ORTHODOX JEWISH NURSES ASSOCIATION

THE OJNA JOURNAL

Issue 13 | Summer 2025

A Peek Inside

Saving Children, Healing Nations

Technology and AI

Palliative Care

OJNA LEADERSHIP

Mission:

The mission of The OJNA Journal is to

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

OJNA Mission Statement:

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

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President's Note

Dear Readers,

Welcome back. We're back—and we're better than ever.

This edition of the OJNA Journal marks more than just another issue. It represents a moment of transformation. Over the past year, we've revitalized our nursing association—welcoming new voices, strengthening our mission, and reaffirming what we've always known: that Jewish nurses are a force of energy, resilience, and impact.

Yes, the world feels heavy. Antisemitism continues to rear its head across college campuses, hospital hallways, and global headlines. But this journal isn't here to dwell on the hate. It's here to spotlight the hope. The strength. The stories.

Because even amid the chaos, we are still here. Still rising. Still caring for patients, publishing research, mentoring students, leading initiatives, and building a more compassionate healthcare landscape—one shift, one lecture, one step at a time.

And we're not going anywhere.

Inside this issue, you'll find exciting new contributions that reflect the heartbeat of our community. From frontline reflections to groundbreaking Israeli research, from personal essays to professional milestones, this journal is a celebration of everything we are and everything we're becoming.

On behalf of the entire OJNA board and journal committee, I want to thank everyone who poured their heart into this issue. We are so proud of what we've created—and even more excited for what's to come.

We can't wait to welcome you at the OJNA Annual Conference on November 12th where our passion and purpose will come to life in person.

Until then, flip the page—and be reminded that Jewish nurses are not just surviving in today's world.

We're leading it.

With excitement,

Hannah Bodenstein

President, Orthodox Jewish Nurses Association

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RESEARCH RECAP

By Shevi Rosner, DNP, RN-C

Breast Milk Sharing

Breast milk is the ultimate source of nutrition for infants and is recommended by national and global organizations, such as the World Health Organization and American Academy of Pediatrics, as the sole source of nutrition for infants for the first six months of life followed by supplemental nutritional intake until two years of age [1]. The components of breast milk are highly variable and specific to lactating women, and there is no complete substitute for it as a complete source of infant nutrition [2]. When a mother's breast milk is not available for their infant, it is recommended to have the infant breastfed by another lactating woman, obtain breast milk from a donor milk bank, and use commercial infant formula as a last resort [3]. The concept of wet nursing and milk sharing goes back decades, but with the advancement of feeding pumps and technology, this practice is even more accessible to mothers and infants in need [4].

With the proliferation of social media groups and networks over the past two decades, milk sharing has become a common practice and topic of discussion. Due to the risk of infection, poor hygiene, and contamination by viruses, bacteria, alcohol, nicotine, and medications in shared milk, the U.S. Food and Drug Administration (FDA), European Milk Bank Association (EMBA), and Human Milk Banking Association of North America (HMBANA) have expressed concerns about informal milk sharing. They recommend milk donors donate their milk to an established milk bank for pasteurization and proper screening and handling [5]. While the idea of milk sharing may seem controversial to some, not everyone has access to a milk bank in their area, and not everyone understands the risk of receiving and sharing milk.

Israel established their first milk bank in August 2020 as a pilot project, and in January 2021 they began to donate milk to hospitals in the area. Oreg and Negev [5] conducted surveys of 250 Israeli milk donors during the peak of the Covid pandemic. Despite strong messaging at the time regarding infection control, hygiene, and hand washing, survey results showed a need for increased education on hand hygiene before and after pumping as well as safe milk storage and temperature considerations.

Spikes in requests and offers for milk donations are seen during times of crisis and emergencies. Following the outbreak of the October 7th war in Israel, Israeli mothers had an urge to provide assistance to families affected by the war. Tannenbaum-Baruchi and Harari [6] performed a qualitative study and noted a doubling of Facebook posts in the month following October 7th regarding the immediate need for breastmilk for infants whose mothers were injured or missing. Information on these groups were shared regarding donation of milk to the National Human Milk Bank. There were also posts of volunteers offering to pick up and deliver milk to families in affected areas. These two studies, performed during the Covid pandemic and following October 7th, highlight the fact that milk sharing is a very timely issue and is still widely practiced today.

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APRN CORNER

By Marcus D. Henderson MSN, RN, Winifred V. Quinn PhD, RN, FAAN, Toby Bressler PhD, RN, OCN, FAAN

Nurse Workforce Staffing for APRN Practice

Nurses are essential for high-quality health care delivery across care settings. Yet their expertise often remains untapped or underutilized because state and federal regulations and institutional policies prevent many nurses from practicing to the full extent of their education and training (National Academies of Sciences, Engineering, and Medicine [NASEM], 2021). The need to respond to the unprecedented health care crisis unleashed by the pandemic, as well as heightened state-level advocacy, led to the lifting of practice restrictions in many states and at the federal level, but much remains to be done. Allowing nurses to practice to the full extent of their education and training will greatly improve access to high-quality, affordable care, reduce troubling and pervasive health disparities, and advance health equity.

Experts have long called for the removal of practice barriers for nurses and have moved the needle on this issue. The Institute of Medicine (2010) released its landmark report, The Future of Nursing: Leading Change, Advancing Health, recommending the removal of practice barriers for nurses. Practice restrictions for advanced practice registered nurses (APRN) have since been lifted in 13 states and at the federal level (38 CFR § 17.415, 2016; NASEM, 2021). Fairman and colleagues (2011) argued for advancing APRN practice due to expanded access to care from the passage of the Affordable Care Act, projected physician shortages, and rising health care costs. More recently, the NASEM report, The Future of Nursing 2020-2030: Charting a Path to Achieve Health Equity, reaffirmed these conclusions, recommending the removal of practice barriers for all nurses in all settings (NASEM, 2021).

Despite recognized benefits, regulatory and institutional constraints hinder the full utilization of nurses in care delivery. Recent reforms demonstrate enhanced access and care quality with APRN full practice authority, yet persistent institutional barriers necessitate continued advocacy for advancing health equity.

The drive to remove nursing practice barriers continues to gain mo-

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mentum. It took 40 years, from 1969 to 2009, for 11 states and the District of Columbia to recognize full practice authority (FPA) for APRNs. Since then, 15 additional states modernized their laws to allow patients more direct access to nurse practitioners. Numerous organizations, including The Heritage Foundation (2012), weighed in on the side of modernizing APRN practice laws, concluding the change would improve consumer choice, access to, and affordability of care. Consumer groups like AARP and Americans for Prosperity joined nationwide and state-based nursing coalitions to lobby policymakers because recognizing APRNs' FPA benefits patients and families.

Current Landscape

The evidence continues to show how FPA for APRNs reduces cost (Poghosyan et al., 2019; Smith et al., 2020) and improves access and care quality (DePriest et al., 2020; Patel et al., 2019; Traczynski & Udalova, 2018; Yang et al., 2021), especially within underserved, rural, and marginalized communities where APRNs are more likely to practice (Buerhaus, 2018). As the pandemic began, it was hard to imagine the chaos it would bring to care delivery and the healthcare workforce, or how it would magnify and worsen health disparities. These changes reverberated in acute and ambulatory care settings, where sick staff and patients were haunted by unrelenting fear of sickness and death. With the limited functionality of staff, patient care delivery seemed diluted (Squires et al., 2022). Despite upheaval and uncertainty in clinical settings, the pandemic's disarray created the opportunity to break down boundaries that have historically kept APRNs from practicing to the full extent of their education and training. The National Academy of Medicine's clarion call for FPA advised institutions to capitalize on the education, training, and expertise of all nurses, including APRNs, to improve care delivery and advance health equity (NASEM, 2021). Many states temporarily lifted APRN practice restrictions to address new and evolving care demands in the wake of the pandemic (Kleinpell et al., 2021). A recent study evaluated the impact of these temporary COVID- 19 practice waivers finding a positive effect on APRN practice, including spending more time with patients, the ability to take on new patients, and expanding access across outpatient settings, rural areas, and provider shortage areas (Martin et al., 2023). Once COVID- 19's grip on the nation eased, several states (Kansas, Massachusetts, New York, and Utah) permanently adopted FPA for at least nurse practitioners. At the federal level, the bi-partisan and bi-cameral act, Improving Care to Access to Nurses (I-CAN), was introduced in 2023. This bill, if passed, would improve Medicare and Medicaid beneficiaries' access to APRNs by removing all outdated barriers that prohibit APRNs from having FPA. Case Study on Advancing APRN Practice One example of how pandemic exigencies removed institutional barriers for nurses can be seen at an oncology unit within a large urban medical center. Limited physician availability at the medical center during the pandemic had leaders pivot and utilize APRNs in an expanded role to oversee patients' symptom management and infusion reactions, as well as conduct follow up and sick visits. The APRN team was also able to oversee chemotherapy and immunotherapy treatments, enabling oncology providers to maintain clinical services for patients without delays in treatment. This meant APRNs were able to transition to billable providers. The process of creating templates for APRNs to see patients independently and manage insurance pars, including IT and administrative paperwork, was accelerated. As a result, patients easily and quickly schedule appointments with providers at this medical center. As new workflows were created, existing policies revised, and new policies implemented, the APRN role and updated practices needed to be harmonized with the medical center's institutional policies. The language embedded within institutional policies was changed from "supervising physician" to "collaborating physician," and the use of "physician" to "provider" was systematically revised. These changes ensured inclusivity for APRNs and all advanced practice providers. By redacting the use of the words like "physician extenders" in institutional policies, a new standard was established that reflected a culture of interprofessional collaboration. To ensure continued review, an Ongoing Professional Practice Evaluation (OPPE) process was created to ensure nursing care indicators are incorporated and nursing-specific language is used to evaluate performance. The OPPE must be approved by the APRN and nurse leader. This new procedure shifted the hierarchical structure, and APRNs now report to a nurse leader. APRN clinical managers are now at each practice site and oversee APRN practice. While these examples are specific to an oncology service line, they can translate across settings where APRN practice barriers can be removed to advance nursing practice.

Table 1: Institutional Barriers to APRN Practice (Source: Kleinpell et al., 2021)

- Restrictive or limiting collaborative/supervising physician practice agreements.
- Hospital and long-term care admitting privileges are limited or restricted. Restricted or limited ability to perform, order, or authorize certain services without physician signature or order (e.g., durable medical equipment, home health, hospice, or select rehabilitation services, prescriptions).
- Physician co-signature required or unable to sign select patient forms (e.g., disability paperwork, sports physicals, death certificates)
- Patient referrals and/or consultations declined by other providers

Strategies for Local Action

The first response to addressing practice barriers is often at the legislative and regulatory levels, but this approach takes time. Further, once FPA is achieved under state law, the work to advance nursing practice continues by eliminating institutional barriers. A recent national study documented the prevalence of institutional APRN practice barriers regardless of state practice environment (i.e., restricted, reduced, or FPA) that need to be addressed (Kleinpell et al., 2021), demonstrating opportunities for targeted action. APRN practice continues to be stifled by restrictions related to prescribing and patient orders, hospital admitting privileges, billing and reimbursement issues, mandated chart reviews, and the ability to sign select patient forms, among others (see Table 1; Kleinpell et al., 2021). Table 2 provides recommended strategies that can be used to advance nursing practice within your own setting. While not an exhaustive list, it highlights available options often overlooked in efforts to advance APRN practice and achieve FPA. While the focus of this commentary is on APRN practice, it is equally important to examine RN practice for similar opportunities to remove barriers. Legislative and regulatory efforts to achieve FPA must continue across the United States, but we must also work to advance nursing institutionally. It is important that efforts to advance nursing practice locally remain within the bounds of one's state nurse prac-

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tice act. The power to germinate action locally for a ground-up approach can have a ripple effect, generating systemic change up to the regulatory level, especially within states without FPA.

Table 2: Recommended Strategies to Eliminate Institutional Barriers to Nursing Practice

- Review institutional bylaws, policies, and procedures for opportunities to advance nursing practice tailored to your local context.
- Assess language used within institutional bylaws, policies, and procedures (e.g., physician vs. provider; physician extender vs. advanced practice provider) and update as necessary to promote an inclusive interprofessional practice environment.
- Review and revise APRN reporting structures (e.g., APRN to APRN practice leader).
- Establish APRN-leadership roles to evaluate, maintain, and promote APRN practice.
- Leverage nursing-physician relationships at the system (i.e., administrative, nurse, and physician leaders) and practice (i.e., APRNs, nurse managers, medical directors, physician colleagues) levels to practice and sustain changes in practice.

