ORTHODOX JEWISH NURSES ASSOCIATION

THE OJNA JOURNAL

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Men in Nursing & Surgical Nursing

The Gender Wage Gap in Nursing

Surgical Scrubs: Then and Now

Honesty in Healthcare

OJNA LEADERSHIP

Mission:

The mission of The OJNA Journal is to

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

OJNA Mission Statement:

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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Editor's Note

Dear Nurses,

This is the first issue where we have decided to feature two topics in nursing as opposed to a single focus. Approximately 9-10% of the nursing workforce are men, and while we do not have demographic data on OJNA members, we are pleased to have many, many men as part of our nursing organization. We are also proud that we remain a frum nursing organization while endorsing, encouraging, and forging alliances between all nurses, men and women. The professional and collegial discussions held on our OJNA Facebook forum are due to the professionalism and respect exhibited by all members. We continue to learn from one another, and frum men in nursing have much to offer in terms of their experiences and perspectives. We have decided to feature some of our male nurses, and we appreciate those who agreed to share their thoughts and stories with us.

From a clinical and educational perspective, the journal team voted to feature surgical nursing, considering that it is relevant to many nurses in surgical and non-surgical fields: pre-op, peri-op, post-op, PACU, labor and delivery, medical-surgical, and even intensive care. All providers in these units and fields encounter patients who have undergone surgery. We've chosen some research to profile, from the rare and obscure to the highly relevant.

We hope you enjoy this Spring 2019 edition of The OJNA Journal! As always, please feel free to send your thoughts or questions to OJNAJournal@gmail.com.

Best,

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

Editor-in-Chief, The OJNA Journal

THIS ISSUE AT A GLANCE:

NEVER LIKED THE TERM "**MALE NURSE**" ANY MORE THAN I WOULD IMAGINE A WOMAN WOULD LIKE TO BE REFERRED TO AS A "**FEMALE DOCTOR**" OR "**FEMALE COP**."

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With regard to lying to patients about their prognosis, **3 times as many** physicians felt that it was ok to lie at times than did their APRN colleagues (24% versus 8%).

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The average turnover time to prepare the OR between cases was **20 minutes** for the OR playing slow music and **17 minutes** for the OR playing fast music.

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If I get it right, I can

preserve his dignity

amidst degradation.

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It appears that the ***gender pay disparity*** for nurses is an issue that cannot be explained by education, certification, hours worked, location, or salary negotiation.

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Psychological issues surrounding facial transplants are related to identity, new facial appearance, mental health issues, substance abuse, social integration, and impact on family members.

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Bastien recognized the need for a tool and staff training to pick up on **signs of abuse and neglect** consistent with human trafficking, such as conflicting stories, fake IDs, unexplained bruises, and not being allowed to answer questions.

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How could I reason with someone who was delirious and confused when he tried to yank out his IVs and Foley catheter in order to totter, on unsteady feet, towards the exit?

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UP UNTIL **1982**, MALES WERE NOT PERMITTED TO ATTEND SOME STATE SPONSORED NURSING SCHOOLS.

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Blima Marcus, DNP, ANP-BC, RN, OCN & Tziporah Newman, BSN, RN

Long Distance Care for Patients with Facial Transplant

There are currently 13 facial transplant (FT) centers in the United States, and only five of them have actual experience performing these procedures. This means that patients undergoing a facial transplant will likely be traveling long distances from home. Transplant patients require long-term follow up to ensure adherence with immunosuppressive regimens, and to be monitored for signs and symptoms of rejection, infection, malignancy, diabetes, and other complications. Often, follow up is performed by local primary care providers or nephrologists who monitor the patient's laboratory tests and look for clinical signs and symptoms of adverse events. However, the interdisciplinary team required for FTs includes speech and swallow therapy, physical and occupational therapy, orthodontics and maxillofacial prosthetics, and extensive psychological and psychiatric care. Psychological issues surrounding FTs are related to identity, new facial appearance, mental health issues, substance abuse, social integration, and impact on family members. When considering a candidate for a FT, communication with local health care providers will ensure the best possible care and outcome. The authors consider the likelihood that they will need to train local healthcare providers to care for FT recipients. Foreseeable concerns related to transferring follow-up care to local providers include: lack of data collection for the FT team, loss of experience for the FT team, and relationship transitions for the patient when switching from the FT team to a local team. These concerns may be mitigated by continued and transparent communication between the FT team, the patient, and the local providers who will be assisting with long-term follow up [1].

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Trafficking

Henry Ford Hospital in Detroit, Michigan has instituted a human trafficking screening tool in their Emergency Department that has saved 17 trafficking victims over the last year [1-3]. Michigan has a high incidence of human trafficking in part due to its highway accessibility and the annual North American International Auto Show [1,3]. The protocol was created by Danielle Bastien, RN, DNP, FNP-BC, an emergency department nurse, as a project for her doctoral degree, and it was quickly instituted as hospital policy [1]. Bastien recognized the need for a tool and staff training to pick up on signs of abuse and neglect consistent with human trafficking such as conflicting stories, fake IDs, unexplained bruises, and not being allowed to answer questions [1-3]. According to the new protocol, the patient is flagged upon initial triage based on these signs, which then alerts the primary nurse to continue with more specfic questions [1]. The patient is offered assistance and if he/she accepts, he/she is offered housing and basic necessities [1-3]. If the patient is not ready to accept help, he/she is are provided with a personal item that has a hotline number on it [3]. Nurses around the country can take a stand against human trafficking by urging implementation of protocols similar to Bastien's. Continuing education with a focus on trafficking, knowing state statistics, and knowing the number for the National Human Trafficking Hotline are a few other ways to help trafficking victims [2].

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Pressure Ulcers in the OR

Hospital-acquired pressure injuries (HAPI) account for $11 billion in cost in direct and indirect costs, and a 2016 study found that they increased hospital costs by 44% per stay. Long surgeries may cause HAPIs since there is limited recourse in off-loading the pressure during operations. An alternating-pressure (AP) overlay was developed which mimics the off-loading of pressure achieved during turning and positioning patients, however, using only a minimal 1-inch of inflation in various zones at different times. A team of researchers evaluated whether this micropressure system was successful at avoiding pressure ulcers in surgical patients. Inclusion criteria included 392 neurosurgical patients whose procedures were anticipated to take longer than two hours. The participants were randomized to usual care or the experimental (AP) group. At five days post-op, the existence of pressure ulcers was evaluated using the Braden Scale. While 18 of the control patients had developed a HAPI, zero of the patients who had used the AP overlay had developed a pressure ulcer. Use of the overlay was not associated with any perioperative complications, increased surgery time, or wound complications. The Association for peri-Operative Registered Nurses (AORN) provides recommendations on bundled care to prevent operative pressure ulcers, and endorses additional research on comparative effectiveness. [1].

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Musical Interludes in the OR

Since the early 1900s, the use of music in operating rooms (OR) has transitioned from experimental to routine. Beginning in 1914, when an anesthesiologist put on a phonograph to calm the patients, to 1929, when Duke University hospital officially installed speakers and radios throughout the facility, the recognition of music as therapy and a mood changer has been shown to be evidence-based. One recent study decided to examine how music in the OR can have benefits beyond surgical team congeniality and patient relaxation: the authors decided to check whether the tempo of music played during surgery had an effect on OR preparation time [1]. For one week, a playlist with a fast tempo (121.4 beats per minute) played in the OR. The next week, a playlist with a slower tempo (108.6 beats per minute) played. During these two weeks, the staff remained the same, and the procedure didn't vary: uncomplicated cataract surgery was performed. The average turnover time to prepare the OR between cases was 20 minutes for the OR playing slow music, and 17 minutes in the OR playing fast music. This three-minute reduction in preparation time translates into a significant savings: at a rate of $62 dollars per minute [2] of OR costs, multiplied by at least 10 cases per day, translates into a savings of $483,600 per OR per year. More research should be done to confirm these findings. Savings of nearly $500,000 per operating room per year is well worth listening to Ke$ha.

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Pay Inequity for Female and Male Nurses

Tobi Ash, MBA, BSN, RN

Introduction

On June 10, 1963, President John F. Kennedy signed the Equal Pay Act of 1963 to abolish wage disparity based on sex [1]. The law states in part that no employer may discriminate on the basis of sex, and that employers must pay wages to employees for equal work; for work that requires equal skill, effort, and responsibility; and for work performed under the same work conditions [1].

Disparity in pay equity between male and female workers for most jobs could be explained by racial and occupational segregation, access to education, bias against working mothers, ageism, and disability for many professions [2]. However, 55 years after the act, pay inequality persists in the nursing profession, with higher salaries for male registered nurses (RN) [3]. The proverbial glass ceiling effect that stymies the women's movement upward in male dominated professions to achieve greater professional and financial success appears to work as a glass "escalator" effect in nursing [4]. Male nurses progress and have increased salaries more than their female counterparts in a female dominated profession [4].

Female and Male Nursing in the Past

Prior to the creation of asylums, sanitariums, and hospitals, the home was the center of health care in the United States. Virtually all at-home nursing was done by women [5]. Men traditionally provided nursing care in religious orders (as monks) or as medics in the military [5].

The Civil War was the first historical event where both women and men provided nursing care to soldiers outside of the home—they provided care on the field and in field hospitals [5]. Male nurses also served in the Spanish American War, but as with the Civil War, once the wars were over, they returned to their businesses or farms [5]. At the turn of the century, the U.S. population increased dramatically with millions of new immigrants into the country [5]. These individuals came with extremely limited resources and unrealistic expectations of "streets paved with gold" [5]. These huge shifts in the population resulted in economic problems and major health issues [5]. Housing shortages, poor sanitation, significant morbidity and mortality, and new social problems characterized the beginning of the 20th century [5].

