ORTHODOX JEWISH NURSES ASSOCIATION

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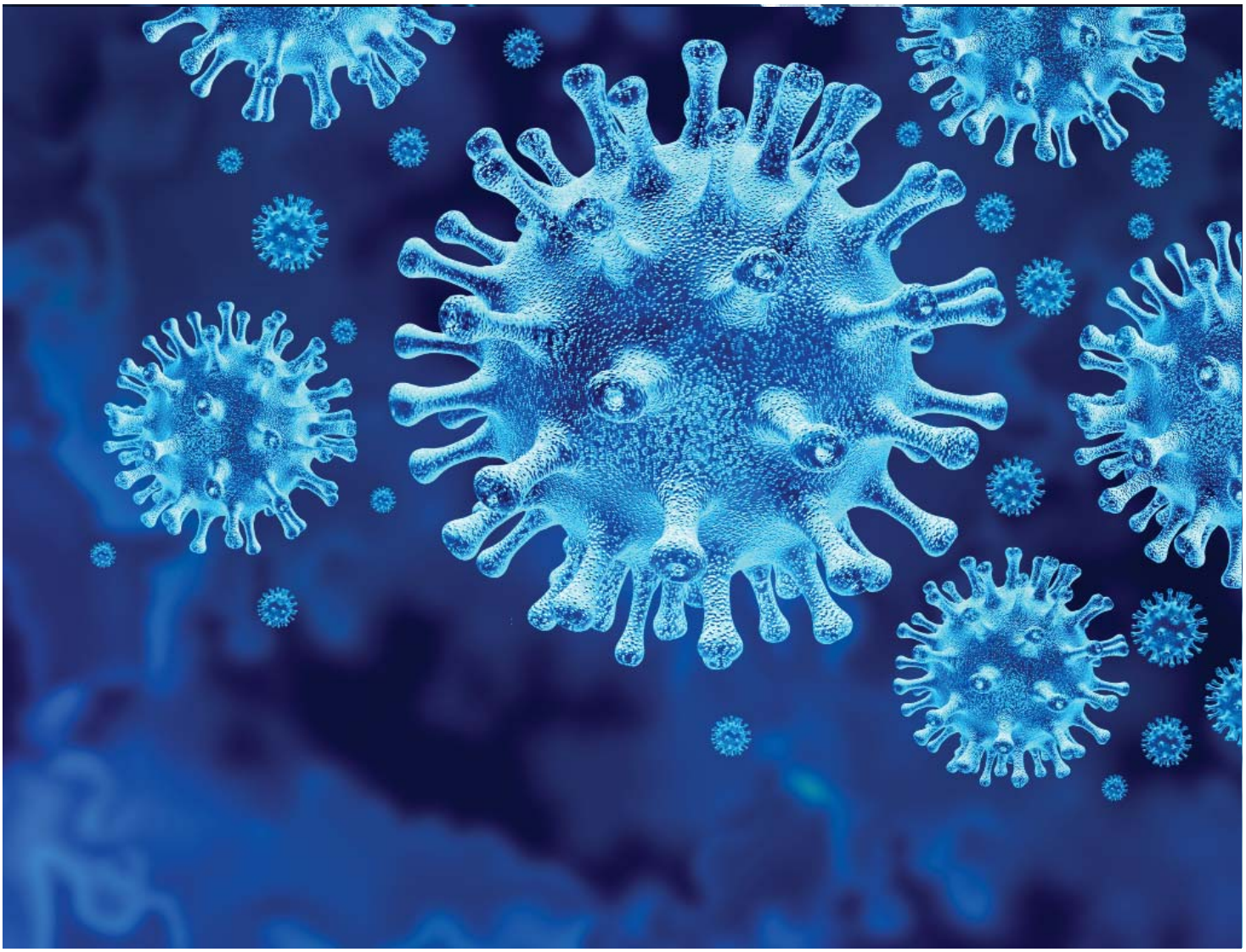

Coronavirus

Dispatches from the Frontlines

COVID-19 Risk Factors

The Great Influenza

OJNA LEADERSHIP

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The mission of The OJNA Journal is to

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

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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 Members,

As a critical care nurse and nurse practitioner for over a decade, I thought I knew what nursing was about. Though there is always more to learn, I was comfortable with my role, my knowledge, and my skills. The last four months have thrown me for a loop. I have never in my career witnessed so much death and dying. I have never felt so helpless in my inability to save patients. I'm hurting for the loneliness of my patients and the terrible distance and fears of their families. I don't like the feeling of flying blind, of having no evidence upon which to base my practice.

That is my personal COVID experience. Yet I know that each nurse is experiencing their own COVID reality. Different patient populations, practice settings, administration, colleagues, amounts of protective gear, family support, pain tolerance, and individual coping mechanisms; all these factors coincide to give each of us a different life-altering COVID existence. Together, we have experienced the gamut of human emotion. We have felt helpless and hopeless. We have felt betrayed and abandoned. Afraid and exhausted. Frustrated and angry. Heartbroken. Depressed. Empty. But we also feel hopeful. And courageous. Proud. Supported by incredible colleagues. Heartened by acts of kindness. Driven to do more, and overcome when our patients do well.

Until COVID-19 erupted with a vengeance, your journal team had been working on a summer journal focusing on mental health and psychiatric nursing. As COVID-19 became the predominant issue on everyone's minds, we changed our focus and decided to publish this special feature journal instead. Though there is a paucity of clinical data and evidence at this point, there is a preponderance of stories. Nurses' voices and stories that scream to be heard. And so, in a departure from prior journals, we have replaced our feature article—typically an exploration of a clinical topic—with a series of essays that OJNA nurses wrote for a Jewish Press column, "Dispatches from the Frontline." The data will come. The clinical knowledge will come. But as we wait for those answers, as we personally generate data that will one day become the very evidence and trials through which we will attempt to pin COVID down, we share our lived experiences to the world at large and within our small internal community. Sharing our stories here acknowledges that we are living this experience together, and together we can find comfort and hope.

With prayers for a better tomorrow,

Chaya Milikowsky, MSN, AG/ACNP-BC

Editor-in-Chief, The OJNA Journal

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Dispatches from the Frontline

Over the past few months, the *Jewish Press* has showcased a series of personal essays by OJNA nurses. Titled "Dispatches from the Frontline," this series has given the Jewish Press readership a glimpse into the lives and struggles of frum nurses taking care of COVID patients. Thank you to all of these nurses for sharing their new world and making a *kiddush Hashem* in the process. More important is the appreciation for all the lives they saved, the suffering they ameliorated, the families they reassured, and the hours, sweat, and tears they gave of themselves to others. To all those of you who have stories yet untold, we hear your unsaid words and we know of your bravery and sacrifices. And please, continue to share your voices. The world needs to hear them.

By Yaakov Shereshevsky, RN

A month ago, I laughed about coronavirus—or as Facebook memes called it, the "WuFlu." It was a world away, and it was never going to affect us here in the US of A. Today, I had actual, physical palpitations when I parked my car at work. I am scared to go in. I am a nurse. I have worked in healthcare in some form or another for the last 14 years, and there has always been risk. But it has always been calculated. Has always been small. Now, I can bring it home and HURT MY CHILDREN. Oh, I'm careful. I strip in the doorway where my wife leaves the laundry bag. I Lysol my shoes and my watch. I wash my hands at work so often my knuckles hurt. I wear a gown. And gloves. And a surgical mask. An N95 particle shield strapped against my face, so tight I have marks for hours after I leave the building. And a splash guard. And a hair cover. And I worry. Is this enough? I am told that it is, but I worry. Because my kids mean more to me than my own life.

I teach my children that if someone asks for help, we cannot say no. And I live this credo. I volunteer time in Emergency Medical Services as an emergency medical technician (EMT) when I am available. I run toward emergencies. And I will continue to do this for as long as I am able. But, God, this is hard. Not the time, or the effort. That part is easy. I am in healthcare because I can't stand to see people in pain. I need to hasten its end, to hear the sigh of relief as a patient feels better. But there is so much pain now! So much pain. Endless. It is horror for healthcare workers now. Lean back in your seat, mouth agape, eyes wide horror. The suffering is unrelenting.

We do what we can, but it is not enough. Not nearly enough. Our medicine is excellent. Our skills are sharp. And it means nothing. If Corona were a movie villain, it would be laughing right now. Our people are dying. And so much pain. Families, desperate for information, calling the hospitals. Hospitals doing their best to give them some news with the little time we have. And not enough supplies. And med shortages, because being on a ventilator requires sedation, and comfort medication, and occasionally, paralytics to stop a patient from unconsciously "fighting" a ventilator. So many meds that we are running out. So we figure it out. Because this is what we do. We daisy-chain IV tubing to make them longer so we can keep the IV poles outside the patient rooms. We swap one med for another, similar meds that we still have in stock. It also requires staff. But we, too, are running out. There is simply not enough staff that have the training to keep up. So we are overloaded with patients who need us. And we come in for extra shifts. And we feel the emotional burn. So we find an empty hallway, sit down on the floor, and cry. And then we go back. I have said the Prayer for the Dying more times than I care to admit. Maybe more than I can handle. But no one dies alone. We do not enter this world alone, and we sure are not going to let someone leave that way.

This is a 34 bed ICU, one of several in this building. When I left yesterday, there were 34 patients. When I came back, 34. But not the same 34. Three patients passed while I was gone, each bed now filled with another patient, just as sick as the last. Each patient had a name. I remember two of their names right away, and struggle to recall the third. I can't, and feel guilty. Too many people here, too much to do. One of the names I remember was my friend's father. I am slowly breaking.

I am not an emotional person by nature. But in the last few weeks I have found myself minutes or seconds away from tears at any given moment. This past Friday night I was with my kids and struggled not to break down while singing a song about baseball.

I get asked frequently by friends and neighbors to check up on people at the hospital. "Just see if they are OK, please?" They aren't. If they were sick enough to be admitted in this time of national crisis, things are not good. Maybe they will be fine. Oh, they were intubated yesterday? I hope they will be OK, I tell them. I wish them well. And I do wish them well. I really, truly do. But an intubated patient that's COVID+ in an ICU? This is not a pretty picture.