When nurses practice to the full extent of their education and training, it means everyone, no matter who they are or where they live, has increased access to high-quality, affordable care and the opportunity to be healthy and well. If legal and institutional practice barriers are left unaddressed, the cost will be felt by patients who will continue to experience ineffective and inefficient care delivery systems, unnecessary and avoidable delays in care, and increased wait times, resulting in reduced or poor outcomes. Optimizing all nurses' scope of practice also helps reduce health disparities and advance health equity. While it is important to value traditions, sometimes long held beliefs impede quality care to patients and families. We are more agile when we are open to change and artificial boundaries are removed. The silver lining of the pandemic has been the rethinking of traditional care models and the resulting ability to utilize nurses to their full capacity. Significant and preventable gaps in access and care will persist if we do not act now to expeditiously remove practice barriers for all nurses.

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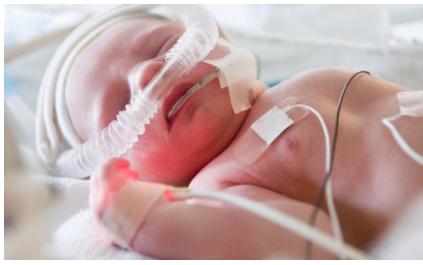
CAREER CORNER

By Shevi Rosner, DNP, RN-C

Transitioning to a New Specialty



I had five years of pediatric inpatient nursing under my belt. I worked on a gastrointestinal, transplant, med-surg unit and took care of complicated pediatric patients. I was a charge nurse, a preceptor, and earned my certification in pediatric nursing. I even lectured for certification review courses to encourage coworkers to get certified. On the side, I did some home care nursing too. To have time for clinicals for my master's degree, I became part-time and transferred to an outpatient pediatric infusion center. There I gained strong IV skills but aside from that, I was bored. After a year and enduring a difficult pregnancy, I switched to full-time in the Neonatal ICU (NICU). I didn't come to the NICU as a new grad as I had lots of skills and knowledge, so this shouldn't be too hard, right? Well, well, well... each unit is different. Each has its own staff members to get to know. Each has its own culture and book of knowledge. My orientation was all on the night shift, as per my request, and I remember I vomited on the way home from my first night in the NICU. I guess the fatigue and big change didn't sit right with me. Almost none of my pediatric nursing knowledge was relevant to the NICU. Everything was different. Everything was dosed so low. The patients were so small. Their feeds were low volume. The pumps and beds were different. And why are there cribs, isolettes, bassinets, AND warmers? Why so many different types of beds? I couldn't understand thermoregulation and isolettes for the life of me. How will I get IVs into these tiny babies? The NICU was huge. Going from a cozy 26-bed inpatient unit with about 60-70 nurses, who I got to know so well, to a 75-bed unit with 190 nurses was overwhelming. Everyone looked the same to me. It took so long to learn everyone's names. It wasn't just a new set of nurses; there were so many providers and ancillary staff members too. The place was huge. There was an older nurse there who bullied me so much. I would cry. I only learned years later that she did this to all new hires and everyone knew about it… I was just the latest to get her special treatment. Another senior nurse yelled at me for leaving too much fresh breast milk in the fridge. I felt lonely. Some charge nurses were kind, while others were rough. It took years to learn everyone's personalities and to feel confident and comfortable in this setting. I tried to read up on new diagnoses during downtime and tap into a provider who was willing to teach. I'll never forget Anna Marie, an outstanding night shift NP, who absolutely loved to teach and gave over a wealth of knowledge. With time, and many years of repetition, along with anticipating what's to come and being prepared and knowing who to ask, I became more comfortable. I became one of the crew. I became a charge nurse and a preceptor again. I was finally respected for my knowledge and skills and got to know everyone. I worked closely with nurse educators to make unit improvements and share my knowledge. I built a web-

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SAVE THE DATE

11.12.25

OJNA Annual Conference

The Grand Event Space

Passaic, NJ

- NEW TOPICS
- ENGAGING SPEAKERS
- FREE ON-SITE PARKING
- NETWORKING
- DELICIOUS FOOD
- INTERACTIVE PANELS
- HANDS ON LEARNING

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site for unit resources and policies, and I presented at grand rounds. I encouraged many colleagues to join the clinical ladder program and continued to be involved in hospital committees and initiatives. I became a mentor for staff, a resource of information, and support for new hires. I've implemented changes on the unit, and I am publishing research together with physicians and nurses. It's been over 12 years in the NICU, and I have no plans to go. I am comfortable where I am, and I am not bored. I learn something new every day.

Shevi Rosner DNP, RN-C is a nurse at Children's Hospital of New York Presbyterian since 2007 and is dual certified in pediatrics and neonatal ICU nursing. Shevi is a professor of nursing at Columbia University, the Director of Education for Yifei Nof Tours for Women in Healthcare, a volunteer for the Academy of Neonatal Nursing, and the former president of OJNA.

ISRAEL CORNER

By Alya Shor

Saving Children, Healing Nations: Inside Israel's Quiet Humanitarian Mission

A Hidden Story Worth Telling

When I first shared the story of *Save a Child's Heart* with Jewish nurses in my circle, the reaction was always the same—wide eyes and disbelief: *"Wait… Israel is still treating children from the West Bank? During the war?"*

Yes. Even after October 7th. Even during air raid sirens, reserve call-ups, and national trauma—Save a Child's Heart (SACH) never stopped saving lives.

That moment of disbelief was what sparked this article. Because if Jewish healthcare professionals don't know about the depth of Israeli humanitarian medicine, then the story needs to be told louder.

To tell it, I reached out to someone who embodies this mission with every part of his life: Ido Gutin.

Born in the U.S. to Israeli diplomats, Ido grew up between New York and Dallas before making Aliyah to serve in the Israel Defense Forces, where he trained as a combat medic in the Artillery Corps. After his service, he continued as a reservist and eventually found his way into the world of medical humanitarian work—not as a doctor or nurse, but as a relentless advocate and connector.

He spent nearly a decade at Magen David Adom, Israel's national emergency medical and blood services, raising critical support for ambulances, trauma equipment, and national response infrastructure. Today, he serves as the Director of External Relations at Save a Child's Heart, helping to bring global attention—and essential funding—to an organization that treats children with heart disease from across the world.

"I wake up daily knowing that my efforts are helping save children," Ido told me. "Not just in Israel—but in places most people can't even find on a map."

In a time when good news rarely makes headlines, Save a Child's Heart is writing its own quiet legacy—one surgery, one nurse, and one child at a time.

From Combat Medic to Global Connector: Ido's Journey

Ido Gutin's path to global healthcare impact wasn't a straight line—it was one shaped by service, love of country, and an unshakable belief in doing good.

His early life in the United States where his family was stationed on diplomatic assignment. Growing up between New York City and Dallas, Ido saw the world through a lens of global responsibility. After completing his undergraduate degree at Queens College, he made the decision to return to Israel—delaying his professional track in order to serve.

In 2006, he enlisted in the Israel Defense Forces and joined the Artillery Corps, where he was trained as a combat medic. Those years, while among Israel's more peaceful periods, taught him lessons that would define the rest of his life: discipline, vigilance, and above all, the sacred value of life.

"The IDF puts a strong emphasis on this code of conduct," Ido said. "You're taught early that while we must defend ourselves, we do it with the highest regard for human life."

His service also brought unexpected personal blessings—he met his wife, Yael, in the same unit. Years later, they would marry and raise their daughter, a testament to how moments of duty can intersect with the beginnings of family.

After completing his service, Ido stayed active in the reserves and began working across sectors—first in security and tourism, and eventually finding his calling in healthcare advocacy. He joined Magen David Adom (MDA) and spent nearly seven years building partnerships across the globe.

There, he oversaw the dedication of hundreds of ambulances, emergency stations, and blood services projects, helping to strengthen Israel's emergency response infrastructure. He worked closely with donors and communities across the United States, United Kingdom, and Australia, supporting groundbreaking efforts like Israel's National Blood Bank, the Wish Ambulance Project, and the National Mother's Milk Bank.

All the while, he pursued his master's degree and deepened his expertise in international relations and public health.

In 2019, Ido was offered a role that brought everything full circle: Director of Resource Development and External Relations at Save a Child's Heart. It was a perfect fit—a chance to connect global communities with life-saving pediatric cardiac care.

"This role is a real honor," he told me. "I know that every meeting, every project, every donor conversation—it all ties back to one thing: saving a child's life."

His journey—across countries, across careers—has made him more

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than a fundraiser. He's a bridge. Between Israel and the world. Between suffering and healing. Between what people assume, and what's actually happening on the ground.

What is Save a Child's Heart?

At its core, SACH exists for one purpose: to save the lives of children born with or suffering from heart disease—regardless of their nationality, religion, or access to care.

Founded in 1995, the organization is based at the Sylvan Adams Children's Hospital at Wolfson Medical Center in Holon, Israel. Since its founding, SACH has treated over 7,500 children from 72 countries—many from areas without diplomatic ties to Israel.

"People ask why Israel, a small country with so many of its own challenges, would do this," Ido said. "But this is what Israel is about. This is *Tikkun Olam*—repairing the world through compassion and action."

Every year, thousands of children are born with congenital heart defects. In many developing nations, these children have no access to cardiac specialists, operating theaters, or proper diagnosis. SACH steps in to change that—either by bringing the child to Israel for surgery or by sending Israeli teams abroad to assess and treat patients on the ground.

And it doesn't stop at treatment. A core part of SACH's mission is training local medical professionals from partner countries—cardiologists, surgeons, anesthesiologists, nurses, and perfusionists—so they can one day build sustainable cardiac care systems in their own communities.

"We don't just fly kids here and send them home," Ido emphasized "We build relationships with Ministries of Health. We train their doctors. We plant long-term seeds."

That model—treat, train, transform—is why SACH has earned international recognition not only as a surgical program, but as a global humanitarian force. It's healthcare diplomacy in action.

And yet, most people—especially in the U.S.—have never heard of it.

"Good news doesn't make headlines," Ido said. "But that doesn't mean it isn't real."

Operating in a Time of War

When October 7th shattered Israel's sense of safety, every Israeli organization had to make a choice: pause and grieve, or press forward and serve. At SACH, there was no hesitation.

"October 7th was a shock to everyone—and still is," Ido said. "But our team did what it always does. We saved lives."

While rockets fell and reservists—including Ido—were called to the frontlines, SACH pivoted quickly. They launched an emergency fundraising campaign to support their host hospital, Wolfson Medical Center, raising over $3 million for trauma and pediatric equipment. Entire departments, including neonatal and pediatric units, were moved to sheltered underground floors so that care could continue during air raid alerts.

Even under siege, the work continued. Flights resumed. Children—mainly from African countries—arrived in Israel for treatment. Staff, many of whom had family or colleagues serving on the front lines, stayed focused on the children before them.

"When I returned to the office after 2.5 months in reserves, it was surreal," Ido said. "Everyone was working as if nothing had changed. That made me so proud. Even in national trauma, our team didn't stop."

This resilience wasn't just logistical—it was deeply emotional. With war comes fear, loss, uncertainty. Yet in the pediatric cardiac ICU, nurses were holding tiny hands. Surgeons were operating. Social workers were comforting families from five different continents.

"We didn't slow down," Ido said. "In fact, we pushed harder."

This response wasn't just a demonstration of operational strength—it was a statement of values. In the face of war, SACH chose compassion. Chose healing. Chose to see every child, regardless of background, as worthy of care.

A Child is a Child: Treating Patients from the West Bank

One of the most extraordinary and underreported aspects of SACH's mission is that children from the West Bank continue to receive treatment in Israel—even after October 7th.

While misinformation and polarization dominate headlines and social media, SACH has quietly upheld its guiding principle: a child is a child.

"The reality in Israel post–October 7th is incredibly complex," Ido said. "But at SACH, our ethos hasn't changed. We believe in the sanctity of life—every life."

Behind the scenes, this commitment requires courage. It demands emotional resilience from the medical staff, and an unwavering moral compass. Despite tensions, fear, and immense personal pressure, the team—both clinical and administrative—has refused to compromise their values.

"Good news doesn't make the news," Ido said. "But it's still happening. While others amplify hatred, we're still treating Palestinian children, still bringing them into our hospitals, and still giving them the best care available."

It's a quiet form of protest against dehumanization. In a time when so much of the world is focused on who deserves care, SACH's answer is simple and profound: everyone.

While some may view this as risky or

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controversial, within the walls of Wolfson Medical Center, politics fade away. The pediatric cardiac unit doesn't ask where a child is from. It asks how to save them.

In fact, many of the children come accompanied by nurses or guardians from their country of origin. And when they don't, Israeli nurses step into that role, providing not just medical care, but comfort, safety, and trust.

"We don't do this for headlines or applause," Ido told me. "We do it because it's right. Because we're human. And because they're just kids."

Nurses at the Heart of Healing

In every hospital, nurses are the heartbeat. At SACH, that heartbeat is especially strong.

While surgeons perform life-saving procedures and physicians diagnose complex conditions, it is the nurses who are at a child's bedside at every stage—from pre-op to post-op, from fear to comfort, from trauma to trust.

"For those in public health, it's obvious: without nurses, the system collapses," Ido said. "At SACH, their role is not just medical—it's deeply emotional."

