THE OJNA JOURNAL

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Cancer: Past, Present & Future

When Your Child Has Cancer

Male Breast Cancer

The Coolest Therapies

OJNA LEADERSHIP

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- Provide timely news and research updates
- Relay evidence-based research
- Share OJNA news and updates

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The Orthodox Jewish Nurses Association was founded in 2008 by Rivka Pomerantz, BSN, RN, IBCLC. It seeks to provide a forum to discuss professional issues related to Orthodox Jewish nurses and arrange social and educational events. We strive to meet the needs of our members, promote professionalism and career advancement, and be a voice for Orthodox Jewish nurses across the world.

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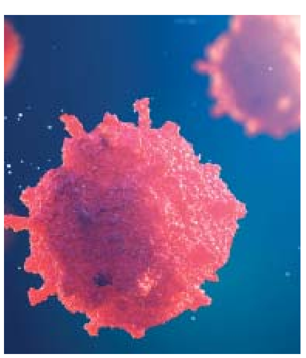

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Editor's Note

Welcome back to another issue of The OJNA Journal! We hope you had a healthy summer and a busy, fulfilling chagim season.

For this issue of The OJNA Journal, the editorial team chose to feature pieces on oncology and care of patients with cancer. While oncology is a highly specialized subset in nursing, a wide spectrum of nurses will come in contact with patients with cancer. From the emergency department to the intensive care unit, from primary care to women's health and obstetrics, and from home care nursing to pediatrics, cancer knows no boundaries. We are all touched by a disease, either personally or professionally, which some still refuse to name; a throwback to an era of stigma, fear, and superstition.

I was diagnosed with a rare cancer at the age of 22. After surgery and a grueling regimen of chemotherapy, I entered nursing school - bald, missing half of my reproductive organs, tottering and shaky, but ready to be on the opposite side of caregiving. However, I swore I would never go into oncology nursing; I couldn't face others who needed to undergo what I had just experienced. Nearly a decade later I have worked in inpatient oncology, outpatient oncology, cancer research, completed my DNP dissertation on an oncology topic, and I would never consider anything else. The opportunity to hold a patient's hand during a journey, as fraught as cancer, is a privilege only compounded by my ability to truly be able to speak to their fears about death, anxieties over loved ones and hair loss, worries for their future, fertility, and little ones at home, and grief for the loss of their health, stalled careers, and the overall paradigm shift that a cancer diagnosis forces.

Groundbreaking research in screening behaviors and tests, and in chemotherapy, radiotherapy, and immunotherapy are resulting in radically-improved survival rates for many cancer patients. With this growth of cancer survivorship comes the need for health care providers who are familiar with the lifelong sequelae of cancer treatment. Even more important is to ensure providers are familiar with screening guidelines, genetic risk, community risk, and more.

This issue of The OJNA Journal will provide a general overview of the history of cancer, some updated guidelines and policies, screening information to share with your loved ones, and some personal essays. Education, prevention, and screenings save lives now more than ever. Nag your friends, family, colleagues, and patients. Ask them about mammograms, PAP smears, colonoscopies. If you're brave, encourage prostate and testicular exams as appropriate. Know what the recommendations are and direct them appropriately. They'll thank you.

Here's to a healthy winter!

Blima Marcus, DNP, ANP-BC, RN, OCN

President, Orthodox Jewish Nurses Association

THIS ISSUE AT A GLANCE:

I MAY NOT KNOW YOUR NAME,
BUT IN MY HEART
I THANK YOU EVERY DAY,
MY ANGEL IN SCRUBS.

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Research into cannabis, whether medical or recreational, is sorely lacking due to its illegal status for many years.

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I settled his head into a better position so that **rigor mortis** would not hold his neck awkwardly.

page 21

All materials explaining **breast cancer** to patients is written for females, further excluding any **male patient.**

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Oral cryotherapy involves maintaining ice cubes in the mouth for a 30 minute duration while chemotherapy is being infused.

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My son was six when he was diagnosed,
16 when he died in my arms.

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Nurses were being excluded from planning or telling patients bad news approximately **50%** of the time.

page 6

When I look at my body today, it is not a terrible reminder of my genetic mutation, but rather a beautiful result of finding a team of supportive surgeons who believe you do not have to ***sacrifice aesthetics to prevent cancer.***

page 14

Over the past **40 years,** as medicine has developed new interventions that can prolong life even at the very end, questions about how much needs to be done have been addressed by the **gedolim of the past generation.**

page 9

As far back as **3000 B.C.,** Egyptian texts describe breast tumors and primitive versions of radical mastectomies.

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HEALTHCARE PROVIDERS FAIL TO ADMINISTER EPINEPHRINE IN **80-85%** OF CASES WHERE IT SHOULD HAVE BEEN USED.

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Cancer: Past, Present & Future

Blima Marcus, DNP, ANP-BC, RN, OCN

History of Cancer

Cancer is often thought of as a current plague: new, prevalent, ever-expanding. However, as far back as 3000 B.C.E., Egyptian texts describe breast tumors and primitive versions of radical mastectomies. Several centuries later, two ancient fathers of medicine, Hippocrates and Galen, coined two of cancer's most used terminologies: *oncos*, Greek for swelling, and *carcinos* and *carcinoma*, Greek for tumors [1]. Over the millenia, many physicians attempted to remove cancerous growths, but as one Roman physician named Celsus observed, "After excision, even when a scar has formed, none the less the disease has returned [1]." A famous surgeon in London also wrote, "All that is locally wrong may be removed, but something remains, or, after a time, is renewed, and similar disease reappears [2]."

Some connections between lifestyle and cancer development were made, and with the development of the microscope, an understanding of the microcellular nature of cancer helped scientists learn more about this class of illnesses. However, treatment remained evasive until the early 20th century. For a time, cancers were even thought to be contagious. The most prevalent takeaway of cancer as an illness is that it was incurable. This fear has persisted to this day, even with the advent of numerous treatment modalities.

Cancer Mortality: Then and Now

Cancer death rates over the last 10 years have dropped 26% for both men and women combined [3]. The cancer incidence rate over the last decade has remained stable for women, and has dropped two percent annually for men [3]. Continuous improvements in treatment options and screening measures have increased survivorship exponentially. Since the development and use of the Pap test in the 1960s, cervical cancer dropped by 70% [1]. Among women being treated for breast cancer in 1944-1954, only 10% lived 10 years or longer. However, women being treated for breast cancer in 1995-2004 had an 86% likelihood of living 10 years or longer [4]. This improvement in survival is attributed to better screening, better treatment, hormonal therapy options, improved surgical options, and better coordination of cancer care [4].

Prevalence & Incidence

Have cancer diagnoses radically increased? This is a question asked by many. However, there are several explanations for the perceived increased prevalence and incidence of cancers. First, other epidemics and plagues which saw a lot of mortality have disappeared with preventive strategies, vaccines, or successful treatment, including influenza, tuberculosis, AIDS, and smallpox [5]. Second, while many young adults and children are diagnosed with cancer, cancer primarily affects the elderly. As life expectancies have increased over the century, so have cancer diagnoses. The median age of cancer death is 72 [5], and 25% of all new cancer diagnoses occur in people aged 65-74. Indeed, advanced age is considered the biggest risk factor for developing cancer [6]. Most cases of cancer occur with repeated, spontaneous mutations to one's DNA: the longer one lives, the more time there is for DNA to undergo changes. Finally, when compared to the number one killer, heart disease, cancer is still at a disadvantage. Heart disease has seen radical changes and improvements with medication management and quick-fix surgical options such as valvular repairs and angioplasty options. Since 1990, heart disease mortality has dropped 44%, while cancer deaths have only dropped 20% [5]. Cancer, with it's persistent, ever-changing, Darwinian features, appears to be the final epidemic we are battling.

Traditional Treatment Modalities

CHEMOTHERAPY

Chemotherapy is used for several reasons: to shrink tumors prior to other modalities of treatment, to destroy cancer cells after surgery, to destroy cancer cells as a primary treatment, or to alleviate symptoms of advanced cancer [7]. Chemotherapy kills fast-dividing cells such as cancer cells; however, it also kills other cells which divide quickly, including hair cells and cells which line the gastrointestinal (GI) tract. This leads to the common side effects of alopecia (hair loss) and GI-related effects such as mouth sores, nausea, vomiting, and diarrhea. Fatigue is also one of the most common side effects. Chemotherapy can be administered orally, intravenously, intrathecally, and intraperitoneally.

RADIATION THERAPY

Radiation uses high doses to kill the DNA in cancerous cells [8]. Like chemotherapy, radiation therapy (RT) can be used to kill cancer cells before treatment, as primary treatment, or to alleviate pain or suffering resulting from tumor burden. Radiation kills cancer cells slowly, therefore, several weeks of treatment are needed before the DNA is damaged and the cancer cells begin to die. Side effects of RT depend on the location being irradiated, but nearly all sites experience hair loss and fatigue as a result of treatment [9].

SURGERY

Surgical options to remove or destroy tumors include traditional surgery and minimally-invasive surgery, as well as laser surgery (beams of light) and cryosurgery (liquid nitrogen) [10]. Surgery is most often used to remove tumors, debulk tumors (remove parts of tumors), or to alleviate symptoms caused by painful tumors.

Novel Treatment Modalities

PRECISION MEDICINE

A newer methodology to treat cancer focuses on targeting the pathways which allow the cancer

(continued on following page)

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(continued from previous page)

to develop, grow, and evade treatment [11]. Using immunotherapy, stem cell treatment, treatment vaccines, and other targeted therapies help the immune system naturally attack the cancer, and make it harder for cancer cells to evade the immune system.

Side effects tend to be tolerable as compared to chemotherapy. Systemic, inflammatory effects, such as myalgias, arthralgias, headache, and fatigue, are most common. However, overreactions by the immune system may occur, triggering the "-itis" (inflammatory) reactions: pneumonitis, thyroiditis, uveitis, hepatitis, and more. Careful monitoring can catch acute reactions and proper management is vital.

Implications for Nurses

Oncology nurses are at the front lines of cancer care: they provide psychosocial care, medication education, symptom management, survivorship care, and end-of-life care. Some of these roles require additional certification, such as for chemotherapy or biotherapy administration. Advance practice nurses (APRNs) work closely with oncologists to provide care to cancer patients who may also exhibit other comorbidities.