Rapid modernization, industrialization, and the population relocation from rural to urban areas changed the way sick individuals received care [5]. No longer able to rely on family for caregiving, sick individuals would go to hospitals that were established to serve those without the resources to provide for their own care [5]. As hospitals proliferated throughout the United States, so did the need for nurses to deliver care [5].

At the very beginning of the 20th century, nursing schools grew exponentially and were mostly associated with specific hospitals [5]. Hospital nurses were all assumed to be female, and they both lived and worked at these hospitals [5]. Female nurses were generally ages 25 to 35, forbidden to marry during their nursing careers, and lived lives similar to those of nuns [5]. Nursing students were not paid and were a source of free labor [5]. Despite these harsh conditions, nursing continued to grow as a desired occupation for women [5]. There were very few nursing schools that admitted men—the University of Pennsylvania was one of the first of approximately nine schools for male nurses [6]. It was also the first nursing school headed by a man, Leroy N. Craig [6]. This all male nursing school was dissolved in 1965, having graduated 551 male nurses [6].

From 1901 until 1955, only females could serve as nurses in the U.S. Armed Forces [7]. The Bolton Act, signed by President Eisenhower, gave males the right to work as military nurses [8]. Up until 1982, males were not permitted to attend some state sponsored nursing schools [9]. Justice Sandra Day O'Connor wrote the opinion of Mississippi University for Women v. Hogan that ruled that Mississippi University's single sex admission policy for nursing school for women only violated the Fourteenth Amendment [10].

When World War I began, there was a need for skilled nurses overseas. Approximately 23,000 female nurses served for the United States during the war, providing exceptional care overseas and at home for the armed forces [7]. There were no male nurses in the military, but men worked as nurses in the United States [7]. By 1930, male nurses represented less than two percent of all nurses in the United States, and they left nursing once they found better-paying occupations [7].

World War II transformed the nursing profession in the United States. All of the 59,000 Army Nurse Corps nurses and 18,000 Navy Nurse Corps nurses were female, with no men allowed in [7]. In 1950, there were 415,439 female nurses and 9,489 male nurses in the United States, still only two percent of the workforce [9]. Most male nurses worked in mental asylums or provided care to male patients [9]. Male nurses were finally permitted to enter Army or Navy Nursing Corps in 1955 [7].

As the hospital-based health care

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Current Statistics of Female and Male Nurses at Work Today

There are approximately 3.5 million professionally active nurses in the United States today [10]. About 2.82 million are female and 338,271 are male [10]. Female nurses have an average age of 43.8 years, and male nurses average at 42.9 years of age [10]. The most common race is white [10].

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system modernized, nurses had to handle far more complex and technical tasks. Nursing education kept pace, and by the 1960s, nursing opened up educational and professional opportunities to all [9]. There was no more discrimination by gender or race [9]. At this time, there was expansion in nurse specialization with nurse practitioners and intensive care unit nurses providing specialized care [9].

Current Statistics of Female and Male Nurses at Work Today

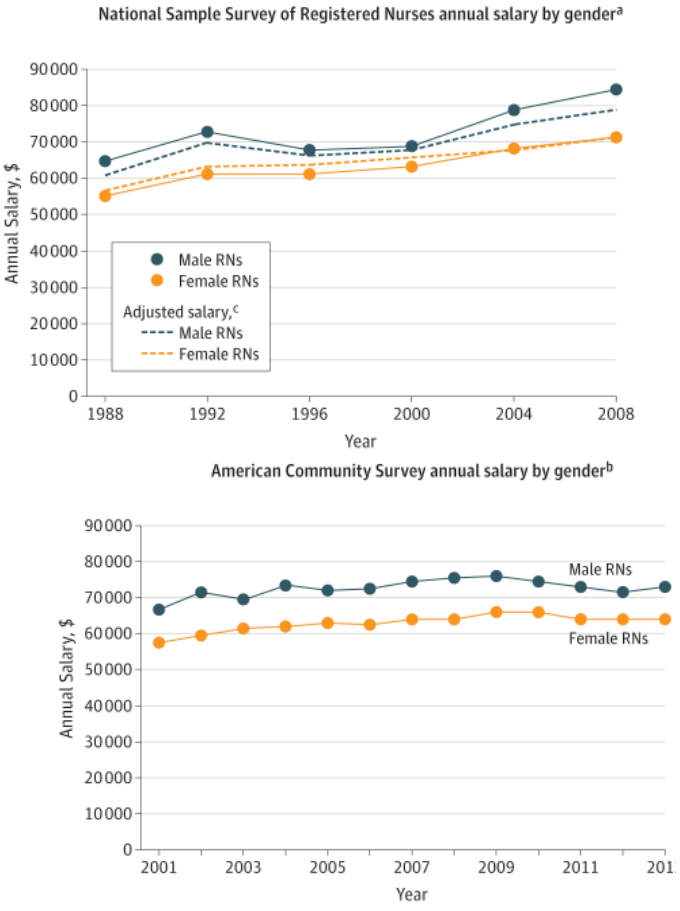
There are approximately 3.5 million professionally active nurses in the United States today [11]. About 2.82 million are female and 338,271 are male [11]. Female nurses have an average age of 43.8 years, and male nurses average at 42.9 years of age [11]. The most common race is white [11].

Current Research on Nursing Salaries

Although nine out of 10 nurses are female, male nurses earn higher salaries [3]. This pay gap has been consistent for the past 25 years [3].

In a 2015 study published in the Journal of the American Medical Association, Dr. Muench and her co-authors examined two large U.S. data sets of nurse salary earnings [3]. The National Sample Survey of Registered Nurses looked at 20 years of responses from almost 88,000 nurses from 1988 to 2008 [3]. The American Community Survey examined 206,000 responses from 2001 to 2013 [3].

For both studies, and in each year studied, male nurses earned more than female nurses. The unadjusted pay gaps ranged from $10,243 to $11,306 from one survey and from $9,163 to $9,961 in the second survey [3]. In-hospital male nurses had a pay gap of $3,783, while outpatient male nurses earned $7,678 more as compared to female nurses [3]. Male nurses outearned female nurses in virtually every specialty—the gap for chronic care was $3,792, with an astonishing $17,290 gap for certified registered nurse anesthetists (CRNA) [3].



JAMA March 24/31, 2015 Volume 313, Number 12 p.1265

Another recent study, the 2018 Nursing Salary Research Report, surveyed 4,500 nurses in all 50 states and U.S. Territories [12]. The data showed that male nurses earned an average of $79,688 annually and female nurses about $73,090—a gap of more than $6,000 per year [12].

There are several factors that may affect the gender gap in nursing wages. These include geographic location, certification and education, hours worked and overtime, and salary negotiation [3].

Nurse Location

The old adage, "location, location, location" rings true. Nurses' salaries vary by region and state. Nurses in California earn close to $50 an hour, for an average annual salary of $102,700 [13]. Nurses in Alabama, Arkansas, Iowa, Mississippi, and South Dakota earn an average of $28 an hour, for an average annual salary of $57,500 [13]. Nurses who work in Puerto Rico, an unincorporated territory of the United States, earn an average of $16.65 an hour, for an annual salary of $34,630 [13].

Male nurses are more willing to relocate to regions or states based on higher paying salaries [12]. On average, male nurses work more hours than female nurses [12]. Males are also more willing to change jobs for higher salaries—54% of male nurses were willing to change jobs within the next three months as compared to 45% of female nurses [12].

Education and Certification

The Nursing Salary Research Report survey shows that additional education and certification narrowed the pay gap between male and female nurses. Male certified nurses made an average of $1,252 more than a female certified nurse [12]. Close to 50% of the survey respondents stated that they were actively pursuing certification, education, or training to raise their salaries [12]. Of the 50%, a greater percentage of male nurses (56%) were interested in additional education and certification [12]. Male nurses also tended to choose nurse specialities rather than remain as staff nurses, and the top 10 paying nurse specialities paid significantly more than staff nurse salaries [14].

Hours Worked

The Medscape RN/LPN Compensation Report 2017 surveyed over 5,000 registered nurses to compare male and female nurse salaries [15]. Male nurses had higher annual gross incomes, whether paid by the hour or salary. Hourly pay was an average of $37 both for male and female nurses. Using this average hourly salary, male nurses made an average of $84,000 a year, while female nurses averaged $80,000. The overall higher average pay for male nurses paid hourly could be due to pay differentials, overtime, location, or certification [15]. However, salaried male nurses made more than $8,000 more per year than female nurses in the same position [15].

Negotiation

According to the Nursing Salary Research Report, the number one compensation factor across the board for all nurses was salary, followed by medical insurance [12]. Male nurses negotiated for salary compensation 43% of the time, while only 34% of female nurses reported doing so [12].

Outside the United States

A partial explanation for the pay disparity for male and female nurses in the United States can be explained by salary differentials based on location, educational and certification choices, and the ability for nurses to negotiate salary [15]. Dr. Ulrike Muench, one of the foremost researchers for the pay equity gap for female and male medical professionals,

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PAY INEQUITY FOR FEMALE AND MALE NURSES

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recently examined nursing pay gaps in Germany [16]. Similar to the United States, most nurses in Germany are female, with males accounting for 10-15% of nurses [16]. Nurses account for the largest workforce in the European Union, with about 700,000 nurses active in the continent [16]. German nurses usually attend a vocational school that follows a country-wide curriculum, rather than enroll in bachelor programs [16]. Additionally, they earn wages that are regulated and developed by a collective agreement with known pay scales for overtime, holiday, and advancement [16]. Overall, nurses in Germany are far more homogenous than nurses in the United States [16]. However, German male nurses outearned German female nurses. The unadjusted monthly earnings for German male nurses was 30% higher than female nurses, with €700 more ($781) per month [16]. After fully adjusting using analyses of hours worked, additional education, nursing and other previous job experience, and years at the medical facility, German male nurses still earned almost 10% more than their female co-workers—about €260 ($300) a month more [16].

