologics, psychotherapy, electroconvulsive therapy, and hormone therapy.

The majority of research tends to focus on the effects of PPD on women. However, PPD affects every member of the family. All members of the healthcare team need to be aware of how postpartum mental health issues may affect fathers and children. This knowledge can be extremely useful for nurses in family practices, obstetrics and gynecology (OB/GYN) clinics, pediatricians offices, primary care facilities, and schools. Awareness of mental health postpartum issues will allow nurses to intervene, educate, and assist families during postpartum mental health episodes. According to a study by Logsdon, Pinto-Foltz, Scheetz, and Myers, "[N]urse educators and managers play an important role in encouraging postpartum depression education [1]." A study conducted in Turkey showed that 77% of nurses in primary care settings effectively detected postpartum depression [2]. While this number is encouraging, nearly half of pediatrician offices do not screen for PPD [3].

Risk Factors

There are many risk factors associated with postpartum mental health disorders that are important to address. An individual with a history of depression, whether it is a personal history or family history, is at an increased risk of developing PPD. Low socioeconomic status, single parenthood, unsatisfactory relationships, lack of and limited accessibility to resources also increase the risks of PPD [4]. Presentation of symptoms in women can occur within the first few weeks after birth [5]. According to Harrison and White, "men are at risk for [PPD] up to a year after their child is born, [however], data suggest that the rate of depression peaks between the three and six month postpartum period [5]."

Effects on the Family

A journal article written by Melrose included the following literature review conducted by Goodman: "[T]he incidence of paternal depression during the first year after childbirth ranged from 1.2-25.5%...and from 24-50% among men whose partners were experiencing postpartum depression [6,7]." Paternal PPD presents as withdrawal, irritability, domestic abuse, somatic symptoms, substance abuse, anger, and indecisiveness [8]. Paternal PPD increases the chances of paternal physical abuse towards children, a disinterest in infant bonding, and family stress. The effects of paternal PPD can have long term effects on children and include psychological disorders such as attention deficit disorder, oppositional defiant/conduct disorder, anxiety, or depression [8,9]. Maternal PPD can have emotional, physical, and mental effects on children. This can include cardiovascular disorders, poor stress management, and disabilities involving communication and gross-motor functioning [10,11]. An infant who does not experience appropriate parent-child bonding can suffer from social, developmental, and behavioral disorders. A child is likely to be able to compensate for parental nurturing if one parent is depressed while the other is mentally healthy. However, when both parents are suffering from postpartum depression it can have detrimental effects on the child.

Implications for Nurses

Nurses should be the leaders in assessing for and treating postpartum depression early. Since postpartum depression can present until a year after birth, nurses and healthcare providers need to assess individuals at follow-

up visits for at least a year post-birth. Nurses need to be educated about the signs and symptoms of postpartum depression, the differing presentation in men versus women, accessibility of resources for families or single parents, and assist in decreasing the stigma associated with postpartum depression. Education should be not limited to OB/GYN specialties. Pediatric clinics, primary care facilities, schools, psychiatry offices, and any specialty that is to come in contact with either mother, father, or child needs to be educated on this topic. This information should be updated as needed as evidence-based research is constantly being published.

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POSTPARTUM DEPRESSION

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Creating pamphlets about postpartum depression is an effective way of reaching out to the community. These can be distributed to specialties that see new mothers, fathers, and infants. Screening tools for mothers are standard practice in many OB/GYN facilities, although this is not currently the case in other practices.

Men are often not upfront about their feelings. Talking to fathers in a candid and appropriate manner may reveal symptoms of PPD. Screening tools specific for men can also help identify those suffering from PPD.

Nurses are the first face our patients see. We have the capability to help the entire family. Nurses need to review their institution's policies and see if there is a way to improve the standard of care for families experiencing postpartum psychiatric complications.