Nurses in other departments will come across oncology patients and need to be prepared to understand basic cancer precepts. Nurses in the emergency room or intensive care unit need to know how to recognize and initiate treatment for oncologic emergencies, such as neutropenic fevers, spinal cord compressions, and allergic responses to treatment. Nurses in primary care should be familiar with screening guidelines so that they may refer their patients for appropriate preventive care, whether that be mammography, colonoscopy, prostate exam, or other tests. Primary care nurses should also understand common survivorship issues, which may begin once a patient is "discharged" from their treatment plan. This may include anxiety or depression, risk management for any radiation treatment they may have received, or understanding long-term risks of chemotherapy to watch out for.

Furthermore, all nurses in all disciplines should attempt to remain informed on policy issues which may affect this patient population, as well as others. Advocating for funding, screening policies, and health coverage is an action plan open to all nurses and healthcare workers. Nurses also need to remain aware of the specific issues arising when dealing with vulnerable populations, including indigent populations, ethnic minorities, and LGBT patients.

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OJNA BOARD LEADERSHIP UPDATES

The board members of OJNA have been focusing on chapter development, creation of an advanced practice nursing committee, and organizational growth and development.

OJNA CHAPTERS

OJNA is developing chapters in cities around the United States with a significant Jewish nursing presence. Legal paperwork and applications are being submitted to the states of Illinois, Connecticut, Pennsylvania, Florida, Ohio, New Jersey, and California. OJNA thanks the members who have persisted in requesting chapters outside of New York and Maryland (where we are currently incorporated), and we will do our best to help facilitate this. If you would like to be a Chapter Representative for any state listed above, or for a state we have not yet mentioned, please email us at OJNABoard@gmail.com. OJNA plans on assisting chapters with networking events and educational events by providing practical support and financial assistance.

APRN COMMITTEE

Under the leadership of OJNA Secretary Chaya Milikowsky, MSN, AG-ACNP-C, the Board has developed an APRN committee dedicated to providing the APRNs of OJNA with specialized networking dinners, educational events, and clinical education with topics in The OJNA Journal geared specifically for the advanced practice nurse.

With the assistance of OJNA Vice President Elisheva (Shevi) Rosner, MSN, RN-C, and Ephraim Sherman, DNP, ANP-BC, RN, the APRN Committee is presenting its first conference this January. While the topics are geared towards NPs, nurse midwives, and other APRNs, it is open to all nurses and nursing students.

COMMUNITY OUTREACH

OJNA feels strongly about being an evidence-based voice for healthcare within the spectrum of Orthodox Jewish communities. To that end, OJNA has been in communication with a leading frum publication regarding the development of a recurring column written by OJNA nurses with a focus on relevant, timely, and common health issues encountered in our communities.

The Board is also seeking to increase its social media presence. If you are interested in finding out what being on the social media team entails, contact us at OJNABoard@gmail.com.

RESEARCH RECAP

Tobi Ash, MBA, BSN, RN

Collaborative Practice Model: Improving the Delivery of Bad News

In the oncology unit, delivering bad news is a frequent occurrence. Giving bad news to patients and their families is not an "optional skill." Dissatisfied with the inconsistent communications with their patients, advance practice nurses (APRNs) in a 31-bed medical oncology unit with 62 team members, sought to create a best practice collaborative model to improve the delivery of bad news.

They first conducted a literature review from 2006-2010 to determine the most common issues in breaking bad news. There were 358 articles related to bad news and almost all of the data focused on perception. The first was how patients and their families perceived the presentation of bad news, as well as the news itself. The second was related to healthcare provider perceptions about their own skills in giving such news and their patients' abilities to understand the news. The overall conclusion from the review suggested that patients and their families had a better experience overall, even in the worst case scenario, when the communication between the patient and the healthcare team was good [1].

The authors then developed a survey looking at daily practices that stymied good communication in their own unit. Nurses were being excluded from planning or telling patients bad news approximately 50% of the time. Reasons included a lack of time due to patient demands, nurses themselves feeling inadequately prepared, and overall poor doctor and nurse communication [1].

At a one day retreat with a 12-member team, the researches addressed these and other barriers to communicating effectively, providing adequate staff support and a sense of inclusion. The practice model first identified what bad news is. The SPIKES protocol was used to simulate trainings. The protocol identified these six areas to focus on: (1) the setting (physical area, patient, and health care provider), (2) perception (patient self knowledge), (3) invitation (patient-guided for communication), (4) knowledge (providing the correct information with clear and easy to understand language in a sensitive manner), (5) emotions (guided by the patient and addressed and assessed by the health care provider), and (6) strategy/summary (planning for the future). The team then assessed daily responsibilities of the healthcare team. The hardest part for nurses was how to support patients when breaking bad news. This program included physical simulation models to practice and foster confidence. Practicing and feeling prepared are the hallmarks of this model [1].

Prior to implementation, all stakeholders agreed to use the model. Six months post implementation, the model was being used 85% of the time. The healthcare team noted improvement in feeling prepared and supported with good communication skills. APRNs were invaluable in creating this program, looking at all aspects of good communication [1]. Ultimately, the model they created stressed inclusion and support. Nurses were being sought out and felt more valued with the collaboration with the entire health care team. This program can be adapted to other clinical settings that require enhanced skilled communication.

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[1] Bowman, P.N., Slusser, K., Allen, D. (2018). Collaborative practice model: Improving the delivery of bad news. Clinical Journal of Oncology Nursing, 22(1), 23-27. Doi: 10.1188/18.CJON.23-27

Male Breast Cancer: Addressing Needs Using an Educational Task Force

Although male and female breast cancer both affect the breast tissue, male breast cancer is different in several ways. First, it is rare; less than one percent of all breast cancer cases are found in men. Although the number of deaths related to male breast cancer have decreased, there have been more cases diagnosed. Second, men are diagnosed much later than women, and at a more advanced stage. Third, virtually all male breast cancer is treated with mastectomy rather than with breast conserving surgery. Fourth, although this cancer appears in males, there is very little attention dedicated to this disease in male populations (in contrast with the ubiquitous pink ribbon). Last, and perhaps most important, there are many studies on female breast cancer, focusing on all aspects of the disease including psychosocial issues. For male patients, studies are mostly limited to treatment efficacy. Very few studies explore the psychosocial and emotional impact for men with breast cancer [1].

Symptoms for male breast cancer are identical to female breast cancer. However, due to a knowledge deficit regarding male breast cancer, many men do not know what to look out for or when to seek medical help. Many health care providers may dismiss these symptoms because of their own lack of knowledge [1]. Compounding the issue, receiving such a female gendered diagnosis is upsetting and exclusionary to many men. Most men who have been diagnosed with cancer of the breast will only share this information with their partner. Furthermore, all materials explaining breast cancer to patients is written for females, further excluding any male patient [1].

Nurses at Memorial Sloan Kettering Medical Center recognized that there were gaps in the educational materials and emotional support for male breast cancer patients. These nurses started a male breast cancer educational task force that looked at 49 written educational materials and modified 19 of them to be more inclusive for male patients. A male peer-to-peer support group was implemented as well, but only two members out of a nine-patient cohort took advantage of it. A six month follow up survey of the entire cohort of the educational materials and support group showed a high level of satisfaction of the participants [1].

It is important for all healthcare providers to treat every patient with dignity and sensitivity. Even though male breast cancer is very rare, the unique needs of this population must be considered. The educational task force created and administered by nurses shows how nurses can modify existing protocols and use their influence to assist all patients in a compassionate way.

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Alcohol vs. Cannabis: Which is Worse?

To evaluate which potentially addictive substance is worse, Business Insider author Erin Brodwin researched multiple medical journals such as the Lancet; the American Journal of Public Health; the American Journal of Addiction; the Journal of Cognitive, Affective and Behavioral Neuroscience; as well as reports from the Centers for Disease Control and Prevention (CDC), National Council of Alcoholism and Drug Dependence, and the Drug Enforcement Administration (DEA). There has been significant research on the effects of alcohol in physical, emotional, psychosocial, and other factors for many years. Research into cannabis, whether medical or recreational, is sorely lacking due to its illegal status for many years [1].

Comparisons in these areas included risk of death, with the Lancet reporting that in an age 15 to 49 cohort, alcohol use was the seventh leading cause of death in 2016. This data was reported from 195 countries over 26 years. The Lancet researchers concluded their study by stating that there is no safe level of alcohol intake. In the United States, the CDC reported that in 2014 close to 90,000 deaths could be attributed to direct alcohol intake or drinking-induced accidents. The DEA, as well as a report from the American Journal of Public Health, determined that cannabis use had not caused a single direct death by overdose [1].

The report also examined the physical effects of alcohol and cannabis on cancer and the heart. The U.S. Department of Health and the National Cancer Institute have stated that alcohol can increase the risk of developing cancer, especially with consistent use. On the other hand, recent reports do not show a correlation between cannabis and cancer [1]. Cannabis can increase the heart rate compared to alcohol which slows it down. A study from the National Academy of Sciences did not find evidence that cannabis can cause or increase risk factors for heart attacks [1].

Social effects of alcohol and cannabis examined driving and violence. Driving while impaired by alcohol is significantly more dangerous than driving while high on tetrahydrocannabinol (THC), a psychoactive compound in marijuana. Most medical marijuana is THC-free, further reducing the risk of impaired driving [1]. Violence is increased with alcohol use. Researchers have found that the equivalent of 2 drinks impaired the decision making area of the prefrontal cortex and that 40% of violent crimes had alcohol as a factor [1].

Both alcohol and cannabis are implicated in mental illness. Cannabis can increase paranoia, psychosis, and development of schizophrenia. Depression and anxiety are linked with alcohol use, including increased risk of suicide [1].

Alcohol and cannabis are both considered vices and "bad for you" [1]. Medical marijuana is legal in 31 states and Washington, DC [2]. Recreational marijuana is legal in nine states and Washington, DC [2]. In comparison, drinking alcohol is legal in all 50 states for those aged 21 and above. Overall, the risks for alcohol appear to be far greater than for cannabis. Long term and more rigorous studies on cannabis are needed for a more accurate perspective.