It appears that the gender pay disparity for nurses is an issue that can persist even after adjusting for education, certification, prior experience, hours worked, location, or salary negotiation, even in a society and country where nursing follows a more homogenous course [16].

Comparisons

A 2017 study examined wages for male and female employees in two of the "pink professions"—or professions that have been traditionally female in nature: nursing and teaching [17]. Salaries of more than 427,000 nurses and 960,000 teachers for a 13 year time span were examined [17]. Male nurses and teachers were paid higher salaries than females: male nurses averaged about 28% more than female nurses and male teachers earned about 20% more than female teachers [17]. Education is touted as a way to increase wages in all professions. However, even if women do pursue additional certification and education, they still earn less than men [2].

Two-thirds of the earnings gap can be explained by differences in education, certification, specialization, experience, hours worked, work position or role, and geographic location [15]. Male nurses may seek certification or pursue higher education, take higher paying shifts (with differential), work in an urban center or inpatient area (that pays more), or change jobs to one with higher pay [17].

However, this still leaves a one-third gap in the understanding of the pay disparity between male and female nurse salaries [18]. If both male and female nurses make the same hourly wage, and female nurses have greater experience than male nurses, why do males earn more, even after adjusting for all of the above factors [18]?

Research of 87,890 registered nurses with data pooled for 20 years (1988-2008), with nurses working full time (35+ hours per week for 50 weeks) looked at career aspiration and motivation, workplace experience, time out for child rearing, and physical capability [18].

Career aspiration and motivation was determined by geographic location and how many nurses changed jobs and job location. Male nurses moved more and changed jobs more frequently than female nurses [18]. Males were also more likely to change jobs for higher pay [18].

The data in this study revealed that male nurses were older when they completed their RN training and had fewer years of nursing experience as compared to females [18]. More males were in nursing's highest paying specialities (psychiatric, critical care, nurse anesthetist) than females (36% vs. 29%) [18]. More males nurses were in higher paying positions, such as administration and senior academics, than females (14% vs. 9%) [18]. What is troubling is that female nurses aged 30 years or younger, with two years and under of work experience, earned $5,265 less than their male counterparts in the exact same position [18].

The idea that there is a "motherhood penalty" for female nurses does not hold true. Female nurses aged 40-45 with no children at home earned $6,207 less per year than male nurses in the same age cohort without children at home [18]. Males earned more than females, even in less physically demanding roles [18]. There was a significant pay gap in all areas for male and female nurse specialty roles with the same education, clinical experience, and hours worked [18]. As the role of nurses continues to expand in the provision of healthcare, there needs to be a serious examination of the disparity of female and male nurse pay.

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NURSE PRACTITIONERS

A recent 2017 survey looked at 6,591 nurse practitioners working a minimum of 35 hours per week, and analyzed salary and gender [19]. Male nurse practitioners earned close to $13,000 more per year than female nurse practitioners after adjusting for speciality, practice type, and location. Male nurse practitioners earned more than females across all specialities [19].

Closing the Gap

Pay equity assessments are needed to identify and ameliorate pay inequality. Education, accreditation, location, and experience do matter, but a disparity in salary continues to exist. Nursing is the largest healthcare occupation in the United States [20]. A combined effort of federal and state governments is needed to address pay inequity for nurses. Annual review of nursing compensation is imperative to ensure greater transparency, open pay policies, and equity adjustments.

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Male Nurse Stereotypes

Men served as nurses in ancient times in the military and in religious orders. When Florence Nightingale went to Crimea, virtually all care was provided by male orderlies. The dramatic changes in population and the rise of hospitals at the end of the 19th century, moved female nursing to the forefront [1].

In 1901, when the American Nurses Association was founded, only female nurses were permitted to serve in the armed forces. This ban against male nurses ended only in 1955 [1]. Many in the armed forces believed that male nurses "had something wrong with them" or were homosexual [1].

There are specific challenges that male nurses face. "Male nurses are thought of as "muscle"'; they are there to help lift heavy patients and move heavy equipment. Another stereotype of male nurses are that they are not capable of being caring and nurturing. Others may believe that male nurses are failed doctors or are just there to see naked women [2].

Barriers for Male Nurses Today

Most male nurses did not receive information on nursing as a career in high school. There is a distinct lack of male nurse educators and mentors. Even once men decide to enter nursing school, many of them report lack of support for their career choice. Many men report that there is suspicion of their hands-on care for female patients. Male nurses may be shut out of certain clinical settings such as labor and delivery [3].

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Nursing Scholarships for Men

To increase the diversity of nursing, there are scholarships available exclusively for male nurses.

HENRY DUNANT SCHOLARSHIP FOR MALE NURSING STUDENTS

Funded by the Henry Dunant Scholarship Committee, this private scholarship of $250 was established to help undergraduate nursing students who are currently enrolled in an accredited nursing program in the United States and need financial assistance. As its name suggests, the scholarship is awarded specifically to male students of any ethnicity who have good academic standing with a cumulative GPA of 2.5 or higher. Applicants are required to provide proof of acceptance in a nationally recognized nursing program and submit a one to two page essay on the history of men in nursing, including the Nobel Peace Prize winner Henry Dunant.

Deadline: August 1st
Contact: Henry Dunant Scholarship for Male Nursing Students
15 Roxbury Dr.
Littleton, MA 01460
(978) 413-4457
m.cabotrn@gmail.com

AAMN FOUNDATION SCHOLARSHIPS FOR MEN

https://www.aamn.org/scholarships

AAMN JOHNSON & JOHNSON SCHOLARSHIP

Beginning in 2004, this scholarship has been offering $1,000 to male nursing students based on proven accomplishments. This fund provides twenty scholarships annually, but only when funds are sufficiently available. Recipients must maintain a minimum 2.75 GPA and be enrolled in a pre-RN program.

JADEH MOORE STUDENT NURSE ESSAY CONTEST

The winner of this contest must be a Pre-RN male student and enrolled in a program that will lead to NCLEX-RN eligibility. He will receive $500 for writing the best response to a question posed by The American Assembly for Men in Nursing.

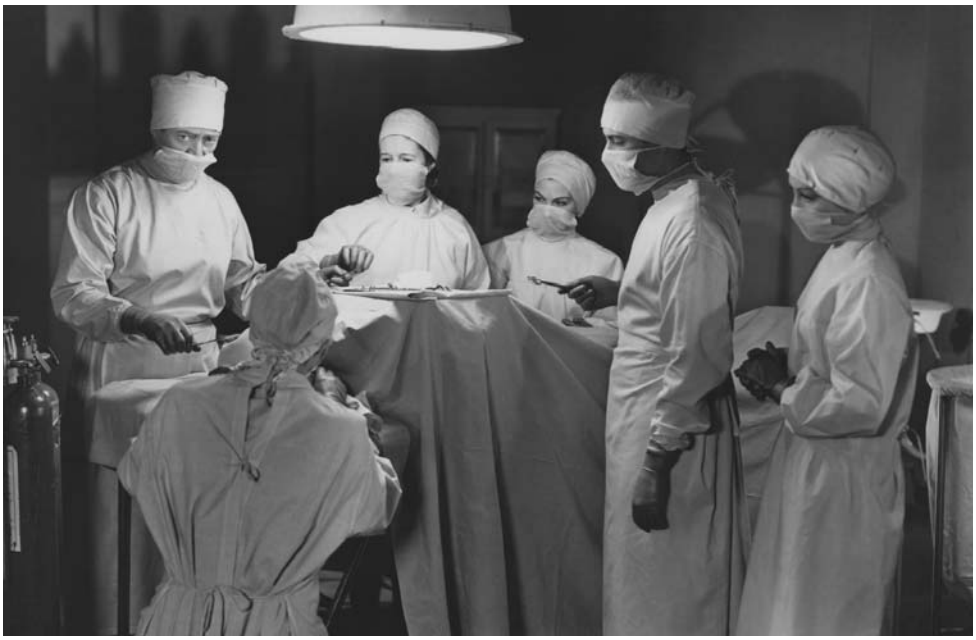
ISTUDYSMART.COM SCHOLARSHIP

This scholarship is geared toward males who are seeking their Associate in Nursing Degree from Excelsior College through the school's distance learning program.

History of Surgical Scrubs

Tamar Yehudis Frenkel, BSN, RN

Seeing someone in a pair of scrubs automatically identifies them as an individual of the medical profession. Historically, only nurses wore uniforms. These ranged from regular aprons (think Florence Nightingale) to white caps and floor-length gowns, to nuns' habits, to starched criss-crossed aprons seen through the last two centuries, to casual scrubs worn today. Currently, nearly everyone in healthcare wears scrubs, from doctors, to nurses, x-ray technicians, and home attendants. It is the stockpile image of someone involved in healthcare. However, surgical scrubs have been around for less than 100 years.



Scrubs and Gowns

Before the 19th Century, surgeons wore their own clothing while operating [1]. They wore no protective garments, only taking off their coats or rolling up their sleeves [1]. Famous paintings, such as Thomas Eakins' 1875 depiction of Dr. Samuel Gross in Jefferson Medical College's surgical amphitheater in The Gross Clinic (pictured), demonstrate common practices of the time. Eventually, surgeons began wearing aprons to avoid getting too bloody, still unaware of the risks of infections to themselves and to their patients [1]. In the late 19th century, surgeons took to wearing full length cotton gowns, described in a letter to Florence Nightingale as "garments of white mackintosh which cover them from chin to toes, and over this a shift—a kind of white cotton surplice with loose sleeves coming to the elbows" [1].