A triple lumen central line in the neck. Each port hooked up to a separate line of medication, likely pressors to keep their blood pressure from dropping too critically. A central venous pressure port on one of those ports hooked up to a monitor to see the filling pressure of the heart. Another one or two IVs in their arms for some other IV meds. Maybe an antibiotic, maybe an anticoagulant to prevent a blood clot. A line in their radial artery for continuous invasive blood pressure measurement. A tube coming out of the nose attached to wall suction to prevent gastric filling of particles they aren't capable of digesting right now. An endotracheal tube out of the mouth connected to a ventilator to breath for them. The ventilator itself, a mass of dials, buttons, numbers, waveforms, and screens to interpret and control a breathing pattern. If kidney function is bad, maybe another two-port central line coming out of the chest connected to a dialysis machine to filter the blood. A urinary catheter to keep track of fluid output. Cardiac monitor. Don't want any arrhythmias, can't have that. Oxygen saturation. Labs. Blood gases. Glucose checks. This does not end.

Oh, normally we have one of these patients. If we are tight, or someone calls in sick, we can get two. But hey, guess what? Surprise, everyone! We don't have enough staff! Now you have three of these patients. It's the Corona Special. Maybe next week we will have four.

I am the person I was a few weeks ago. Maybe now even more. But I am also less. Like a chipped and re-

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paired glass, I am technically all here. But run your fingertip along the glue line. You can still feel the crack. You can see the imperfection. I will never again be exactly who I was. There are so many cracks now. So very many. My wife knows this. She is the emotional support holding me together, though I don't think she realizes quite how much. My kids do not yet understand, but in time I believe they will. Daddy is a Super Nurse, Mommy tells them. Daddy is a Super EMT! I'm not. Just another guy trying to stem the tide in our favor. Maybe help somebody feel better. But we are outnumbered, outgunned.

I work with some amazing people, though. EMTs and paramedics that do the utmost for our people. Waking up at 2am to get dressed and run to help someone in need. Then another call, 15 minutes after they get home and back to bed, at 3:30. Guys who would give the shirt off their backs to spare someone else discomfort. Angels wearing human skin. I have no other descriptors. They just aren't adequate.

Respiratory therapists, maybe until now the most undervalued healthcare workers. Not anymore. Never again. Intensive care docs, PAs, and nurse practitioners. Freaking rock stars. Doing what they can to keep up with the tidal wave of patients. Treading in choppy waters, but somehow staying afloat. Custodial and building services staff who are nonstop disinfecting rooms and surfaces to keep us safe. Patient care techs running everywhere and back to grab needed supplies. Pharmacy sending the meds and keeping track, so nobody gets the wrong med or incorrect dose. And nurses (I'm biased). The caring professionals who have gone so far above and beyond the job description that words to describe it are meaningless. And all the restaurant owners sending wave after wave of food and coffee to keep us fed and alert. Without them, I would literally have not eaten for 13 hours straight while tending to those who need it. Say what you want about New Yorkers, but when push comes to shove, we have each other's backs.

I know there will be movies made about this. And I imagine I will feel about it the way a soldier must feel when watching a war movie. Film will never be able to capture the moment the way human eyes do. Suffering does not digitize. It is real, and it is raw, and it has ragged edges. It hurts.

Never have I been more heartbroken or filled with so much sorrow. Never have I been more proud to be in healthcare.

Yaakov Shereshevsky
EMT. Nurse. Human.

DISPATCHES FROM THE FRONTLINE

By Noami Kramer, RN

All those in the medical field put themselves at risk every single day. Even before the novel coronavirus, on any given day we never knew what we were walking into. As a pediatric intensive care nurse for seven years, I have been in my fair share of dangerous situations. I've been exposed to viruses and bacteria without knowing. I've cared for a child beaten to death by his father while the father was not in custody. I have cared for teenagers involved in gangs and shootings, with police standing outside the door in case gang members show up. We swipe our IDs and confront whatever danger awaits us without hesitation. As COVID-19 spreads across our country, our job and our commitment to helping the sick never wavers.

On March 29, I showed up to my Pediatric Intensive Care Unit (ICU) to be told that in 48 hours we would be transitioned to an adult COVID-19 ICU. We would have two to three days to train and learn, and on April 1 we would open as a fully functioning adult Medical ICU. As a nurse for 7+ years, I have only ever cared for the pediatric population.

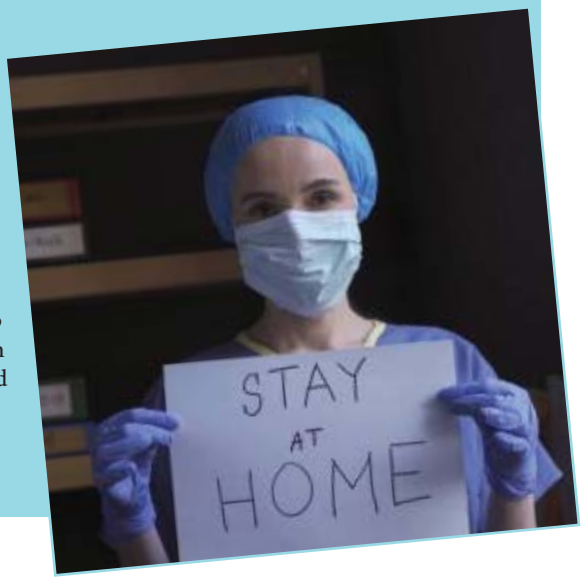
This does not make me a hero. This does not make my co-workers, doctors, physician assistants, respiratory therapists, or any ancillary staff heroes. What makes us heroes are the sacrifices we are forced to make because we are now exposing ourselves to COVID-19 every single day. What makes us heroes is the nurse who sends away her husband and two small children to minimize their risk, not knowing how long it will be until she can hold or even see her children again. What makes us heroes are the days we finally have a break from the hospital and must spend them alone. What makes us heroes is that all of us can no longer be with our family, indefinitely. What makes me a hero is being a single Orthodox woman who now has to spend Pesach and Shabbos alone. And it's ok. I don't share this for pity, I share this so that each and every one of you understands the sacrifices that every medical professional has been forced to make.

When we chose this field, we chose to help others before we help ourselves. We never knew we would be forced to choose between our patients and our families. But now we are, and every single one of us has chosen you. We choose you and your loved ones over our own. We choose to keep fighting this nasty, scary virus even though it means we can't be with any of our loved ones for a long time.

This is more than a plea to just stay at home, it's a plea to understand, really truly understand, that while you're all stuck at home with your families or friends, we are working 12-hour shifts running straight into the fire. You spend your days avoiding the virus and doing everything in your power to protect yourself from it. We are literally surrounding ourselves with this disease day after day. We are putting ourselves at risk everyday to try and eradicate this deadly virus. But aside from our own personal health, we have each sacrificed more than you can ever know.

I'm lucky to work in a profession where I can help so many people. I'm lucky to work in a profession where I can do my part to help during this crazy situation we have all been thrown into. We medical professionals are heroes, not because we show up to work and help those who are sick, but because without hesitation we have given up on everything around us. I hope and pray this pandemic will end soon so no more people have to suffer and die. So my friends can be reunited with their families. And so I can finally go and hug my nieces and nephews and talk to my family from less than six feet away.

Stay home, please. Please. Stay home so I can go home. So we all can go home to our families and not have to choose our patients over our families anymore.



DISPATCHES FROM THE FRONTLINE

By Chaya Milikowsky, MS, AG/ACNP

They don't believe me when I say they need to be intubated, and soon. Their blood oxygen levels are dropping to dangerous levels, in spite of maximum noninvasive support, and yet they often feel ok. They are scared of being intubated, and ask if we can avoid it, what they can do to push it off. I am scared for them too. I don't want to tell them that this conversation we are having, it may very well be the last conversation they will ever have. I don't want them to push off intubation, because then they will die for sure.

If we have a bit of time and if they have a bit of breath, I tell them to call their loved ones. Let their family hear their voices a bit. If it's not the last time ever, it will be the last time for weeks, since COVID patients have been requiring longer bouts of intubation than with other pathologies. They won't hear, touch, or see a loved one for a long time. And maybe forever.

"Will I die?," my patient asks me. I cannot tell him the truth, that more than half of COVID patients who develop this extent of respiratory failure die. "Not on my watch," I promise him, "not while I'm here." That's the best truth I can offer him. I won't let him die tonight.

We call Anesthesia to intubate and they meticulously prepare everything outside of the room. They can't forget to bring any item with them, because there will be no time to degown or go through the pantomimes of communicating with those outside the airborne protected room. At the same time, they mustn't bring excess supplies, because everything that enters the contaminated room gets thrown out if unused.

It's during the intubation process that my decision to have the patient intubated is confirmed correct, with no room for doubt. Had I been second-guessing that decision, I no longer do now. These patients have no respiratory reserve. Their oxygen levels drop dramatically, and often take a long, heart-stopping time to respond to full ventilatory support. I now wonder whether we should have intubated much earlier.

Though they are on the ventilator, we are not out of the woods. Blood pressure is dropping and I need to insert a central line. The nurse inserts a nasogastric tube and a foley catheter. We order restraints so that all important lines and tubes remain where they should be. Can't have them coming out, when it takes us so long to go in.

Every time a patient needs something, it's a process. Mask on, face shield on, gown on, gloves on. Check and recheck for a good N95 seal. And if we realize too late that we need something, it's a song and dance communication game. Bang on the glass door and get someone's attention. Scribble our request on the handheld whiteboards and hope those outside can find one to respond in kind. You can't hear our shouts with the doors shut tightly and the massive air filters running loudly, and you can't read our lips covered with masks. Rapid scribbles and pantomime have become the communication methods of choice.

The filter noise and the full body protective equipment make it difficult to communicate with the patients as well. We all look the same, save for our eyes. We shout to get our words heard. Patients are scared, which makes it even harder to comprehend the words they barely hear. It's difficult enough for those patients who are not intubated. And for those patients that are intubated and deeply sedated, dramatically weakened and deconditioned, barely able to communicate their needs anyway? There is no family at the bedside to understand a subtle look or hand squeeze. The nurses struggle with their desire to nurture and care and comfort a patient, with the law of self-preservation that says get out of the room as soon as you can. You have a spouse and children at home, you cannot get them sick and you cannot die on them. And besides, you will be of no help to any patient if you become sick. And then there are your other patients as well, alarming, oxygen levels dropping, blood pressure fickle, and meds to be given. But this patient needs you.

As a nurse practitioner, I am not in the room nearly as often as the bedside nurses. It makes me feel relieved, and also guilty. Sure, I get my time when we intubate, when a patient is decompensating, when I need to perform a procedure, to pronounce a death. But it's less direct patient contact than it used to be and I feel guilty. I don't go into the room to round every shift like I used to. I peer through the glass wall, and that will have to be enough. There is so much guilt everywhere now. We are doing all we can, but are we doing enough? We must protect ourselves so that we can continue to care for others, but have we neglected the basics of human touch and healing? When I do go in, I can't help but apologize to the patients; to the deeply sedated patients, and to the dead bodies. I am so sorry. As I touch their shoulders, I am so, so sorry.