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APRNs & Medical Marijuana

Cannabis remains illegal under federal law. However, many states have approved cannabis for treatment of various illnesses and symptoms. Advanced practice nurses may be asked by their patients about using medical cannabis to treat medical conditions; however, there is very little evidence to the efficacy of medical cannabis. This is due to lack of rigorous research. The dearth of research in medical cannabis leads to an absence of guidelines in dosing, safety, and long term effects for use [1]. Nurses need to familiarize themselves with safe cannabis use and prescribing in the absence of strong evidence.

Some questions nurses might ask themselves when patients ask for medical cannabis: First, can you assess who might be a good candidate? Second, does the patient have a condition that medical cannabis can treat? Third, does the patient understand how medical cannabis is administered and works [1]?

In general, the rule with medical cannabis is start low and go slow: Low doses are recommended, and the provider may want to request that the patient take note of their symptoms and keep a log to best determine an adequate and safe dose [1].

Medical cannabis can help many medical issues, but it should be used with caution by those under 25 years of age, pregnant, or breastfeeding; or anyone with a history of substance abuse, cardiac issues, psychosis or schizophrenia, or a hormone-positive cancer. The most common side effects of cannabis include dry eyes, cognitive and psychological impairment, fatigue, dizziness, and tachycardia [1].

Advanced practice nurses should continue to educate themselves about medical cannabis so they can serve as a resource to their patients, and remain familiar with state legislation so as to practice nursing safely.

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Best Practice Guideline: Administering Epipens

Scott Topiol, BSN, RN, PHN, CEN, EMT

Do you know when to give epinephrine (i.e. an EpiPen or EpiPen Jr.) for an allergic reaction? According to some studies, healthcare providers fail to administer epinephrine in 80-85% of cases where it should have been used [1]. This is despite the fact that epinephrine is the first and most important treatment for a severe allergic reaction.

When should epinephrine be given? Contrary to popular belief, you do not have to wait for extreme symptoms such as shortness of breath, hypotension, or anaphylactic shock to use it. Give epinephrine immediately when a patient with a known or suspected allergic reaction experiences any of the following rapidly-occurring symptoms [2]:

- Respiratory: Shortness of breath, wheezing, repetitive cough
- Cardiovascular: Weak pulse, cyanosis or pale skin, dizziness
- Throat: Tightness or hoarseness, difficulty swallowing, trouble breathing
- Mouth: Significant swelling of the lips or tongue
- Skin: Widespread hives or redness
- GI: Repetitive vomiting or diarrhea

Epinephrine should also be administered for the following mild symptoms when more than one body system is affected [2]:

- Nose: Itchy or runny nose, sneezing
- Mouth: Itchy mouth
- Skin: A few hives or mild itch
- Gut: Mild nausea or discomfort

Allergic reactions can progress rapidly and are unpredictable. Each reaction may be different or worse than a previous reaction. Antihistamines such as diphenhydramine (Benadryl®) will not stop anaphylaxis and are not a substitute for epinephrine [3].

Administer epinephrine into the mid, outer thigh. An EpiPen or EpiPen Jr. can be given through clothing. Remember, "Blue to the sky, orange to the thigh" when injecting, and hold the needle in place for three seconds, and then massage the area for 10 seconds [4]. You can repeat the dose after five minutes if symptoms worsen or do not improve.

Epinephrine does not cure an allergic reaction, but it does buy time so that further hospital care can be obtained. With a duration of action of 10–20 minutes, all patients receiving epinephrine should be transported to the hospital via ambulance, as they are at risk for recurrent anaphylaxis. Call 9-1-1 as soon as possible and advise the dispatcher that a severe allergic reaction has occurred and that the patient has been given epinephrine. The patient will likely be observed for a minimum of four hours after being brought to the hospital, and will typically be discharged if he/she remains symptom free [5].

Do not be afraid of epi! It's better to give it when you are not completely sure than to regret not giving it when you should have. Anaphylaxis kills, and early treatment with epinephrine saves lives.

About the author:

Scott Topiol, BSN, RN, PHN, CEN, EMT, is a nurse educator for the Los Angeles County Fire Department, a certified emergency nurse at Cedars-Sinai Medical Center, co-owner of CPR Ready, an American Heart Association training site, and a volunteer responder for Hatzolah of Los Angeles. He and his wife, Nicole, have three children, ages nine months to seven years.

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Hospice and Halacha

Rabbi Daniel Rose

There are many reasons why it is difficult to talk about the period of time we call the end of life. Most obviously, it is a subject we would prefer to consider theoretical. But, like many aspects of life that are difficult to discuss, our approach to the end of life is an important topic that is often misunderstood.

Caring for someone towards the end of life is often marked by confusion, stress, and tension. In many ways, this has been exacerbated by the innovations that modern medicine has made available to us. Having to learn about the relevant medical and halachic issues in the moment compounds the challenge and is hardly conducive to good decision making. But, with a little education and preparation, we can hope to bring more peace, calm, and meaning to the final stage of life.

A caveat is in order: there is no single correct approach to making the decisions that arise at the end of life. There are different *halachic* opinions about many critical issues, and each patient will have different priorities as to what is most important to him or her. Our goal is to present the issues and options, as well as the mainstream *halachic* approach.

When Is the End of Life?

We often think of the end of life as the last few days before someone passes away. While there are many questions that are unique to those few days, many other issues are relevant weeks and months before that point. Hospice care is accessible to people who have six months or fewer to live. And many questions will arise sooner than the very end. While patient's wishes may change over time—and we can always revisit our decisions—we can help our patients by discussing a plan of care before a crisis arrives.

The Torah's Values

The Torah values life: whether that life lasts for years or moments, whether that life is filled with joy, physical ability, and spiritual accomplishment, or whether it is accompanied by extreme physical limitations or even unconsciousness. When someone's life is in danger on Shabbos, we violate Shabbos to preserve it, even if we know that the person will be able to survive for only a short time. Our devotion to life is a badge of honor.

At the same time, though, this often gives rise to the misconception that a person is required to do everything possible to extend his or her life in all circumstances. This is not the case. Over the past 40 years, as medicine has developed new interventions that can prolong life even at the very end, questions about how much needs to be done have been addressed by the *gedolim* of the past generation: Rav Moshe Feinstein [1], Rav Shlomo Zalman Auerbach [2], the Steipler Gaon, and many others. While there are differences among them, all agree that when a person is suffering from pain and there is no medical hope that the person will recover from their illness, one is not required, and is sometimes even forbidden, to provide treatments that will only extend the person's suffering.

There are two important implications of this *halacha*. First, when someone is at the very end of life, the *halacha* is that some treatments designed to cure the illness or prolong life are stopped. The details of this are too intricate to delve into here. Broadly speaking, the Torah still requires us to provide those elements that our bodies need to function. Primarily, this means that everyone must be given food, water, and oxygen, as well as other important provisions in certain cases. On the other hand, other treatments—such as medications designed to slow the illness down, to prop up some of the body's systems, or even, sometimes, resuscitation—are often not provided. It is important to underscore that the goal is never, *chas v'shalom*, to cause someone to die sooner. The goal is to avoid artificially prolonging a life of suffering when recovery is not possible.

The second implication can be more difficult but is also important to know. Often, people facing a serious illness have treatment options that are risky, painful, and are expected to extend their lives only by a limited amount. In many such cases, the *halacha* does allow a person to choose whether they want to pursue those treatments. Without question, in many circumstances, we would encourage someone to pursue treatment, especially when it can give them a period of time in which they can perform *mitzvos* and spend meaningful time with those they love. But it is important to know that there are situations when a choice is halachically sanctioned. Certainly, when someone is unsure about pursuing a course of treatment, it is better to ask than to assume what the answer will be.

It goes without saying that these halachic issues require a careful and detailed conversation with a *rav*. While the broad *halacha* is clear, the details are very complicated, and each situation requires an approach all its own.

Challenges of the System

Some recent trends in the healthcare system have presented new challenges for those seeking to follow *halacha* at the end of life. Chief among these is an enhanced focus on avoiding what is seen as futile treatment. For example, there are different attitudes about the efficacy of artificial nutrition in end of life patients suffering from cachexia (extreme weight loss and muscle wasting due to severe chronic illness). In such cases, many will take the approach that nutrition should not be provided unless there is a strong indication that it will improve quality of life. This, however, is not usually the halachic approach.

In conversations with *rabbanim* about this issue, I have heard a version of the following anecdote more than once: The *rav* receives a phone call from a doctor who works in the intensive care unit (ICU). The doctor is calling to say that one of the *rav's* congregants is a patient in the ICU and has taken a turn for the worse. The doctor does not believe there is anything more he can do and is calling, at the family's request, to find out what to do next. "Rabbi," he says, "we have two options here. We can do it the cruel way or the compassionate way: we can be cruel and continue to provide every intervention, or we

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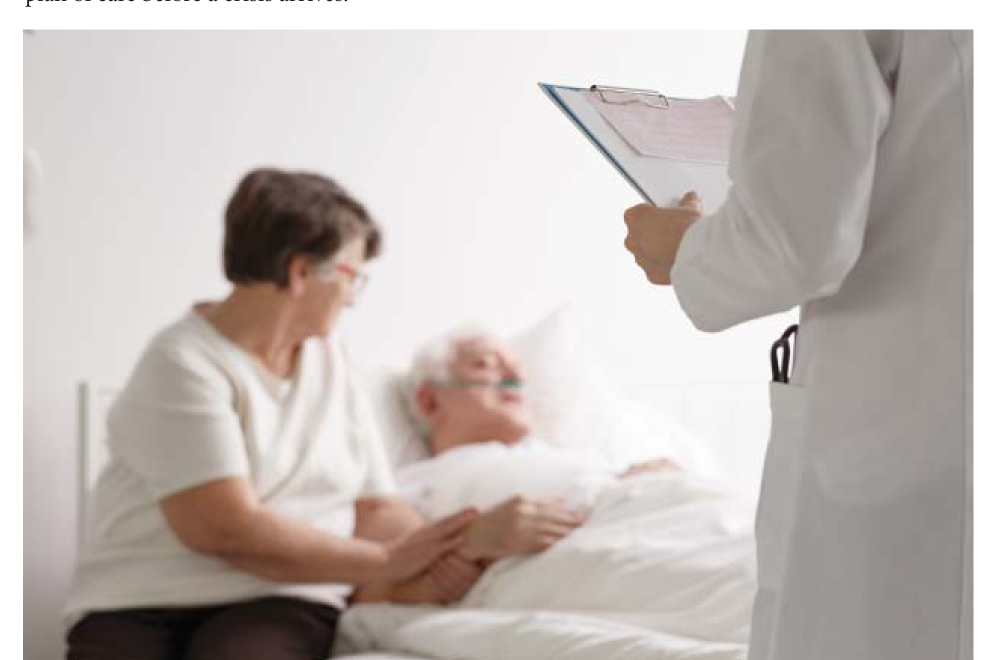

When Your Child Has Cancer

Mindy Blumenfeld, MSW, LCSW

For someone who has never experienced it, it is hard to convey the absolute chaos into which a family descends when a child is newly diagnosed with a life threatening illness and the subsequent journey through hell. Imagine lying on a hammock in your magnificent backyard and someone throws a heavy, dark quilt over your head, effectively suffocating you, blocking out light, air, and the ability to move freely. Something like that, only much, much worse.