Children who come to Israel for surgery often arrive with little context, limited language, and in many cases, without a parent. In those moments, it's the nurses—Israeli and international—who become their caregivers, translators, and family.

"They tend to the children's needs around the clock," Ido explained. "They're not just giving medication—they're giving emotional safety, warmth, and dignity."

One story captures this impact with incredible clarity: Aklil, a young girl from Ethiopia, was flown to Israel by SACH nearly 20 years ago for a life-saving heart surgery. At the time, she was accompanied by her mother and a nurse named Salamnesh, whose gentle care and calm presence left an unforgettable mark.

Years later, inspired by that experience, Aklil pursued nursing herself—and in early 2023, she returned to Israel. But this time, she came as an ICU nurse, accompanying a group of Ethiopian children through the very same journey she once walked.

"It's one of the most powerful full-circle stories I've ever seen," Ido said. "She credits her decision to become a nurse to the care she received as a child. Now, she's that person for others."

In her own words, Aklil described how one nurse changed her entire trajectory. And now, she's doing the same for others—modeling not only clinical excellence, but profound empathy.

For nurses reading this—from students to seasoned professionals—Aklil's story is a reminder of the long-term ripple effect of your care. At SACH, it's not just about healing one child—it's about transforming generations through the power of presence.

What Jewish Nurses Should Know

As Jewish nurses and healthcare professionals, we are often taught to lead with empathy. To heal across divides. To treat every human being with dignity.

And yet, many of us have never heard of SACH—a program that's doing exactly that, day in and day out, in the heart of Israel.

"Israel has a long-standing tradition of humanitarian medicine," Ido told me. "But it rarely makes headlines. You won't see it trending. But it's real—and it's happening quietly, every single day."

From the Sylvan Adams Children's Hospital in Holon, Israeli medical teams are delivering world-class care to some of the most vulnerable children on the planet. They're treating kids from countries with no diplomatic ties to Israel. They're operating on patients who can't pay. They're training local teams in Africa, South America, and the Middle East to build sustainable, community-based cardiac care systems.

And yes—they're still treating Palestinian children, even after October 7th.

"This isn't about politics. It's about humanity," Ido said. "And we need more healthcare professionals to understand that."

He quoted Dr. Ami Cohen, the late founder of SACH, whose vision lives on through every life the organization saves:

"The task is big enough. There is work for everybody. There are no dollars and cents in it—but it is worth a fortune."

For Jewish nurses in the U.S., Ido's message is clear: Don't overlook Israel's role in global healthcare because it's quiet. Instead, look closer. You'll find stories of collaboration, compassion, and courage—stories that deserve to be known, shared, and celebrated.

"This work is about giving every child a chance," he said. "And every nurse, every healthcare student, can be part of that mission—whether directly or by sharing the story."

Looking Forward: The Future of Save a Child's Heart

While SACH has already saved over 7,500 children across 72 countries, its vision for the future is even more ambitious.

"We're not just trying to help more kids—we're trying to help smarter, deeper, and more sustainably," Ido said.

SACH is expanding in every direction—scaling its clinical capacity, training pipeline, and educational infrastructure to meet the growing demand for pediatric cardiac care worldwide.

Three major goals define the next chapter:

Building a new Adult-Congenital Cardiac Unit at Wolfson Medical Center to serve patients who were once SACH children and are now adults managing long-term heart conditions.

Expanding the Children's Home, which is consistently at full capacity, to accommodate more children and their families, as well as more international doctors in training.

Investing in simulation-based medical training to bring hands-on, high-tech education directly to partner countries. This ensures that doctors, nurses, anesthesiologists, and perfusionists return home equipped to build lasting cardiac care systems in their own communities.

"Real transformation starts when a doctor or nurse from Rwanda, Tanzania, or South Sudan takes what they learned in Israel

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and uses it to save lives at home," Ido said. "That's where the future is. That's how we create real health equity."

Beyond clinical expansion, SACH is also focused on broadening its community—inviting not only surgeons and cardiologists, but also nurses, medical students, educators, and volunteers to become part of the mission.

Many volunteers—often undergraduate or nursing students—come to the Children's Home in Israel to help care for children during their recovery. They play games, offer comfort, and help restore normalcy for kids far from home.

"These students see what global healthcare really looks like—not from a textbook, but from eye contact, language barriers, and real human connection," Ido said.

For Jewish nurses and students in particular, SACH offers something rare: a chance to be part of a compassionate, non-political, cross-cultural movement that is changing the world through healing.

"At its heart, SACH is about what happens when people choose compassion over conflict," Ido told me. "It's about what's possible when people from opposite sides of the world—and often opposite sides of history—come together to save a life."

Full Circle: Why This Mission Matters

This article isn't just a feature. It's personal.

During my time serving in the Israel Defense Forces, I spent many of my weekends volunteering at SACH. I was still in uniform—young, uncertain, and searching for purpose—but every time I stepped into the Children's Home, I saw what purpose looked like. I wasn't just witnessing medical care. I was witnessing transformation.

Children would arrive from across the world—some weak, some scared, some far from home—and I watched them be met with tenderness, skill, and hope. Israeli nurses would hold their hands, play games with them in the hallway, and sit quietly by their beds when words weren't enough. There were moments of joy, of heartbreak, and above all, of human connection.

I didn't know it then, but those weekends planted the seed that would later grow into my decision to become a nurse. I saw the kind of healing that transcends language and borders. I saw what it means to give, without expecting anything in return.

Today, as a nursing student at Hunter-Bellevue School of Nursing, and as a member of the OJNA Journal Committee, I carry those memories with me. Writing this article has been more than a reflection—it's been a return to the source of what inspired me. It's also a reminder that the work we do as nurses doesn't end with the patient in front of us. It echoes outward—across families, across nations, across generations.

"At its heart, SACH is about what happens when people choose compassion over conflict," said Ido. *"It's about what's possible when people from opposite sides of the world—and often opposite sides of history—come together to save a life."*

SACH is not just saving children. It's modeling the world we want to live in—where healing takes precedence over politics, and where medicine becomes a vehicle for peace.

To every Jewish nurse reading this: you don't need to be on the front lines to make an impact. You already are. And stories like this are proof.

A child is a child.

Let's keep showing the world what that means—through the way we care, the way we lead, and the way we tell our stories.

Alya Shor is a nursing student at Hunter-Bellevue School of Nursing, a former combat soldier in the Israel Defense Forces, and a current first responder with Magen David Adom, Israel's national emergency medical and disaster response service. She serves on the Youth Leadership Committee at Save a Child's Heart, an Israeli organization providing life-saving cardiac care to children worldwide.

To Bamba or Not to Bamba: The LEAP Study and More

By Shifra Broder BSN, RN, CPEN, TNCC

Peanut allergy is a significant health concern affecting children worldwide, with prevalence rates on the rise in recent decades affecting approximately 2-3% of children in Western countries [1]. The problem is characterized by an abnormal immune response to peanut proteins leading to a range of symptoms from mild reactions to severe, life-threatening anaphylaxis [2]. The increase in peanut allergies has been attributed to various factors including changes in dietary habits, environmental influences, and genetic predisposition. The clinical implications of peanut allergies in children are substantially impacting their quality of life, social interactions, and psychosocial state in addition to placing an economic burden on families [3]. Furthermore, the management of peanut allergies requires strict avoidance of peanuts and prompt treatment of allergic reactions which can be challenging and stressful for both children and their caregivers.

While promising prevention and therapeutic strategies are being developed, food allergies currently cannot be cured. Early recognition and learning how to manage food allergies, including which foods to avoid, are important measures to prevent serious health consequences.

Back in 2002, Dr. Gideon Lack, Head of The Department of Pediatric Allergy, Kings College, London & Lead Author of the Learning Early About Peanut Allergy (LEAP) Study gave a lecture to a large group of pediatricians and allergists in Tel Aviv, Israel. As there were a growing number of reports that this problem was on the rise in the UK and USA, he spoke of peanut allergies. After asking the audience for a show of hands as to how many of the doctors had seen a child with peanut allergy in the last year, unexpectedly, only two or three Israeli doctors raised their hands. In speaking to his Israeli colleagues and parents of young children, he discovered that in Israel, almost all babies were being fed peanut snacks early in the first year of life. As a research fellow, he had learned that early feeding of foods

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such as egg, milk and peanuts to young mice prevented the development of food allergies - a phenomenon called oral tolerance induction.

Genetic variation was another possible explanation, however, Jewish children in London who shared the same ancestral heritage as Israeli children, were developing a peanut allergy in the UK. In order to confirm this hunch and exclude genetics as an explanation, he ran a comparative study of approximately 5,000 Jewish children in each country. Shockingly, the rate of peanut allergy in the UK children was 10-fold higher than in Israel. While Israeli infants were consuming approximately 1.7 grams of peanut protein per week from a very early age in their first year of life, in contrast, in the UK (similar to the USA), the majority of babies were not consuming any peanuts. This practice in Israel contradicted the guidelines in the UK and USA at the time, which recommended avoiding peanuts early in life. This led to the realization that the advice given to prevent peanut allergy might not only be incorrect but could also unintentionally contribute to the rise in food allergies [4].

Despite these observations, there was no concrete evidence to prompt a change in policy. This led to one of the most cited studies done on this topic, the LEAP study, conducted with colleagues supported by the National Institutes of Health and the Immune Tolerance Network. Initially hoping for a modest reduction in peanut allergy rates, researchers were delighted to find that when the children reached five years of age, the rate of peanut allergy in those consuming peanut snacks had decreased by more than 80%. This randomized controlled trial confirmed the hypothesis that early introduction of peanuts could prevent peanut allergy and indicated that the previous avoidance strategy adopted in many countries was potentially exacerbating the issue. Based on the new research, the avoidance guidelines have changed in many countries to encourage early peanut introduction [3].

Looking at the research conducted since the LEAP study was published in 2015, several themes stand out:

Early Introduction vs. Delayed or No Introduction of Allergenic Foods: Studies consistently show that early introduction of allergenic foods, including peanuts, is associated with a lower incidence of peanut allergy compared to delayed or no introduction. This finding supports the hypothesis that early exposure to allergenic foods may help reduce the risk of developing allergies later in life [3,5,6,8,9].

Long-Term Effects of Early Introduction: Long-term follow-up studies, such as the LEAP-On study, demonstrate that the protective effect of early peanut introduction against peanut allergy persists even after several years. This suggests that early introduction may lead to sustained unresponsiveness to peanuts [5].

Risk Factors and Predictors of Allergy Development: Studies identify various risk factors and predictors of allergy development, such as eczema, other food allergies, specific IgE levels, and skin prick test results. Understanding these factors can help identify infants at high risk for allergies and guide intervention strategies [3,7,8,10].

Compliance with Guidelines and Barriers to Implementation: Studies highlight the importance of implementing guidelines for early allergenic food introduction but also identify barriers, such as lack of clinic time, parental concerns, and the need for additional training among healthcare providers [1].

Role of Maternal and Environmental Factors: Maternal peanut consumption during pregnancy and lactation, as well as environmental peanut exposure, may influence the development of peanut allergy in infants. However, the exact mechanisms underlying these effects require further investigation [11,12].

Oral Immunotherapy and Tolerance Development: Oral immunotherapy shows promise in inducing tolerance to allergenic foods, such as peanuts, in children with allergies. Studies demonstrate varying success rates and suggest that factors like wheal diameters on skin prick testing and antibody levels may predict treatment outcomes [13].

Overall, these themes underscore the complex interplay of genetic, environmental, and dietary factors in the development of peanut allergy in infants and highlight the importance of early intervention strategies to reduce the risk of allergies later in life.

Recommendations for Translation to Practice:

Early Introduction of Peanuts: Healthcare providers should consider recommending early introduction of peanuts in infants at high risk for peanut allergy to reduce the incidence of peanut allergy by age 5.

Long-Term Protection: Encouraging sustained consumption of peanuts in high-risk infants may provide long-term protection against peanut allergy. Low-Dose Consumption: Intermittent low-dose consumption of peanuts after prolonged consumption or avoidance did not result in new-onset peanut allergy. However, longer-term effects require further study.

Early Introduction of Allergenic Foods: Educating parents about the importance of early introduction of allergenic foods, including peanuts and eggs, to breastfed infants may reduce the risk of food allergy. Healthcare providers should provide guidance on how much of each allergen to ingest.

Oral Immunotherapy for Egg Allergy: Oral immunotherapy represents a promising therapeutic intervention for egg allergy in children raising the reaction threshold and allowing for the incorporation of egg into their diet without symptoms in some cases.

Assessment of Tolerance to Baked Egg: Clinicians could consider assessing tolerance to baked egg at 12 months to predict the resolution of egg allergy by 2 years of age, guiding counseling and interventions for infants with egg allergy.

Barriers to Guideline Adherence: Interventions are needed to address barriers to pediatrician adherence to guidelines and reduce peanut allergy incidence in infants. Providing additional resources and training for pediatricians, especially those serving Medicaid populations and rural areas, is crucial.