Portrait of Dr. Samuel D. Gross (The Gross Clinic) Source: Thomas Eakins. 1875. Philadelphia Museum

A German surgeon by the name of Gustave Neuber of Kiel is noted to have been the first doctor to implement sterile gowns [1]. In 1883, he noticed a reduction in infections of surgical sites with the use of caps and gowns [1,2].

When the use of sterile surgical attire became more widespread, the color white was used since it was considered easier to wash [1]. Eventually, with the invention of electric lights, the white of the scrubs and the bright lights became too tiring for the eyes, so the color was changed to green [1]. In 1914, a San Francisco surgeon, Harry Sherman, stated the color green would help, as it "keeps the surgeon's eye acute to red and pink" [1]. In the 1950s, when color TV was utilized for taping procedures and teaching medical students, the color blue became popular as well [1].

Masks

With the combination of increased attention to Lister's germ theory in the 1800s and the Spanish Flu pandemic in the early 20th century, doctors began wearing cotton masks to protect themselves from catching diseases from patients [1]. However, it was not until 1926 when a clinical study showed correlations between masks and the reductions of surgical site infections [2]. After that, the use of masks became more widespread, but the practice varied from hospital to hospital [2]. In 2016, the American College of Surgeons released specific guidelines for surgical attire, including face masks for all operating room staff [3]. While current evidence does not support the likelihood of surgical site infections for masked versus unmasked operating rooms [4,5], the current expected professional attire includes the mask [3].

Gloves

In 1893, Dr. Joseph Bloodgood noticed gloves lead to a reduction in infection rates [1]. He began to use them, but other surgeons of his era did not like wearing them, as it decreased their sense of touch [1,2]. Often, surgeons would remove their gloves or operate with bare hands [2]. Early gloves were made of cotton or silk, and sometimes coated with paraffin [2]. The first rubber surgical gloves were created in 1889, used to protect the hands of the surgeon from irritating chemicals used during surgery, rather than protect the patient [2]. In 1946, the Ansell Rubber Company developed automatic machinery to manufacture rubber gloves, increasing production, and in 1965, they created the first sterile glove [6]. By 1966, rubber surgical gloves were the standard in the operating room (OR) [7].

The beauty of science is in its capacity to evolve, based on evidence. As doctors began to understand the relationship between cleanliness, sterility, and patient infections, they changed the way they performed surgery. The idea of doctors in the 19th century with open surgical theaters and bare-handed manipulation of tissue seems barbaric. A patient going into an OR expects the now familiar sight of the blues or greens and professionally scrubbed surgeons, nurses and staff.

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APRN CORNER

Honesty in Healthcare: How Physicians and APRNs Differ in Practice

Chaya Milikowsky, AG/ACNP-BC

At times, basic principles of medical ethics seem to be at odds with one another. Perhaps telling a patient the extent of his terminal diagnosis will harm him psychologically, and destroy the precious last few months he has to live. Can a provider justify lying to this patient—just a little white lie, , an expression of optimism—so that he and his family can grasp onto the small measure of hope they have left? Is it right to sacrifice some patient autonomy to uphold the principle of nonmaleficence?

What about other forms of benevolent lying? Can a provider lie to an insurance company to obtain a crucial treatment for a patient? *Should* a provider lie in this case? Will beneficence trump justice? Further, how might one feel about less altruistic forms of lying? Should a provider lie to protect a colleague who committed a medical error, if no harm resulted to the patient? Is there any reason to let the patient and family know? What about in a case where a patient was harmed?

Self-serving lies aside, the majority of cases where providers lie—or at least condone lying—occur in situations where there are opposing ethical values. Examples of conflicting principles include protecting a colleague in a near-miss situation when no actual patient harm has occurred, obtaining reimbursement or approval for a medical therapy by lying to insurance companies, or promoting patient psychological well-being with untruths about a prognosis.

Studies done in the past decade [1,2] show that the majority of physicians would report the truth when it comes to medical errors. In cases where no actual harm befell the patient, physicians are still likely to report the error, although to a lesser extent than if harm may have occurred. On the other hand, significant percentages of providers feel that lying to obtain medical treatment for a patient may be justified. And as far as lying to patients about prognosis, as one internist noted, "... doctors have hope too" [3].

A 2019 MedScape poll reveals a fascinating difference in attitudes towards lying among physicians and advanced practice nurses (APRNs), with physicians far more likely than APRNs to be comfortable with untruths [3]. With regard to lying to patients about their prognosis, three times as many physicians felt that it was ok to lie at times than did their APRN colleagues (24% versus 8%). Lying to obtain medical treatment was the arena in which both physicians and APRNs felt lying was most acceptable, but physicians were still more likely than APRNs to condone the behavior (29% versus 23%). Furthermore, 12% of physicians and 4% of APRNs found it acceptable to lie about medical errors.

In addition to attitudes about lying, the MedScape poll further assessed actual incidence of lying among providers. Physicians were more likely to report lying overall—to patients about errors and prognosis, and on behalf of patients to obtain treatments—than APRNs [3].

Whether or not one agrees with the morality of these untruths, and regardless of the potential benevolence inherent in these lies, the data does highlight the integral foundation of honesty embedded within the nursing model. Nurses have been ranked the most trusted and ethical profession on the Gallup poll for the last 17 years [4]. This recent MedScape poll serves to validate this long-held opinion.

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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.

Member Milestones

AVIGAIL KLAGSBRUN, BSN, RN, CCRN, graduated with her ADN from Phillips Beth Israel School of Nursing in May 2012, and with her BSN from Utica College in August 2014. She currently works in the pediatric intensive care unit (PICU) at St. Peter's University Hospital in New Brunswick, New Jersey. In December 2018, she received her Pediatric Critical Care Nurse (CCRN) Certification.

MICHAEL KUPFER, RN, graduated with his ADN in December 2018 from Cuyahoga Community College in Cleveland, Ohio. He passed his NCLEX in February 2019. He started his first job as a registered nurse in the beginning of March on the epilepsy monitoring unit at the Cleveland Clinic.

ESTHER LAUBER, BSN, RN, graduated with her BSN from North Park University in Chicago in December 2016. She started a new position working on the pediatric transitional unit in October 2018 at Maryville Academy in Chicago.

2019 marks the 20th year of **TOBI ASH, MBA, BSN, RN,** providing classes on puberty to 5th and 6th grade girls and their mothers at several of the Jewish girls' schools in Miami. She teaches the girls how to go through these physical, emotional, and spiritual changes from a Torah perspective in a fun and approachable way.

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

OJNA EVENTS:

Since our last journal publication, OJNA has hosted many events, ranging from our larger Advanced Practice Registered Nurses (APRN)-focused conference, to smaller local events.

Our first **APRN-Focused Conference** was held in Touro College in Manhattan on January 6 and featured speakers on the topics of antibiotic stewardship, the halachic and medical aspects of pregnancy termination, and opioid prescription and addiction. The conference also included a hands-on suturing workshop that was widely appreciated, inspiring requests for future hands-on activities. Of course, as with all OJNA conferences, the opportunity to network and connect with fellow-minded frum nurses was a highlight.

In recent months, we have hosted events for nearly every OJNA Chapter.

South Florida held a networking social event at China Bistro restaurant in October 2018.

The Florida OJNA chapter also hosted a CPR class for men in March.

Cleveland hosted a networking lunch at Jade Restaurant in November 2018.

In January 15, **Chicago** nurses of the OJNA met at the home of Raina Leon to socialize and learn about the many benefits of OJNA membership. Following the event, the Chicago OJNA nurses resolved to create a mentoring partnership with a local Jewish college. They also plan to work on expanding local events to include medical halacha shiurim, with the eventual goal of bringing an OJNA conference to the Midwest.

A few weeks later, **Detroit** nurses met at the home of Tova Winters to network and discuss ways to navigate their nursing careers, as well as to enjoy a beautiful buffet.

Pittsburgh held its first chapter event in the beginning of March with a potluck meet. The 15 nurses who participated felt a sense of warmth and camaraderie, despite ranging from new nurses to more experienced nurses and coming from a variety of backgrounds and nursing specialities.

On April 9, **Maryland OJNA** members held a networking social event in Silver Spring. Rabbi Eli Reingold, Rosh Kollel in Silver Spring, attended and answered medical halacha questions submitted by attendees.

To create an OJNA Chapter in your area please contact

ojnaboard@gmail.com

On March 7, our **New-Grad Committee** held an educational evening in Brooklyn, featuring Rabbi Jack Abramowitz, notable author of six books and editor at the Orthodox Union. He discussed how nurses—and especially new nurses—can navigate the tricky multicultural healthcare environment, with a specific focus on how to explain Orthodox Judaism to those who are unfamiliar with its practices and nuances. In addition to the continuing education, CE-approved component of the event, there was a fun ice cream bar and photo-op opportunities.

OJNA members in **Southern California** have requested the creation of a chapter in their region, and an initial event is being planned. Keep on the lookout for dates and details!

NURSES TO KNOW

David M. Pasternak, MBA, MSN, RN-BC

Nursing Role: Nursing Informatics Specialist

What is your exact title and credentials?

I am a nursing informatics specialist. After completing my Associate of Science in Nursing (ASN) from Middlesex County College, I went on to earn my Master of Science in Nursing Informatics (MSN) from Rutgers University, and completed my board certification from the American Nurses Credentialing Center (ANCC) in Nursing Informatics. Additionally, I have a Bachelor of Science in Psychology, a Master of Business Administration (MBA) in Computer Information Systems, and I am also currently enrolled in a post-MSN certificate program for Psychiatric-Mental Health Nurse Practitioner.