I am intelligent, rational, organized; possessing a strong personality and naturally assertive. And that is how I was perceived for the 10 years my son battled a brain tumor. It was a constant refrain I heard as I navigated the medical maze of treatment, surgery, and hospital visits; how unbelievably strong I was, how well I managed my son's care, how incredibly I held up the torch to lead my family through this darkest time. And maybe it was true. But it was not possible without the entire Jewish community that came to stand at my side. The volunteer rides to the hospital, the patient advocacy services that made my insurance foot the $330,000 bill for 30 days of proton radiation, the mountains of food, presents, and free accommodations at every step of the way. The teen volunteers who entertained my son so I could grab a shower and a half hour at the computer catching up in my life, the hours of Tehillim (Psalms) recited, and the various events to create merits so he should live.

But if I would have to point to a single most powerful support in this journey, it would be the nurses who tended to my son. The good ones shone like beacons of hope, joy, and light; the indifferent ones threw us into holes of frustration, tears, and despair.

In the hospital, no matter my rank and privilege in the normal world, I was stripped to dependency on the nurses who cared for my son. My son was six when he was diagnosed, 16 when he died in my arms. And in the 10 years between, hundreds of nurses who addressed his needs, some with good humor, affection, and respect; others with callousness, irritation, and disrespect. It is not important the bad experiences, because it was part of our journey and we learned to accept with grace what we could not change. But if I can convey to my readers, an illustrious body of Jewish, religious nurses, the power of healing conveyed by your presence, then it will matter much to me.

As you can all well appreciate, it is very difficult to tolerate the slow moving machinery of the treatment protocols, of finding a diagnosis, treatment, second opinions, insurance red tape, and hospital bureaucracy. This is inevitable and frustrating beyond belief. The doctors, committed and dedicated as they may be, are often part of the problem, enmeshed in hospital and interdisciplinary politics. In addition, the nature of their jobs does not always lend themselves to a great bedside manner, even as their genius and care is evident. It falls on the nurses, at the front line of treatment, to be the liaisons between the doctors and the patient, between the cancer and the person, between the stick of the needle and the child.

Let me tell you the ways in which you can make the life of a child, of any patient, that much easier; how your presence can calm even the most grief-stricken parent.

I know you are very busy, often understaffed and overworked. Let your patient know that. Sometimes you can't change the situation, but you can change the attitude towards an event. Say something like, "I know that when you press the call button for me to come, it is really important to you. It is really important to me too. Sometimes, I am busy with an emergency and I am so sorry. Please press it again, and don't worry that you are bothering us."

Help a family acclimate to their new environment. Say, "It takes some time to get used to the hospital and tomorrow a patient advocate will be around to tell you where the showers are, the recreation room, and your rights as a patient." Let them know there are services, and how to access them. Yes, the parents are probably exhausted and can't hear a word you are saying, but when they have a second to breathe, they will at least know the questions to ask you or the next nurse.

Be culturally sensitive. If a family from a different culture comes onto your ward, find out if there is anything you need to know about their way of doing things. Ask your supervisor, search google, or even ask the family.

If they seem upset about something that is outside of your jurisdiction, tell them that. Tell them how they can access help about that situation. Don't leave them floundering, feeling lost in the vastness of hospital bureaucracy. If you don't know, put in a request for the social worker to pay them a visit.

I can tell you what nurses have done for my son and family over the years that have made an impact, softened the terrible diagnosis that made the pain more bearable.

Nurses brought my son Curious George stickers because he loved Curious George the whole first year of his illness. Made silly cartoon faces on the mask he wore to radiation. Asked him about his older brother who supposedly was getting engaged, although none of us had heard anything about it. Made him laugh by practicing their Yiddish on him. Made sure to wrap his little wounds with the stretchy bandage instead of Band-Aids at his request. Used the thinnest needles for blood drawing possible. Nurses found Harry Potter videos for him to watch because he didn't want any of the other 500 movies the hospital owned. Nurses came the minute he pressed his call button, and when they couldn't, they let him know they were on the way because they needed to help another kid. Nurses listened when he talked, explained when he asked hard questions, apologized for the pain they knew he would endure as part of his care. They smiled. A lot. They laughed. A lot. They complimented and caressed and fussed and flattered. Nurses showed me where the fresh linens were and turned the other way when I helped myself instead of asking. Nurses made me feel we were the only ones that mattered by their sympathy and solidarity.

The good nurses did not get offended when my son grew up to be a very religious boy, understanding that a teenager needs to find meaning in his illness and use whatever works to cope with imminent death. They did not get insulted, even when he refused to engage with a nurse because she was female and he was a Chassidic boy. Instead, they asked questions about his reli-

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gion, about his behavior, about our values, and expressed understanding, and even admiration, for his courage and commitment to what he believed in. The good nurses did not get offended when he was no longer a cute six year old, but a frustrated teenager who was tired of being sick, or when he said things we did not bring him up to say but did anyway; and no, we were not going to discipline him for that behavior. The good nurses did not ignore our call button, respond to us with irritation, or come to our bedside with tight, pursed lips and rigid body postures. The good nurses paid attention to the details, to the minutiae that made our lives bearable in the moment. Refills of water, of those spongy toothbrushes, of sponge bath stuff when we needed them. Extra pillows, extra smiles, extra visits to our bedside. Sometimes, the good nurses whispered to us stuff they might get into trouble for saying. Like, "Ask for Dr. X next time." Or, "If that child in the next bed keeps on his TV all night, you can put in a complaint to the social worker. But in the meantime, I will close the TV for you."

All this is about being a good nurse to any child, any family. But I cannot begin to tell you the absolute relief we felt each time we entered a new situation, a new treatment center, and not only was the nurse wonderful, but she was Jewish. Religious. That familiarity in such an alien environment was the feeling of being rocked to sleep in a cradle. The kinship of a frum nurse, of her presence in this strangeness, simply decreased the anxiety and we felt we could make this place once again another extension of our home. Seriously. Do not underestimate the deliciousness of your presence simply by being a religious Jew.

It's about being sensitive to the needs of a family, of the child, of the pain, both physical and mental, that they are experiencing. Your smile, your light touch, your reassurance calms and soothes like nothing else.

Until today, I have the warmest memories of most of the treatment centers we encountered on our 10-year journey. On the shloshim (30 days after the passing) of our son, we delivered lunch, cookies, and notes to some of those facilities to say thank you. I pass those places and, because of the nurses within, they feel like home. Warm memories, gratitude, and a sincere appreciation for their dedication; in the path less traveled, you made all the difference.

About the Author:

Mindy Blumenfeld, MSW, LCSW, is a clinical social worker in private practice who provides individual, couple, and family counseling for teen and adult clients presenting with relationship issues, difficulties transitioning to changes in life and/or age-appropriate tasks, trauma, sexual abuse, marital/parenting issues, issues of sexual identity and disorders, grief and bereavement, phobias, and anxiety disorders. She is also a professional lecturer, author, and frequent columnist.

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can be compassionate, disconnect everything, and allow the patient to pass away."

There are two elements to the doctor's comment that are discomfiting. One, of course, is the idea that wanting to continue to provide some treatment should be considered "cruel." The value we place on life and our devotion to continuing it is sacred, and we should not feel the need to be apologetic about it.

But the second problem is the notion that there are only two approaches: do everything or do nothing. The *halacha* tells us that there is a third, middle path. Even when we reach the point at which we decide not to try to cure the disease anymore, we do not stop every aspect of care. As mentioned before, we still provide oxygen, nutrition, and hydration. In many cases, we still provide antibiotics to help treat infections. We do not pursue all or nothing; we pursue a carefully nuanced, moderate approach.

A Note on Hospice

One way to reach this halachic middle ground can be the engagement of hospice care. For many reasons, *frum* Jews often have a preconceived notion about hospice that renders it outside the halachic pale. But in my work, I have come to learn that hospice can be made compatible with *halacha*; sometimes, it can even provide for the best halachic approach. Members of the hospice staff are focused on the patient's comfort and are skilled at addressing pain, anxiety, and other symptoms that often accompany this stage of life. My experience has been that because hospice is focused on fulfilling the patient's particular wishes, it can be supportive of the middle ground that the *halacha* requires. For example, hospice has helped patients continue to receive artificial nutrition and hydration by carefully calibrating what is provided so that it gives the maximum benefit to the patient and does not cause harm. In addition, because they are attuned to the patient's needs, it is natural for hospice professionals to include the patient's *rav* in discussions. With the right structure and halachic consultation, we should feel comfortable discussing hospice as a viable and potentially beneficial option.[3]

The Role of the Nurse

As disease advances, the insights that nurses uniquely can provide take on a new importance. Assessing the patient's overall condition and comfort becomes as important as identifying the optimal clinical options. Is the patient suffering from pain or anxiety that is going unaddressed? Is the patient expressing a strong desire to avoid hospitalizations? Has the patient's decline started to accelerate recently? These questions have a bearing on both medical and halachic considerations.

In addition, patients and families often do not even realize what questions they should ask their doctor or their rabbi about end of life care. Nurses can help educate them about what options might be available to them and guide them in finding the right questions to ask. And perhaps most importantly, this time of life can be marked by confusion and fear. Nurses can provide a calm, soothing, and confident presence that can help patients and families face this experience with faith and peace.

About the Author

Rabbi Daniel Rose received *semicha* from Yeshivas Ner Yisroel and trained in pastoral counseling at Johns Hopkins Hospital. He is the assistant rabbi at Bnai Jacob Shaarei Zion Congregation in Baltimore and the director of Seasons Jewish Hospice Services of Maryland.