Prevention of Cow's Milk Allergy (CMA): Daily ingestion of cow's milk formula between 1 and 2 months of age can prevent CMA development without competing with continued breastfeeding.

Environmental Exposure to Peanuts: High levels of environmental exposure to peanuts during infancy may promote sensitization, while low levels may be protective in atopic children. Strategies to reduce environmental peanut exposure or introduce peanut protein early in the diet to induce oral tolerance should be explored in randomized controlled trials.

Implementing these recommendations into clinical practice may

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help reduce the incidence of peanut and other food allergies in infants at high risk, ultimately improving their quality of life and reducing healthcare costs associated with allergy management.

Further research is needed to address several knowledge gaps in the prevention and management of food allergies in infants and young children. While early introduction of peanuts appears effective in reducing peanut allergy incidence by age 5, additional long-term studies are required to assess its continued effectiveness into later childhood and adulthood. Optimal timing and dose of peanut introduction also need clarification for different populations. Similarly, while oral immunotherapy shows promise for egg allergy treatment, further research is needed to determine its long-term effectiveness, safety, and optimal protocols.

Identifying additional predictors of allergy development beyond current markers like eczema and specific IgE levels is crucial for improved risk stratification and early intervention. Understanding and addressing barriers to guideline adherence for early allergenic food introduction is also essential. Moreover, the impact of maternal diet on allergy development requires further investigation, despite current indications that maternal peanut consumption during pregnancy or lactation may not significantly affect peanut allergy development.

Randomized controlled trials are necessary to explore strategies for reducing environmental peanut exposure during infancy and introducing peanut protein early in the diet to induce oral tolerance. This research could inform public health policies for peanut allergy prevention. Additionally, more research is needed to determine the impact of early introduction of allergenic foods on breastfed infants and the optimal approach for introducing these foods in this population. Addressing these gaps through further research will advance our understanding and management of food allergies, leading to better outcomes for at-risk children.

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Israeli Lactation Consultants' Perceptions of Breastfeeding During the Early Period of Operation Iron Swords

Dr. Ilana Azulay Chertok, Dr. Rada Artzi-Medvedik

On the early morning of Shabbat Simchat Torah, October 7, 2023, Israelis awoke to the piercing sounds of sirens, warning of attacks, while those living in the Gaza-border communities tried to fend off and escape brutal terrorist attackers. Families throughout Israel were affected by the terrorist attacks, as victims, relatives and friends of victims, and as witnesses. Levels of stress and fear rose while the devastation, loss, and grief were shocking and overwhelming.

Yet, within a short time, accounts of brave and dedicated first responders, soldiers, and healthcare professionals surfaced, contributing to a national sense of resilience. Nurses and other allied health professionals were among the first responders who provided care to families who were injured, torn apart, hiding in bomb shelters, evacuated, and called up to active reserve military service. Maternal-infant dyads are especially vulnerable during emergency situations and require immediate and anticipatory guidance, support, and encouragement particularly regarding infant feeding (Aros-Vera, Melnikov, & Chertok, 2021).

Dr. Ilana Chertok and Dr. Rada Artzi-Medvedik conducted a qualitative study using focus groups to explore lactation consultants' perceptions of providing breastfeeding support early in the war, Operation Iron Swords. Eight lactation consultants from around Israel, seven of whom are also registered nurses, who work in hospitals, community clinics, and private practice participated in the focus groups.

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They shared their impression of the mothers and their own experience during the first few months of the war. There were three primary themes that emerged from the narrative data that relate to the impact of the war on mothers, the influence of the stress of war on breastfeeding, and changes to professional lactation consulting due to the war. (OR "life during the war," "breastfeeding during sirens," and "we work from within our people.")

There was an observation of overwhelming sense of shock and stress among breastfeeding mothers in Israel. The lactation consultants shared a common question they received on insufficient milk supply which was felt by many women with the sudden onset of the war. They discussed methods to help mothers increase their milk supply and to restart their milk supply ("relactate") and resume breastfeeding which is more reliable during the emergency situation. They guided mothers in how to prepare for breastfeeding while staying for extended periods in bomb shelters and how to access donated milk especially for mothers who were injured or were called up to serve. They encouraged and comforted mothers who had been evacuated from their homes and those whose partners were called up to active military reserve duty and who were managing their children and households on the home front alone.

In general, the lactation consultants who participated in the focus groups described the importance of supporting breastfeeding to mothers experiencing acute stress during the early period of Operation Iron Swords which was affirmed by the Israel Ministry of Health, Maternal Child Division (2023). The lactation consultants also faced challenges as they themselves were living and working under stressful conditions, professional resources were shifted from the community-based maternal-infant clinics, hospitals were overwhelmed with the wounded, and the healthcare system was managing an increased burden. They developed an online support group for each other, facilitating the sharing of ideas and resources, approaches to care under difficult circumstances, and group problem solving. The lactation consultants recognized their critical role in helping mothers feel supported during the war and in empowering them in managing their infants' feeding and care.

The findings of this qualitative study highlight the importance of emergency preparedness for the many aspects of healthcare in Israel, including in the field of maternal-infant health. Lactation consultants in Israel supported their clients and each other in providing care during a period of vulnerability. There was a sense of togetherness, even in threatening circumstances, demonstrating that "All of Israel is responsible for each other."

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TECHNOLOGY CORNER

By: Jennifer Shepherd DNP, MHA, RN, NEA-BC, NPD-BC and Mitchell Silberberg BSN, RN, PHN

Technology Beyond Automation: AI and New Graduate Nurse Onboarding, Ethics, and Wellbeing

Artificial Intelligence (AI) has quickly become part of our everyday lives, ushering us into a new era of technology. Tasks we used to do manually—like searching for information, planning a trip, or managing our calendars—can now be done faster and smarter with AI. Digital assistants help us book flights, AI tools predict what we might need before we even ask, and the systems are learning and improving daily. It's easy to imagine a future where AI touches nearly every part of our lives. But as exciting as it is, AI isn't a magic fix for everything. Just like the medications we give our patients, AI comes with benefits and risks. We must approach it thoughtfully, asking the right questions and keeping patient safety and ethical practice front and center.

Definitions and Key Terms

The American Nurses Association (ANA) defines AI as "the capability of computerized systems to perform tasks that typically require human intelligence" [1]. In nursing, AI tools like DAX Copilot, Bayesian Health, and electronic health record-based personalized learning modules support clinical decision-making by offering insights that enhance, rather than replace, the nurse's role.

To use AI effectively, nurses must understand how these systems work, the data they rely on, and how to interpret their outputs. This

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knowledge helps nurses remain central to decision-making and assess the impact of AI on patient outcomes. AI is advanced technology that simulates human learning, problem-solving, and decision-making [2], enabling machines to recognize objects, understand language, and learn from new information.

Key AI concepts include Machine Learning (ML), Deep Learning (DL), and Natural Language Processing (NLP). ML allows machines to learn from data and improve accuracy over time. DL, a subset of ML, uses artificial neural networks to mimic the human brain for complex pattern recognition and decision-making [3]. As seen in Generative AI like ChatGPT, NLP enables machines to understand and generate human language [2].

Benefits of AI in Nursing

AI has proven beneficial both clinically and administratively in nursing. It streamlines tasks like documentation, improving accuracy, efficiency, and patient outcomes, while freeing up time for direct care [4]. Notable applications include:

- Predictive Modeling: Supports clinical decision-making, identifying errors, and creating order sets.
- Generative AI: Tools like Zoom AI Companion (meeting summaries), Grammarly AI (editing emails and papers), and OpenAI's ChatGPT (research support).
- Clinical Decision Support (CDS): AI algorithms detect early signs of deterioration (e.g., sepsis, stroke) and assist in emergency department triage.
- Documentation & Charting: NLP tools auto-fill or summarize patient notes; speech recognition reduces documentation time.
- Remote Monitoring & Telehealth: AI analyzes wearable data to alert nurses about abnormal vitals and supports chronic condition management.
- Workflow Optimization: AI predicts staffing needs, automates scheduling, and streamlines supply chain tasks.
- Patient Education & Communication: AI-powered chatbots offer health education and follow-up reminders, especially for multilingual or low-literacy populations.

Risks of AI in Nursing

Despite its benefits, AI in healthcare carries specific risks that must be addressed:

- Privacy & Security: Use enterprise AI, not open-source versions, to comply with HIPAA for protected health information (PHI). Reinforce information security best practices [2].
- Safety: Small or outdated data sets may affect prediction accuracy. Ensure data is current to support safe patient care [3].
- Clinical Supervision/Decision Making: AI use in onboarding and decision-making should be accompanied by policies that protect nurses' autonomy and ethical considerations, preventing moral distress [4]
- Plagiarism: Over-reliance on AI may weaken critical and creative thinking [2].

AI and the New Nurse: Navigating Onboarding

AI can support new graduate nurses during their transition to practice by personalizing their learning, reducing information

overload, and offering timely clinical guidance. Adaptive learning systems can customize onboarding curricula to address individual knowledge gaps, while AI-powered simulation tools provide realistic and responsive training scenarios [5]. Additionally, AI-enabled decision-support tools can guide novice nurses through complex decision-making processes, boosting their confidence and competence early in their careers.

AI can also improve mentorship matching by connecting new graduates with experienced clinicians based on shared interests, specialties, or learning goals. This accelerates professional growth and fosters a sense of connection and support, key factors in retention and job satisfaction [6].

However, successful AI integration requires careful planning. Systems should be intuitive, seamlessly integrated into clinical workflows, and aligned with evidence-based practice. Nurse educators and preceptors must also be trained to model and support AI usage effectively. Poorly implemented AI tools can lead to frustration or safety risks, undermining their potential benefits. New graduate nurses often face a steep learning curve when transitioning from academic training to real-world clinical practice [7]. Therefore, integrating AI into onboarding must address opportunities and ethical challenges, ensuring it supports autonomy, moral agency, and clinical reasoning.

Example: A predictive algorithm flags a patient as low-risk based on outdated data. A novice nurse, sensing clinical deterioration, faces a dilemma. If systems don't support moral courage and clinical challenge, the patient—and the nurse's trust in their judgment could suffer.

While AI can enhance clinical decision-making, its use mustn't reskill novice nurses. Effective onboarding programs should train new nurses to interpret AI outputs rather than passively accept them. Incorporating simulation-based education with AI-powered tools allows novice nurses to practice complex, nuanced clinical decisions in a safe, responsive environment. Additionally, pairing new nurses with mentors trained in AI-supported care can help model critical thinking and reinforce the importance of clinical judgment alongside technological assistance.

Ethical and Professional Considerations

The rise of AI in healthcare prompts essential questions about equity, accountability, and the nurse's role in clinical decision-making. AI systems are inherently shaped by the data and algorithms they rely on. If these inputs reflect bias or do not represent diverse populations, the outputs can exacerbate disparities and introduce harm.

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Nurses must advocate for the ethical use of AI, emphasizing transparency, fairness, explainability, and safety. Transparency ensures that clinicians understand how recommendations are generated, fairness guards against discrimination, explainability allows nurses to justify decisions based on AI recommendations, and safety protects patients from unintended consequences.

Importantly, AI should never replace the nurse's clinical judgment. Instead, it should be an adjunct that enhances situational awareness and supports timely, informed care [1]. Professional nursing organizations, including the ANA, are advancing guidelines and position statements to support ethical AI adoption [8]. Nurse leaders should incorporate these resources into institutional policies, procurement decisions, and education.

Supporting Nurse Wellbeing with AI

The nursing workforce faces unprecedented challenges, including staffing shortages, burnout, and moral distress [9]. When implemented thoughtfully, AI can be a tool for improving nurse well-being. Automating repetitive tasks, streamlining documentation, and filtering nonessential alerts can reduce cognitive load. Predictive analytics may aid in workload balancing, staffing optimization, and early identification of burnout risk.

However, the opposite is also true. If poorly deployed, AI can increase workload, create inefficiencies, or reduce nurses' sense of control. Thus, implementation strategies must be co-designed with frontline nurses to ensure usability and relevance [10]. Psychological safety must also be prioritized so nurses can learn, give feedback, and iterate without fear of error or reprimand.

AI evaluation metrics should include indicators of well-being, such as job satisfaction, emotional exhaustion, and perceived workload. Technology success should not be measured solely by efficiency or cost savings but by contributing to a healthier, more resilient workforce.

Leading the Future of AI in Nursing

AI is not a temporary trend but a permanent shift in how healthcare is delivered. Nurses must be leaders in AI design, implementation, and governance to ensure that this transformation supports rather than undermines the profession. This includes engaging in interdisciplinary development teams, informing regulatory frameworks, and advocating for systems that reflect the values of patient-centered care.

Building AI literacy across the nursing workforce is essential. Nursing curricula should include foundational knowledge in data science, ethics, and emerging technologies. Professional development programs must prepare nurses to use AI and critically evaluate its appropriateness and effectiveness.