But it's not just guilt and sadness. There is also an incredible feeling of camaraderie, of innovation, of we-are-in-this-together-and-we-will-come-out-stronger. Our core of intensive care unit (ICU) staff—nurses, doctors, nurse practitioners, physician assistants, respiratory therapists—has been bolstered and supported by additional hospital players who have joined our ranks and support us at every turn. Anesthesia is ever present and checks in often. They offer to insert invasive lines and find out who is on our "watch list". Post anesthesia care unit nurses, travel nurses, cath lab nurses, and floor nurses have all taken shifts in our ICU to help where we are hurting. Management checks in on us to make sure we are ok. Our intensive care doctors have become champions of the patients, getting them into clinical trials, learning about and instituting new protocols from newly generated evidence. People outside the hospital are sending in food daily; I cannot eat it, but I'm comforted by the outpouring of love and support. And our ICU team has become incredibly innovative, changing practices to improve ease of care. Our ventilators have been dismantled so that while the "body" of the vent is near the patient, the "brain" remains outside the room for easy access. We've done the same with IV machines and meds; we can hang and titrate medications from outside the room, with long, thin tubing lines snaking under and around doors to deliver the medications to the patients. It truly is an honor and a privilege to work with a team that is so focused on supporting the staff and caring for our patients.

We have become invested in our patients, and we will never forget a single one. To this end, our unit has begun painting a COVID mural, with a large tree set against bare ground and sky. Every time we lose a patient, the nurse paints a star in the sky. And when we successfully send one of ours home, we celebrate by painting a flower on the ground. "Be a flower, not a star" has become our new mantra. "Be a flower" we whisper to our patients. But if you become a star, we will memorialize you just the same.

DISPATCHES FROM THE FRONTLINE

By Emily, RN

I walk through the double glass doors as usual, wave to the security guard, and we share a quick smile. At that moment, I don't yet know that I have taken my last deep breath of fresh air for the next 14 hours. I arrive onto my unit to a sea of yellow see-through gowns and blue masks with flimsy plastic attachments.

Their eyes. I should have paid more attention to their eyes. It's hard to recognize my coworkers and friends this way. As I walk past my manager, she hands me a flamingo pink N95 mask and says, "Here. This is your one. Keep it dry and don't lose it. Sign here." I take a deep breath, the air dry and still not as fresh as it was before those glass doors, but I am used to it. Anxiety hits me as I walk towards the break room for a few minutes of silence before my shift starts. The silence is then broken by a blaring alarm reminding me to clock in. It's time. I take another deep breath, put on my pink armor, and walk onto the floor.

I look at my assignment. All COVID. Last week, it was just one. Now it's every single one. I can't breathe. Is my mask on right? Why does my breath smell so bad? I remember brushing my teeth this morning. I only slept an hour but I definitely brushed my teeth. Maybe it was the cheap, old coffee I found in the back of my cabinet that I made that morning because Starbucks closed down. Okay, I can do this. I receive report from the night nurse. Every patient sounds like they are on the verge of death. They all can't breathe. The nurse's parting words are, "By the way, you probably won't even take that mask off the whole day. There's just no time in between patients." Great. Now I can't breath. I check in on all my patients. At least my patients and I have something in common.

My hands start to shake. Caffeine definitely becomes less potent in coffee as the years go by, right? My heart is fluttering. Can it be atrial fibrillation, a life-threatening arrhythmia? That's my cardiac nursing background talking. That's pretty irrelevant now. I take another deep breath; except it doesn't feel so deep, so I take another. My stomach begins to flip. All my patients are calling for my help at the same time. I run to the bathroom. I rip my mask off as quick as I can, lay my back against the bathroom door with my hand on my chest, slowly sliding to the dirty floor. Breathe, I tell myself. Breathe. I try to call my sister, but I can't dial. But still, thoughts roll through my head such as: Is this my new reality? How is everyone wearing their masks, breathing in stale carbon dioxide filled air for 12 plus hours straight? Everyone seems so calm, so why can't I pull myself together? I throw up in the toilet. I start to feel a bit better. I take another two minutes to myself. One last breath of dry air. I put my armor back on and go into Room 2 Bed B, burying my own anxiety somewhere. "It's okay, Mr. Brown, we're taking care of you. Deep breaths. Just breathe. In through your nose, out through your mouth. I'll do it with you." I was saying those words to him as much as I was to myself. I felt calm in the moment and continued on. One hour; one shift at a time.

DISPATCHES FROM THE FRONTLINE

By Robert (Chaim) Davis, MBA, MSN, RN

Working as a nurse manager, being a nurse and a leader, I have had many challenges and trying moments throughout my career. I wear many different hats: nurse, emergency medical technician (EMT), firefighter, professor, husband, and father. I am blessed that I have always been able to overcome any challenge thrown my way. However, COVID-19 may prove to be the one challenge I may not overcome, mentally or physically. Somehow I am one of the lucky healthcare professionals who has not gotten COVID-19, but the everlasting effects of this virus is something I may never be able to recover from. I have compared this pandemic to the likes of 9/11, which is the reason I became an EMT/firefighter and ultimately a nurse.

Many of my colleagues around me unfortunately have gotten sick from COVID-19, thereby adding additional stress to middle management. This has led me to cover multiple units, flip from day shift to night shift, and put in 16+ hour days seven days a week. While I have many hats outside of nursing, every day now I have to assume the role of leader, mentor, frontline nurse, nursing assistant, and transporter. Those of us in leadership positions already struggle with work-life balance. This pandemic adds an additional struggle; the emotional strain of home life, supporting the needs of senior leadership, as well as the physical and emotional needs of the front line staff, who are engrossed in COVID-19, and their need to protect themselves while providing the best care they can for their patients.

A couple of weeks ago an article was written by Emily, RN, and the need for her to reuse her N95 mask. On the flip side, the anxiety and frustration for a leader to potentially put their staff in harm's way, and making these requests, is overwhelming. A leader has to trust and support what they are instructed to do in times of crisis, hoping that the information is valid, as well as support and relay the message to the front line staff and field any concerns they may have. What we are asking the healthcare profession to do is overwhelmingly exhausting, mentally and physically. We are asking skilled staff to go above and beyond the call of duty. We are asking skilled nurses to take care of patients they have not been trained to take care of. We are asking care providers to assist in patient care that they have never done before. Because of this forever changing virus we are asking them to support the unknown.

My fear is the unknown long term effects of this pandemic—mentally, physically, and emotionally. Of course I am concerned about the patients, however I am also very much concerned about the healthcare professionals, including myself. The mental trauma and anguish of having numerous patients die around you, waking up every morning achy and sore from providing lifesaving efforts to multiple patients a day. Waking up every morning anxiety stricken, not knowing what lies ahead for your upcoming shift. Waking up in the morning and thinking about those healthcare providers who were so overwhelmed with this pandemic that they felt it was better to take their own life than to walk away. Who is going to be next?

As a leader, I feel that we always have to find the positives in every situation. Thank G-d I have been able to. For me, my telemetry nurses and staff have been given the opportunity to experience what it means to be a critical care nurse ever since the hospital converted half my unit to a critical care COVID floor. We have obtained new technologies and lifesaving equipment. We are able to experience each other at our best and at our worst and have been able to create bonds that will last a lifetime. I am fortunate that I have had friends, families, and strangers come out and support the team, donating personal protective equipment, food, or whatever else they could think of. Having just celebrated nurses week, and with the year 2020 being designated as the year of the nurse, I am proud to be a nurse. Regardless of what I have been put through. Regardless of how I will be tested. I can honestly say, there is no other place I would rather be than alongside my fellow healthcare professionals during this pandemic. My hope is, unlike 9/11, we remember this pandemic for a long time. My hope is that we continue to remember and value the importance of hand hygiene, the importance of friends and family, and most importantly, remember the importance of each hero at the frontlines putting themselves in harm's way in order to save a life.

DISPATCHES FROM THE FRONTLINE

By Mara McCrossin, MSN, AGNP-C

When I heard about this new disease, the coronavirus, I initially thought, this is a disease far away from me. This is happening in China. Maybe the government is overplaying what is going on. There is no way this is as bad as they are saying. It is similar to the flu. In fact, the flu is more deadly than this. It will not affect me…

Boy, was I wrong!

My first experience with the disease happened before the big changes in New York. My friends and family were sitting down at the Purim seudah when we all received an email stating our children had been exposed at school the previous week, and the school would be shut down with classes being converted to distance learning. My first thought was that my son will be in quarantine and now I may expose my patients to this disease. My second thought was, now I have to be a mom, nurse practitioner (NP), and teacher. How am I supposed to do that while working night shift? It wasn't long before the rest of the state was shut down and we were all in the same boat.

About a week later, I understood why we were in isolation. The hospital started to see a large influx of patients and new COVID-19 units were opened to help manage it. My schedule was adjusted by management to help avoid exposure and keep us safe, but that also meant another new change for me; working on Yom Tov and Shabbos. That was something that I never imagined having to do in my career. I have always been fortunate enough to have employers who were happy to accomodate my religious beliefs. However, I understood the dire situation that we were in and that these changes were necessary. With a consultation from a trusted rabbi, I was able to comfortably agree to this schedule. Now that I could say that my managers were doing what they could to protect me, what did that mean for protective equipment? What about the patient population? Would I now be working in a completely different place?

We were given one N95 mask, one face shield, and one pair of goggles. The N95 was to be used all day, the face shield and goggles to be sanitized and reused daily. In the past, we would use a new N95 each time entering a patient room and not just one per day. Of course, guidelines on this were changing by the second. I was just grateful to have my one when so many had none.

Being an NP during this time carries risks. Working in an intensive care unit makes those risks even higher. Each day as I go to work, I worry about the hospital "redeploying me" away from my trusted co-workers and the comforts of my department to an unknown "COVID-19 unit." Hearing horror stories of those who were deployed makes my fear rise exponentially. Stories that include patients, despite having a breathing tube, being unable to breathe, having to lay them on their stomachs to increase the ability of their lungs to take in oxygen, and giving a little known malaria medication as treatment for a virus we know little about. Of course, my redeployment will only happen if there is no need for my neurosurgical NP expertise.

Before this era of COVID began, we would see multiple neurosurgical emergency cases per day. Now that number dwindles, some days down to zero. I keep asking myself, where are the patients with strokes or brain bleeds? We soon learn that those patients are so afraid to come into the hospital for fear of contracting COVID-19 that they stay home, many dying there. That, to me, is one of the scariest thoughts. So many who could be saved have resigned themselves to the fact that they would either live paralyzed for the rest of their lives or would rather die in their homes with their family than die of coronavirus in the hospital.