He is the author of *Building Eternity: A New Perspective on the Meaning of Marriage.*

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[1] See, for example, *Igros Moshe, Choshen Mishpat 2:73-75.*

[2] See, for example, *Nishmas Avraham* to *Yoreh Deah* 339; *Shulchan Shlomo, Erkei Refuah* Section 2 pp. 3-7.

[3] It should be noted, however, that working as a hospice nurse for patients who do not follow *halacha* can pose significant halachic challenges. Careful consultation is required before considering entering this field.

Cancer Screening Tests

Tobi Ash, MBA, BSN, RN

Screening is the use of a diagnostic test (blood, urine, imaging, or DNA tests) in a healthy population to search for cancerous cells or tissue to identify an individual who *does not yet show symptoms* but has cancer. Screening tests can lead to cancer prevention through early diagnosis. Screening tests should be safe, well tolerated, and effective with low rates of false results.Screening tests are used in the general population and include mammography, pap smears and colonoscopy. The challenge of detecting other cancers such as brain, bladder, oral, liver, thyroid and other cancers is that the individual must take responsibility to show their symptoms to a healthcare provider.

		American Cancer Society/(ACS) [1]		US Preventative Task Force (USPTF) [2]	
Type	**Test**	**Age**	**Frequency**	**Age**	**Frequency**
Breast	Mammography	40 to 54	Annually	50-74	Every other year
		>54	Every 2 years		
	Clinical Breast Exam	20-39	Every 3 years	50-74	Every other year
	Breast Self Exam	20 and up	As needed		
Cervical	Papanicolaou (Pap) test/smear	21-39	Every 3 years	21-65	Every 3 years
	Pap + HPV	30-65	Every 5 years	21-65	Every 5 years
		>65	With ≥3 consecutive negative Paps or ≥2 consecutive negative Paps + HPV within last 10 years can stop cervical cancer screening		
			If a woman has a hysterectomy no need for screening		If a woman has a hysterectomy no need for screening
Colo-Rectal	Fecal Occult Blood Test (gFOBT)	45-75	Annually: all positive results should be followed up with a colonoscopy	50-75	Annually: all positive results should be followed up with a colonoscopy
	Fecal Immunochemical Test (FIT)	45-75	Annually: all positive results should be followed up with a colonoscopy	50-75	Annually: all positive results should be followed up with a colonoscopy
	Sigmoidoscopy	45-75	Every 5 years		
	Colonoscopy	45-75	Every 10 years		
		76-85	Screening should be individualized based on the patient's history		
		≥85	Discourage from testing		
	CT Virtual Colonoscopy	45-75	Every 5 years with a follow up colonoscopy if polyps are found		Insufficient evidence of effectiveness
Lung	Low Dose Helical Computed Tomography (LDHCT)	50-74 who currently smoke, smoked for ≥30 years, or quit within the last 15 years	Annual screening	55-80 with a 30 pack-year smoking history and currently smoke or have quit within the past 15 years	Annual screening. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery
Prostate	Prostate Specific Antigen Test (PSA) and Digital Rectal Exam (DRE)	≥ 50 >45 African American men or with a family history	Individual decision	Individual decision	Does not recommend PSA screening
Testicular			As part of regular physical exam		Does not recommend annual screening
Skin			As part of personal self exam care and health care provider annual skin checks		Does not recommend annual screening

These screening tests have demonstrated a decrease in cancer deaths: [1,2]

Colon Cancer	Colonoscopy, Sigmoidoscopy, High Sensitivity Fecal Occult Blood Tests	Ages 50-75
Lung Cancer (in heavy smokers)	Low Dose Helical Computed Tomography	Ages 55-74
Breast Cancer	Mammography	Ages 40-74 (especially after age 50)
Cervical Cancer	Pap Smear	Ages 21-65

Other Diagnostic Screenings in otherwise asymptomatic patients:

Liver Cancer	Alpha-Fetoprotein	Combined with ultrasound of liver for those at high risk [3]
Breast Cancer	Breast MRI	For mutations of BRCA1 and BRCA2 gene or increased risk of breast cancer [4]
Ovarian Cancer	CA-125	Combined with transvaginal ultrasound but not regarded as an effective screening test [5]
Prostate Cancer	Prostate Specific Antigen test	Combined with digital rectal exam. No longer recommended routinely [6]
Skin Cancer	Visual skin exam and skin biopsy	Exams have not shown decreases in skin cancer deaths. Nevertheless, any changes in skin should be examined by a physician and biopsied if needed [7]

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How an At-Home Genetic Test Saved My Life

By Laura Osman, Sharsheret Peer Supporter

Earlier this year, curiosity about my ancestry spurred me to order an at-home genetic testing kit by mail. And, although I went through a rigorous prenatal genetic testing process while pregnant with my third child less than two years earlier, I figured the small price to do some more genetic testing could be worthwhile. When the kit arrived, I quickly spit in the tube and sent it off, not giving any thought to the genetic and ancestry testing boxes I checked off.

Several weeks later, an ordinary morning coffee before heading out on a morning run would become extraordinary. Quickly scrolling through my emails, I clicked on my available testing report from the at-home genetic testing kit. First came my ancestry: 99.9% Ashkenazi Jewish. As I kept scrolling, my heart stopped as I saw *BRCA1* POSITIVE. CONSULT WITH DOCTOR. This must be a mistake! No men or women in my family have had breast or ovarian cancer. Shaken, yet hopeful of a lab error, I called my obstetrician/gynecologist (OB/GYN) and explained the situation. That afternoon, I was sitting in her office awaiting a medical grade test, the gold standard in BRCA testing.

Exactly seven days later, I received the call confirming my nightmare. I was *BRCA1* positive. My initial shock and anger were replaced with a paralyzing fear that I already had developed cancer. Immediately, I knew feeling sorry for myself was not a productive option.

Women carrying the BRCA mutation begin advanced screenings starting at age 25, and here I was at age 37 having never had a mammogram or ovarian cancer screening. After the initial cancer screening consisting of a mammogram, CA (cancer antigen) 125, and a pelvic ultrasound came back negative, I breathed a momentary sigh of relief, realizing how lucky I was to catch this. With the *BRCA1* mutation, I faced up to an 88% lifetime risk of developing breast cancer, and a 45% lifetime risk of ovarian cancer. My body, which I have always viewed as healthy and strong, pushing myself to the limit as a former National Collegiate Athletic Association (NCAA) collegiate track and cross country All-American, was a ticking time bomb.

Five weeks after receiving the initial email from my at-home genetic testing company, I underwent my first surgery: a laparoscopic tube and ovary removal with my doctor at a major Los Angeles hospital. Eleven days later, my doctor laughed when I showed up to my post-op checkup anxiously awaiting to be cleared for exercise in my running shorts. Running for over 25 years has changed the activity from a form of exercise to part of my life that gives me a sense of normalcy and joy. Although I was hobbling and out of breath on that first run back, I was also smiling, knowing I had significantly reduced my risk of ovarian cancer.

Next, I had to tackle the surgery that scared me the most. A double mastectomy is unique in that it is not only a physically difficult surgery, but also an emotionally loaded process. Connecting with other women has opened the doors to a beautiful community of supportive, educated, and encouraging women. Instead of ignoring my fears, I began open conversations about my emotions, the pain and recovery, and how it could potentially change my relationship with running.

That's what Sharsheret is all about. Sharsheret is the national Jewish not-for-profit organization that supports women and families facing or at high risk for breast and ovarian cancer. Sharsheret's Peer Support Network is a confidential program that connects women one-on-one with others who share similar diagnoses, treatments, family constellations, and experiences. Beyond the peers, Sharsheret has a team of skilled and sensitive social workers and a genetic counselor who speak to thousands of women like me, helping us to cope and stay strong and resilient while making very tough decisions about our bodies, our health, and our future.

Without regret, I chose to preventatively remove both healthy breasts. On July 26 of this year, I underwent a nipple sparing bilateral mastectomy with immediate direct to implant reconstruction. Although the initial recovery was filled with some dark moments, each week I gained strength and was surrounded by an army of support, which undoubtedly helped me heal both physically and mentally.

Now, eight weeks past my surgery date, I am back to my eight mile runs and chasing around three small kids. As I set out running, I am so grateful to be strong, healthy, and pain free. Each step is a reminder of how lucky I am to have caught my *BRCA* mutation before it was too late. When I look at my body today, it is not a terrible reminder of my genetic mutation, but rather a beautiful result of finding a team of supportive surgeons who believe you do not have to sacrifice aesthetics to prevent cancer.

The final piece to my puzzle was finding the origins of my *BRCA1* mutation. As it turns out, my father carries the *BRCA* gene. Although male carriers are at increased risk for prostate cancer, the mutation often goes undetected in men, as it did in my father who had prostate cancer. A common misconception is that women cannot inherit BRCA from their fathers. Because no women in my family had breast or ovarian cancer, the possibility that I carried *BRCA* flew under the radar.

All Ashkenazi Jewish women and men carry a 1/40 risk of carrying a *BRCA* mutation as compared to 1/500 in the general population. We all need to ask more questions about our family genetic history on both our paternal and maternal sides. It is time for us to begin conversations with our doctors, even when they may not initiate them with us. We need to be educated, and to raise awareness about how *BRCA* and other genetic mutations can be passed down from both parents. While prophylactic surgery might not

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be the right choice for every woman, knowing our risks and understanding our options will empower us to take control of our bodies and our lives, and will enable us to make informed and potentially life-saving decisions.

Although being *BRCA* positive might seem like a curse, I am in fact lucky that a random box checked on an at-home genetic testing kit test likely saved my life.

Some important breast cancer facts:

In the United States, the average woman has a 12% chance of developing breast cancer and a 1-2% chance of developing ovarian cancer. But certain genetic mutations, such as *BRCA1* and *BRCA2,* can increase those lifetime risks to up to 88% and 45% respectively, according to studies published [1] in the Journal of the American Medical Association. These mutations are found in Ashkenazi Jews 10 times more frequently than in the general population. At least 50% of hereditary breast cancer is related to genes that are not known how to look for yet.