References

[1] Logsdon, M., Pinto-Foltz, M., Scheetz, J., & Myers, J. A. (2010). Self-efficacy and postpartum depression teaching behaviors of hospital-based perinatal nurses. The Journal of Perinatal Education, 19(4), 10-16. http://dx.doi.org/10.1624/105812410X530884

[2] Kurtcu, A., & Golbasi, Z. (2014). Postpartum depression: Knowledge and opinions of nurses and midwives employed in primary health care centers . Firat University Medical Journal of Health Sciences, 28, 93-99. Retrieved from http://tip.fusabil.org/pdf/pdf_FUSABIL_1007.pdf

[3] Kerker, B. D., Storfer-Isser, A., Stein, R. E., Garner, A., Szilagyi, M., O'Connor, K. G., ... McCue-Horwitz, S. (2016). Identifying maternal depression in pediatric primary care: Changes over a decade. Journal of Developmental and Behavioral Pediatrics, 37, 113-120. http://dx.doi.org/10.1097/DBP.0000000000000255

[4] McCaskill, D. (2012). Postpartum depression: Recognition, risks, and effects on the family. Retrieved from https://www.ahvna.org/tiny_uploads/forms/Postpartum%20Depression%20-%20Recognition%20Risks%20and%20Effects%20on%20the%20Family.pdf

[5] Harrison, Y. & White, M. (2017). How postpartum depression can affect new fathers. Urology Times, 45(8), 28-28,30. Retrieved from https://search.proquest.com/docview/1918884148?accountid=14375

[6] Melrose, S. (2010). Paternal postpartum depression: How can nurses begin to help? Contemporary Nurse: A Journal for the Australian Nursing Profession, 34(2), 199-210. Retrieved from https://search.proquest.com/docview/374995205?accountid=14375

[7] Goodman, J. H. (2004). Paternal postpartum depression, its relationship to maternal postpartum depression, and implications for family health. Journal of Advanced Nursing, 45(1), 26-35. Retrieved from https://search.proquest.com/docview/232490337?accountid=14375

[8] Stadlander, L. (2015, April). Paternal postpartum depression. International Journal of Childbirth Education, 30(2), 11-13. Retrieved from https://search.proquest.com/docview/1677665911/fulltext/DED548DEFD724720PQ/8?accountid=14375

[9] Ramchandani, P., O'Connor, T. O., Evans, J., Heron, J., Murray, L., & Stein, A. (2008). The effects of pre- and postnatal depression in fathers: A natural experiment comparing the effects of exposure to depression in offspring. The Journal of Child Psychology and Psychiatry, 49(10), 1069-1078

[10] Abdollahi, F., Abhari, F. R., & Zargham, M. (2017). Postpartum depression effect on child health and development. Acta Medica Iranica, 55(2), 109-114. Retrieved from http://acta.tums.ac.ir/index.php/acta/article/viewFile/5665/4902

[11] Gump, B. B., Reihman, J., Stewart, P., Lonky, E., Darvill, T., Granger, D. A., & Matthews, K. A. (2009). Trajectories of maternal depressive symptoms over her child's life span: Relation to adrenocortical, cardiovascular, and emotional functioning in children. Development and Psychopathology, 21(01), 207-225. doi:10.1017/s0954579409000133

[12] Breese-McCoy, S. J. (2012). Postpartum depression in men. In M. G. Rojas-Castillo (Ed.), Perinatal Depression (pp. 163-176). http://dx.doi.org/10.5772/1282

[13] Edler-Schiller, C., Meltzer-Brody, S., & Rubinow, D. R. (2015). The role of reproductive hormones in postpartum depression. CNS Spectrums, 20, 48-59. http://dx.doi.org/10.1017/S1092852914000480

[14] Mayo Clinic Staff. (2015). Postpartum depression. Retrieved from https://www.mayoclinic.org/diseases-conditions/postpartum-depression/symptoms-causes/syc-20376617

[15] Anxiety and Depression Association of America. (n.d.). Postpartum disorders. Retrieved from https://adaa.org/find-help-for/women/+postpartum-disorders

[16] Schaar, G. L., & Meilssa, H. (2013, August). A nurse-led initiative to improve obstetricians' screening for postpartum depression. Nursing for Women's Health, 17, 306-316. http://dx.doi.org/10.1111/1751-486X.12049

NURSE'S PERSPECTIVE

Be Nice to Floats!

Havivah Sebbag, BSN, RN, CCRN

There is a widespread problem in many hospitals and it is time it was addressed head on. For too long we have accepted it as the status quo, and while we grumbled about it amongst ourselves, no concerted effort has been made to put a stop to it once and for all. Let's say it loud and clear: we are often not nice to those who float to our units.