I don't know what the future looks like, but one thing I do know is that this is my new reality for now. Fear of the unknown, complacency with what has already happened, and the will to try and help all those that I can.

DISPATCHES FROM THE FRONTLINE

By Rochel Eleff, RN

Hair net, N95 mask, shoe covers, gown up, double glove, face shield. I have all my belongings to go into the patient's room, or so I hope. I head in. I am friendly and smile to my patient even though my smile can't be seen. I carry on. Vitals, medications, personal hygiene care, questions, answers. Oh wait, I forgot that the patient asked for another warm blanket. I don't see anyone in the hallway who can get it for me. I need to decontaminate before exiting. Take off the gown, face shield, and gloves and get the blankets. Gown up again, double glove over my now sweaty palms and, oh, before I forget, the face shield. Okay, let's do this again. This time I smile brighter; maybe then my eyes will smile, maybe my caring touch can be felt through my double gloves. I do the best I can to take care of this patient. I know this patient feels alone and I know this patient feels like he is being taken care of by aliens who all look the same. I do the best I can and I carry on. Onto the next patient in need.

I walk into work and in my mind I am preparing for battle. I need all my protective gear, all my supplies, a strategy, a plan of action, efficiency. How will I safely care for my patients today? How will I be able to care for them like I normally do despite our restrictions? How can I make sure I am protected? How much longer will we have to fight this battle?

The hardest part of all of this is seeing the patients all alone, sick and alone. Talking to the worried families and trying to reassure them when I don't feel reassured myself. Keeping the patients company without over exposing myself. This juggle, this pull, is the toughest part of it all.

My name is Rochel Eleff. Until recently, I worked as a pre-op/post anesthesia care nurse at Memorial Regional Hospital in Florida. With the decline of surgeries and increase in COVID patients, I have been transferred to become a resource nurse for the COVID unit and for the hospital as a whole during this trying time. This was and currently is a life-changing experience for me. An experience that I am grateful for and simultaneously humbled by. To see the fear in my colleagues' eyes who yet still suit up, and to witness strangers coming together despite the tense atmosphere, these have made me delve deeper into who I am and into what role I can best serve the community around me further.

I thank all my fellow nurses who are fighting this battle with me. I know the challenge it brings, and I know the worries you face. We are all in this together!

DISPATCHES FROM THE FRONTLINE

By Chaya, RN

In March, my New Jersey hospital began treating COVID-19 patients. What started out as an organized and systematic plan for caring for COVID-19 patients soon became quite chaotic and unsafe for both patients and nurses. At first, one intensive care unit (ICU) became isolated as the exclusive COVID floor. However, very quickly the number of COVID patients multiplied and multiplied and another three units were converted into exclusive COVID units. More nurses were needed on these floors related to the acuity of these patients and how quickly they were known to decompensate. There were simply not enough nurses to safely staff the COVID and non-COVID units. Nurses were floated to other units. Telemetry nurses were now frequently being floated to COVID and non-COVID ICUs.

One morning, I arrived at work and had to wait on a line to receive one flimsy surgical mask and a brown paper bag with instructions to keep this mask from shift to shift and to only have it replaced if visibly soiled. I felt very scared and unprotected with this clear protective personal equipment (PPE) shortage. That same day I was floated to a non-COVID ICU where I was assigned an intubated patient. I am not a trained ICU nurse and I was now responsible for an intubated patient with zero training in managing this kind of patient. I felt very alone. I cried and felt like my superiors did not care about my outcome or the outcome of my patient.

DISPATCHES FROM THE FRONTLINE *(continued from previous page)*

Rapid responses and deaths started becoming more and more common.

When I arrived at work my next shift I saw that my previous unit had been converted into a COVID unit. We started with 12 patients, and by the end of the 12-hour shift, our census had nearly doubled. Our nurse-to-patient ratio policies had been suspended, our right to question if a patient's acuity belonged on our unit was suspended. We were instructed to accept any and all patients that arrived to our unit from the emergency room. We were now cohorting COVID patients as well. During this same shift, we were also instructed to reuse our PPE gowns. The gowns that are normally doffed in a specific technique to limit contamination were now being doffed gently in order to not rip the gown and were placed on a hook in the patient's room. In addition, we were only to receive one N95 mask if, and only if, you were assigned a known COVID positive patient WITH ordered aerosolizing treatments. If we needed more masks, gowns, and even gloves and sani wipes we had to call down to the "COVID command center" and plead our case and practically beg for protective equipment. At one point, I had left the unit to retrieve some PPE from the command center on the first floor. I had worn my shoe coverings since that was the only pair I was given for the shift. An administrator stopped me on the first floor and told me I am not allowed to wear shoe coverings off of my COVID unit. My eyes started to tear up because I knew I wouldn't be able to find another pair. More than losing my shoe coverings, I felt very uncared for by our administrators. I felt unappreciated and taken advantage of by someone who was not on the front lines like I was.

That same shift, we had a few new graduates orienting on our unit. The whole day was so chaotic and full of what had previously been considered unsafe practices that I felt like I could not properly train or reassure our orientees because this was not a normal situation. On that day I was also the evening charge nurse. When the night shift arrived it was so disheartening and demeaning for the night charge and myself when we had to beg for protective equipment for the night nurses, as the command center had gotten a lot more stingy with their PPE distribution over the course of 12 hours. By the end of this shift, I was physically and emotionally drained. This shift was the shift that ultimately made the decision clear to me that I needed to leave the hospital.

During this tense time I felt like I was constantly anxious. Throughout the day my respirations would spike at different points and I would feel short of breath. I constantly needed to remind myself to relax and take deep breaths. A couple of evenings at home I felt like I had a panic attack from the overwhelming anxiety I was feeling. I felt so scared about returning to work for 13 hours without proper protection and then getting the virus and dying.

Many times before I had said the phrase, "my health and my family are my number one priority." But until COVID-19, I never actually had to consciously make a decision to prioritize this. I was never previously in such a severe situation where I felt so unsafe. I spoke to my manager and voiced my concerns. He told me that not feeling safe is not a legitimate reason to not come to work. He said firemen can't walk away from a fire, policemen can't walk away from crime, and soldiers can't walk away from war. Soon after that I made the ultimate decision to leave my dear colleagues at the hospital. I felt guilty for leaving my fellow nurses and the patients who needed me. But I never took an oath to run into a burning building naked. I was feeling anxious like I've never felt before. I decided to stand up for what was the right decision for me and my family. I left the hospital.

I feel like a new person. I am still a nurse. I am working in a non hospital setting. I am still helping COVID patients. I am happy with my decision. This is the way COVID-19 has affected me.

DISPATCHES FROM THE FRONTLINE

By Malka Kruger, MSN, RN

Uncertainty. Insecurity. Since I first learned of the novel coronavirus spreading in China, this is the predominant mental state that I've experienced. Occasionally there is anxiety, and some fear. Anxiety over the unknowns. Fear of what may happen and what can happen. But even these circle back to the uncertainty.

Uncertainty. Ambiguity. Is it going to come to the US or stay in a city I'd never heard of, in a country so far away? Is it going to be treatable? How is it transmitted? Who is at risk? Different answers every day, from the same people Some answers, now: Yes, it is coming to the US. Maybe it is treatable… but we're still not sure. It seems like it's spread by droplets, but maybe it's through aerosols. Probably people with underlying respiratory conditions are at greatest risk, but maybe it's really not a simple respiratory illness. Maybe. Probably. Not definitely. Still uncertain.

Uncertainty. Doubt. Could it affect my life, my families' lives, my community, my country? My son's bar mitzvah invitations were ready to send out at the end of March. Ebola virus was deadly and scary, but it never came to the US at a level that needed concern. My colleagues and I trained and prepared for Ebola but we never used the PPE. The stock market didn't fluctuate and no Americans lost their jobs then. Some answers, now: The shuls are closing, and gatherings of even ten men for a minyan are prohibited and unsafe, no bar mitzvah celebration, my life, my family, my community - all affected. New Yorkers were getting sick and coming to the hospital. Every hospital. Not just New York. Some clarity in the uncertainty.

Uncertainty. Hesitation. Should I change my behavior even if no one else is? Is public transportation safe? Are my patients in danger? Do I need to take precautions to protect them? How will I know if and when I should wear a mask or a gown? Are those symptoms of a benign condition like a cold or seasonal allergies, or is it something worse? The big 'C' is coronavirus now, worse than and scarier than the big 'C' of cancer from an earlier time. Some answer, now: I should do everything I know to keep safe; hand hygiene, masks, and distancing. Public transportation is high risk. Very high risk. Yes, my patients are in danger. I try to take precautions. I don't have enough masks or gowns. Now some of my patients have died. They had coronavirus. It wasn't cancer and it wasn't benign. I'll never know if I did enough. I'll always be uncertain.

Uncertainty. Indecision. Can I stay safe and keep my patients safe? If I can't do that, what can I do? What should I do? Am I a real nurse if I did or if I didn't? How will I know? I have to advocate, and to do that I have to know. But I can't know what no other person knows. So I have to decide with what little information I have. Some answers, now: I might be safe, I haven't been seriously ill. But maybe I'm an asymptomatic carrier. So it's not an answer. And I don't know if my patients are safe. I'm trying. I'm wearing gowns and gloves and goggles and masks and face shields and covers for my head and for my shoes. That's what I should do. I should try. There's a lot I don't know in this time of coronavirus. There's a lot I may never know. But one thing, finally, I know. No uncertainty. I am a real nurse. I have to try. And I have to decide to keep trying every day, until this ends. Whenever that may be because, you know, uncertainty.

Prolonged Mask Use Among Healthcare Professionals During COVID-19

By Elisheva (Shevi) Rosner, MSN, RN-C

In March 2020, New York State encountered its first official case of COVID-19. This novel coronavirus, referred to as SARS-CoV-2, originated in Wuhan, China, in December 2019. Within a short amount of time, hundreds of thousands of cases were diagnosed around the world, causing the World Health Organization (WHO) to announce it as an infectious disease pandemic on January 30, 2020. New York City quickly became the epicenter of the United States COVID-19 pandemic due to its tremendous number of cases.

COVID-19 is spread by respiratory droplets, and healthcare professionals are mandated to wear personal protective equipment (PPE) when caring for COVID-19 patients. PPE includes gowns, gloves, masks, and face shields. Aside from a major shortage of PPE across the United States causing stress to hospital administrators and healthcare professionals on the front lines, many expressed added stress from the adverse effects of prolonged PPE usage.

The last incidence of prolonged use of PPE among healthcare professionals was during the Severe Acute Respiratory Syndrome (SARS) outbreak in 2003-2004, which originated in Guangdong, China. Studies focusing on effects of prolonged use of PPE during the SARS outbreak were published in subsequent years [1,2].