BRCA genes are normal genes that everyone carries, and they help our bodies prevent cancer. When a mutation is present, the result may increase the carrier's risk of cancer considerably. These mutations often result in diagnoses of breast and ovarian cancer, but they can cause other types of cancer as well, such as pancreatic, prostate, male breast cancer, and melanoma. Mutations in *BRCA1* or *BRCA2* can be passed down by men AND women.

At-home genetic testing companies may offer tests for three such mutations most commonly found in people of Ashkenazi descent, making it much easier for people to get tested. It's important to note that anyone who takes an at-home genetic test should first and foremost get tested by a medical provider, as well as consult a genetic counselor to discuss his or her results and help navigate the next steps.

To schedule a free and confidential conversation with Sharsheret's genetic counselor or to be connected to a Sharsheret Peer Supporter, contact Sharsheret at clinicalstaff@sharsheret.org or (866) 474-2774.

Learn more about Sharsheret at www.sharsheret.org.

Reference:

[1] U.S. Preventive Services Task Force. (2005). Genetic risk assessment and *BRCA* mutation testing for breast and ovarian cancer susceptibility: Recommendation statement. *Annals of internal medicine, 143*(5), 355–361. doi: 10.7326/0003-4819-143-5-200509060-00011

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Chaya Milikowsky, MS, AG/ACNP-C

Oral Cryotherapy

Oral mucositis, or the development of ulceration in the mucous membranes of the mouth, is a fairly common side effect of chemotherapy, affecting approximately 40% of patients undergoing chemotherapy [1] and up to 75% of high risk patients [2]. The degree of mucositis varies, ranging from mild asymptomatic ulceration to wounds that preclude the patient's ability to eat or drink [3]. In addition to the pain of mucositis, other associated negative effects include increased risk of infection, reduced oral intake, delays in and reduction of treatment, prolonged hospital stay, and psychological distress [1,3].

Although there is no definitive treatment for mucositis, multiple supportive therapies have been utilized to manage the uncomfortable symptoms. These treatments include saline rinses, sodium bicarbonate mouthwashes, and the practice of good oral hygiene. In recent years, however, there is increasing recognition and utilization of oral cryotherapy as an adjunct treatment in the management of mucositis symptoms.

Oral cryotherapy involves maintaining ice cubes in the mouth for a 30-minute duration while chemotherapy is being infused. To chill the entire mouth, the ice cubes are swished around, and new ice cubes are provided as the old ones melt. The theory underlying cryotherapy is that the cold induces vasoconstriction of the oral vasculature, which in turn limits the amount of chemotherapy circulating through the oral mucosa. Less local exposure to cytotoxic drugs leads to reduced regional mucositis [1,3].

Recent studies have focused on the use of oral cryotherapy in managing mucositis pain in patients undergoing treatment with 5-fluorouracil (5-FU) for solid tumors. A study done by researchers at the University of Malaya Medical Centre in Malaysia compared the use of oral cryotherapy in combination with a sodium bicarbonate rinse against the use of the bicarb rinse alone. Participants in the study were all undergoing treatment with 5-FU for colorectal cancer. Patients in both the control and the experimental groups used a sodium bicarbonate rinse every eight hours; the sodium bicarbonate works to reduce oral mucositis by creating an alkaline oral environment that is more hostile to bacteria, and also assists with oral hygiene and comfort. The patients in the experimental group additionally incorporated 30 minutes of oral cryotherapy during 5-FU administration. There was a statistically significant reduction in the pain reported by the interventional group and there was also a statistically significant difference in the mean mucositis scores of the two groups, as measured by the World Health Organization oral mucositis grading scale [3]. This particular study corroborates the results seen in earlier studies also focused on mucositis associated with 5-FU [2].

Another class of patients for whom oral cryotherapy appears to be somewhat effective is patients undergoing chemotherapy prior to bone marrow or stem cell transplant. A study done by Askarifar, Lakdizaji, Ramzi, Rahmani, and Jabbarzadeh (2016) in Iran looked at the use of oral cryotherapy as compared to the use of a normal saline mouthwash in patients with Hodgkins and non-Hodgkins lymphoma and multiple myeloma who were undergoing chemotherapy prior to bone marrow transplantation [1]. Again, there was a statistically significant reduction in the severity of pain and mucositis in the interventional group, both at the seven day and 14 day marks.

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THE COOLEST THERAPIES

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In light of the above and other studies, the use of oral cryotherapy to reduce mucositis has been gaining support. The Multinational Association of Supportive Care in Cancer and International Society of Oral Oncology guidelines now support the use of oral cryotherapy in the management of mucositis due to specific chemotherapeutic regimens, particularly those with a short half-life [4]. Not only have recent studies found the therapy to be effective in reducing the pain associated with mucositis, but the therapy is cheap and has few to no side effects. With a greater impact yet lower costs than alternative regimens, oral cryotherapy should be offered as an adjunct in the management and reduction of mucositis symptoms.

Scalp Cooling

One of the most well recognized side effects of cancer treatment is chemotherapy-induced alopecia, or hair loss. Though hair eventually grows back, hair loss during cancer therapy can be very distressing to patients, leading to profound psychological stress and occasionally may lead patients to choose a less effective chemotherapeutic regimen in an effort to minimize hair loss [5]. Scalp cooling is an intervention that has been recognized since the 1970s as an option to minimize hair loss. One theory behind scalp cooling is essentially the same as that of oral cryotherapy; the cold temperature leads to vasoconstriction of the scalp vasculature which is thought to reduce the amount of cytotoxic drug that reaches the hair follicles. Another theory is that the cold temperature diminishes the metabolism of the hair follicles which then makes them less reactive to chemotherapy which targets rapidly dividing cells [6].

Studies on scalp cooling have found wide variation in the success rate of the therapy. Results seem to vary based on the particular drug used, drug dosage, thickness of the patient's hair, how well the patient tolerates the discomfort of a chilled scalp, and the method used for cooling [5]. Though there has been some concern regarding the potential for scalp metastases and tumor seeding, this intervention has been established as safe when used in the setting of solid tumors such as breast cancer. Scalp cooling is contraindicated in patients undergoing treatment for hematologic cancers, as well as those with diseases sensitive to cold temperatures such as cold-agglutinin disease [5,6].

Scalp cooling can be accomplished via ice packs, cold caps, and now newer mechanized scalp cooling machines. Until recently, patients have obtained cold caps on their own from the manufacturers, and have been responsible for placing and managing the caps during their chemotherapy treatment. Recent studies have found increased benefits with usage of the scalp cooling machines. They can be offered directly from and managed by the infusion center, are more comfortable due to gradual cooling and rewarming, and provide a more consistent temperature [8]. Though there are now two systems cleared by the Food and Drug Administration for usage, the DigniCap and Paxman systems, there still exist barriers to their practical use.

A study done by Fischer-Cartlidge, Ross, Hernandez, Featherstone, and Haase (2018) looked at the implementation of a large multi-site, nurse-driven, machine-based scalp cooling program at Memorial Sloan Kettering Cancer Center in New York [7]. There were many considerations to be dealt with prior to implementing this machine-based scalp cooling program. These considerations included physical space and facility resources, clinician resources, patient education, legal considerations, technological and IT integration, scheduling issues, financial determination, interprofessional collaboration, and training of staff. Some of the largest barriers found by the study were provider buy-in and projection of cost. However, in spite of the challenges to implementation, the scalp-cooling program was first successfully implemented in eight facilities, and then expanded to another six, with a combined greater than 1,800 scalp cooling treatments provided [6].

Scalp cooling is an intervention which poses potential benefit for patients undergoing chemotherapy, with effectiveness varying based on chemotherapeutic regimen, hair characteristics, and cooling techniques. For patients who are profiled to have maximum benefit from scalp cooling, this is a treatment option with minor adverse effects as compared to benefit. Complaints during trials of scalp cooling included headache, scalp itchiness, and cold discomfort, however, overall tolerance was good [7]. Patient and chemotherapy characteristics should be used to guide the decision whether to incorporate scalp cooling into a cancer treatment regimen.

Conclusion

Chemotherapy can be a life-saver, a beacon of hope in situations that appear dire and dismal. At the same time, it is far from a benign treatment, with the side effects of chemotherapy often seemingly worse than the cancer itself. Interventions to prevent or mitigate those symptoms are therefore essential, not only in the management of the symptoms themselves, but also to increase the likelihood that the chemotherapy will be tolerated in the appropriate dose and for the intended duration, maximizing the chances of success. Oral cryotherapy and scalp cooling are both interventions with minimal side effects and without great cost, and should therefore be offered to patients who fit the benefit profile. Nurses and providers should educate themselves on these options, so that they can offer their patients the best chances for the best outcomes.

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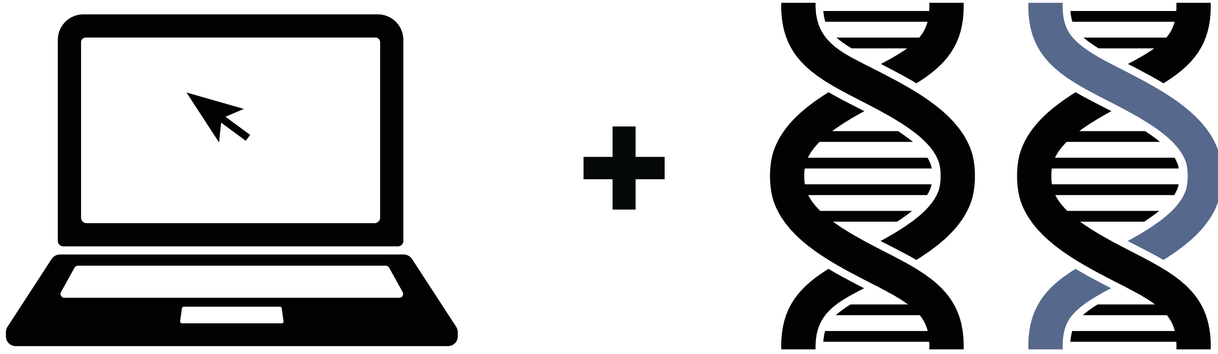
Chaya Milikowsky is an acute care nurse practitioner who covers the Intensive Care Unit at MedStar Montgomery Medical Center at nights. She received both her nursing and nurse practitioner degrees at University of Maryland, Baltimore. She lives in Silver Spring, Maryland, with her husband and five children.