Where do you currently work?

I work in the Nursing Informatics department at Hackensack Meridian Health Raritan Bay Medical Center (RBMC) in New Jersey. I also continue to work as a per-diem staff nurse in a short-term commitment facility.

Can you describe what your responsibilities are at work?

That is actually not as simple as it sounds because nursing informatics spans so many areas. Essentially, my department (there are three of us) is tasked with supporting the safe and effective use of health information technology (IT) to promote and improve clinical decision-making, safety, and positive patient outcomes. Technology that is difficult to use or poorly designed negatively impacts staff productivity and places patients at risk. We serve as the liaison between the various clinical areas (not "just" nursing staff) and IT. We analyze clinical workflows and develop the requirements for system enhancements/optimization requests; we may also recommend changes to the workflows, based on our analysis. We are also responsible for testing the technical solutions before they're released into the production environment for use by staff. We do a lot of data extraction, analysis, and reporting to support various initiatives, both internal (as in analyzing medication charting errors) and external (such as Meaningful Use attestation). We also mentor several MSN students each semester during their Nursing Informatics practicums.

We have always been very involved in staff education, but that role escalated recently. In January of 2016, RBMC became part of the Meridian Health network. Later that year, Meridian Health merged with Hackensack University Medical Center (HUMH) to form Hackensack Meridian Health (HMH). Until last year, the various HMH hospitals used multiple charting systems, none of which talked to each other effectively, making it difficult to share clinical data. The decision was made to implement a single electronic medical record—Epic, which was already in use at HUMC—throughout the healthcare network. RBMC became the first hospital to go live with the new system and all staff had to be trained in the new functionality. My coworkers and I went through an intensive train-the-trainer program to become Epic Credentialed Trainers and were part of the team responsible for training all of RBMC's personnel—nurses, physicians, and ancillary staff. We are now getting ready to travel throughout the rest of the network to train their staff, as each hospital prepares for its conversion to Epic.

My coworkers and I also sit on several hospital committees. For example, I represent our department on the Clinical Informatics and Patient Education, Nursing Quality and Practice, Coordinating Council, and Delivery System Reform Incentive Payment (DSRIP)/Readmission Task Force Committees, just to name a few.

How long have you been doing working in your field and was this field your first choice?

Nursing is a career change for me. I spent most of my career in the IT world. I received my RN license in 2012 and started working as a staff nurse on an inpatient psychiatric unit. Because of my IT background, I served as our unit's representative to the hospital's Informatics Committee. In 2015, I transferred to the Nursing Informatics department. Blending the skills of my old and new professions just seemed to make sense.

How did you hear of/become involved with OJNA?

One of my nursing school classmates, Tzippy Newman, recommended it to me about a year ago.

Please describe your experience being a male nurse in a predominantly female profession.

Well, I have to admit that my female counterparts have a much larger selection of shoes and scrubs than I do, and I am very happy that I didn't have to find a cap for my pinning ceremony! Seriously, though, I have never liked the term "male nurse," any more than I would imagine a woman would like to be referred to as a "female doctor" or "female cop." Even though there have been more men and women crossing the so-called medical gender divide, there is still a tendency in healthcare to refer to nurses as "she/her" and doctors as "he/him." In nursing school, out of approximately 100 students, I was one of only eight or nine men. Socially, that took some getting used to, since I think we naturally tend to gravitate toward same-gender social groups. During clinicals, I had some patients refuse care because of my gender. Since receiving my nursing license, though, I haven't really found myself being treated any differently. I have had several patients address me as "Doctor" and I would simply correct them, saying, "No, I'm the nurse taking care of you today; that woman over there is your doctor." In short, I am a nurse, not a "murse," and I am very proud to be a member of the most trusted profession in the United States.

What is something you have done within your workplace that you are most proud of?

I was responsible for developing and implementing a system to distribute patient education videos directly to the bedside via our hospital TV network. This system was featured prominently in the document supporting our recent application for Magnet redesignation.

Nursing Informatics Specialist

Tziporah Newman, BSN, RN

Job title

Nursing Informatics Specialist

Job Description/ Basic Responsibilities [1,2,3]

The International Medical Informatics Association (IMIA) defines nursing informatics as the "science and practice [that] integrates nursing, its information and knowledge, management of information, and communication technologies to promote the health of people, families, and communities worldwide."

- Collaborate in the planning, development, design, implementing, upgrading, and evaluation of systems and programs, particularly electronic health records (EHR), that meet the needs of all medical personnel in compliance with health care facility policies and federal laws
- Education and support of computer systems
- Research and analytics
- Quality assurance
- Project management

Educational Requirements [1,3,4]

- RN license
- BSN at a minimum, advanced practice degree, such as MSN in Nursing Informatics, encouraged
- Certification:
  - Informatics Nursing board certification (RN-BC) through the American Nurses Credentialing Center (ANCC)
  - Certified Professional in Healthcare Information Management Systems (CPHIMS) through the Healthcare Information and Management Systems Society (HIMSS)

Recommended experience [1]

According to the HIMSS 2017 Nursing Informatics Workforce Survey, nurses had anywhere from 1-20+ years of clinical experience prior to transitioning to Nursing Informatics. Nurse Informaticists had the most clinical experience in med/surg, critical care, administration, and emergency department.

Salary [1]

Nearly half of individuals surveyed in HIMSS 2017 Nursing Informatics Workforce Survey earned more than $100,000 annually.

Work environment [1,3]

Hospitals, health systems, clinics, consulting firms, academia, government, ambulatory, long-term care facilities, and IT companies.

Typical Work Schedule

8-12 hour shifts. Additionally, nursing informatics specialists may have to work evenings, overnights, weekends, and holidays in order to be on call if a problem arises.

Job Outlook [3]

The growing use of computers and technology in health care leads to an increase in related career opportunities, including nurse informatics who can combine technology and nursing.

Suggested Skills [2,3]

- Proficient computer skills
- Conflict resolution
- Analytical and critical thinking
- Strong teamwork and communication skills
- Project management
- Problem-solving

References:

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NURSES TO KNOW

Adam Sragg, RN

Nursing Role: Circulating Nurse in OR

What is your nursing background? Degrees/credentials?

I received my BSN from University of Maryland School of Nursing.

Was this your first choice job? What led you to choose this position? How long have you been working in your field?

This job was not my first choice, but it has worked out well and has been a great experience as a new graduate. I applied to many nursing jobs and surgical nursing worked out best for my personal life and the ability to observe Shabbos. This is my first job out of school and I have been working for two years.

Where do you currently work?

I work as a circulating nurse in the operating room (OR) at Washington Adventist Hospital in Takoma Park, Maryland.

What are your responsibilities?

I perform patient safety roles, including proper sterile technique for Foley catheter insertion and skin preparation for procedures. I am responsible for correct patient positions, confirming patient name, verifying expiration dates of medications, and assisting anesthesia in safe airway placement during endotracheal intubation and extubation. I also perform thorough patient interviews, including medical history reviews to ensure preparation for surgery with no contraindications.

What is your favorite part about your job? Any specific highlight you would like to share?

I enjoy serving as a patient/family advocate and liaison to communicate pertinent information or questions throughout the perioperative experience. I try to foster exceptional patient/family experiences through establishing rapport and sense of trust. In addition, I work in a large variety of surgical specialties, such as vascular, neurology, urology, gynecology, orthopedic, podiatry, ophthalmology, plastic/cosmetic, otorhinolaryngology, gastroenterology, cardiothoracic, and pulmonology. This helps me build a nurse-to-patient relationship in many different patient populations.

There are times where I get patients ready for surgery and I can tell they are nervous about the procedure. It is my job as the circulating nurse to make sure they feel as comfortable as possible. It is very humbling when I go in the OR and I find my patient was wondering where I was and requesting me at his/her side before the surgery begins. I have had a couple of scenarios where unfortunately the patient went to the intensive care unit (ICU) after surgery. I like to follow up with these patients and visit them in the ICU. I find it extremely rewarding when they remember me. It is gratifying to empower a patient and make sure they feel comfortable. It is not just a job to get them to surgery. The way I interact with them can make their experience positive overall.

Is there any special training or credentials required for your position?

We are required to have BLS and ACLS training and are encouraged to pursue our Certified Nurse Operating Room (CNOR) license. I learned to scrub as part of my nine month training. I generally do not scrub-in unless they really need me and it is a minor procedure.

What do you do when you are not at work? Any tips on work/life balance?

When I am not at work, I am busy with family. Outside of work, I incorporate the teamwork I learned as a nurse. Whether it means helping my family, personal needs, or community, I try to balance teamwork in my life. Working together with a spouse, family member, or friend has helped me balance my life's needs. In addition, I am about to start a program for Family Nurse Practitioner.

How did you hear of/get involved with the OJNA?

My family friend Sarah Bracha Cohen reached out to me about joining OJNA.

Please describe your experience being a male nurse in a predominantly female profession.

In most areas that I work in, I have been respected by my female colleagues. However, something which I have noticed as a male nurse is the expectation to further my degree and career goals. Whether at work or in my community, people expect that a male nurse will do more in nursing and not stop at the bachelor level. I personally would like to further my degree, but it is important to know there seems to be this male expectation that male nurses may be confronted with.

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.

Registered Nurse First Assist (RNFA)

Tamar Yehudis Frenkel, BSN, RN

Job title Registered Nurse First Assist (RNFA)

Job Description According to the Association of periOperative Registered Nurses (AORN), an RNFA is a perioperative nurse whose role is expanded. They work under the direction of a surgeon, in collaboration with the other members of the medical team.