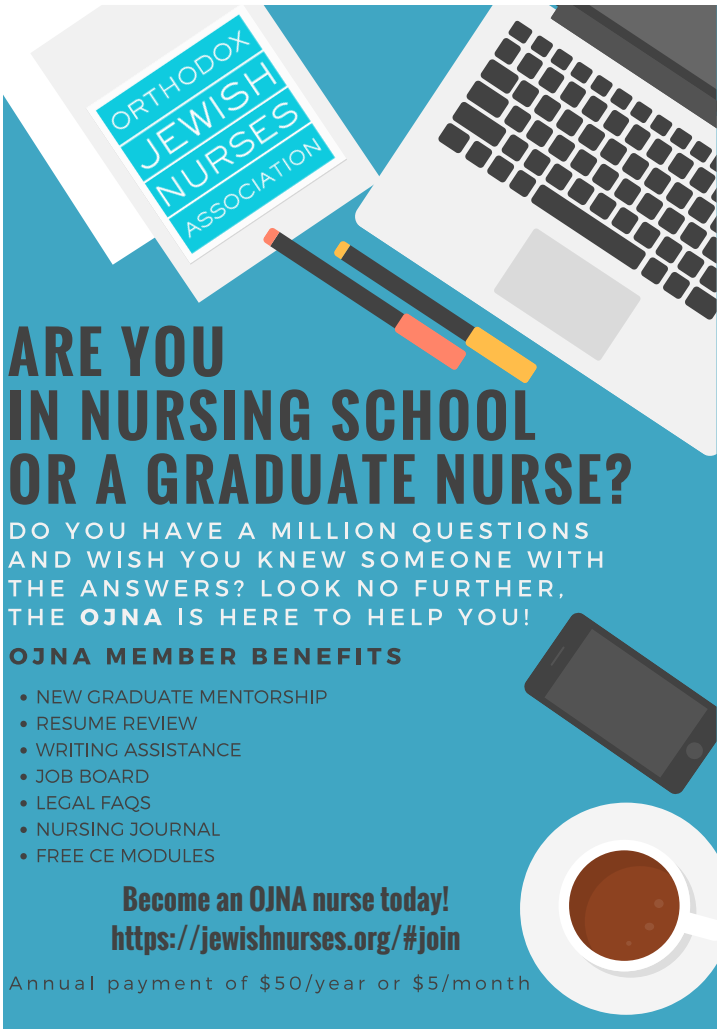
No one wants to float. Nurses expect to work on their assigned unit with their colleagues, familiar with the location of supplies and when they'll go on break. It's upsetting to arrive at work and find out that one has to go elsewhere because another unit is short-staffed. With this in mind, one should expect the understaffed unit to greet the float with open arms as a welcome gift, treating them with great respect and graciousness.

But here's our dirty little secret: the opposite usually occurs. Instead of being fair and giving them the open assignment or district, we rearrange ourselves so they get the worst district, the one with the patient with chronic diarrhea and two confused, verbally abusive patients. When they are frazzled and looking for supplies, we roll our eyes as if it is their incompetence that caused their confusion. Floats often end the shift feeling exhausted, taken advantage of, and very much alone.

If we welcomed a guest into our homes, would we want them to be relieved when they can leave, praying they never have to come back? We need to start thinking of the situation in these terms; our units are our home (and we all know some of us spend more of our waking hours there than at our real homes sometimes!) and the floats are our welcome guests. As such, we should treat them as we'd treat a guest.

To start, welcome the float and thank them for coming. Even though they did not choose to come, good manners still apply. As they are there to help you and alleviate a shortage, gratitude is in order. Make a point of learning their name, the name they want to be called. Let them know who are their colleagues for the shift. Identify the charge nurse and which RN/PCA they'll be working with. Give them the assignment that is open; don't give the disadvantaged the most challenging assignment

Throughout the shift, periodically check on the float, offer a hand, reinforcement, or direction if needed. If they take you up on your offer, be gracious and kind. At the end of the shift thank them once more for all their help.



We should take pride in our units and how we treat those floating to it. One day, we may be in their shoes, and we will be really glad that everyone is making a concerted effort to be nice to floats!

Havivah Sebbag, BSN, RN, CCRN, is a veteran nurse of 20 years and has worked in home care and hospitals. She has spent the last decade on night shift in critical care and has been floated many times.

NURSES OF OJNA RECOMMEND:

"Do No Harm" Applies To Nurses Too!