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NURSES TO KNOW

Sara Porush, RN, OCN, and Aliza Parver, BSN, RN, OCN

Nursing Role: Inpatient vs. Outpatient Oncology

Where do you currently work and can you describe your responsibilities?

Sara: I am an Infusion Nurse at an outpatient hematology oncology office in Chicago. I schedule patients for and educate them about their upcoming treatments for a large variety of malignancies. I give IV infusions, mostly chemotherapy, but other infusions (e.g., iron, Remicade, hydration, antibiotics) as well. I help coordinate with the financial office to confirm insurance coverage for treatments, and do billing for my role as well.

Aliza: I currently work day shift at Mount Sinai Hospital in Manhattan, New York, on their adult blood and marrow transplant unit. We care for all liquid tumor patients, including leukemias, lymphomas, and multiple myeloma. We care for our patients from newly diagnosed through the transplant process. We have autologous and allogeneic transplant patients and we have also been doing clinical trials and treatment with CAR-T cells. We do all nursing functions, including medication administration, line maintenance, and chemotherapy administration, as part of the preparatory regimens for transplant.

How long have you been working in your field and was this area of nursing your first choice?

Sara: I have been working in oncology for more than five years. I always thought that I wanted to work in a pediatric intensive care unit (PICU). However, the nearest PICU to my home was over a 30-minute drive away, so I decided to apply for a variety of positions at a hospital much closer to my home instead. I was offered a position on a mixed medical-surgical/oncology floor, and the rest is history.

I worked inpatient for close to five years before I switched to outpatient. When I worked inpatient, my patients were a mix of oncology and med/surg. I had a big mix of responsibilities, ranging from typical administration of antibiotics and the like to inpatient chemotherapy. We also absorbed the hospice unit so we would care for patients at end of life. It was a great honor to be the person accompanying a patient along that journey. Since they were often our oncology patients, we had very close relationships with the patients and their families, which was both comforting and heartbreaking.

Inpatient and outpatient are very different. In the inpatient setting it's "run run run"—administer medications, acknowledge the orders, get it done. In my role in outpatient oncology I really have the time to get to know each of my patients. There are some that I see every week, sometimes multiple times per week. I know about their families and friends and can tell when they aren't feeling well and can take the time to help them. While outpatient is a lot slower physically, it can be a lot more draining emotionally because we all get so close to the patients. There is no feeling like hugging a patient upon finishing his/her last chemo treatment and being told he/she couldn't have done it without your support.

Aliza: I've been working in oncology for the last 7.5 years. I started 4.5 years ago on a med/surg oncology unit in northern New Jersey before coming to Mount Sinai three years ago. Oncology was not my original field of choice, but after doing the med/surg oncology as my first hospital job, I fell in love with the field.

Do you require any special credentialing to work in your specific area?

Sara: I have my chemotherapy/biotherapy certification and my Oncology Certified Nurse (OCN) certification. The chemotherapy/biotherapy certification was required, but the OCN was not. I personally wanted to achieve that certification.

Aliza: In order to work on my unit, all nurses must maintain chemotherapy administration certification, which we renew every two years. I have also been an oncology certified nurse for the last 4.5 years.

Where do you see yourself in 10 years within the nursing profession?

Sara: I would like to return to school to earn either a master's in nursing or a nurse practitioner (NP) degree.

Aliza: I see myself getting an advanced degree as either an NP or in the public health field. I really enjoy oncology nursing research and the advances that are all over the oncology world.

Do you have work/life balance tips to share?

Sara: When I left my inpatient job to move to an outpatient setting, I told my manager the following: "I love my job, but I love my family more." I always try to remember that my kids will only be young once and I have a lifetime of working years ahead of me. I try as hard as I can to be present for my family as much as possible. I try to be as organized as possible and stay one step ahead. (And I could never live without my cleaning help.)

Aliza: Work/life balance is rough. I emotionally deal with a lot of stressful and trying life circumstances for many of my patients on a constant basis. I try to work as many days as I can in a row to help with less transitions between my work life and home life. I, baruch Hashem (thank G-d), have a very supportive and involved husband and we work as a team to accomplish given our busy schedules and three kids.

It's impossible to really care for patients and not get emotionally involved. In oncology, I find that I can educate and emotionally be there for patients and their families when they are going through some of the most harrowing times of their lives. I find it very rewarding to help people in this way. I found that when I switched to Mount Sinai, I had more Jewish patients to care for which was especially meaningful to me. I find it very grounding to work in a hospital that has a shul where I can daven and decompress.

How did you hear about Orthodox Jewish Nurses Association (OJNA) and how long have you been involved?

Sara: I joined OJNA on Facebook more than six years ago when I was finishing nursing school OJNA has been an invaluable resource to me as I have navigated through my nursing profession.

Aliza: I have been part of the OJNA Facebook group for at least four years and I have attended two of the conferences. I try to contribute and help out and make connections when reading all the posts in the group.

If you would like to be profiled in future issues of The OJNA Journal, send a short paragraph detailing your background and role to OJNAjournal@gmail.com.

CAREERS TO CONSIDER

Infusion Nursing

Tziporah Newman, BSN, RN

Job title	Infusion Nursing
Job description/ basic responsibilities	Initiate and maintain IV lines, central lines, and venous access ports utilizing appropriate devices and sites Administration of fluids and medications, such as chemotherapies, blood transfusions, and nutrition replacement, through IVs, central lines, or venous access ports Evaluate and monitor patient responses to treatment Educate nurses on how to start and maintain IV lines Educate patients and families on IV line maintenance Develop plans of care in regard to prescribed therapies [1,2]
Educational requirements	RN license Basic level of education is ADN [1,2] Certified Registered Nurse Infusion (CRNI) certification requires a minimum of 1600 hours infusion therapy experience over a 2-year span [3]
Recommended experience	1+ years clinical experience as an RN (especially in pediatrics, oncology, OR/PACU, ICUs, or skilled nursing facilities)
Salary	Median American salary of $86,327, ranges from $78,108 to $93,609 [4]
Work environment	Hospital, homecare, long-term acute care, and outpatient facilities, such as primary care, oncology clinics, and infusion centers [2]
Typical work schedule	8-12 hour shifts depending on the work environment
Job outlook	Expected to grow as more people utilize healthcare services related to the Affordable Care Act of 2014 [1] More individuals are being discharged with continuing treatment outpatient
Suggested skills	Patience and the ability to remain calm under pressure [2] Good communication skills Organized Knowledgeable and good critical-thinking skills

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MUSINGS

Angels in Scrubs

Aidy Sternhill

I wonder if I would recognize you, were our paths to cross again. It seems strange that someone who played such a vital, albeit short, role in my life could ever be forgotten. But even as your face grows dimmer in my mind's eye, your memory will never be erased. The heart remembers what the mind can forget. For although at the time I was part of your job description, you were my lifeline.

Waking up post open-heart surgery was the most frightening experience of my life. I was 22 years old at the time, a young mother of two boys, and absolutely terrified. My doctor warned that I'd feel like a truck rode over me, yet he failed to mention the size and weight of said truck. The pain was crippling in ways even my worst nightmare can't conjure. My body felt like it was cleaved in two and then hastily sewn back together.

The blinding fluorescent lights and monotonous beeping machinery were drowned out by my singular focus on the morphine drip. Count 15 minutes. Click. Hear a double beep and then some relief. And again. And again. Those 15 minutes felt more like hours. Nothing existed besides that circular button crammed into my sweaty fist. My husband, parents, and in-laws tried consoling, caressing, cheering, but I was alone in my pain. My tears flowed without end and I could barely breathe through the pain long enough to hear my next fix making its way through the tube.

All I could think and feel at the time was anger and frustration. I was perfectly fine! I was doing great! Now look what they've done! Words like aortic stenosis and membranes meant nothing to me. All I knew was that I felt jolly good, thank you very much, and then my doctor chose to operate. My typically confident and cheerful self vanished and was replaced by a quivering whimpering excuse for a woman-child.

And then you walked in. With practiced skill you ushered out those around me. Resting time, you said, and calmness descended. Throughout that first painful and never-ending night you hovered near, never quite out of sight. At first you went about your tasks with quiet precision. Medications. Blood draw. Warming blanket. Sponge bath. You walked me through each and every step, never making me feel like I was on your to-do list.

And as the night wore on and my mind took me to terrifying places, you stopped what you were doing and sat down. You held my hand and spoke to me with tenderness. You whispered soft reassurances and waited until the terror abated.

Somehow, miraculously, you let me discover my inner strength. You kindled the fortitude needed to push through this wretched night. You gave me my sense of self, the knowledge that I can and will conquer this demon. I may not know your name, but in my heart I thank you every day, my angel in scrubs.

About the Author:

Aidy Sternhill is a stay-at-home mother of five who sometimes wishes she weren't a stay-at-home mother. She consoles herself by reading Harry Potter and Calvin & Hobbes, writing, and crocheting gartels. This is her first published piece in an academic journal.

Critical Care: A New Nurse Faces Death, Life, and Everything in Between

Book Title: Author: Theresa Brown
Reviewer: Yehudis Appel, BSN, RN

Critical Care: A New Nurse Faces Death, Life, and Everything in Between by Theresa Brown is a memoir about an English professor turned registered nurse and her journey as a new nurse and a nurse writer. At the time the book was written, Brown had decided that it was time to abandon her PhD in English because she wanted a career that would be more fulfilling. Brown received her BSN from the University of Pittsburgh. Brown has also been published in the New York Times and this is the first of two books she has published. While talking about the career change that she has never regretted, Brown brings to light what it really means to be a nurse and patient advocate and how it changed her life for the better. Brown wanted to be a nurse who wrote about what it is truly like to be a nurse and she did just that.

Brown discusses why she made her career change and what this new nursing career means for her. She also recalls occasions when she was scared and happy while just starting out as a new nurse—something that we can all remember about ourselves. She also talks about her first encounter with patient death and what an ordinary or extraordinary day on the oncology floor was like. As the reader, I felt as if I was standing right beside the author as she prioritized her patients' needs throughout each shift. Ethical situations are spread throughout the book, particularly when the reader learns that patients are given medications that are supposed to help them, but are so toxic that they can kill them as well.