Nurse leaders play a pivotal role in this evolution. By prioritizing ethical frameworks, inclusive design, and evidence-based implementation, they can ensure AI is leveraged to advance care quality, protect human dignity, and sustain the nursing workforce.

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How to CUS for Safety

By: Samantha Smith DNAP, CRNA

How do you *communicate your perspective* when feeling concerned about a clinical situation? If you verbalize your viewpoint, what tends to happen next? If you refrain from making your voice heard, have you reflected on the 'why'? A common barrier is unfamiliarity with how to express your perspective in a clear, compelling, and professional manner.

To empower and support healthcare providers with verbalizing their perspective when advocating for patient safety, the Agency for Healthcare Quality & Research (AHQR) developed the CUS communication tool. CUS is an acronym for Concerned, Uncomfortable, and Safety Issue. These three letters and associated words delineate empathic escalating terminology for interprofessional communication.

Source: https://www.ahrq.gov/sites/default/files/wysiwyg/teamstepps-program/teamstepps-pocket-guide.pdf

CUS Explained

You begin this stepwise approach by verbalizing, **"I am concerned!"**

Support your claim with relevant clinical context that is concise and objective. Any team member receiving this information has an opportunity to process and respond. Your judgment of clinical acuity determines the appropriate time frame for a verbal or nonverbal response.

If your concern is unresolved, escalate to stating, **"I am uncomfortable!"** Reframe or provide additional clinical context to your claim. Allow time for response if appropriate.

If the clinical situation is not resolved and you perceive potential harm, escalate to stating, **"This is a safety issue!"**

By labeling a clinical situation as a safety issue, you indicate there is concern for patient or staff safety. Nurses are safety advocates. At this point, the AHQR indicates your role is to *Stop the* Line, and the threatening procedure or patient activity perceived as dangerous must be addressed. Institutional processes, policies, protocols for addressing a patient or staff safety breach vary according to each hospital system.

For now, let's focus on the universal significance of interprofessional communication amongst healthcare providers. Team-based care delivery is effective when providers work together to achieve the shared goal of delivering safe and quality care. Thereby, all healthcare providers are responsible for speaking up if something doesn't seem right. This interprofessional exchange of information fosters collaboration for optimal care delivery. Application of the CUS tool is a practical strategy for enhancing interprofessional communication and empowering nurses.

CUS Application in Nursing Practice

You are the primary nurse on a surgical unit for a patient recovering from robotic hysterectomy. The indication for post-operative admission is prolonged monitoring and intravenous antibiotics. Handoff report reveals a surgical complication of bowel perforation. Currently, the patient is six-hours post-operation and reporting a pain level of 8 out of 10. The patient received all scheduled non-narcotic medications and one dose of oxycodone 5mg upon request. Your assessment reveals tenderness at surgical sites and increased abdominal distension since admission.

You send an electronic message to the covering surgical intern linked to the patient's chart and state: "I am **c**oncerned- this patient's pain level is 8/10. Nursing assessment reveals tenderness at surgical sites and significant abdominal distention."

The surgical intern responds that he will order additional narcotics. Meanwhile, the patient becomes febrile at 39°C with a heart rate of 120 and blood pressure of 84/43.

You send a follow-up message in the same thread that states: "I am **u**ncomfortable- The patient's abdominal pain is getting worse. She is also now febrile, tachycardic, and hypotensive. Can you please evaluate?"

The surgical intern's response is that he will evaluate the patient after finishing his next scheduled surgery.

Your next message in the thread: "This is a **s**afety issue: The patient's vital signs are unstable and meeting Systemic Inflammatory Response Syndrome (SIRS) criteria."

This last message indicates a safety issue, and the threatening clinical situation must be addressed. The process of how to best "stop the line" relates to your institutional best-practices. Examples range from calling a supervisor by escalating the chain of command or activating a response team call.

The CUS technique is applicable to diverse patient care scenarios. CUS is also a communication strategy that is part of the AHQR's interprofessional curriculum entitled Team Strategies and Tool to Enhance Performance and Patient Safety® (TeamSTEPPS ®). The process of learning TEAMSTEPPS® prepares you to advocate for clinical safety. Additional information about the CUS technique and TEAMSTEPPS® is free and readily available online.

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The New Face of Trauma Informed Care Application in Nursing

By Nisa Harris BSN, RN

A 'trauma revolution' was started with Dr. Peter Levine's Somatic Experiencing (SE) technique, Dr. Stephen Porges's Polyvagal Theory (PVT), and Dr. Richard Shwartz's Internal Family Systems (IFS) Approach. All three theories gained a tangible recent increase in momentum in the therapeutic and coaching realms through their similar focus on pausing to reflect, connection, safety, curiosity, repressed emotions, feeling seen/heard, embodiment, and movement. Utilizing a combination of these approaches, the potential for mental health benefits for the average person is great, both in outcomes and in decreased amount of time before people feel improvements in mental and physical well-being.

The approaches mentioned differ from typical approaches such as CBT and long-term exposure therapy, in that the need for long talks or revisiting traumatic experiences gets removed. SE pays attention to internal body sensations, PVT highlights the daily subtle subjective threats our nervous system receives that create subconscious patterns over time, and IFS focuses on the "parts" of ourselves. All three help the person to safely explore an existence where no part of themselves is worthy of shame, suppression, or judgment. In learning how to embrace what occurs in our nervous system and body, people start to recognize triggers that create sensations of dysregulation in their bodies and instead create conscious choices that change previous patterns. The experience enables what is termed a 'discharge of survival energy'[1].

What Do the Results of Somatic Experiencing Look Like?

Instead of the typical cognitive form of therapy, SE is a body-oriented therapeutic approach:

"Clients' attention is directed to internal sensations, both visceral (interoception) and musculoskeletal (proprioception and kinaesthesis), rather than to primarily cognitive or emotional experiences…. In doing this, clients are trained to gradually reduce the arousal associated with the trauma by increasingly tolerating and accepting the inner physical sensations and related emotions and by activating internal and external resources, such as identifying parts of the body or memories that are associated with a positive and reassuring feeling. The resulting increase in interoceptive and proprioceptive awareness leads to a 'discharge process' after which the trauma-related activation is resolved" [2].

To understand "discharge" of energy, consider a speaker about to go on stage with pent up energy. In order to not continue to be nervous, they can breathe, walk, do jumping jacks or whatever they need to stabilize the energy level so that the excess dissipates and they can present in a leveled manner. The energy needs to go somewhere and if not processed through the body, it remains stuck thereby causing dysregulated sensations.

Learning the language of the body can feel foreign at first to participants. In a 2025 article titled "Veterans; experiences of somatic experiencing and prolonged exposure therapies for post-traumatic stress disorder: A qualitative analysis" they acknowledge that with SE, "Talking less and working more with the body was not immediately clear to participants, 'All this talking less and more calming, I've never been through something similar in my life, but slowly, slowly, I gave it a chance and (then) you understand' (participant 8)." Another participant in that analysis reframed the typical way of approaching therapy and described "When I requested this therapy it was with the thought of like putting tipex (white-out/eraser) on the event, and at the end of the therapy I realized that there was something inside of me that didn't want to wipe it out, rather simply learn to live with it and I think those are the tools I got' (participant 4)" [1].

Learning to "Live With" What We Experience

The significance of learning to "live with" the things that trigger us can be better understood if we consider what Dr. Porges calls Neuroception. One can imagine Neuroception as though people have a Spiderman-like "spidey sense", which helps us to detect danger regularly. When people subconsciously feel threats, their nervous system kicks into survival mode. Without the awareness that they are in a hypervigilant state of being, they get stuck in the Fight/Flight or Freeze/Fawn/Shutdown. Over time, running away from simply experiencing that which we subconsciously feel is a threat can overload our system. Hence chronic mental and physical ailments emerge.

Neuroception helps to better understand Dr. Levine's findings. Essentially, we have all developed subconscious patterns as to what constitutes our subjective threat. In other words, if you got a look from your parent whenever you would cry, you may have learned that it was a *threat* to show vulnerability and therefore you learned the pattern of suppressing the part of yourself that shows emotion.

The possibilities for how these patterns appear are endless and have the potential to create subconscious repressed emotions that create stress, which again, in turn, creates chronic illness, etc. In the nursing field studies have shown that something as mundane as self-criticism can increase Midwives' risk for developing PTSD. The findings in the 2024 article "The role of self-criticism and self compassion in the development of PTSD among midwives" show "Severity of the PTSD correlated with their self-criticism and the pain catastrophizing rates" [3].

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What SE, PVT, and the IFS approach all require for healing to occur is ultimately learning a feeling of safety with all aspects of what we experience as opposed to those subconscious threat patterns. Safety, connection, embodiment, and curiosity are keys to unlocking the rational part of the brain, the prefrontal cortex, which helps to get the person out of the 'stuck state' of being. In other words, teaching our bodies that we are safe to accept all the parts we may criticize, shame, or suppress, can begin mental and physical healing.

The Difference Between PTSD and Everyday "Trauma"

These approaches highlight that our bodies go into survival mode more regularly than we are aware of without knowing how to diffuse that dysregulation from daily triggers. Our reactions to triggers can look like anger, angst, depression, stress, overwhelm, poor self-esteem, etc. How does this differ from someone with a diagnosis of PTSD?

MRI scans note that "PTSD subjects compared to trauma-exposed non-PTSD individuals showed a significant volume reduction of a large left-sided grey matter cluster extended from the parahippocampal gyrus to the uncus, including the amygdala." They conclude that a shrinking of the hippocampus, which is responsible for memory, and the amygdala responsible for fear, contributes to the expression of symptoms that people with PTSD display. Such loss of volume would create a scenario where someone with PTSD cannot necessarily distinguish between the time frame that a past, present, or future threat is occurring and therefore remain at a heightened hypervigilant state as though they are all potentially occurring presently [4].

Not only is it more difficult to be in a calmer mode, but a person with PTSD's go-to for calm ends up being disconnection so that they don't overwhelm their system. In my work with Veterans for more than a decade, I have noted the common symptom of Veterans with PTSD feeling 'detached from their bodies', where they don't know what joy, safety, or some general emotions feels like for them. There have been studies that show that "PTSD-associated alterations in neural connectivity with the DMN and SN, which together, may help to facilitate improved emotion regulation abilities in PTSD." In other words, those changes seen on the MRI of patients with PTSD can potentially heal [5].

How Do We Regulate Daily?

Dysregulation can be thought of as any moment that someone's actions and or emotions are misaligned with the current setting. Ultimately, if we understand our triggers and how to regulate, there is something in PVT called co-regulation which thereby helps others to regulate as well. The power of co-regulation is demonstrated beautifully in a podcast with Dr. Danny Brom, a renowned expert on trauma and resilience in the face of terror and disaster and the treatment of Psychotrauma in Israel, where they spoke on dealing with displaced people in Israel and the soldiers. Dr. Brom remarked, "What regulates people is another person. When you are together with someone you really trust, that helps. When you get a safe hug from someone who is really interested and curious to hear from you, that is something that regulates" [6].

Movement therapy takes regulation a step further and teaches that literal movement itself helps the body not to feel stuck and signals on a somatic level that safety that we aim to reteach our nervous system. Furthermore, stimulating the Ventral Vagal branch of the Vagus nerve helps people get out of the survival modes. These exercises can be learned from several Vagal nerve reset programs but also eventually intuitively recognizing that a certain breath, touch, movement, voicing something, posture, etc., could be what your body needs at any given moment to regulate.

An example with my client demonstrates the potential for faster healing of mental and physical issues. When I had the honor of doing a somatic movement session with an Israeli soldier suffering from PTSD nightmares 6 months after war, he told me it was the best session he had and didn't have nightmares the following nights. Once my clients learn the language of their nervous system and body, they begin to not fear the angst and overwhelm that shows up, and instead see it as an opportunity to heal. They recognize that their emotions and how they manifest in their daily lives are signals for them to take note of and they can redirect their mental and physical orientations. With enough practice, these shifts become second nature.

Application in Nursing

Generally, becoming conscious of the unconscious and being led in a safe way to get introduced to the language of your body, nervous system, and all your moving parts is the path to a more regulated existence. Proper guidance is needed so as not to get stuck in a shutdown survival state. However, as nurses, we touch on patients' interoceptive cues regularly. Interoceptive cues include sensations such as physical pain, temperature, heart rate, breathing rate, the need to utilize the restroom, etc. SE starts with those basics and expands on gaining awareness of those sensations.

Some examples that illustrate the potential application of these modalities in the nursing practice:

A patient with HTN sees a 30-point drop in blood pressure in real time after two minute breathing exercises, the nurse teaches them that breathing is literal medicine for their veins.

If a patient states that they feel numb or has a high pain tolerance, a nurse can be clued into knowing to offer Mental Health services.

An overwhelmed patient seems like they are trying to hold it together during a physical assessment, the nurse can give permission to let them feel their feelings and see the discharge of energy when they give themselves what they need; have a good cry instead of suppressing.