The Centers for Disease Prevention and Control (CDC) and WHO recommend wearing N95 masks during care of patients with highly transmissible diseases such as tuberculosis, SARS, and COVID-19. The N in N95 stands for NIOSH, the National Institute for Occupational Safety and Health of the United States, and 95 indicates filter efficiency of particles. Thus, an N95 mask is 95% effective at filtering airborne particles, including very small ones. In comparison, while surgical masks provide a barrier against large respiratory particles, they are ineffective at providing protection from smaller particles. Surgical masks also do not prevent leakage around the mask when the user inhales. Therefore, surgical masks are ineffective and do not provide enough protection when performing direct care for patients with COVID-19 [3].

To prevent the spread of COVID-19, hospitals require their employees and visitors to wear a mask at all times within the facility. Generally, employees and visitors wear surgical masks, and employees don N95 masks when providing direct care for COVID-19 patients.

Wearing masks for a prolonged amount of time causes a host of physiologic and psychologic burdens. Activity cannot be performed as long or as efficiently while wearing masks as compared to when masks are not worn [4]. Additionally, the timeframe that an activity can be sustained is decreased when wearing masks and PPE [4]. Prolonged use of N95 and surgical masks causes physical adverse effects such as headaches, difficulty breathing, skin breakdown, acne, rashes, facial itching, and impaired cognition, vision, communication, and thermal equilibrium [1-2,4-8].

Headaches related to prolonged mask use can be attributed to mechanical factors, hypercapnia, and hypoxemia. Tight straps and pressure on superficial facial and cervical nerves are mechanical features causing headaches [1]. Cervical neck strain from donning PPE, sleep deprivation, irregular mealtimes, and emotional stress are other sources of headaches among healthcare professionals during prolonged mask use [5]. Tight fitting masks cause inadequate ventilation and increased levels of carbon dioxide (CO_2), known as hypercapnia. As CO_2 is a known respiratory stimulant, a buildup of exhaled CO_2 between the mask and face will cause increased lung ventilation and respiratory activity. Symptoms of hypoxemia, such as chest discomfort and tachypnea, are also noted in healthcare professionals with prolonged mask use. Exhaled CO_2 builds up between the mask and face, and increased levels of CO_2 cause confusion, impaired cognition, and disorientation [4].

A hot and humid environment, found in the facial region covered by masks, causes discomfort and hyperthermia. This may create a situation where the healthcare professional is unable to recognize dangers and perform manual tasks, and it also significantly affects motor skills [4]. The moist environment and pressure from tight fitting masks also block facial ducts, which can explain the increase of acne with prolonged mask use [2].

Frequent PPE and mask changes may cause shearing and breakdown of the skin. Additionally, tight fitting masks and goggles put pressure that leads to skin breakdown on the bridge of the nose and cheek bones. [6]

Urticaria and contact dermatitis can occur from sensitivity to components of masks and PPE. Formaldehyde is a chemical used in PPE that some are sensitive and/or allergic to. Others may react to thiuram which is found in the ear loops of surgical masks. [7]

As we are still amidst the pandemic, and second waves are predicted in the future, tips and recommendations for enduring prolonged mask use are vital for the health and comfort of healthcare professionals.

Recommendations have previously been addressed in the literature. The first is frequent work breaks to be incorporated into work shifts to allow for shorter duration of mask use and reduction of PPE exposure [1,8]. A second recommendation is preventative measures such as

(continued on following page)

MASK USE *(continued from previous page)*

applying moisturizers, emollients, and barrier creams to prevent skin breakdown [9]. Caution should be taken that dressings, moisturizers, and lotions do not interfere with the seal of the mask, thereby causing decreased protection against COVID-19 particles. A third recommendation is improved mask design, with a focus on safety, comfort, and tolerability [4].

A survey [10] was recently completed by over 330 healthcare professionals on the front lines of the COVID-19 pandemic about their experience with prolonged mask use. A large percentage of the respondents worked in New York City during COVID-19, and almost all reported the adverse effects mentioned above with some suggestions to handle these issues. To prevent headaches and impaired cognition, survey respondents recommended frequent short breaks, neck massage, increased hydration, especially before the start of the shift, alternating between surgical and N95 masks (if possible), wearing an N95 mask with a filter to allow for better ventilation, and wearing a mask that fits one's face best. To manage acne, survey respondents recommended moisturizing skin and lips before and after shifts, avoiding facial makeup, and using facial cleanser wipes throughout the shift to cleanse the skin. Lastly, to prevent skin breakdown, survey respondents recommended using an ear saver, paper clip, or a headband with buttons to allow ear straps to rest on these items instead of behind the ears. The use of tegaderm, tape, or a dressing on the bridge of the nose, and using a clean, fresh mask for each shift are also recommended by the survey respondents to address skin breakdown.

Prolonged use of N95 and surgical masks by healthcare professionals during COVID-19 has caused adverse effects such as headaches, rash, acne, skin breakdown, and impaired cognition in the majority of those surveyed. As a second wave of COVID-19 is expected, and in preparation for future pandemics, it is imperative to identify solutions to manage these adverse effects. Frequent breaks, improved hydration and rest, skin care, and potentially newly designed comfortable masks are recommendations for future management of adverse effects related to prolonged mask use.

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To Pause and Honor Our Patients and One Another

By: Chaya Milikowsky, MS, AG/ACNP

At a National Disaster Medical System conference she attended a few years ago, my boss, Kiersten Henry, DNP, ACNP, listened to a speech about the psychosocial impact of caring for Ebola patients in Liberia. She was struck by the report of a ritual the healthcare team there started to honor their patients. Anytime a patient died or was discharged from their unit, they added a symbol to a mural on their unit wall. As coronavirus began taking its toll on our local population, and as the psychological impact of caring for these patients became apparent, Kiersten mentioned this idea in passing, as though wouldn't it be nice if we could do something to support our own group of nurses?

[Bit of background here: I'm a wannabe artist and Michaels' addict.] I immediately recognized that I had all requisite supplies to recreate this meaningful ritual in our own unit. I brought large canvases, paints, brushes, and gemstones that I had lying around my house [for real, I do just keep tens of canvases of differing sizes in my guestroom]. With no planning at all, our own COVID mural began to take place. While I painted the initial background and tree, our intensive care unit (ICU) team took over and personalized the painting. Every time a COVID patient dies, his personal nurse takes a moment to reflect internally and then memorialize him personally with a star in the sky. And we all fight, eagerly, for the privilege of painting a flower for our ICU miracles, those COVID patients who are discharged. It is at times difficult to wait before painting those flowers. Can we consider a patient who has stepped down to the floor a flower? What about when discharge is just pending placement at a rehab facility?

In the words of Kiersten Henry, "When people ask how we are coping, these are the small ways that we pause and honor our patients and one another." We cannot forget these patients and their stories, and we will not forget all that we invested in them.

Piskei Halacha Relevant to COVID-19 of Rabbi Hershel Schachter, Rosh Yeshiva and Rosh Kollel, RIETS

Returning from the Hospital on Shabbos in the Time of Corona

During the current coronavirus epidemic, a person who was discharged from the hospital on Shabbos or Yom Tov may return home, since it is not advisable to remain in the hospital longer than necessary. Since it is potentially dangerous for the patient to get into a taxi or an Uber, a family member may drive on Shabbos to bring the patient home. However, every attempt must be made to minimize the amount of chilul Shabbos (desecrating Shabbos) involved whenever possible. This means the car should be turned on with a shinui (in an unusual fashion), by turning the key with one's weaker hand or by pressing the button with one's knuckle. When turning off the engine, it should also be done with a shinui. Additionally, a shinui should be used when opening and closing the car door. However, a shinui or any deviation from safe driving practices should never be used in the actual operation and driving of the car.

Advocating for a Patient on Shabbos—Safek Sakanah

Often, a patient's chances for survival are significantly increased when someone is advocating on their behalf, especially if this advocate is himself a doctor or medical professional. In the current situation, family members are usually not allowed in the hospital, both due to overcrowding and to concerns about their own safety. The halacha is that we violate the laws of Shabbos, even if there is only a slight chance that it will save a life. If family members—especially medical workers—would call the doctors or nurses tending to their loved ones to check in and to discuss the situation, it may lead to greater care and concern for the patient, thus increasing the chances of survival. Therefore, the family should arrange that these communications be made, even on Shabbos and Yom Tov, in order to advocate for the patient in the hospital.

Chillul Shabbos and Yom Tov for a patient in Isolation (Excerpt)

If the government or a physician has decided that an individual must remain in isolation over the course of Yom Tov and this individual has a psychological condition where physicians who know this patient have determined that there is a possibility that this person being alone over the course of Yom Tov could lead to possible suicide, this would be a situation of pikuach nefesh. If the individual was not able to communicate or speak with family members, then the family members must reach out to this person over Yom Tov to speak on the phone or use the internet by leaving a connection open from before Yom Tov. Rav Moshe Feinstein has decided that, in certain circumstances, psychological danger is considered life threatening. Rabbi Soloveitchik went further and noted, in the name of his grandfather Rav Chaim Soloveitchik, that even if there is a concern that someone will lose his or her mind even if their life is not in danger, that too is considered a case of pikuach nefashos.

If a person is physically ill and alone and the physicians have determined that there is a possibility of the condition deteriorating further to a point of being life threatening, then the family must remain in contact using electronic devices with that person over the course of Yom Tov in order to check on the person's well being.

However, if someone is not as ill as described above, and they must be confined and alone because of the circumstances related to the coronavirus, then they may not use any electronic devices in order to connect to family members on Shabbos and Yom Tov. Although it is painful and sad to be alone and people want to be with family and friends, this is not a sakanas nefashos, a life threatening situation, and there is no place at all to allow the violation of Shabbos and Yom Tov.

Priority in Treatment

If two patients present to the hospital at the same time and require a ventilator for life saving treatment, and one will almost certainly survive if he receives ventilation and the other will almost certainly not survive treatment, it is obvious that the one who will survive should receive treatment. If one is elderly and is estimated to only be able to live for lease than 12 months (חיי שעה) and the other is young and is estimated to be able to live for longer than 12 months (חיי עולם) than the younger patient should receive the ventilator.

Even if the patient who is not expected to survive arrives first, if it is known that patients who can survive will present in the next few hours, it is considered as both presenting at the same time and the patient who can survive should be given the ventilator. If the patient who cannot survive was given the ventilator, and afterwards it became clear that other patients who can survive will present and require the ventilator to survive, it would be forbidden to extubate, but it seems that it would be correct to make the first patient DNR, as there is no requirement to start a new treatment for a life that cannot be saved if instead treatment will be directed to a life that can be saved.