The topic of how to professionally and properly communicate with fellow nurses, doctors, transporters, the rest of the healthcare team, and especially patients and their family members is spoken about as well throughout the entire book. The reader learns how important proper and effective communication really is, especially when caring for critically ill patients. Brown truly shows the reader how detrimental poor and improper communication can be, as it literally has a direct effect on the patient's life and how one communication error can cause death and, as her title suggests, everything in between.

As nurses, we tend to put our patients and jobs before ourselves, and this is proven to be true when Brown found herself benched after becoming injured by simply slipping outside on the ground in the rain. Because of her injury, Brown became the patient and the reader gets a feel of what it is like to be a nurse on the other side of the bedrail.

The reader will learn important, yet all too common lessons when he or she reads about the conflicts on Brown's unit. She recalls how she often encounters nurse-on-nurse bullying and discusses why it is a serious recurring problem in the nursing profession. After all, how can nurses, who are known as caring and trusted professionals, be so cruel, callous, and mean towards one another?

All in all, Theresa Brown reminds us that even though we have to look at the big picture of situations, we should never forget that many times, for the patients, it is the small things that count. Even though she mentions throughout her book the numerous medical situations and treatments that were used for her patients, Brown really shows her readers the true art of nursing.

This is a very special book and the reader will not want to put it down. It is entertaining, yet provides much truth to the stories, situations, and emotions that we encounter every single day as nurses. I highly recommend this book to all registered nurses, nurse practitioners, and especially new nurse graduates. This is a wonderful book for nursing students as well. In the back of the book, there is a small section of questions and topics to discuss amongst nursing students and faculty. This book can be purchased as a paperback, hardcover, audio CD, audiobook, and for use on the Kindle.

About the Author:

Yehudis Appel, BSN, RN is an emergency room staff nurse at SUNY Downstate Medical Center, University Hospital of Brooklyn. Yehudis earned her ADN from Phillips Beth Israel School of Nursing at Mount Sinai Beth Israel and her BSN from Excelsior College. Yehudis has been published in Nursing2016: The Peer-Reviewed Journal of Clinical Excellence and Nursing2018 Critical Care: The Evidence-Based Journal For Acute And Critical Care Nurses.

JOB OPENINGS AND INTERVIEW DAYS:

Recent jobs posted on OJNA's job board:

1) Summer 2019 Internship Program, New York City
2) Northern Westchester Interview Day on 11.8.18, New York
3) Penn Medicine Virtual Open House on 11.8.18
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5) OR and PACU Nurses, New Jersey
6) Sleepaway Camp Nurse at Camp Morasha, Pennsylvania
7) John Hopkins Open House 11.13.18, Pennsylvania
8) Nurse in Allergy Office, Woodmere, NY

Visit our job board, jewishnurses.org/job-dashboard/, to see more details and to share a job you know about!

Palliative Care

Julie Rubenstein, BScN, RN

Last week, my patient died. Over the course of a few hours, his gasping, grunting, tachypneic breathing turned into Cheyne-Stokes respirations, gradually settling into periods of apnea that became longer and longer until he released his final breath. I then pronounced him dead.

I spent a few minutes tidying up the room. I threw away trash, disconnected the now-useless IV, spread his blanket just so, and settled his head into a better position so that rigor mortis would not hold his neck awkwardly. It's my way of showing respect to the deceased, assisting them to lie in state in a clean environment, ready to receive their final visitors until their transfer to the morgue.

Afterwards, I called the family, expressed my sincerest condolences, discussed the next steps, and listened to their grief and crying. I made my next phone call to the on-call physician so that he could sign the death certificate. Once the certificate was signed, a colleague and I cleaned and wrapped the body. We paged a porter to come with a special stretcher to bring the deceased to the morgue. Each step was done with all the respect and dignity that I could muster.

After the gentleman had been wheeled away from the unit by the porter, I asked a colleague for a hug, because while not grief-ridden, I too had been affected by this gentleman's death and dying. I reflected on what I had done for the patient in his final days. I had spoken with his family to determine what sort of environment he liked, and prepared a quiet room and turned the lights down. I had helped his family make peace with the dismal situation, assuaged their fears that they had not done enough, held them as they cried, explained the dying process so that they would know what would happen, and guided them through what ended up being their final goodbyes. I also reviewed palliative medications with my colleagues to determine what would be of the most benefit at this time.

It all sounds rather bleak, but I really do enjoy palliative care. It combines my favorite aspects of nursing—to provide comfort in times of great sadness and fear, to use my knowledge of physiology and pharmacology to alleviate physical suffering, to teach patients and families, to guide the family from a medical approach to a comfort approach, to collaborate with colleagues to provide the best possible care, and to demonstrate my respect to the patient even when he/she is no longer present to sense it. It makes me feel like I am making a difference in my patients' lives, even as those lives end.

About the author:

Julie Rubenstein, RN, graduated with her BScN from the University of Ottawa in 2015. She has worked in home care, palliative care, and general medicine. She is a member of the Registered Nurses Association of Ontario. Born in Ottawa, Canada, she now makes her home in Toronto with her husband.

OJNA NEWS

OJNA has developed a Vaccine Task Force to combat the rising rates of Orthodox families who do lot vaccinate their children. Thirty nurses responded to a call for action to help contribute evidence-based information, and to help educate various communities via in-person, informal, educational forums. Topics to be covered include: epidemiology of various infectious diseases, the safety rates of vaccines, the importance of herd immunity and rates of immunocompromised individuals in the U.S., dispelling of common myths related to vaccines. The NYC Department of Health has agreed to review the information gathered and written by the OJNA nurses.

Nurses will also be teaching community members how to critically appraise information they receive from anti-vaccine propaganda. To join this task force or be an educator in your community, email OJNAboard@gmail.com

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Philip Zachariah, MD, MS

Abortion: Is it Required, Permitted, or Forbidden According to Halacha? All of the Above
Rabbi Aaron Glatt, MD & Michele K. Silverstein, MD

Addiction: An Ounce of Prevention is Worth a Pound of Intervention
Ephraim Sherman, DNP, RN AGPCNP & Perella Perlstein, Ph.D.

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Member Milestones

BROCHA FRIEDMAN STROBEL, RN, graduated with her ASN from Kingsborough Community College in June 2018 and passed her NCLEX examination in August. She will be starting CUNY School of Professionals' RN-to-BSN online program in Spring 2019. She is currently searching for her first nursing job.

BATSHEVA L. BANE, CNM, MSN, RNC, CBC, graduated with honors from Frontier Nursing University in August 2018 with a Master of Science in Nurse Midwifery and passed her Midwifery boards later that month. In November 2018 she will begin practicing full-scope midwifery in North Jersey, providing well women gynecologic, prenatal, intrapartum, and postnatal care. She is a member of the American College of Nurse Midwives, the New York State Association of Licensed Midwives, Sigma Theta Tau International Nursing Society, Tau Sigma Nursing Society, and OJNA.

JOELLE HARARI, BSN, RN, graduated from Molloy college in January 2018 with her BSN. She started working as a labor and delivery nurse, her dream job, at Long Island Jewish in June.

SCOTT TOPIOL, BSN, RN, PHN, CEN, EMT, graduated with his ADN from Los Angeles City College in 2012, his BSN from Western Governors University in 2016, and is expected to graduate with his MSN in Nursing Education from Western Governors University in 2019. Effective October 16, 2018, Scott started a new position as senior nursing instructor for the Los Angeles County Fire Department. His job responsibilities include providing training and education to the county's paramedics. He previously worked full time in the emergency room at Cedars-Sinai Medical Center in Los Angeles and will continue working there on a per diem basis.

BLIMA MARCUS, DNP, ANP-BC, RN, OCN, has been appointed Adjunct Assistant Professor at the Hunter-Bellevue School of Nursing, City University New York. She is guiding a class of DNP students on their capstone projects, a two-year doctoral quality improvement project. She also has an article pending publication (December 2018) in the American Journal of Nursing, titled Get On Board With Being On a Board.

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

OUR NEXT ISSUE

The next issue of The OJNA Journal will be focusing on:
immunizations and community health, and the role nursing has. Evidence-based practice, policy updates, and articles on community health may be submitted to OJNAjournal@gmail.com.

We will also spotlight men in nursing, along with the experience of Orthodox male nurses. Any articles and perspectives on this topic are welcome! While we hope to feature pieces submitted by our male nurses, all thoughtful articles on this topic will be considered.

Recurring columns include:

Nurses to Know:
profile a nurse you find inspirational

Careers to Consider:
write up an analysis of a nursing career you find interesting (request a template from the editors)

Musings: thoughts on being a nurse, being a patient, or anything in between

Book Review: any book you feel OJNA nurses would enjoy and learn from

Please review author guidelines at www.JewishNurses.org under the Journal tab or email us at www.OJNAjournal@gmail.com

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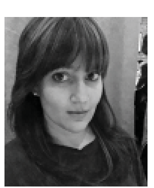
Brooklyn, NY 11219-4729

MEET THE TEAM:



Blima Marcus, DNP, ANP-BC, 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 an Adjunct Assistant Professor at the Hunter-Bellevue School of Nursing. She 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, and the American Cannabis Nurses Association. 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.

Batsheva L. Bane, CNM, MSN, RNC, CBC, recently graduated from Frontier Nursing University with a Master of Science in Nurse Midwifery, after working as a Registered Nurse in neonatal critical care and postpartum care units. She is practicing as a Certified Nurse Midwife at Jersey City Medical Center while pursuing her Doctorate of Nursing Practice. She is a member of the American College of Nurse Midwives, the New York State Association of Licensed Midwives, Sigma Theta Tau International Nursing Society, and Tau Sigma Nursing Society, and OJNA. She lives in Clifton, New Jersey, with her husband and children.

Sarah Bracha Cohen, MS, RN, received her Bachelor of Arts in Health Sciences 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, The Honor Society of Phi Kappa Phi, and the American Nurses Association.. 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, and is a post anesthesia care unit (PACU) nurse at NYU Langone in Manhattan.

Shaindy (Shari) Lapides BN, RN, received her Bachelor of Nursing from McGill University and her RN from Dawson College in Montreal, Canada. She has worked with children with visual, motor, and hearing impairments. She works as a Clinical Evaluation Manager at Visiting Nurse Service of New York where she completes Uniform Assessment System for NY State. She lives in Manhattan with her husband and baby.

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 as a field nurse with medically fragile children. She recently took on the additional role as Nurse Supervisor. 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