When a nurse can somatically feel the difference between what other's angst versus their own, there is a decrease in the overwhelm and self- criticism that can leave nurses vulnerable to chronic conditions.

When a pediatric oncology patient is acting out, a nurse finds what helps them feel safe and connected instead of assuming they are 'bad'; co-regulating to alleviate a cycle of poor behavior.

If a patient is encouraged by the nurse to be gentle with themselves and aim to wiggle a few fingers if they feel stuck in depression, a patient can begin to connect back to their body.

When vasovagal symptoms begin, a nurse with an understanding of PVT can help prevent a syncopal event and teach the patient how to in the future.

If a nurse gives themselves a moment to breathe and stretch because they understand that they can reset their Vagal nerve before tackling daily or stressful situations, everyone benefits.

The new face of trauma therapy no longer solely belongs to the Mental Health field and patients with PTSD. As Levine put it, "Al-

though originally developed to treat trauma-related disorders, SE is therefore increasingly used in clinical practice to treat other mental disorders as well" [2].

Through the newer approaches to trauma listed in this article lies the potential to alleviate overwhelm, burnout, stress, chronic illness/fatigue, body dysmorphia, loneliness, addiction, pain, anxiety, compulsive and impulsive behaviors, depression, and even PTSD symptoms. Furthermore, with such awareness, nurses can apply this to themselves and their patient care. When nurses and patients learn to process their stress within regular daily activities, without needing to have major talk therapy sessions, lasting healthy regulation naturally occurs faster. There is a lack of SE and somatic movement therapy trials in research literature and more clinical trials could be beneficial in ensuring that these modalities are more widely effective, understood, and applied.

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Maimonides Health's Team Lavender Peer Support: A Comprehensive Response to Healthcare Worker Emotional Well-Being

By: Deborah Douek MS Ed, LCAT, LPAT, ATR-BC, ATCS, CPXP, GC-C

Healthcare workers face unique and significant stressors compared to other professions, akin to the pressure faced by military personnel in combat. However, the COVID-19 pandemic introduced an unprecedented level of stress on healthcare workers that had not been seen for generations. Nurses, physicians, allied professionals, hospital chaplains, and support staff were not only battling to save the lives of their patients but were also at risk themselves. Recognizing the critical need for emotional support, Maimonides Health implemented the Team Lavender Peer Support (TLPS) program through its interdisciplinary Workforce Workstream group.

Program Overview

Although peer support programs for healthcare workers were not new, Maimonides Health's Team Lavender was modeled after successful initiatives at institutions such as HH+, Northwell Health, and Cleveland Clinic. However, the concept dates back to the early 2000s when Dr. Earl E. Bekken first coined the term "Code Lavender" at North Hawaii Community Hospital (DeMarco & Resnicoff, 2024). In 2020, Maimonides launched its own pilot of TLPS on five high stress units and expanded across the system by April 2021. TLPS is a 24/7 rapid-response support system designed to provide immediate emotional assistance to staff members. The program is staffed by both clinical and non-clinical personnel, all of whom are trained in Psychological First Aid (PFA). Until December 2023, the program was entirely led by employee volunteers. However, recognizing the program's value, Maimonides human resources hired a dedicated manager to lead this program.

Training and Structure

PFA training is a central component of TLPS. This four-hour training is delivered by an Emergency Department physician and a clinical psychologist. The program involves both interactive didactics and role-playing exercises with paid actors to simulate real-world situations where employees may require support. These simulations are based on actual events within the hospital to ensure relevance and accuracy.

After completing the PFA training, responders undergo a Team Lavender Orientation, which prepares them for active participation in the program. TLPS operates on a monthly on-call schedule, and new responders are paired with seasoned members to ensure adequate support and scaffolding. Currently, there are 27 active volunteers, predominantly covering weekday daytime shifts. Night and weekend coverage remains a challenge, but the program leverages rapid response team members and night-shift nursing education staff who are also trained in PFA.

Team Lavender Response Activation

To activate a TLPS response, any member of a team calls the Team Lavender phone number and gives the pertinent information to the dispatcher. For a team response, either in the moment support is dispatched or a response is scheduled for a time more conducive to the department in need. Once a response is activated, the responders are notified and dispatched for the designated time to the location to provide support. Responses are typically between 10 minutes to one hour depending on the acuity and needs of the staff. Team Lavender resources are provided for the staff and a follow up is scheduled if needed. The responders complete their report on the TLPS form and a follow up email is sent to the unit leader or staff member that called in the request for support.

The Role of Nursing in Team Lavender Peer Support

Nurses, as primary caregivers in hospitals, are particularly vulnerable to stressors such as compassion fatigue and burnout. These challenges, combined with the healthcare culture of "soldiering on" through difficult cases, can adversely affect their emotional well-being, potentially leading to suboptimal patient care and safety risks such as medication errors. According to a survey by McKinsey and Company (2023), despite sustained and high levels of burnout, approximately two-thirds of surveyed nurses indicated they were not currently receiving mental-health support.

At Maimonides Health, nursing teams have been the primary recipients of TLPS with 40

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responses to nursing-specific cohorts in 2024 alone. These responses are initiated by nursing leadership, staff nurses, or by outreach from Team Lavender following adverse events. Although the original criteria for TLPS focused on team support, individual nurses have increasingly sought assistance for issues involving colleagues, patients, and personal challenges.

Increasing Utilization and Outreach

The increase in TLPS usage over the past three years can be attributed to a robust internal marketing campaign which includes information at new employee orientations, laminated flyers in staff lounges, departmental in-services, and other educational initiatives such as lunch-and-learns, lobby tables and screensavers. TLPS has also established a close partnership with nursing leadership to advocate for the use of TLPS following adverse events, ensuring that staff are aware of the emotional support available to them.

- Individual calls to TLPS often relate to a range of emotional challenges such as:
- Conflicts with colleagues
- Patient-specific issues
- Personal medical or chronic conditions
- Feelings of being overwhelmed
- Grief and loss
- Work-life balance difficulties
- Social issues, such as domestic violence or stalking

Although the program primarily focuses on team responses, no employee who contacts TLPS is ever turned away from immediate support. Employees are then directed to the appropriate resources for long-term care as needed. As individual calls have increased, TLPS is reassessing its criteria to ensure adequate support for all staff members.

Case Example

In one case, a nurse contacted TLPS at 9:30 PM on behalf of a distressed colleague who had been emotionally affected by the death of a young patient. The nurse had worked beyond her shift in an effort to save the patient, only for the patient to die, leaving behind a newborn and another child. This nurse experienced feelings of grief, guilt, and exhaustion. In the moment, TLPS provided emotional support, listening to the nurse's feelings and helping her strategize a coping plan. Following this interaction, the TLPS manager reached out to the unit nurse manager to suggest that the entire team might benefit from a collective response. The following Monday, a Team Lavender response was scheduled, allowing the nursing staff to discuss their emotional reactions to the death. This opportunity led staff to process other recent patient losses and complicated cases that they may not have otherwise processed.

The team shared their grief, and the opportunity to talk through these emotions was both cathartic and supportive. TLPS played a crucial role in guiding this discussion and providing emotional space for the staff.

Team Lavender Metrics

There has been a significant increase in response since the initiative's inception with 73% more calls in 2024 than in 2023. This uptick is largely due to increased internal marketing, word of mouth referrals, and increase of normalization of talking about and getting help for mental health concerns.

Moving Forward

While much of the world has returned to normalcy following the end of the COVID-19 pandemic, healthcare workers continue to face the cumulative emotional toll of the crisis. The rising acuity of patient care and high patient volumes leave little time for staff to process and cope with emotional strain. According to a 2023 study by the American Hospital Association, 93% of healthcare workers experience some form of emotional distress, yet only 13% access behavioral health services. The increase in TLPS calls reflects both the program's growing presence within the institution and the delayed emotional effects of the pandemic.

Moving into 2025, the TLPS program aims to expand its impact by partnering with the trauma and rapid response teams to provide immediate support following critical incidents. Additionally, there will be a greater emphasis on educating staff about available resources for emotional wellness, both within the health system and in the wider community. Expanding the roster of TLPS responders, particularly for nights and weekends, will also be a priority. TLPS is working with human resources leadership to identify potential incentives that could be offered to increase the roster of dedicated responders.

TLPS will continue to leverage its unique position that straddles

Team Lavender Metrics Comparison Years 2022 - 2024

Year	Total Team Lavender Responses	Total Staff Related Responses	Total Patient Related Responses
2022	13	10	3
2023	30	14	16
2024 YTD	54	28	26

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team where there is often crossover. In addition, working closely with outpatient behavioral health has been instrumental in fast-tracking appointments for employees who need them.

Finally, TLPS will continue to collaborate with safety and bioethics committees to address issues raised during peer support responses, ensuring that the program remains responsive to the evolving needs of healthcare workers. TLPS also works closely with employee health services, outpatient behavioral health, and organizational wellness departments to provide comprehensive support for employees facing emotional distress.

Maimonides Health's Team Lavender Peer Support program is a vital initiative addressing the emotional well-being of healthcare workers during an era of heightened stress. By offering immediate, compassionate, and accessible support, the program helps mitigate the emotional toll faced by professionals across the health system, with a special focus on those at the bedside who navigate the most challenging moments. As the healthcare landscape continues to change, expanding and integrating such programs into broader mental health efforts is imperative to fostering resilience and sustaining the workforce's well-being.

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Deborah Douek is the manager of Team Lavender Peer Support and the Healing Arts Program at Maimonides Health, the largest safety-net hospital in Brooklyn.

Member Milestones

SHEVI ROSNER DNP, RN-C published an article titled "Baby-Friendly Hospital Initiative: Past, Present, and Future" in Neonatal Network in January 2024 and an article titled "Early Milk Expression for Mothers of Premature Infants and its Impact on Milk Volumes" in Journal of Nursing Care Quality in June 2025.

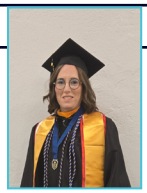
SCOTT TOPIOL MSN, RN, CEN, MICN transferred from USPHS to the U.S. Navy Reserve. Lieutenant (O3) in February 2025. He will be serving part-time with a deployable field hospital unit based out of Camp Pendleton, CA.

JULIE RUBENSTEIN RN, CDE became a Nurse Prescriber in May 2025 with the ability to prescribe certain medications under new Ontario law. She also obtained certification as a first aid and CPR instructor in June 2025.

NINA SABGHIR CNM, WHNP received the YEmmy Award (York Eminent) for excellence and innovation in teaching from York College (CUNY, Queens, NY) in May 2025. This award is chosen by the York College School of Nursing.

SIMONE SHAFIRO BSN, RN graduated from Molloy University in May 2025 and will be working at the CTICU/SICU at NYU Langone in Mineola, NY.

RIVKY SANDEL RN graduated with honors from Dominican University of New York in May 2025 at age 53 and passed the NCLEX in June 2025.



MITCHELL SILBERBERG BSN, RN, PHN started his first nursing job in May 2025 as a nurse supervisor of a skilled nursing facility / rehab in Los Angeles, CA. He recently got a nurse residency offer on a telemetry unit in a large hospital in the area.

ZECHARIA ROTHKE BSN, RN obtained his pediatric CCRN certification in March 2025.

MICHAEL KUPFER MSN, PMHNP graduated from Ohio University as a Psychiatric Mental Health Nurse Practitioner in May 2025.

TO HAVE YOUR MILESTONE FEATURED IN OUR NEXT JOURNAL, SCAN THE QR CODE HERE AND FILL OUT THE FORM!

NURSES TO KNOW

By: Mitchell Silberberg BSN, RN, PHN

Pessie Koff, BScN, RN

Palliative Care Nurse

Briefly share your professional career to this point, and how you entered into palliative care:

I got my first job out of nursing school in home care. In Canada, all medical care is covered by the government, so I was hired by an agency that receives referrals from a government agency, Ontario Health at Home. For the first seven years of my career I worked in med-surg nursing (diabetics, wound care, drain care, IV medications etc and palliative care). When I came back from my fourth maternity leave, they were creating health teams and my agency got a contract for palliative care in North York where I live. I really believe that this was all Hashem's hand guiding me, and I will say that I had two incredible patients who I started seeing for 'regular' nursing and then I stayed on through their illness and their transition to palliative care. I knew that caring for the whole patient, not just their wound or drain, is where I was headed. While I was on maternity leave I began taking courses through the de Souza Institute to enhance my palliative care skills. I did not know at that time that my agency would be awarded the contract for palliative care. And that's when it all came together.

Can you describe your role, and what a typical day might look like?

We start our day at 8:30 am with huddles, 10 minutes per area for a total of 40 minutes. Huddles are updates provided by the nurses, doctors and care coordinators to make our care so seamless and efficient.