If circumstances require that one ventilator be shared by two patients, it is permitted to do so even though there is a possibility that this treatment may cause one patient to be harmed by the other, as long as all possible precautions are taken and this is deemed to be the best possible course of treatment. This is learned from the permission of the Torah for the healer to treat a sick person (ורפא ירפא), which Nachmanides explains as the allowance for treatment even though there exists the possibility of inadvertent adverse effects, including death. The science of healing has continuously developed, and in each circumstance the healers are enjoined to treat according to the best of their knowledge and ability.

If one patient was put on a ventilator and the hospital staff wants to add another patient to the same ventilator, it is permitted. It is not considered as if the ventilator belongs to the first patient, as when he was first assigned the ventilator it was understood that it was only being given until the best course of treatment for the entire pool of patients was decided. For this matter, all of the patients who present in the same general time frame are considered as if they came at the same time and have equal rights to the ventilator.

Excerpted and adapted from

Rabbi H. Schachter. (2020). Piskei Corona, retrieved June 10, 2020 from rabbinicalalliance.org/wp-content/uploads/2020/04/Rav-Hershel-Schachter-Piskei-Corona.pdf

RESEARCH RECAP

Risk Factors for COVID-19

By Tobi Ash, MBA, BSN, RN

COVID-19 (SARS-CoV-2) is a virus that can affect anyone with a wide range of symptoms—from asymptomatic to extraordinarily severe, even resulting in death. An article published in the Lancet on May 15, 2020, purports to be the first study to investigate risk factors for testing positive for SARS-CoV-2 in the overall community.

Risk factors can increase the need for hospitalization, need for intensive care, and risk of death from the virus. For patients, knowing their risk factors can help them make better decisions to take extra precautions to avoid exposure, and reduce their risk by managing their medical conditions. This is a new disease and more work is needed to better understand its risk factors to assist patients and provide medical management.

Of the 3,802 patients observed in the Oxford Royal College of General Practitioners (RCGP) Research and Surveillance Centre primary care network from the end of January to the beginning of April, 2020, 587 patients tested positive.

Risk factors, adjusted for potential variables include:

- Increasing age
- Gender: Males have a higher risk of death
- Living in a densely populated area: Crowded living conditions
- Lower socio-economic status: Poverty
- Black ethnicity
- Chronic kidney disease
- Obesity

Surprisingly, smokers had a lower incidence of a positive test.

One of the largest studies to date in any country analyzed health data of 17.4 million National Health Service (NHS) patients from the first of February through the end of April 2020 in the United Kingdom. In this study as well, white people fared better than people of Asian and Black ethnic origin. Investigators thought that perhaps it was the lower socio-economic status or higher prevalence of comorbidities that contributed to the higher risk of death in these communities. However, an examination reveals that this accounts only for a small part of the excess risk. Risk factors previously identified, such as male sex, economic deprivation, older age, uncontrolled diabetes, and severe asthma, have an increased risk of death due to COVID-19.

Though there are currently close to 800 published articles on COVID-19 (SARS-CoV-2) in The Lancet as of June 8, 2020, further work must be done to understand the increased risk factors.

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Additional Resources: The Lancet COVID-19 Resource Centre: https://www.thelancet.com/coronavirus/archive

Multisystem Inflammatory Syndrome in Children (MIS-C)

By Tziporah (Tzippy) Newman, BSN, RN

The pediatric population has been largely unaffected by the novel SARS-CoV-2 [1]. However, since the pandemic started, a Kawasaki disease-like syndrome has surfaced in pediatric patients across the globe, called Multisystem Inflammatory Syndrome in Children (MIS-C) [1]. Additionally, according to two studies performed in Italy and the United Kingdom [1,2], most MIS-C patients have either tested positive for COVID-19 via nasopharyngeal or oropharyngeal swabs, or have positive SARS-CoV-2 antibodies. This presents the question—is this inflammatory syndrome an immune response to SARS-CoV-2 or is this an entirely different emerging syndrome?

Common symptoms being seen in MIS-C patients are a rash, fever, swollen lymph nodes, mucosal changes, conjunctival infection, gastrointestinal upset, and in severe cases, shock and cardiac function irregularities [1,3]. Immunoglobulin therapy in conjunction with anti-inflammatories such as corticosteroids seem to help stabilize patients [1,3]. Nurses should educate parents and clients on signs and symptoms of MIS-C. Additionally, nurses should iterate the importance of effective handwashing in infection prevention.

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Therapies in COVID-19

By Chaya Milikowsky, MS, AG/ACNP

To date, there are no Food and Drug Administration (FDA) approved treatments for the SARS-CoV-2 infection. For now, the mainstay of treatment is supportive care that includes close monitoring, prophylactic anticoagulation, hypoxemia management with oxygen therapy and intubation as needed, prone positioning, lung-protective ventilation, and management of renal, cardiovascular, coagulation, and secondary infection complications [1]. There are a number of antiviral and immune-modulating therapies that are under investigation, but so far no magic bullet has been identified.

Remdesivir is an investigational broad spectrum antiviral drug with in-vitro activity against the COVID-19 virus that has been granted emergency-use authorization from the FDA. Produced by Gilead Sciences, remdesivir is now being trialed at up to 75 sites through a randomized double-blind study funded by the National Institute of Health and the National Institute of Allergy and Infectious Disease [1]. Preliminary data from this study involving over 1,000 patients seems to indicate that patients treated with remdesivir recover faster than those who receive the placebo, with an average 11 days to recovery as opposed to 15 days for those in the control group [2]. The preliminary reports also appear to show improved mortality of 8% as opposed to 11.6% respectively [2].

Another antiviral medication that has received much press attention is hydroxychloroquine, an old antimalarial and antiinflammatory drug used in lupus and rheumatoid arthritis. Initial excitement for hydroxychloroquine was generated after a small, nonrandomized, single-center study in France showed that patients treated with hydroxychloroquine had lower viral loads than those who did not receive the drug [3]. Unfortunately, further larger studies have not been able to replicate these results. An observational study conducted on over 1400 patients in a large NYC hospital failed to show any association between hydroxychloroquine and the end-points of either intubation or death [4].

A final antiviral that had been hoped to provide protection from severe COVID-19 is lopinavir-ritonavir, an HIV medication. A small, randomized controlled trial done on 199 patients showed no benefit with lopinavir-ritonavir over supportive care [5]. There was no significant reduction of sick days, improved mortality, or reduced viral detectability [5].

Immune modulating therapies are also being investigated with the current recognition of the Cytokine Release Syndrome, or cytokine storm, that appears to be responsible for the progression to Acute Respiratory Distress Syndrome (ARDS) and other forms of morbidity in severe COVID-19. Pro-inflammatory cytokines such as IL-6 seem to be especially implicated in the cytokine storm, so research is ongoing into IL-6 inhibitors, such as tocilizumab. A small study in China investigated the use of tocilizumab in patients with severe COVID-19 and noted significant decrease in inflammatory markers such as CRP and eventual decrease in IL-6 [6]. Additional small studies have also found apparent clinical improvement and prevention of disease progression with tocilizumab [7]. Further larger studies need to be done to corroborate these findings.

Steroids are probably the most common immune modulating drugs, and their use in COVID-19 is controversial, with contradictory recommendations from different guidelines. For example, the Infectious Disease Society of America does not recommend steroids other than in the context of a randomized controlled trial, while the Surviving Sepsis Campaign recommends that intubated ARDS patients, including those with COVID-19 etiology, receive steroids [8]. Some of the factors that may determine whether steroids are helpful or harmful include the timing of steroid initiation, the severity of disease, and the presence of elevated inflammatory markers. In general, studies appear to show that steroid use in mid to later disease has the most benefit [8].

Another immune modulating therapy currently under large investigation is the use of convalescent plasma collected from individuals who have recovered from COVID-19. The antibodies in the plasma are hoped to confer passive immunity to neutralize the virus. The FDA is supporting a very large national Expanded Access Program, that together with the Mayo Clinic and many academic centers, has already transfused many thousands of units. Data on the effectiveness of this therapy has not yet been published, though early safety reports show very rare incidence of adverse effects [9]. A recently published small randomized trial by Li, Wei, Hu, et al. [10] did not show statistically significant time to clinical improvement with convalescent plasma, however the trial was stopped early and may not have been large enough to identify significant results.

One final therapy worth discussing falls into neither the category of antiviral nor immunomodulation, but targets a more recently recognized manifestation of COVID-19. Some post-mortem examinations of COVID-19 patients showed the presence of microvascular clots suspected to be contributing to the profound hypoxemia in COVID-19 respiratory failure. Further, hematologic and coagulation abnormalities are frequently seen in deteriorating COVID-19 patients, aligning with the prothrombotic state of inflammation. Large vessel thromboses are being seen as well [11]. It is now recommended that all hospitalized patients receive prophylactic anticoagulation [12], and some centers are studying the use of systemic anticoagulation in patients with rising d-dimer or fibrinogen levels. A retrospective study conducted in Mount Sinai Health System in New York found that longer duration of systemic anticoagulation led to reduced mortality, with the most notable effect in the sickest patients [13].

So while there are no approved treatments for COVID-19 at this point, there is a lot of ongoing research and the hope that we may one day soon identify the best therapies for mitigating severe COVID-19 disease.

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During an outbreak of a novel disease, evidence rapidly evolves and initial data is generally low level and subject to change. Please note that the therapies detailed herein are current only as of mid June.

By the time of publication and certainly distribution, there are likely to be updates and shifts in current management trends of patients with COVID-19.

APRN CORNER

COVID-19 May Change Practice Requirements for Nurse Practitioners

Chaya Milikowsky, MS, AG/ACNP, RN

Until recently, only 22 states plus the District of Columbia allowed nurse practitioners (NP) to practice to the full extent of their licenses. The remaining states maintained additional restrictions that tied nurse practitioners to physician oversight or collaboration. With the advent of COVID-19 and the massive influx in hospitalized patients, it is important that all available practitioners be able to manage patients to the fullest degree to ease the burden on the healthcare system. With this in mind, the American Association of Nurse Practitioners issued a letter to the governors of all 50 states asking that restrictions on NPs be loosened, at least temporarily, to maximize patient access to care.

As of March 24, a number of states, including Louisiana, Kentucky, New York, New Jersey, and Wisconsin, have temporarily suspended all practice agreement requirements. Some other states, such as California, Texas, Pennsylvania, and Virginia, have temporarily waived specific practice agreement requirements. Different states have chosen to waive different specific practice requirements. In Tennessee and Kansas, executive orders to loosen restrictions on NPs have already expired, while some states, such as Florida and Georgia, have not responded to the call to action at all.