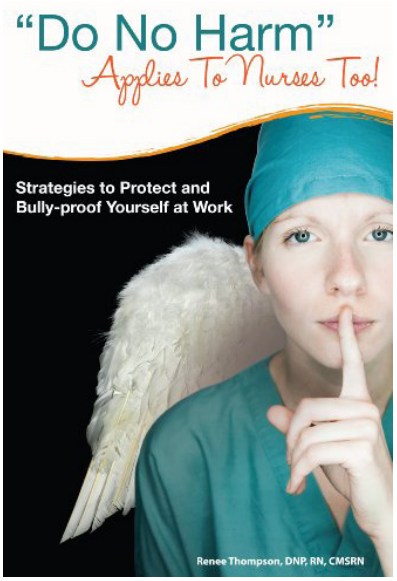
Author: Renee Thompson, DNP, RN, CMSRN
Reviewed by Yehudis Appel, BSN, RN

Dr. Renee Thompson, an international speaker, author, consultant, nurse educator, and professional nurse bullying expert, explores the alarming world of nurse bullying bullying in her book *"Do No Harm" Applies to Nurses Too!*. Nursing school does not prepare its graduates for bullying in the workplace, also known as "horizontal violence." Unfortunately, it is said that many nurses "eat their young" often lacking awareness of their actions. This book delves into nurse bullying from the victim's and bully's points of view.

In her book, Dr. Thompson takes on the bully: Why does bullying happen and what are the common characteristics of a bully? In doing so, she hopes to bring self-awareness to the behavior of nurse bullies. The author also discusses the victim—how a nurse may empower oneself professionally, how to recognize bullying, and how to avoid becoming a bullying target.

Dr. Thompson provides clear and practical steps on how to help eliminate the bullying behavior. She also offers suitable scripts that the reader can practice and use with future encounters with a bully. There is also a guide on how to properly report a bullying incident. The author differentiates between making a formal complaint about someone and vocally complaining about an incident without going through the proper step.

By reading this book, the reader will feel a sense of "being helped," and because of its easy-to-read style, it will be hard to put the book down. All nursing students, practicing nurses, nurse managers, charge nurses, and nurses in other leadership roles should be required to read this book. If it would be part of the required reading curriculum in nursing schools, then perhaps bullying in the workplace amongst nurses would be eliminated more quickly. In conclusion, the author presents all aspects of nurse bullying in an extremely clear-cut, precise, and detailed manner. Nurse bullies should never "eat their young," and the victims of nurse bullying should never have to experience the treachery of being bullied.



Yehudis Appel, BSN, RN, is an emergency room staff nurse at SUNY Downstate Medical Center, University Hospital of Brooklyn. Yehudis earned her Associate Degree in Nursing from Philips School of Nursing at Mount Sinai Beth Israel and her Bachelor of Science in Nursing from Excelsior College.

Lessons Learned Supporting Jewish Women Struggling with Crisis Pregnancies

By Erica Pelman

Many women face the crisis of infertility and longing to be a mother. Other women experience a crisis when they become pregnant and are unprepared socially, emotionally, or financially to raise another child. Some women are thrown into crisis mode when they learn their unborn child will have a disability.

Since 2009, In Shifra's Arms has been the only Jewish organization in the United States reaching out to Jewish women struggling with crisis pregnancies. We do not offer ethical, *halachic* or medical guidance regarding abortion. However, we do offer a range of social services including:

1. Free phone counseling with licensed social workers. For women who call us during the pregnancy, we provide phone counseling throughout the pregnancy and baby's first year. We also offer this service to women who are post-abortion or miscarriage.

2. Material aid, such as baby and pregnancy supplies.

3. Targeted financial grants: Whether the woman needs a year-long supply of diapers or career assistance, we offer financial support that is customized to fit the woman's most urgent needs.

Below are lessons learned from our work with women across the United States.

LESSON #1: Validate all feelings and be cautious with indifference.

In the case of crisis pregnancy, it is important to acknowledge a wide range of feelings. A woman can feel love for her developing baby, fear and anxiety, or a sense of being angry and trapped. At the same time, some women – perhaps in reaction to the intense possibilities- report feeling numb. While all feelings are valid, for a woman who is considering abortion, numbness and indifference are important warning signs and indicate a need to slow down and process the reality of the situation.

For example, one of our clients was 24 weeks pregnant and strongly considering abortion. She stated that she did not "feel pregnant". It turned out that her disassociation from her body was driven by the fact that she was under severe pressure to abort. Once she took the time to connect with her body and her developing baby, she chose to continue her pregnancy and work through her fears. She went on to be a happy and loving mother.

LESSON #2: Help women problem solve by first helping them choose how they frame the problem.