- Preoperatively, the RNFA ensures the operating room is set up, does a thorough chart review of the patient, performs focused nursing assessments, and collaborates in the patient's plan of care.
- Intraoperatively, the RNFA performs surgical first assistant techniques, including making incisions and manipulating tissue, using proper instruments and medical devices, providing hemostasis, suturing, and providing wound management under the supervision of the surgeon. Most importantly, the RNFA does not work as a scrub nurse during the same case.
- Postoperatively the RNFA may make rounds independently or with the surgeon, as well as assist with patient discharge planning.

Educational Requirements [1,3]

- Active registered nurse (RN) license, certified nurse operating room (CNOR), and completion of the RNFA coursework, regulated by AORN.
- With an advanced practice license, such as a nurse practitioner, CNOR is not required.
- A bachelor's degree is required for RNFAs practicing after January 1, 2020.
- To become a certified RNFA, an additional 2,000 hours of experience working as an RNFA, as well as a bachelor's degree, is required.

Recommended experience [3] At least two years working in perioperative nursing.

Salary [3] This is a unique job, so specific salary information is limited. According to payscale.com, the average yearly salary is $73,507-$105,139.

Work environment [1] Perioperative

Job Outlook [3] As the number of ambulatory surgery/same-day centers grows, the need for RNFAs will increase as well.

Suggested Skills [1,4] Dexterity, fine motor skills, and visual acuity are all needed to provide surgical assistance. In addition, hand-eye coordination and critical thinking is essential.

References:

[1] Association of periOperative Registered Nurses. (2018). *AORN position statement on RN first assistants* (9th ed). Retrieved from https://www.aorn.org/-/media/aorn/guidelines/position-statements/aorn_position_statement_rnfa.pdf?la=en&hash=3A2D31A5305AF3990370972D4A7C34CC

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Additional resources:

https://www.aorn.org/guidelines/clinical-resources/rn-first-assistant-resources

Transcending the Smallness

Yonah Solomon, BSN, RN, PHN

I'm not certain why. Maybe it's because I'm a man. Maybe it's because I'm in my mid-forties. Maybe it's because I always wear a suit and tie. But, I can tell you that from the day I decided to become a nurse, I have fielded the following cynical question countless times: "So, do you really want to change people's diapers for a living?"

Of course, as an ambitious and competitive student I had my answers. At first I played the Alphabet Game: No, you don't get it! You're confusing my role with that of the CNA (certified nursing assistant) or maybe even the LVN/LPN (licensed vocational/practical nurse). But I'm going to be a real professional! I'm going to be an RN (registered nurse), maybe even someday an NP (nurse practitioner) or a CRNA (certified nurse-anesthetist)! But you know, once you start playing the Alphabet Game, you lose people at ABC.

When I started nursing school itself, all of a sudden I had a whole new vocabulary: You're talking about changing diapers? Ugh! You are so task-oriented! Nursing is about critical thinking, therapeutic communication, patient education; we're at the nexus of care between physicians and families, therapists and caseworkers.

And of course it's all true—I am still blown away by how consistently smart and competent the nurses I've worked with have been. And yet these "answers" somehow left me dissatisfied. There was something niggling at me that I could not quite put my finger on.

Until about six months ago.

There I was, about a month or so into my advanced med-surg rotation. The patient: A 64-year-old male with a cirrhotic liver and hepatic encephalopathy, who is altered, labile, and grumpy. We're administering Lactulose to bring down his ammonia level to help him start thinking straight again. But that stuff makes you go!

"Student nurse! This one's a good patient for you."

The patient is pungent with body odor as it is, and now I have to walk him to the bathroom, stand with him as he relieves himself, and clean him when he's done. That question started to play again in my mind. Is this really what I want to do for a living?

That's when I was brought back to a teaching I had shared with my students in my Judaic studies class years ago. Thinking of it at that moment helped me clarify my purpose then, and I think it bears sharing now.

Towards the beginning of the Book of Exodus a story is recounted. It tells of Pharaoh's decree to have every newborn Jewish male thrown into the Nile to die. Two heroines, the Israelite midwives, Shifra and Pu'ah, risk their own lives to defy the decree and successfully rescue countless others.

According to Jewish tradition, Biblical names always convey essence; they somehow capture and express the core identity of the person or thing so named. According to Talmudic tradition, the names of these heroines are actually honorifics conferred in tribute to their great work and self-sacrifice, as if to say that these acts were transformative experiences that redefined the very essence of who these women were.

But what do these names actually mean? The Talmud states that Shifra means "one who beautifies" because she would cleanse and beautify the baby when he was born; Pu'ah means "one who soothes" because she would soothe the crying newborn with comforting song.

Now, as special as those acts of care may actually be, this statement really begs two important questions:

1. Are those really the best ways we can describe their acts of heroism? These women saved lives—and risked their own to do so. Shouldn't they be called names that reflect the magnitude of their deeds: "Rescuer," "Savior," "Risk-Taker"?
2. Cooing to a crying baby and cleaning a newborn child from amniotic fluid are things any caregiver would do. We might even call it negligence to withhold such care. So how is it that these mundane acts are identified as singularly noble and transformative?

Rabbi Yerucham Levovitz, one of the great Jewish ethicists of the 20th century, offers this simple, yet profound, answer: There is, in fact, no such deed that is inherently momentous or inconsequential. It is, rather, the investment, the presence, of the person in that act which gives it its transformative power.

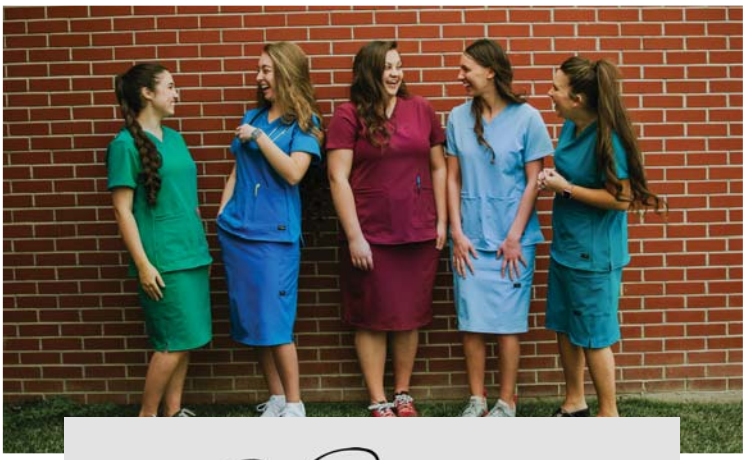
Shifra and Pu'ah acquired new essence, they became qualitatively different people, by the devotion, love, and nurturing that they were able to squeeze into their seemingly mundane acts of daily care for others in vulnerable circumstances.

Back to that moment at the bedside. Yes, I can get trapped in the pettiness of being repulsed by filth. I can be annoyed by undeserved complaints.

But I can also appreciate this man's suffering. I can help shoulder his burden. If I get it right, I can preserve his dignity amidst degradation. I can restore some of his humanity. If I can transcend my smallness; I can become a little bit of a different person today.

That's really the mission of the nurse. Yes, that's really what I want to try to do every day.

Rabbi Yonah Solomon, BSN, RN, PHN, is completing his nursing residency in a medical-surgical/oncology unit at Providence St. Joseph Medical Center in Burbank, California, and is beginning additional oncology training toward earning his chemotherapy certification. He earned his nursing degree in December 2017 from California State University, Northridge (CSUN) following a 14-year career as a seventh grade rebbe and high school limudei kodesh teacher. R' Yonah lives in Los Angeles (Valley Village) with his wife and eight children, and tries his best to still make it out most nights to learn and teach in the local night kollel. He can be reached at nurseyonah@gmail.com.



OJNA RECOMMENDS: BOOK REVIEW

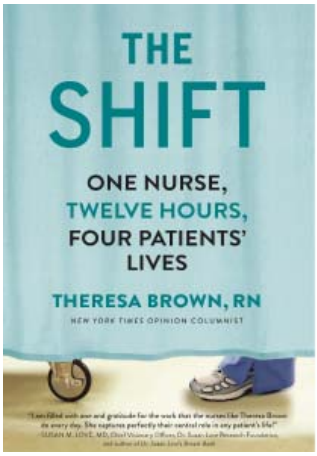
The Shift: One Nurse, Twelve Hours, Four Patients' Lives

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

The Shift: One Nurse, Twelve Hours, Four Patients' Lives is a memoir by Theresa Brown about the challenging ride of caring for four patients on an oncology unit during one 12-hour shift. This book highlights the often-unspoken realities of life and death while working in a hospital as an English university professor-turned registered nurse.

Brown shares how it feels to start a shift with three patients, knowing that an admission could be rolling into her unit. She shows the reader how she constantly reprioritizes tasks throughout her shift. It is easy for the reader to imagine him/herself being in similar situations and handling comparable scenarios on any unit, making this book relatable to the majority of bedside nurses.

Brown has a compassionate yet authentic approach to nursing and the way that she cares for patients. Nurses often worry about whether their physical assessments are accurate or not and if they "missed" something. Nurses may also feel defeated if they cannot figure out what is wrong with their patients, despite completing a thorough assessment and doing everything right. When Brown auscultates her patient's bowel sounds using the all too common yellow disposable "toy" stethoscope and hears nothing, she knows that something is not right with her patient, yet she fails to deduce that her patient is in fact having a medical emergency. Brown sends the patient to get a CT scan of her abdomen, to find out that the patient had a perforation. She describes her disappointment at not having seen the signs of a bowel perforation and she kicks herself because of that. Readers will feel relieved in noticing that they are not alone in second guessing their judgements and assessments.