It will be interesting to see whether any of the changes to the legislative and regulatory barriers that restrict NP practice will become permanent.

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STUDENT CORNER

To Be Someone I am Proud Of

By: Eve Chava Segal

It is 6:15 a.m. on a Sunday; it feels as though my face is glued to my pillow. As my body begs me to go back to sleep for "just five more minutes," the voice in my head knows that I dare not be late to clinicals.

As I sit in the hospital saying my regular morning prayers, there is something important that needs to be added every time I step foot into that lobby: Hashem, please help me not make any mistakes today. Please help my tired brain, my inexperience, and distractions not, G-d forbid, affect a patient. Please be there at my side throughout the day and for many years to come.

Clinicals have taken over my Sundays. The day I was supposed to have off, my day for bridal showers and weddings, a day for family events and activities, became days that no longer felt like my own. Did clinicals have to be on Sunday? One of the first things I learned in nursing school is that it is okay to say no to family obligations and commitments. My focus was nursing school and academics. I taught myself to limit my obligations and do only what I can. I reminded myself that I would not be able to attend every bridal shower, birthday party, and engagement party and people would understand. For my birthday this year, my sister gifted me a sweatshirt that reads, "I can't, I'm in Nursing School." While my professors relayed the message that "nursing school should be your lives," I did not let that interfere with spending time with friends and attending events that meant a lot to me, while ensuring I also concentrated on my studying and assignments.

It was a few months into clinicals when I found myself in a precarious situation. I had not realized that my close friend's wedding would be smack in the middle of a day of clinicals. Clinicals were never to be missed, but neither were close friends' weddings. This was the first time it really hit me. Would nursing school actually take over my life? I went back and forth about what to do. Would my clinical instructor even take me seriously if I asked him to miss clinicals for a wedding? I just imagined him laughing at my crazy request. My stomach was in butterflies as I debated, "Should I ask him? Should I not?" At the end of the day, I mustered up the courage and asked. It turned out, by happenstance, he was canceling clinicals that day. My clinical instructor needed to attend a conference—what perfect timing! It was at that moment that I knew everything would work out.

There are days that are hard. Days when it feels as though you just cannot do it. The exams are difficult and the workload challenging. At the beginning of this past semester, I was sick for two weeks. Those weeks were ones during which I had planned to study for my upcoming exam. It was a difficult exam and I anxiously awaited the results. A few days later, I studied for my next exam, trying to concentrate while simultaneously thinking about all that I needed to study, as well as my performance on the next exam. When I scrolled through social media for a much-needed break, I saw a picture that touched my heart. It was a photo of a black background with a stethoscope that read, "I am working hard to be someone I am proud of". I quickly made this picture the wallpaper on my phone. In the moment, everything sometimes feels overwhelming. Taking a step back and seeing this reminder of why I am pursuing this challenging but rewarding career path has truly shifted my mindset and my perspective.

Nursing school comes with stress. There are many assignments, hours are long, and exams are seemingly impossible. There is trial and error, and you figure out what works best for you. Whether you need the extra hours of studying, a different study method, or a designated study area, it all works out in the end. After family and friends, one of the greatest support systems in nursing school has been my fellow classmates. We all come from different backgrounds. Some are Jewish, some are not; some live with their parents and some have many children of their own. It is amazing to see people from different backgrounds, different walks of life, and different experiences understand you in a way you did not anticipate. There is a shared goal, which creates a community and a bond I did not expect, but which I appreciate. You both know the feeling of anxiously studying for an exam, and, perhaps feeling ill-equipped and unprepared to take said exam, despite all of the studying. You know the feeling of balancing nursing school, regular life, and events. You have watched patients breathe their last breath as you look to each other for reassurance. The camaraderie of a fellow nursing student helps me grapple with potentially difficult situations.

COVID-19 has had an incredible impact on my nursing school experience. Although in the beginning it was nice to wake up a little bit later, go to class in pajamas, and not have to wake up at the crack of dawn for clinicals, I quickly realized all that I was missing.

(continued on following page)

From the minute clinicals were officially cancelled due to COVID-19, I felt a sense of helplessness. The clinical setting was the catalyst that helped me apply the material I learned in lecture and where I gained an incredible amount of experience. It gave me the opportunity to speak to patients, perform head-to-toe assessments, administer medications and vaccines, and learn about patients' conditions. It gave me the opportunity to experience a wide spectrum of emotions; the joy of helping a patient put on her clothing to finally go home, as well as the struggle of watching another patient take his last breaths. I am now longing to return to the clinical arena. I eagerly anticipate and look forward to helping another patient. I am ready to apply the vast amount of information that I have learned through Zoom the last few months to real-life situations in the hospital.

Virtual nursing school came with new difficulties. Our apartment, with my parents and four siblings, was not the ideal place to study. I do not have my own room, all of my siblings are also attending school online, and there is always a distraction of some sort. I have realized that the motivation for studying in quarantine comes from within. Having the incentive to sit down for a few hours to study is not always realistic. Sometimes, I sit down to study and it feels impossible. I have learned to forgive myself. It is acceptable to study for three hours one day and zero the next. It is okay to sleep late and listen to a lecture recording when you fall asleep at 3 a.m. the night before. It is okay to know when you are emotionally exhausted and need a break. This would be my best advice for those in nursing school and specifically in quarantine: know yourself. Know when you have reached your limit. Give yourself permission to take a break if you need one. Be your own best mental health advocate. Overworking yourself will ultimately cause more damage than good.

Of note, my professors have been incredibly understanding. Many of our assignments are due at the end of the semester and many of our exams are open for 24 hours in order to accommodate each student. There has been a weekly meeting to discuss any issues that may have risen in between our weekly meetings, and our professors constantly reach out to see how we are doing. I have been amazed by my professors. I appreciate the care and concern they show their students. On their side, however, what they do for us is remarkable. Reaching out to others and showing care and compassion has been affirming to me as a student. My professors are nurses first. They are most experienced in care, compassion and understanding.

COVID-19 has affected nursing students in many ways, specifically students who have graduated this June. I spoke to an upperclassman of mine who reported that the NCLEX is still in person and that the number of questions needed to answer correctly to pass the exam has been reduced to 60 to decrease the amount of time spent sitting with other test takers while social distancing. She explained that applying for jobs as nurses has been complicated; working on a medical-surgical floor is generally recommended in order to gain a lot of experience early on, however, many students have young children and babies, live with their parents or high-risk family members, and do not want to risk bringing home COVID-19. Therefore, if possible, people prefer to start off in a specialty unit. Another issue is the change to non-traditional orientation methods. It can be intimidating and scary to be "thrown in" to an acute care setting during a pandemic, especially when a new graduate has not been in the clinical setting for a while.

Nursing school comes with its challenges. Despite these challenges, and sometimes, because of them, I appreciate the position I am in. The incredible amount of applicable information that I learn daily is an amazing experience. The end goal of helping others and doing something that I will love is worth all of the hard work. I am dedicated to work hard to be someone of whom I am proud. My top tips for anyone who is either in nursing school or plans to go to nursing school are as follows: study in advance, trial and error is okay, forgive yourself, bond with your classmates, and try avoiding nursing school burnout by taking breaks, enjoying family and friends, and allow yourself to have days set aside from school work and studying.

Member Milestones

YEHUDIS APPEL, BSN, RN, was recently published in the May issue of Nursing2020: The Peer Reviewed Journal of Clinical Excellence. The title of her article is "You're the Best Nurse I Ever Had".

RAHEL LIAZADEH, BSN, RN, graduated on the Dean's Honor List in May 2020 with her Bachelor of Science in Nursing from California State University, Los Angeles.

JEREMY SHERMAN, EMT, graduated summa cum laude in June 2020 with his Bachelor of Science in Nursing from Touro College.

EVE ROSENSTOCK, MSN, RNC, IBCLC, graduated in May 2020 from Stony Brook University's MSN-Certified Nurse Midwifery Program.

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NURSES TO KNOW

Robert S. Davis, MBA, MSN, RN-BC, NE-BC, NHDP-BC

Nursing Role: Administrative Nurse Manager

Where do you currently work and can you describe your responsibilities? How long have you been working in your field?

I have been a nurse for 11 years and an emergency medical technician for 16 years. I have been in a leadership role for the past seven years. I currently work in a large NYC hospital. As a nurse manager, I oversee a 30-bed step down/telemetry unit specializing in heart failure and post-cardiac catheterization patients. I am responsible for daily staffing and making sure the unit stays within budget. Additionally, I contribute to all aspects of nursing care, ensuring nursing duties are carried out as directed and treatments are administered in accordance with hospital policies and physicians' orders. I also serve as co-chair on several hospital committees, the CAUTI Council team, and the Nurse Manager Leadership Council. Recently, I assisted in the conversion of our unit to a critical care unit during the COVID-19 pandemic.

What type of unit do you work on? Did your unit become a designated COVID-19 unit?

I work on a telemetry step down unit. Initially we were going to be a clean unit since we take care of post-cardiothoracic surgery patients and post-catheterization patients. However, due to the severity of the pandemic we became a designated COVID-19 unit. Eventually, half our unit was turned into a critical care unit.

How prepared was the unit for the pandemic? What has changed as a result?

We weren't really prepared. I don't know how you prepare for a pandemic of this magnitude. However, I am blessed to be a leader of an amazing team. No matter what was asked of them, they did it and were amazing at it. What changed? Some early retirement, some cool, new equipment and technology, some new education from front line staff. We got cameras installed in every room so we can visualize patients without going in the room unnecessarily. We also got new telemetry monitors that transmit wirelessly to a central station that we could view outside the room. Previously, our telemetry monitors only transmitted heart rate and pulse ox readings. With these new machines we could do blood pressure, a-lines, pulse, and heart rate. They were also portable and could be used as a transport monitor. Since we were converted into a critical care unit, the staff got hands-on training for critical care-type patients. They created an 8-hour class for the staff to receive training on different areas of critical care. Personally, I had not been familiar with a-lines and I am now trained on them.

I have done a lot of self-reflection on how communication is truly the key driver to getting things done. Explaining the "why" is ultimate, but in a pandemic you may not always be able to. Basic communication can do wonders for a team.

How is your unit now, as of mid-June 2020? Have you returned to "normal" or are you still seeing COVID-19 admissions?

For the most part, we are back to normal. We still have one or two COVID-19 patients on the unit, but the number is decreasing system-wide and we are seeing an increase in patients undergoing routine cardiac procedures.

Without sharing any identifiable information, can you share a COVID-19 story that has a positive outcome?