(continued on page 16)

LESSONS LEARNED FROM CRISIS PREGNANCIES

(continued from page 15)

In the case of an unplanned pregnancy, how the woman frames the problem can limit the solutions she sees available to her. If she chooses to define the developing baby as the problem then the only possible solution might seem like termination. Therefore, it is important for women to know that there are several ways to frame the problem of an unplanned pregnancy.

Defining the crisis as circumstantial and treating circumstances as fluid can give a woman a sense of freedom and the increased ability to problem solve.

Nira* called In Shifra's Arms feeling very conflicted about her pregnancy, as she already had a young child and was very financially strapped. When she examined what 'the problem' really was, she saw that it was temporary. In two years, after her husband completed his training, they would be in a much more secure financial situation. She chose to continue her pregnancy and find ways to make it work for the following two years.

LESSON #3: If she does not continue the pregnancy, make referrals to address underlying issues and screen for potential post-traumatic stress.

Women who abort an unplanned pregnancy are 55% more likely to have subsequent mental health issues than women who did not abort an unplanned pregnancy [1]. It is important to ensure women are screened for signs of post-traumatic stress and also receive referrals to follow up on the underlying issues which led to the decision to abort.

LESSON #4: If she continues the pregnancy, help her make a plan and find supportive resources.

Diane Greene Foster has studied women who pursued abortion but due to advancement in their pregnancy or state restrictions, they were unable to have the procedure done [2]. In her study, she found that 95% of them adjust to motherhood and do not wish that they had had an abortion. However, the majority of these women are financially strapped with many of them receiving welfare. To beat these odds, women need to be working with organizations that can help them create an educational and career plan and move towards a goal of self-sufficiency.

References

[1] Coleman, P. K. (2011). Abortion and mental health: quantitative synthesis and analysis of research published 1995–2009. The British Journal of Psychiatry, 199(3), 180-186.

[2] Lang, J. (2013). What happens to women who are denied abortions? New York Times. Retrieved from http://www.nytimes.com/2013/06/16/magazine/study-women-denied-abortions.html

Erica Pelman is Founder and Executive Director of In Shifra's Arms. More information about In Shifra's Arms is available on their website: JewishPregnancyHelp.org.

Member Milestones

TOVAH JULIE GAMARNIK, BScN, RN, graduated from the University of Ottawa in 2015. Her research has been published in the Journal of Pediatric Surgery. She has worked in research, home care, and palliative care. She recently started working in inpatient general medicine in Toronto. She enjoys mentoring newly hired nurses and her favorite role is as a patient and family educator.

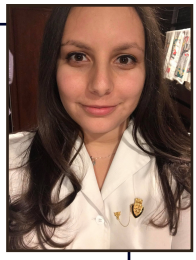
SARAH BRACHA COHEN, MS, RN, graduated with her Master of Science with a concentration in Nursing and Clinical Nurse Leader (CNL) from the University of Maryland School of Nursing in December 2017. She passed the NCLEX in February and will begin working in the post-anesthesia care unit (PACU) at NYU Langone in April. She joined The OJNA Journal committee in January.

YEHUDIS APPEL, BSN, RN, attended Phillips Beth Israel School of Nursing for her associates degree in nursing, graduating in May 2013. She graduated with her BSN from Excelsior College in January 2016. She has been published in Nursing 2017, The Peer Reviewed Journal of Clinical Excellence. She will be published there again, most likely towards the end of 2018.

ANGELIKA DOBKIN, MPH, BSN, RN, is a Minimum Data Set (MDS) coordinator assistant. She was the 2017 American Association of Nurse Assessment Coordination President's Scholarship Recipient. She is a certified Resident Assessment Coordinator. In her application, Angelika wrote, "I feel most rewarded when my job positively impacts a resident's quality of life and that I am able to make recommendations in guiding the care we provide based on my MDS assessment. Nothing makes me feel more satisfied in this role."

TO HAVE YOUR MILESTONE FEATURED IN OUR NEXT JOURNAL EMAIL OJNAJOURNAL@GMAIL.COM

JOELLE HARARI, BSN, recently graduated from Molloy College with her baccalaureate degree. She completed a double major in Nursing and Psychology. She is currently waiting to take her boards.