We visit our patients in their homes, and at each home visit, we assess and manage pain, nausea, breathing, fatigue, anxiety and depression, among other symptoms. "I always say that 80% of my assessment is done by walking through the front door." I know if the patient had a good or bad day by how the family or caregivers greet me. Although I do take vitals at most visits, numbers are not the focus of my care.

Is there something specific about your area of nursing that you love?

Seeing patients and families in their own environment, with their pets and pictures on the wall, gives so much more meaning to their life and their death. I love the connections I make with my patients and families and with the doctors and nurses on my team.

Is there something about your field that you'd like to share with our readership?

Palliative care has taken on a different meaning in the last decade. It's no longer just the last few weeks, days or hours of a person's life. It's active medical treatment of any pain or symptom for anyone with a life limiting illness. Most of my patients are cancer patients but they can be anywhere in their illness trajectory when they are referred, from newly diagnosed, going through any active treatment, or close to end of life.

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

I am certified by CAPC, the Center to Advance Palliative Care.

Do you find that being an orthodox Jewish nurse is an asset or a barrier to being a palliative care nurse?

As an orthodox Jew, I am easily identifiable. The area where I work is 50% Jewish but maybe only 5% orthodox. The Jewish patients are always thrilled to have a Jewish nurse and the non Jewish patients typically have a friend or neighbor who is Jewish and they are usually able to make a connection or play Jewish geography.

I never had any negative experiences in my workplace; not with my agency nor with my patients, as an orthodox Jew. Everyone knows my religious scheduling needs (Saturdays and holidays) and they have always been accommodating.

Specifically in palliative care, I think being an openly orthodox Jew has been an asset. Jewish patients usually want to have a proper Jewish burial even if they never kept anything religiously for many years, and I am able to help them navigate this important part of life.

I will add that I don't have a lot of orthodox patients in palliative home care because of their associations with the old school version of end-of-life-only palliative care. There is a huge lack of understanding that palliative care is active medical treatment and not just "being sent home to die". They don't recognize that palliative care can also mean pain and symptom management. Most orthodox Jews want "everything possible done" and they'll often want every single symptom investigated and will go into the hospital for that. I am always happy to be a resource for people in the community, but I rarely find them accepting of all the available care that palliative care encompasses. I find that if *halachic* questions are asked properly, they can have really good symptom control, and then when a person reaches the point where no more treatment options are available, they can die comfortably in the setting of their choice.

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

NURSES TO KNOW

By: Mitchell Silberberg BSN, RN, PHN

Yonah Solomon, DNP, AGACNP-BC, ACHPN

Palliative Care Nurse

Briefly share your professional career up until this point.

I was a former Rebbi for a number of years and then transitioned a few years ago into oncology nursing.

How has it been transitioning from the RN to NP-C roles? What does your typical patient case look like? Their care management?

I enjoy the increased schedule flexibility, family time, and work-life balance that comes with being a nurse practitioner (NP). At the same time, there are stresses from new responsibilities, and I am still adapting to my new role. Compared to being a registered nurse (RN), the NP role has "much lower stress," which was a pleasant surprise for me since bedside nursing requires a constant demand on one's time with multitasking. Currently, I see about 4-6 patients a day as a palliative care NP. A large percentage are oncology patients, but also those with advanced dementia, end-stage liver cirrhosis, end-stage renal disease, people considering dialysis, and ICU stroke patients. With dementia patients, the provider communicates with the family when the patient lacks sufficient capacity. These conversations revolve around goals of care and possible enteral feeding.

Patient interactions differ in length from five minutes with patients who refuse his care to over an hour with those who need more support. These meetings begin with rapport building, starting from a place of humility. Humility sits at the core of palliative care, since one must follow the nursing process by assessing first. Reading the room is a key skill since coming in with an agenda can turn patients off. We come to serve, putting ourselves in a position of reliability and usefulness to everyone. This patient-provider relationship can be episodic, throughout a patient's hospitalization, or even extend for years, such as in the case of patients with cancer. A difficult aspect of palliative care, both halachically and psychologically, is the discontinuing of life support, now often called "compassionate extubation."

Typically, RNs carry out the orders. In my current hospital, I do not put in the order set for morphine or fentanyl drips, nor for compassionate extubation. It was different during my clinical hours as an NP student at City of Hope. There, they had certain protocols for ordering those order sets. It can get complicated halachically, so I was glad to be removed from it. According to halachic guidance I received, facilitating the conversation and giving the orders are halachically more okay, but everyone should ask their local Rav.

Do you have any special credentials to work in Palliative Care?

As an RN, I was certified as a Certified Hospice and Palliative Nurse (CHPN) certification through the HPNA, Hospice and Palliative Nurses Association. I also have Advanced Certified Hospice and Palliative Nurse (ACHPN) certification now, which is for advanced practice registered nurses (APRN).

What is Palliative Care, and how does it differ from Hospice Care?

Many individuals, including clinicians, confuse these two types of care along with comfort care and end-of-life care. Palliative care (PC) is provided alongside a patient's regular medical care: primary, cardiology, nephrology, etc. "It's an additional consult that's along for the ride with the patient. Sometimes it's episodic or a one-time consultation for certain decisions." Given that it is provided alongside the patient's regular medical care, "Palliative care also serves as an extra layer of support for patients, families, and providers." It provides symptom management related to long-term life-limiting illness(es). At the same time, holistic care for the individual is also important; disease has physical, metaphysical, and psychological components. It touches on family dynamics, fears felt, and even life review.

The most commonly time-intensive aspect of PC is clarifying the goals of care. PC providers help patients and families navigate complex information, difficult feelings, and questions to facilitate meaningful decision making. Patients should be well-informed about their decisions. Regarding PC's impact on other providers, it is important to note that they have a large number of patients to care for each day. Although PC providers cannot decide on different regimens of expert care, they can sort out goals of care and provide emotional support, which both take up a significant amount of time. PC saves precious time for doctors and other clinicians by preventing delays in treatment, which might happen if those providers' widespread medical management of patients were slowed down with time-consuming conversations.

Practically speaking, PC practitioners provide symptom management related to disease or even treatment. They also provide emotional and spiritual support while continuing the ongoing process of goals of care conversations. They support patients' and family members' understanding of the medical jargon medical providers use. Medical jargon can be overwhelming and confusing, so PC smooths out this continual process in order to leave patients with informed decisions best attuned to their values and goals.

On the other hand, hospice care (HC) is related yet quite different. Once the patient and family decide to no longer pursue curative treatment and transition to comfort measures, the primary medical team hands over care so that the hospice team becomes the primary provider(s). HC involves non-curative measures to more simply and affordably treat symptoms. They might continue treatments we don't typically think of as symptom-oriented, such as

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beta blockers or antihypertensives, since these are vital to keeping the patient alive. Hospice Care is not trying to expedite death but only shifts the focus to general health maintenance. For example, if a seizure-risk patient went off their antiepileptics, they might develop seizures, which can be quite harmful. The goal now is to ease their suffering and promote comfort, rather than cure them.

In my hospital, his PC team works alongside hospice counselors and, at times, has ordered Hospice evaluations or education. This has helped streamline care for patients. Shockingly, sometimes hospice orders were given before palliative care orders! This can be psychologically harmful to patients since the hospice order could have happened before patients were informed of a serious prognosis. This is why PC's sensitivity is needed.

Yonah also touched on the concepts of primary vs specialized palliative care:

Primary/General Palliative Care is done when a general clinician, such as an RN or a provider, engages in family support. This is also an important component of true nursing care because attentive assessment keeps in mind the multidimensional component of caring for a human being. If, for example, a patient had a difficult conversation about prognosis with a provider, it is beneficial to feel out their feelings of fear and upset with mortality or regrets. Consulting a Social Worker for coping or emotional support is beneficial too. Another example might be when a hospitalist begins or fully independently provides Palliative Care for a patient with certain comorbidities, which require challenging decisions around barriers to care, managing pain, etc., which might be a quality of life the patient does not want to pursue.

Specialized Palliative Care requires specialty training, which he got 3 months of through mentoring during a palliative care rotation. Certification is available to become this specialist who can pick up where other providers left off. They come in and spend the time to build rapport and trust in order to move the ball down the field.

What are some of the challenges Palliative Care Specialists face?

There are still many false assumptions and fears surrounding Palliative Care. Patients and family often still hold the stigma that they are not ready for PC, given the confusion with hospice. They are scared of writing off a patient for death. Meanwhile, PC exists to support goals and treatments, even going so far as to help with trials and symptom management. PC advocates for somebody to have their voice heard while not pushing them in a certain direction to decide for them. Even colleagues in healthcare still hold false assumptions about PC. They do not necessarily know what is brought to the table or how it will be beneficial to them. They might also believe that Social Work or Case Management should have been called instead. This is why it is important to effectively define and promote palliative care.

Yonah shared the interesting perspective many have taken, that "Palliative care is classically not revenue-producing but is resource-sparing." On the business end of hospitals, there is a complex cost-benefit analysis for employing a PC team of doctors, APRNs, social workers, and chaplains versus a physician who can bring in revenue with procedures. At the same time, Palliative Care is able to bill at a much lower rate. For example, advanced care goals discussion planning bills higher than symptom management. It can provide orders, but it does not have more revenue-producing procedures. This is why hospitals are reticent to invest in PC. Meanwhile, literature shows that hospitals' well-developed Palliative Care programs actually save a lot of money. Patients receiving it have effective goals of care conversations, shortening their length of stay in the ICU. This can be because care comes to resolution with compassionate extubation, simply not waiting in limbo in the ICU, or educating the family after the intensivist team decided it was appropriate for the patient to transition to "trach, peg, and LTAC." Palliative Care Specialists are trained and experienced in conducting these delicate conversations, informing patients and families better and faster.

What new changes have you seen in palliative care developing, or are on the horizon?

Yonah is happy that May 1st marks the start of his second year in the field, so he is still gaining experience. He believes there could be upcoming developments with respect to pharmacological interventions or technologies. There are also different models of implementation per hospital.

He was excited to read in a recent HPNA journal article about embedded speciality palliative care: a speciality within a speciality. This means that a hospital, likely major academic centers, has an individual Palliative Care professional just for Oncology, Cardiology, etc. This bolsters expertise and perhaps improves patient outcomes, given that this provider would know trajectories of illness per kind of disease, courses of illness, and the struggles families face.

In some hospitals, like Cedars-Sinai and City of Hope, it is now called Supportive Medicine. This helps with the stigma and fear associated with the specialty and also expands the term to include the idea of a team as well.

Why did you go into it?

His interest was piqued during a nursing school presentation from a hospice RN who stressed how profound the psychosocial aspect of PC can be. Yonah's background related to this much like Pastoral Care in that he dealt with people's challenges and struggles in tune with previous experiences.

How has it been being an Orthodox Man in Nursing? Has it been more of an asset or a challenge?

He expressed that challenges at the bedside are pretty similar for any Frum nurse, man or woman, and center on issues of Tznius. This has been far less of a problem as an NP, now that he is more physically removed.

In terms of identity, he always wears a yarmulke. If anything, it has been an asset and never an obstacle or concern. It helps build trust in that patients and family realize, "Oh, this is a spiritual person who might get part of what I'm going through!" This might partially be because the population he provides for is predominantly Latino with strong religious identities that appreciate his religiousness. At the same time, Yonah does not bring up spirituality or religion, but follows the patients' lead. He will of-

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ten encounter someone religious saying, "G-d is in charge, not the doctors." Handling a difficult prognosis with a faith-centered patient population has unique challenges. There is significant mistrust of medical professionals when talking science, diagnosis, and prognosis while they live with G-d in faith, knowing He is all-powerful. To navigate these situations, he has shared that, "You and I both know that G-d is in control. If He should choose to perform a miracle, and I hope so, that would be wonderful. At the same time, we may need to plan for the event that doesn't happen. I wanna ask you questions, not to bother you or cover the hospital's bottom line, but to have you think of alternatives to plan in case things go differently. We will continue hoping for the miracle." It is essential to try to meet the patient where they are.

Some nonreligious or atheist providers might say the patient and family "don't get it" and get frustrated. To them, medical care is purely scientific, so they cannot connect spiritually. Yonah says it is important to show respect by humbly listening and honoring the patient's beliefs. After all, when you start from a position of respect, people trust you more.

What advice would you give someone entering the nursing profession?

New Grads and Nursing Students should really try to reinforce and become more deeply aware of the profound opportunity to deeply impact somebody in a transcendent way, well beyond seeing their progress in medical recovery. Very often in the way he/she provides care, he/she can impact someone more deeply than in what he/she provides. We sometimes forget the incredible power of presence and respect. It is something patients really note and remember. It leaves a huge impact on their sense of security and feeling seen.

Related to this, He shared one of the core lessons that's stuck with him since nursing school. Professor Zarmine Naccashian from CSUN defined spiritual care quite simply: "It is not a religious assessment to speak with a chaplain or to check off a box for their faith background. Spiritual care is when I walk into the room and say to my patient, 'I am here for you, today.'"