One of the first COVID-19 patients in our hospital was inpatient for almost 2.5 months. She was a young law student. She was in the intensive care unit for most of her stay, before eventually being transferred to my unit. On the day of her discharge we received the news that even though she missed many classes due to COVID-19 and her subsequent hospitalization, she graduated that day. My staff and I, alongside all of the hospital's senior leadership, were able to escort her out of the building to her rehab facility. It was a very emotional time amidst the crazy that we saw.

How did you hear about the Orthodox Jewish Nurses Association (OJNA)?

My best friend's wife, Mara McCrossin, is involved with OJNA. She highly recommended joining.

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.

"NOT ALL HEROES WEAR CAPES"








OJNA LEADERSHIP UPDATE:

The board members of the Orthodox Jewish Nurses Association continue to work on organizational growth and development, strengthening OJNA committees, and growing our reach across the United States, Canada, and Israel. The organization continues to grow in membership, expand and improve member resources and services, and host multiple social and educational events.

Career Building

With increasing antisemitic attacks around the world and United States a few months ago, the OJNA organized a panel discussion for healthcare professionals to discuss legal, hashkafic, and psychological aspects of antisemitism in the workplace. Over 60 individuals attended this event in February in New York City, with live streaming in New Jersey, Georgia, Michigan, Maryland, Illinois, and Pennsylvania. Thank you to the Orthodox Union and Chai Lifeline for their support of this event, and to our incredible speakers: Allen Fagin, Esq. and Rabbi Jack Abramowitz of the Orthodox Union, Rabbi Dr. Dovid Fox of Chai Lifeline, and Jack Newhouse, Esq. of Virginia and Ambinder, LLC.

COVID-19 Response

The Orthodox Jewish Nurses Association initiated numerous projects to assist its members and the community during the COVID-19 pandemic.

Due to the scarcity of personal protective equipment in many hospitals and facilities during the COVID-19 pandemic, the OJNA fundraised and distributed over 700 face shields and over 9,000 N95 and surgical masks to more than 900 health care professionals on the front lines in New York, New Jersey, Maryland, Florida, and Connecticut. Special thank you to the many donors and volunteers for making this project an outstanding success.

The OJNA held seven virtual support calls, covering medical, emotional, halachic, and psychological topics related to the COVID-19 pandemic. Up to 170 participants joined the calls each week and the feedback on this initiative was extremely positive. We are grateful to all our speakers for offering engaging and educational presentations to our group.

Recognizing that early detection of a decrease in oxygen saturation levels was critical in the treatment and management of COVID-19, the OJNA initiated a project to distribute pulse oximeters to high risk community members in New York and New Jersey. Over 420 pulse oximeters were distributed, free of charge, and detailed education and self-monitoring information was provided.

Weekly columns, written by our nurses on the frontlines of the COVID-19 pandemic, were published over several weeks in The Jewish Press. Thank you to our writers for sharing their experiences with the public.

The Orthodox Jewish Nurses Association collaborated with many prestigious national nursing organizations to send a letter to President Donald Trump regarding the mental health of nurses affected by the COVID-19 pandemic. As the OJNA recognizes that this is a critical issue affecting nurses across America and the entire world, the organization was proud to provide endorsement and support for this endeavor.

Community Education

Important pulse oximeter education was provided to high risk community members during the COVID-19 pandemic.

Continuing Education

The annual OJNA conference draws a large number of attendees and offers a full day of engaging lectures and continuing education credits. Due to the COVID-19 pandemic, this year's conference, originally scheduled for June 2020, had to be pushed off and we continue to hope that it will be able take place later in the year. We look forward to securing a date once the safety and legality of an in-person conference is established.

Membership

The OJNA continues to increase its membership and some of the newest members hail from Alabama, California, New Jersey, Pennsylvania, New York, Georgia, Texas, Illinois, Ohio, Connecticut, and Israel. Welcome aboard!

Networking Events

OJNA hosted networking events for nurses in Atlanta, Detroit, and South Florida in the months prior to the onset of COVID. Attendees enjoyed meeting one another, sharing best tips for career and work/life balance success, and heard from inspiring speakers.

To host a networking event in your area, contact us via our website and we will be glad to assist with logistics, publicity, and finances!

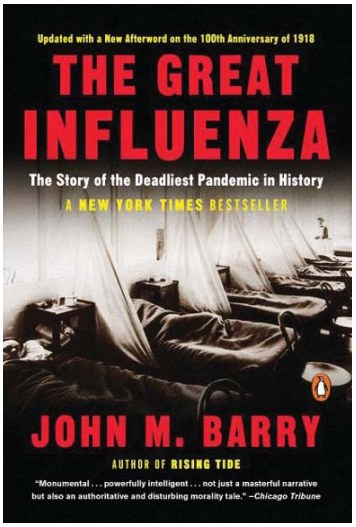
Professional Development

The World Health Organization designated 2020 as the Year of the Nurse, as it marks the 200th birth anniversary of Florence Nightingale. The goal was to advance nurses' critical position in transforming healthcare around the world. Our nursing profession has also been recognized as the #1 most honest profession for 18 years in a row, and nurses have made their mark being in the spotlight throughout the COVID-19 pandemic.

OJNA RECOMMENDS: BOOK REVIEW

The Great Influenza

Book Author: John M. Barry
Reviewed by OJNA Journal Staff



A devastating infectious disease races through the world's population and sows death and destruction in its path. Societies grow fearful, streets are deserted, and businesses shut down. People avoid one another, turn away from others in the street, and wear masks when in public. A desperate call for more doctors, more nurses, more hospital beds. And the healthcare world is at a loss, with no known treatments at their disposal. This all sounds eerily familiar. The Great Influenza explores the world of 100 years ago as it dealt with the Spanish flu while simultaneously fighting a war overseas.

The book is split between describing the course of the virus and its effect on the population, and by closely following the many characters influential in the race to identify the pathogen and develop a cure. Their struggle to halt the influenza virus is further framed in the context of the evolution of modern medicine, and the author therefore begins with the development of medical education and research facilities in the United States such as the Hopkins and the Rockefeller Institute. The book also identifies many other individuals with power to alter the course of the disease—politicians, military personnel, scientists—and reflects on how their choices affected the course of the disease.

A parallel is continuously drawn throughout the book between the war inflicted by people on others, and the war launched by the influenza virus on humanity. The parallel is powerful and apt.

The 1918 influenza outbreak may have first surfaced in Kansas, and soon thereafter appeared in multiple military cantonments in early 1918. It moved with military transports across the sea to Europe, where it appears to have struck in a relatively mild form. Many were infected and a significant number of younger and middle aged people died, but it seemed to have abated and the pandemic was assumed on the decline. In late 1918, the virus was conjectured to have mutated into a much more deadly form and a second wave struck the United States and around the world, with much of the virus transported along with soldiers and then leaking out into the civilian population. Unlike former bouts of influenza, this virus disproportionately affected healthy young adults, and it ravaged with a breathtaking rapidity. People fell ill suddenly, and could be dead in less than a day. Bodies piled up in hospitals, in military bases, in morgues, and in homes. A transport ship would leave one port filled with healthy soldiers, and arrive at the next port with many ill and dead. The disease appeared like influenza, but in many ways it was different and many wondered if this was a new disease.

Scientists and researchers in the United States struggled to understand the epidemiology of the disease, to identify the pathogen, and to recognize how it affected the human body. Though the pandemic occurred in the pre-antibiotic era, treatments such as antitoxins and vaccines were in use, and a specific treatment for influenza was actively sought. This book traces the work of players such as Welch, Flexner, Lewis, Avery, Cole, and Park as they worked in labs and in the field to track down and triumph over the virus. A bacillus bacteria, identified by Richard Pfeiffer, seemed to many to be the causative pathogen for the Spanish influenza and was hopefully named Bacillus influenzae. Whether or not this bacteria caused influenza was a point of heated debate among many scientists at the time, and history would eventually prove this hypothesis false.

The book is a fascinating read, especially in light of the current COVID-19 pandemic. It does become repetitive at times, but overall it is an important read. One of the most relevant messages of the book is the importance of transparency and honesty by those in positions of authority. While the desire to maintain morale is understandable, it is most imperative that the population be able to trust those in charge.

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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. 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 the Nurse position on the Health Care Advisory Committee for the City of Miami Beach for two consecutive terms. She sits on the board of the Greater Miami Jewish Federation, LimmudMiami, EMES Initiative, NCSY Southern Region, Miami Beach Garden Club, Helping Hands, and is the former chair of Ohel South Florida Advisory Board. She lives in Miami, Florida.

Toby Bressler, PhD, RN, OCN, is the Director of Nursing for Oncology and Clinical Quality in the Mount Sinai Health System. She received her BSN Magna Cum Laude from SUNY Downstate, Master's degree from NYU and her PhD from Molloy College of Nursing. Dr. Bressler's research interests focuses on the Orthodox Jewish community, care of the cancer patient, the promotion of palliative care and quality of life of patients and families. She has authored more than 50 articles, chapters, and posters and has presented widely. Dr. Bressler is an elected officer with the American Nurses Association NY, Vice Chair of the Nursing Section of the New York Academy of Medicine, Chair of the Eastern Nurses Research Society Palliative Care Research Interest Group and also served as a Jonas Policy Scholar with the American Academy of Nursing. She lives in New York.

Sarah Bracha Cohen, MS, RN, received her Bachelor of Arts in Health Sciences from Hebrew Theological College in 2013 and her Master of Science in Nursing and Clinical Nurse Leader 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. She is a fertility nurse at Reproductive Medicine Associates (RMA) of New York. In addition to her work for the OJNA Journal, she volunteers for the Vaccine Task Force of the EMES Initiative, is a birth doula and is on the board of In Shifra's Arms, helping Jewish women with unplanned pregnancies. She lives in New York City.

Tziporah Newman, BSN, RN, received her Associate Degree in Nursing from Middlesex County College in 2012. She received her Bachelor of Science in Nursing from Thomas Edison State College in 2014. She currently works as a field nurse with medically fragile children. She recently took on the additional role of 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. She lives in Highland Park, New Jersey.

Yocheved Weinreb, RN, OCN, received her Bachelor of Science in Nursing from New York University in 2011. She started her nursing career as a bone marrow transplant nurse and found her passion in oncology nursing. She recently transitioned to working in supportive oncology and palliative care at Mount Sinai Downtown. She is a member of the Oncology Nursing Society and was chosen for the Mount Sinai Emerging Leaders program. She is currently pursuing her Masters in Nursing Education from Chamberlain University and hopes to be an oncology nurse educator or nurse administrator in the future. She lives in Brooklyn, New York.