MARTHA DE CRISCE, BSN, RN, is currently completing her Doctor of Nursing Practice in Family Medicine with an expected graduation date of May 2018. Her DNP project is titled "Addressing Pregnancy Loss Among Jewish Women." She will be defending her project in the spring. Martha submitted a short article to OUTCOMES (e-newsletter) that appeared in the January 2018 issue, Volume 4, Number 1. She looks forward to submitting articles to various journals and to be a poster presenter at the annual OJNA nursing conference.

OJNA NEWS

PITTSBURGH CHAPTER

Fifteen nurses in the Pittsburgh, Pennsylvania, area met on February 10, 2018 at the home of Esther Luzer, RN, to discuss becoming an official chapter of the OJNA. Nurses exchanged workplace stories including how they deal with Shabbos and holidays. They also discussed the upcoming OJNA Conference in New York City and made plans to have a second meeting after the conference to discuss what they learned. Attendees include nurses working in L&D, education, oncology, long-term care facilities, ICU, home care, med-surg, and a retired nurse.

CLEVELAND CHAPTER

On March 10th several nurses enjoyed waffles and ice cream at Ellie's in Cleveland, Ohio, to discuss becoming a formal chapter of OJNA. Led and initiated by Leslie (Leah) Kushner, MSN, RN, the nurses brainstormed ways to contact more nurses in their region. They discussed jobs and careers, issues common to new graduates, and about the upcoming conference in NYC. Their next meeting is planned for after Pesach.

FLORIDA CHAPTER

On February 18, 2018, Susan Winograd, PT, presented to the Florida chapter of the OJNA on the topic of Pelvic Floor; The Dynamic Duo and Kegels: Not A One Size Fits All Exercise. She first explained the anatomy of the pelvic core. She then spoke about the importance of good posture, avoiding poor exercise techniques, and the importance of balanced breathing. In context of the Kegel topic, she spoke about how it is essential to treat the entire system (body) and not one component in isolation. She emphasized that there is no one exercise that fits everyone. For more information on Susan Winograd and her healing work, please visit her website at https://www.pelvicorerehab.com.

OJNA is growing and expanding its regional chapters!

We currently have active chapters in Florida, Pennsylvania, Ohio, and Maryland. Please contact your chapter representative (see below) to join and get involved.

If your area does not currently have a chapter, and you are interested in forming one, please be in touch with our Chapter Liaison, Esther Lebovic, at esther.lebovic@frontier.edu.

Los Angeles/West Coast Region:
Esther Lebovic, esther.lebovic@frontier.edu

Pittsburgh, PA:
Na'ami Kurinsky, nachisdoll@gmail.com

Cleveland, OH:
Leslie (Leah) Kushner, kushnerfam@aol.com

Miami, FL:
Malka Feibush, malka.feibush@gmail.com

Baltimore, MD:
Rivka Pomerantz, rivpom@gmail.com

Coming soon! Chicago, IL:
Esther Laber, elaberil@gmail.com

ORTHODOX JEWISH NURSES ASSOCIATION

CONFERENCE FOR ORTHODOX JEWISH NURSES

Thursday,
May 10, 2018

7:45 am -
4:30 pm

Lander College
for Women
227 W 60th St.
New York City

6.8 contact hours
Pending approval by Northeast Multistate Division An accredited approver by the American Nurses Credentialing Center's Commission on Accreditation

Cholov Yisrael Breakfast and Lunch Provided by Riverdale Kosher Market

Discounted Parking Available

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CONFERENCE COMMITTEE:
Goldie Burstein, RN-C CCM
Shevi Rosner, MSN RN-C
Linda Segel, BSN RN

The Rabbinic Conception of Conception
Reproductive Technology in Jewish Law
Rabbi Edward Reichman, MD

Understanding PANDAS
Pediatric Autoimmune Neuropsychiatric Disorder Associated with Strep
Susan Schulman, MD

Anti-Vaccination and Halacha
Protecting our Children and Communities
Rabbi Edward Reichman, MD

Transformational Leadership
Mentoring Others and Promoting Psychological Safety
Toby Bressler, PhD, RN, OCN

Growth of OJNA
Past, Present, & Future
Rivka Pomerantz, BSN, RN, IBCLC

Malpractice in Nursing
How to Protect Your Nursing License in the Workforce and as a Volunteer
Ira Newman, Esq.

Genes: Knowledge is Power
Impacting the Health of Future Generations
Esti Rose, MS, LCGC

Atopic Dermatitis
The Effective Role a Nurse has on Patients with Atopic Dermatitis
Shulamit Burstein, MA, PSI

Sexual Health Assessment
Discussing the Uncomfortable
Esther Lebovic DNP, FNP-BC, CSC

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OUR NEXT ISSUE

Health care professionals see an increase in trauma related injuries and unintentional deaths during the Summer season.