Any nurse will appreciate this book, especially if he/she is a bedside or oncology nurse. Nurses come home from their shifts feeling exhausted and drained, and there are times when they feel that there is no one who can comprehend the stressors and rigors of the daily routines of their jobs. This book shows its readers that they are not alone and that there are other nurses who experience similar situations.

Interestingly, this book is also a great read for patients because it demonstrates that nurses are truly watching over them throughout their entire shift. This also shows patients that nurses have an overwhelming amount of tasks that must be properly prioritized throughout the day, and while the nurse might tell the patient that she will get them some water, or a new shower curtain like Brown did, there are often other tasks that must be done first. This is sure to be an eye opener for patients.

All in all, Theresa Brown reminds us that it is truly a privilege for us to do what we do. While this book talks about Brown's shift and her personal story, it contains many elements of all nurses' experiences.

JOB OPENINGS:

Since 2018, over 230 jobs have been posted to our website's job board.
The most recent job listings are:
1) Nurses for NYPD - New York
2) Nursing Home RN - Woodcliff Lake NJ
3) Insurance Company RN - Brooklyn, NY
4) School RN, part time- Westwood NJ
5) RN in Allergy Office - Brooklyn NY
6) Dept of Health School RN - Hiring Event, NY
Members are able to post and view all job openings.

If you are not a member and want to share information about a job, please send info via the Contact form on our website.

Nursing is Where It's At

Yaakov Shereshevsky, RN

I always knew I was going to be in the medical field. I was the kid who couldn't look away when my pediatrician drew blood at the office. At eight years old, I had my dentist tape a mirror to the overhead procedure lamp so I could see my own root canal taking place. When I was 10 and needed stitches under my eye from a boomerang accident, my mom held the mirror steady so I could watch.

When I first became an emergency medical technician (EMT), I thought the next logical step for me would be to attend medical school. I spent thousands of hours on the ambulance, providing care to patients in emergency situations and transporting to various emergency departments.

As I spent more time in hospitals, my experiences grew and my perceptions evolved. I realized that the role I wanted to fulfill was not that of a doctor; it was at the bedside, providing direct bedside care. The physicians' role at a hospital is vital to the patient, but it was not where I wanted to be. Nursing, direct patient care, was calling to me.

Nurses spend time with their patients. They explain what each medication is for, and actually administer them. They give injections, start IV lines, and remove them as necessary. Nurses get the patients out of bed, prep them for surgery, and help them deal with the aftermath of terrible diagnoses. They help families adjust to new medical devices. In the worst of cases, they explain cause of death to a family in a manner that shows that this case was not just a number or a diagnosis, but a person who mattered to them.

I started nursing school, and was not shocked to learn that I was not only the only religious Jew, but the only religious Jewish male! Nine out of 10 nursing students are female, and even fewer of the males are Jewish. I wear a yarmulke proudly, and I ask a lot of questions. Suffice it to say, I stood out.

I was hired at a prestigious institution in a stepdown unit for patients undergoing cardiothoracic surgery. The training was intense, and I learned a lot in a very short time. After a few months, I was moved to the cardiothoracic intensive care unit (CTICU). My colleagues were excellent, and I was happy to learn from them as well. I learned about other cultures, and my experiences and understanding grew and evolved.

One of the aspects I love most about being a nurse is the impact that we can have on each other, especially in such a fragile setting. A hand on a shoulder or the right tone of understanding can mean so much to a patient or family member. When they see how much we really care, when they see that we really want to make them feel better, the rest of their stay can be so much more bearable. Nurses make an unequivocal difference.

A short while ago, I was assigned a female patient who was in end stage heart failure. She had been waiting for a heart transplant and could wait no longer. In the interim, she was evaluated and approved as a candidate for a left ventricular assist device (LVAD), a mechanical pump that is worn by the patient on a harness or belt and allows blood to circulate through the body. It is an amazing piece of technology which saves lives daily, and I get to teach patients to manage the care of it, as well as how to live with this device at home.

This particular woman was a religious Muslim who spoke only Arabic. She refused interpretive services and would only allow her son to translate for her. Her son said that she never learned any English at all. As her son explained to me, she would not touch a man who was not her husband, brother, father, or son. I responded that I would be as delicate as possible to minimize physical contact, but that her care would be my priority. I would still need to check her blood pressure and listen to her lungs, but would do so as carefully as possible. He said he understood, and after a brief conversation with her, he told me that she was happy with this arrangement.

Because of her medical condition prior to surgery, she had a central line access, which required her to be washed from head to toe daily with a strong antimicrobial solution to lower bodily surface bacteria, and minimize her chance of infection.

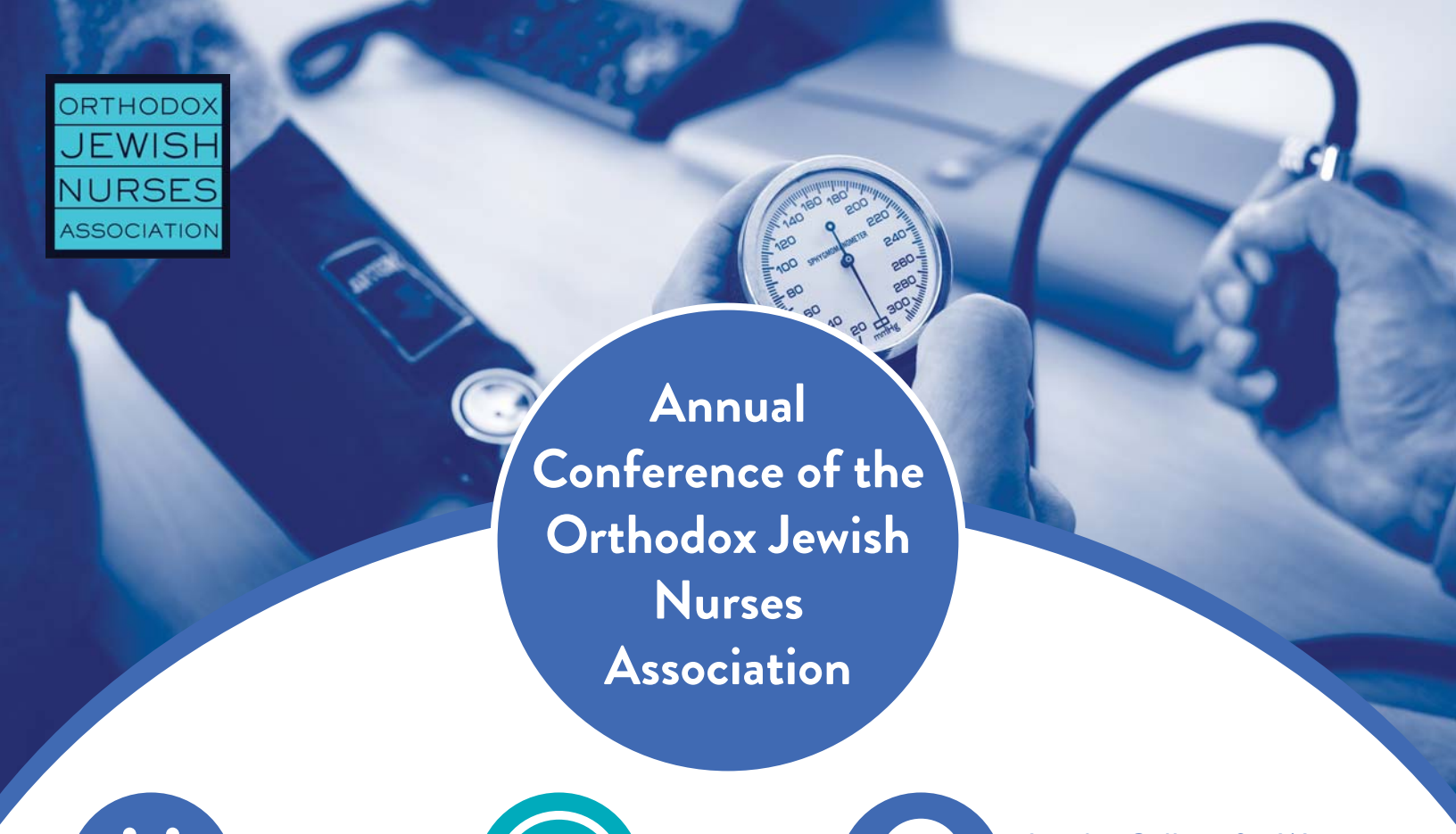
When it was time for her wash up, I could see how uncomfortable she was. She nodded OK, but her face told me she was about to cry. I asked to her to wait a moment. I stepped outside the room and asked a female nurse who was available to take this aspect of care over for me, and meanwhile I would take care of what her patients needed. The arrangement worked out well, and my patient looked happy about this. Her relief was obvious, and I was satisfied that today was a win.

The next day, I was given the same patient, and again, she was scheduled for a wash up. Today, however, was different. Today was surgery day. I could see at the beginning of the shift how nervous she was about the upcoming procedure. Her son asked many questions on her behalf, and though we went over the plan again and again, the apprehension was palpable. When it came time to be washed up, I once again was able to have a female nurse take care of it while I "traded" and took over tasks for the other nurse's patients.

Six a.m. arrived and suddenly it was go-time. The operating room called our unit and said they were ready. A wheelchair was brought to her room and she got into it. I bent over a bit so we were eye level. I looked her in the eye, and with her son interpreting, I told her that I wished her luck and hoped that the surgery went well. As the wheelchair passed me, she motioned for the patient transporter to stop. She grabbed my arm, pulled me in for a hug, and with tears on her cheeks, said the only English words I ever heard her from her: "Thank you."