For our next issue of The OJNA Journal, we are sourcing articles and updated CDC guidelines on the following topics:

Water Safety: Drowning, Near Drowning

Weather Safety: Sunburns, Heat Related Illness, Lightening

Insect Safety: Mosquito, Tick Borne Illnesses

Playground and Camp Safety

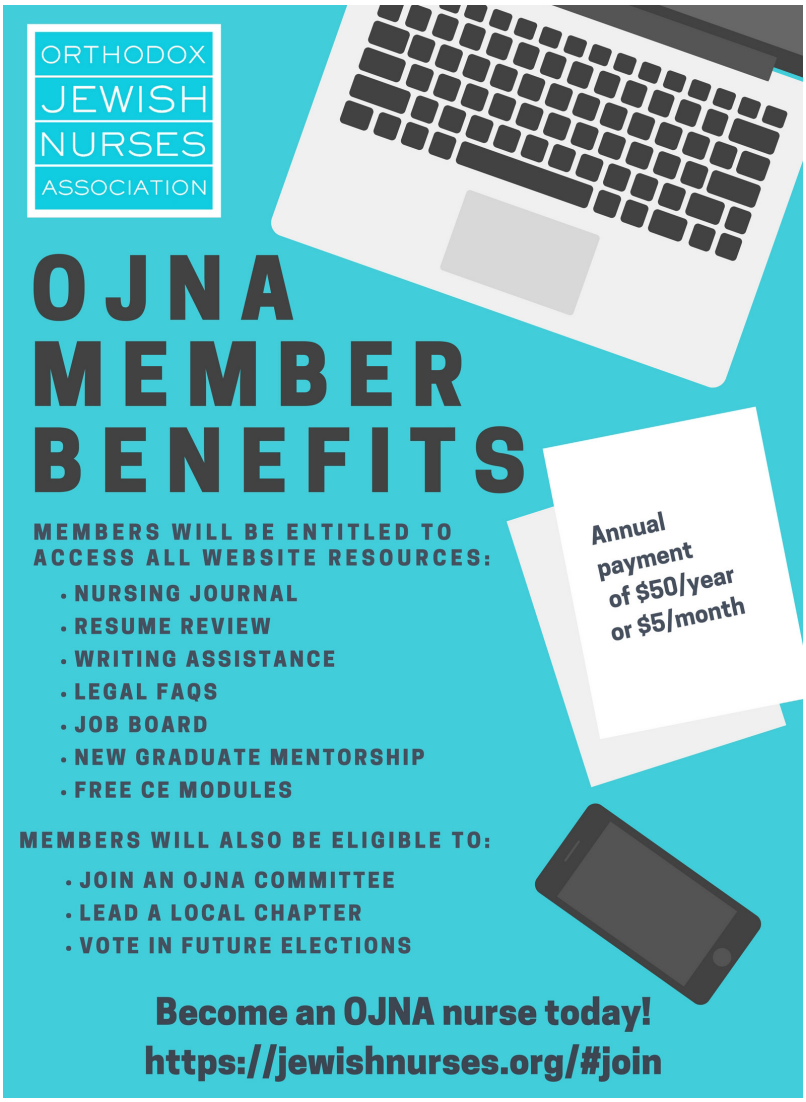
Pedestrian Safety: Bicycle, Skateboard, Walking

Camp Nursing

We are also accepting general pieces including: original academic work, book reviews for nurses, creative pieces on nursing, or brief clinical overviews of medical conditions.

If you want to contribute an article, please review Author Guidelines and How to Pitch an Article on our website at https://jewishnurses.org/journal/.

Questions? Contact us at OJNAJournal@gmail.com



JOB POSTINGS:

1. We are looking for LPNs or RNs in Brooklyn (Boro Park) for a very sweet 7 month old baby with a trach.

2. We are actively recruiting for a dynamic High School Nursing Director. This individual will oversee the High School Nursing Program citywide. Managerial experience is required and strong experience in adolescent nursing is a plus!

3. Administration of vaccines. Credential clearances/ clearing nursing students, volunteers, and employees for work. Respiratory fit test, urine drug screening. Light traveling required to business health sites. Monday through Friday 9 am to 5 pm. Shabbat and holiday friendly. Very accommodating. Medical/dental/403 and tuition reimbursement 6 months after employment. Non-union.

4. Pediatric Specialty Care is dedicated to meeting the unique needs of medically complex and technology dependent individuals ranging from birth to 21 years of age. We are seeking RNs.

Qualifications:

Current Pennsylvania RN License
Current credentials and immunizations
1-2 years RN experience preferred
Pediatric experience preferred
Experience with Vents and Trachs.

5. Summer Sleepaway Camp in Honesdale, Pennylvania is looking to hire a Nurse to join their Medical Team. June 24 – Aug. 15.

6. Seeking a Director of Nursing over a Skilled Nursing Facility in Orange County, New York. This facility has been serving the area and is located on a beautiful 30-acre campus that is associated with a Joint Commission Accredited hospital.

The Director of Nursing will oversee the care management team and overall facility operations.

7. JCC preschool summer camp is looking for a nurse for July and August.

8. Seeking a Nursing Director to work in our Med/Surg and Hospice Department. The ideal candidate must have 7 years of nursing experience with demonstrated competence in nursing practice and leadership skills with at least 3 years experience in a managerial role. Acute care hospital experience required as a supervisor or senior nurse.

Candidate must be able to work a flexible schedule including evenings and nights shifts. He/She must have a current New York State license to practice as a Registered Nurse, BCLS required. ACLS, PALS preferred. Bachelor's degree in Nursing required. Master's degree in Nursing Preferred.

For more information, or to apply, visit https://jewishnurses.org/job-dashboard/

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Olney, MD 20832

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MEET THE TEAM:

Blima Marcus, DNP, RN, OCN, received her Bachelor of Science in Nursing from the New York University Rory Meyers College of Nursing and received her Doctorate in Nursing Practice in adult primary care from the Hunter-Bellevue School of Nursing in January 2018. She is a nurse at the NYU Perlmutter Cancer Center and has been published in the American Journal of Nursing and in the Forward. She is a member of Sigma Theta Tau International Honor Society of Nursing, Oncology Nursing Society, American Cannabis Nurses Association, and Eastern Nurses Research Society. She lives in Brooklyn, New York, with her husband and two children.

Tobi Ash, MBA, BSN, RN, received her Bachelor of Science in Nursing from Barry University in 1998, her Masters in Business Administration from Nova Southeastern University in 2001, and is currently completing her Ph.D. at Walden University. Tobi is the Director of Women's Health Care at Nano Health Associates in Miami Beach, Florida. Tobi has more than 20 years of experience working with families, with an emphasis on women's health. She is a member of Sigma Theta Tau International Honor Society of Nursing and served on the Health Care Advisory Committee for the City of Miami Beach for two consecutive terms. She lives in Miami, Florida.

Batsheva L. Bane, BSN, RN, received her Bachelor of Arts from Adelphi University, her Bachelor of Science in Nursing from New Jersey City University, and is currently pursuing her Master of Science in Nursing at Frontier Nursing University. She is a Certified Breastfeeding Counselor and is a member of Tau Sigma National Honor Society, the New York State Association of Licensed Midwives, and the American College of Nurse Midwives. Batsheva worked at Monmouth Medical Center in both the neonatal ICU and postpartum units, and at CHEMED health center in the Women's Health Department. In addition to her role at OJNA, she volunteers for the New York State Association of Licensed Midwives for the IMPACT committee. She lives in Riverdale, New York, with her husband and children.

Sarah Bracha Cohen, MS, RN, received her Bachelor of Arts from Hebrew Theological College and her Master of Science in Nursing and Clinical Nurse Leader (CNL) from the University of Maryland School of Nursing in December 2017. She is a member of Sigma Theta Tau International Honor Society of Nursing. In addition to her work for the OJNA Journal, she works as a doula, is an editor and contributing writer for a local Jewish newspaper newspaper, and will begin working in the post-anesthesia care unit (PACU) at NYU Langone in April.

Tziporah Newman, BSN, RN, received her Associate Degree in Nursing from Middlesex County College and Bachelor of Science in Nursing from Thomas Edison State College. She currently works with medically fragile children as a private duty home care nurse. She previously worked as a Director of Nursing for a home health care agency, supervising and teaching nurses and home health aides. She is a member of the American Nurses Association, the New Jersey State Nurses Association, and the Society of Pediatric Nurses. She actively volunteers for Chai Lifeline and her local Bikur Cholim.