Nursing is where it's at for me.

Yaakov Shereshevky is cardiovascular certified RN at NYU Langone Medical Center in New York, where he has worked for the last 3 years. His previous experience includes 10 years of working with children with autism in a group home setting. In his spare time, he teaches CPR and volunteers as an EMT in his local chapter of Chevra Hatzalah of Canarsie/Mill Basin.



ORTHODOX JEWISH NURSES ASSOCIATION

Annual Conference of the Orthodox Jewish Nurses Association

Sunday
May 19, 2019

8:00 am -
4:30 pm

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

6.5 Contact Hours
Provided by the
Northeast Multistate Division
An Accredited Approver by the
American Nurses Credentialing Center's
Commission on Accreditation

6.25 CME
Provided by American Association
of Physicians Assistants

Discount for OJNA Members

Cholov Yisroel
Breakfast & Lunch

Open to Men and Women

Register at jewishnurses.org

Conference Committee:
Goldie Burstein, RN-C CCM
Shevi Rosner, MSN RN-C
Linda Segel, BSN RN

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TRUECARE Madison Programs Abbott

Get Into the Rhythm: EKG Primer
Alexander Kushnir, MD, PhD

Stroke: The Changing World of Treatment and Prevention
Steven Rudolph, MD

Drama-Free Shifts: Interactive Conflict Resolution Workshop
Omar Morgan

Picky Eaters: Nutritional Challenges in the Neonatal Population
Helen Towers, MD

When the NICU is Your Nursery: A Father's Journey
Moshe Krakowski

Shift Work: Navigating Family, Intimacy, and Taharas Hamishpacha
Toby Carrey, MSW

Still a Long Way to Go: Mental Health Stigma in Our Communities
David Pelcovitz, PhD

Working Alongside the Symphony Orchestra

Tova Julie Rubinstein, RN, BScN

Some days I hate the sounds of the machinery at my job. The feeding pumps whistle. The intercom dings. The pagers trill. The IV pumps beep loudly and insistently no matter how many times I push their buttons, straighten patient's arms, and re-prime their tubing. On particularly bad days, I will sit at the nursing station and cover my ears with my hands for a minute or two, just for a short break from the cacophony. Still worse, is the sound of the people who are suffering. Confused patients ask when they can go home. Patients with delirium beg for help and release. Patients with advanced dementia shriek and moan. It's a veritable orchestra, each musician blending together in a symphony of human misery.

When I started out in nursing, it would drive me insane and sometimes to tears. How could I avoid it, when there were people crying out for succor and I was unable to provide enough to make everything all better? How could I reason with someone who was delirious and confused when he tried to yank out his IVs and Foley catheter in order to totter, on unsteady feet, towards the exit? What was I to say to someone with dementia who asked, for the twentieth time that hour, where she was and she was there? What did I say to the person that I had to put in restraints so that he did not hit me or the other nurses?

I still have not totally figured it out. I can try to distract with TV and radio. I can put someone in a wheelchair with a restrictive tray up at the nursing station so that the whole team can guard him or her. I can dole out pain medication and sedatives and even discuss with the doctor about obtaining a better management regimen. There is only so much I can do. I wish I could do more.

Thanks to experience and the wisdom of senior nurses, I am better at managing the human misery now. I am able to stay calm when telling Betsy for the twenty-first time that she is in the hospital and that no, she cannot leave just yet. I have learned to do what I can for Rosa screaming with dementia, giving out pain medication and dimming the room and providing a nice warm blanket to help her settle. I have learned that my safety is more important than freedom for Benny's fists. Perhaps most importantly, I have learned to sometimes block out the music when I need to concentrate on something else. But then I wonder, have I become better at working alongside the symphony around me? Or have I become a worse person, able to ignore it? I'm sure some visitors are worried when they see nurses laughing at a joke at the nursing station when a patient is visibly upset only a few meters away.

A mentor of mine once told me that a good nurse is a nurse who is afraid that she might harm patients through her ignorance, because that nurse will stay on her toes and constantly observe and reassess and ask questions. She is overall a very safe nurse for that patient. Is it similar for a nurse who, though he works with the orchestra playing in the background, never forgets that it is there? He is working hard, but never forgets why he originally went into nursing: to make people feel better, to turn the tempestuous symphony of misery into a glorious overture of health and wellness.

The symphony continues playing, and the orchestra doesn't go away. The musicians may continue to have pain, and mental anguish and dementia. They direct discordant angry sounds towards the nurses who are just trying to help. And while there is only so much I can do to adjust the volume, I also know how to work to its rhythm. I hope that I always remember that while I may be unable to silence the orchestra of human misery, I can always do my best to keep the volume down.

Julie Rubenstein, RN, BScN(Imm), graduated from the University of Ottawa School of Nursing (Canada) in 2015. Since then she has worked in palliative care, home health and geriatrics, and is currently employed as a floor nurse on a general medicine unit. Her professional interests include chronic disease management, patient teaching, patient advocacy, and mentoring new nurses. When not working or reading up on tests and treatments, Julie enjoys reading, cooking, knitting, and snowshoeing in the winter. She lives in Toronto, Canada. She doesn't think there is enough snow there in the winter.

OJNA NEWS

In the last 18 months, OJNA has grown in membership, expanded member resources and services, and held multiple social and educational events.

Effective February 19, 2019, Blima Marcus has stepped down from her position as OJNA President to pursue other professional projects. We thank Blima for her time serving as the President of OJNA. We wish her luck in her future endeavors. Elisheva Rosner, Vice President, has assumed the role of President of OJNA.

Effective May 5, 2019, Toby Bressler PhD, RN, OCN has joined the Executive Board as Vice President. Toby's appointment will restore the Board to its full complement of four members.

Toby is currently the Director of Nursing for Oncology and Clinical Quality at Mt. Sinai Health System in New York and is an Assistant Professor of hematology and oncology at Icahn School of Medicine. Prior to functioning in these roles, Toby has held many nursing leadership positions, taught at various nursing schools, and received numerous nursing leadership awards.

Please join us in welcoming Toby to the OJNA leadership team!

Elections for Secretary and Treasurer positions will take place on December 1, 2019. Nominations should be submitted by November 1, 2019. OJNA members who have active, paid membership for at least six consecutive months prior to elections will be eligible to vote.

Board members commit to stay in their position for two years.

Qualifications to join as a board member:

- Active RN license
- Bachelor's degree in Nursing; Masters or Doctorate preferred
- Leadership experience
- Active paying member of the OJNA for at least 6 months

Do you remember the feeling of being a new nurse?

OJNA is looking to expand its team of mentors for its new grad mentorship program. Mentors work with mentees for about six months and ease their transition into the world of nursing. Please email ojnamentor@gmail.com if you are interested.

Call for Resume Experts

Do you have experience in HR or as a manager? Join our team of resume reviewers and assist us in reviewing resumes for OJNA members.
Email ojnamentor@gmail.com if you are interested.

Continuing Education

We have 50 continuing education modules on our website - all free for paying members!

Recently added to our website:

- The Role Of The Intestinal Microbiota In Necrotizing Enterocolitis And Neonatal Sepsis
- Wound Healing And Nutritional Management
- Dietitians Leading Innovation: Using Data For Quality Improvement And Patient-Focused Transitions Of Care
- Open Wide: Broadening the NP Role
- Care Coordination: Children with Medical Complexity
- A Mentorship Program for New Graduate Nurses
- Teen and Intimate Partner Violence Screening
- Utilizing Continuous Glucose Monitoring Data To Improve Diabetes Care

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

In the last few months, OJNA chapters across the United States have hosted events where nurses came to enjoy each others' company, network, and learn. We have held events in Florida, Ohio, Michigan, Illinois, Pennsylvania, and Maryland. If you would like to be involved in developing a chapter in your region, please email us at OJNAboard@gmail.com. The OJNA assists chapters with event planning, financial assistance, publicity, and more.

VACCINE EDUCATION

In response to the current measles outbreak centered in Orthodox Jewish communities in the New York area, a group of OJNA nurses developed the Vaccine Task Force that aimed to address vaccine hesitancy and misinformation related to vaccine safety. The group provided evidence-based vaccine education to groups of women in intimate settings and worked on the development of a professional educational publication for widespread dissemination. The work of these OJNA nurses garnered much positive media attention and their work has been featured in many media outlets to include The New Yorker, CBS Good Morning, the BBC and more. As the work of the Vaccine Task Force continued to develop, their scope grew beyond the OJNA umbrella and as such their work will now be continued under the auspices of the EMES Initiative under the leadership of former OJNA president Blima Marcus. We encourage all OJNA nurses to continue to support this important endeavor.

Orthodox Jewish Nurses Association Inc.
411 Hempstead Turnpike, Suite 200
West Hempstead, NY 11552

layout & design: coloryourdesignportfolio.com

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 an inpatient nurse practitioner at the Memorial Sloan Kettering 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.

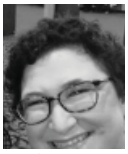
Tobi Ash, MBA, BSN, RN, received her Bachelor of Science in Nursing from Barry University in 1998, her Masters in Business Administration from Nova Southeastern University in 2001, and is currently completing her Ph.D. at Walden University. Tobi is the Director of Women's Health Care at Nano Health Associates 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.

Tamar Yehudis (Tami) Frenkel, BSN, RN, received her Associate's Degree in Nursing from Phillips Beth Israel School of Nursing in 2011 and her Bachelor of Science in Nursing from Chamberlain University in 2014. She started her career working at a clinic for pediatric Allergy and Immunology, and now currently works at Maimonides Medical Center in Brooklyn as a medical-surgical nurse.

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