There is much work to be done about the range and depth of what that means in our interactions with people. A good nurse passes medications on time, does a thorough assessment, and informs the interprofessional team of changes in status and needs. But if the nurse can also bring into that a presence and focus on being in tune with the mental state of the patient, it makes an entirely different experience for the patient. It is also an opportunity to deepen the provider as a person, and can be a transformative experience for both sides.

Lastly, Yonah stated, "People are typically surprised by Palliative Care. It has been deeply meaningful and satisfying to give support to patients themselves and family members, and loved ones at times of such suffering, angst, loneliness, and fear. To be present for somebody, even if not solving their problems. It's a powerful experience, giving a comforting presence and respect."

OJNA BOARD LEADERSHIP UPDATES:

OJNA is proud to welcome **Hannah Bodenstein MBA, BSN, RN,** as our new **President** as of **November 2024.** Hannah serves as the **Senior Director of Business Intelligence and Quality** at **Maimonides Medical Center** in Brooklyn, New York. With her combined clinical and data expertise, strategic vision, and deep commitment to community, Hannah brings a renewed focus on education, innovation, and outreach across the organization. We are excited for the direction she is charting and look forward to a year of continued growth and meaningful engagement under her leadership.

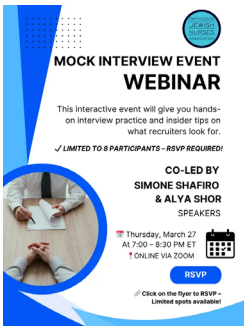
Lectures & Education (2025)

OJNA's commitment to lifelong learning and accessible clinical and Halachic education continued in 2025 with a robust schedule of events and collaborations:

- **Chemed Lecture Series**: The entire **Chemed 2025 lecture series** was made available to OJNA members, offering a broad range of topics relevant to clinical practice in the frum community.
- **April 2025**: Rabbi **Benzion Leser** delivered a thought-provoking session titled *"Nutrition and Halacha at the End of Life"*, exploring the complex intersections of medical care, dignity, and Jewish law.
- In collaboration with **Eimatai**, OJNA co-hosted a deeply resonant event on *"Navigating Kibud Av V'em and Aging"*, offering guidance and support for nurses navigating elder care from both professional and Torah perspectives.

Student & Early Career Support (2025)

OJNA continues to invest in the next generation of Jewish nurses through targeted programming and mentorship opportunities.



In **March 2025**, OJNA hosted a highly impactful **Mock Interview & New Grad Support Event**, designed to help nursing students and recent graduates enter the workforce with confidence. **Simone Shafiro** and **Alya Shor** co-led this dynamic session, offering practical strategies on interview preparation, resume development, and professional presence. Attendees valued the chance to engage in real-time practice and peer networking in a supportive environment.

This event reflects OJNA's broader commitment to mentorship, skill-building, and career development for emerging professionals across the country.

Chapter Events (2025)

Scrubs & Sushi – Nurses' Night Out took place on **June 11, 2025** in **Houston, TX** as an informal evening of sushi, networking, and a brief CE lightning talk, giving local members a relaxed setting to connect and recharge.

Our Heritage Our Health - a lecture and dinner for OJNA nurses took place on **June 30, 2025** in **Cleveland, OH**. The event was coordinated by **Leah (Leslie) Kushner** and attendees heard from Dr. Stuart Ditchek about Ashkenazi Jewish Genetic Diseases: Gaucher Disease Type 1. We thank Sanofi for sponsoring this event.

Upcoming Events

OJNA is looking ahead with enthusiasm as we continue to expand our educational programming and professional presence through national conferences and online engagement opportunities.

- **OJNA Annual Conference – November 2025** - Following the success of our 2024 gathering, OJNA's **Annual Conference scheduled for November 12, 2025** in Passaic, New Jersey is already in the works. Nurses, nurse practitioners, and allied professionals will once again convene for a full day of continuing education, inspiration, and community. More details to follow.
- **JScreen Genetics Education Series (Coming Soon)** - OJNA is partnering with **JScreen** to launch a **4-part live Zoom series** on **genetic diseases in the Jewish community**. These educational events will empower nurses with tools and insights to better support patients through screening, counseling, and family education.

Chapter Events & Community Engagement (2024)

OJNA chapters across the country thrived in 2024, offering meaningful opportunities for connection, education, and professional development. Highlights included:

- On **April 26**, OJNA hosted a **Mock Interview Event** supporting new graduates in their career transitions with guidance and coaching.
- On **June 14**, the **New Jersey chapter** held an inspiring event with **Dr. Stuart Ditchek**, featuring a discussion on clinical care and community advocacy.
- In **July**, the **Pennsylvania chapter** hosted a local in-person event, fostering regional networking and collaboration.
- On **November 11**, we enjoyed our annual OJNA Conference in **Lakewood, NJ**. Everyone had a wonderful time networking, learning, and indulging in the inner works of nursing and Judaism.
- Later in the year, the **South Jersey and Philadelphia chapters** celebrated Chanukah with festive gatherings that brought warmth and community spirit to the winter season.
- A **webinar with Rabbi Dr. David Nesenoff** offered thought-provoking insights and spiritual inspiration.

SCRUBS & SUSHI

CONFERENCE 2024

ANA Conference Report – June 26–28, 2025

Hannah Bodenstein, President, OJNA

Advocating for Nurses, Patients, and the Future of Care:
Reflections from the 2025 ANA Conference

From the steps of Capitol Hill to robust organizational dialogue, the American Nurses Association (ANA) Membership Assembly and Conference, held June 26–28, 2025, brought together nurse leaders, organizational affiliates, and policymakers from across the country to champion the priorities shaping the nursing profession. I had the opportunity to participate in a powerful few days of advocacy, insight, and collaboration.

Hannah Bodenstein and Jennifer Shepherd at ANA Conference

Thursday: Advocacy on the Hill

On June 27, ANA members from New York—including myself—met with staff from Senator Kirsten Gillibrand and Majority Leader Chuck Schumer's offices. Our focus was clear: elevate the voice of nurses and highlight urgent priorities, including:

• Violence in the Workplace: Supporting legislation to address and prevent escalating violence against nurses and other healthcare workers. I was also able to speak about the growing antisemitism being felt in the workplace.

• Medicaid Cuts: Urging Congress to reject harmful reductions that would devastate access to care, strain the nursing workforce, and disproportionately impact vulnerable communities.

• The ICAN Act (Improving Care and Access to Nurses): Supporting this bipartisan bill that removes outdated federal barriers limiting nurse practitioners (NPs) and advanced practice registered nurses (APRNs) from providing full-scope care—especially vital in rural and underserved areas.

• HRSA Nursing Grants: Reinforcing the need for strong funding pipelines for nurse education, workforce development, and faculty recruitment at all levels.

• Support for NINR (National Institute of Nursing Research): Highlighting the value of nursing science and its role within NIH research priorities.

Hannah Bodenstein on Capitol Hill

Organizational Affiliates: Voices Across the Spectrum

During the Organizational Affiliates (OA) assembly, affiliate leaders shared successes and common challenges—particularly around membership engagement, visibility, and social media presence. The sheer diversity of specialty organizations was inspiring! I was thrilled to make new connections with others navigating similar challenges.

Key Governance Dialogues

Though OJNA, as an OA, does not vote on ANA bylaw amendments, we were present for important discussions, including:

• Artificial Intelligence in Nursing: Our own OJNA member, Jennifer Shepherd, contributed to this critical conversation around AI integration in clinical practice and education, both in the Organizational Affiliates discussion and in the larger forum. We are proud to have Jennifer as an active and contributing member of OJNA!

• LPN Inclusion in ANA: This sparked passionate debate, with many in favor of formally including Licensed Practical Nurses within the ANA structure.

• Rural Nursing Representation: A thoughtful discussion unpacked the systemic challenges faced by rural nurses, suggesting future structural acknowledgment within ANA governance.

• Billing for Nurse Services: The American Academy of Ambulatory Care Nursing (AAACN) is working on proposals to develop codes that would enable nurses to bill directly for their services. This topic generated a robust and passionate discussion.

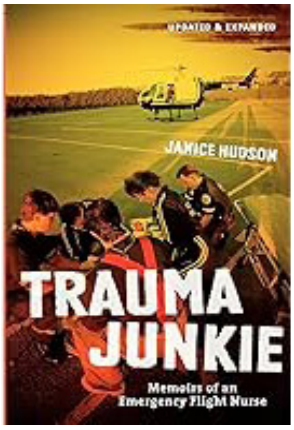
Leadership Elections: Engaging and Accessible

The conference concluded with voting for ANA leadership. Delegates had the opportunity to meet candidates and vote online—perfectly timed before Shabbat!

This year's ANA conference was a testament to the collective strength, clarity, and compassion of nurses nationwide. The message was clear: nurses are the backbone of American healthcare—and they deserve to be heard, supported, and empowered.

OJNA RECOMMENDS: BOOK PUBLICATION

Trauma Junkie



Author: Janice Hudson
Book review by Alya Shor

In this adrenaline-packed memoir, Janice Hudson—a veteran flight nurse—takes readers inside the cramped, chaotic helicopter cabins of California Shock/Trauma Air Rescue (CALSTAR). With raw honesty and vivid storytelling, she chronicles the relentless demands of high-acuity trauma care, where seconds matter, outcomes are uncertain, and emotional stamina becomes as critical as clinical skill.

Hudson shares visceral, real-life cases: a gunshot victim with brain matter on the backboard, pediatric injuries, violent crashes. These aren't just war stories—they're intimate portraits of the unseen toll exacted by trauma care. Alongside the physical chaos, she unflinchingly examines the emotional aftermath: the sleepless nights, the phantom guilt, the mental endurance it takes to show up again for the next shift.

And then comes her own shock—her diagnosis with multiple sclerosis. Suddenly, Hudson must confront the limits of her body, the vulnerability of her identity as a caregiver, and what it means to serve when she herself is in need of care. Her response? Adaptation, resilience, and an unwavering commitment to show up—for others and for herself.

Trauma Junkie is gritty, compassionate, and emotionally resonant. For nurses in all fields—especially those drawn to trauma, critical care, or emergency transport—this book is a visceral reminder that nursing is not just a clinical profession, but an emotional one. Hudson's memoir reminds us why mindset matters just as much as medicine, and why caring for others must begin with caring for ourselves.

A Nursing Student's Reflection

What stayed with me most was not just the trauma Janice Hudson encountered, but the family she found in the field. As her memoir comes to a close, she updates us on where her fellow flight nurses and paramedics are today, reminding us that these intense, high-stakes bonds don't just fade. They become permanent fixtures in your life.

And then, in a powerful turn, the caregiver becomes the patient. Hudson's own diagnosis with multiple sclerosis could have ended her career, but instead, it deepened her perspective. She developed a profound appreciation for the very system she'd worked within for decades and found the courage to prioritize joy, purpose, and personal well-being.

Hudson is someone who has seen the worst of humanity and still chose to show up—for thirty years. Her story reminds us that we often choose our profession to fill a gap others can't. And when life becomes overwhelming, we don't quit. We persevere. We break through the fire.

Trauma Junkie opened my eyes to a world of nursing I didn't know existed—and what excites me most is that there's still so much more to discover. This is just the beginning of my journey, and I truly can't wait.

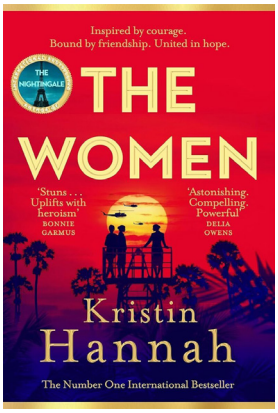
As you reflect on Trauma Junkie, consider:

- What does emotional resilience look like in your practice? Where do you go to "reset"?
- Hudson shares traumatic experiences that she carried with her for years. How do we process and release what we witness as nurses?

Hudson's experiences challenge us to think not only about what we do—but what it costs us. And whether we're doing enough to care for the caregivers.

OJNA RECOMMENDS: BOOK PUBLICATION

The Women



Author: Kristin Hannah
Book review by Hannah Bodenstein

Kristin Hannah's The Women is a powerful and emotionally charged tribute to the unsung nurses who served in the Vietnam War. Centered around Frankie McGrath, a young woman who enlists in the Army Nurse Corps in the 1960s, the novel follows her transformation from a sheltered college graduate into a seasoned trauma nurse facing the brutality of combat medicine.

From a nursing perspective, Hannah's portrayal is striking in its emotional accuracy. The novel captures the intense, often chaotic demands placed on combat nurses—managing mass casualties, making life-or-death decisions, working under fire, and coping with limited resources. Frankie's initial naivety and growing competence reflect a journey familiar to many nurses: the rapid maturation that comes from caring for patients in extreme circumstances.

Hannah also explores the mental toll of nursing in war zones—what we would now recognize as moral injury and PTSD. The characters struggle with guilt, loss, and a society that minimizes or ignores their experiences. The novel paints a stark contrast between the nurses' sacrifices and the lack of recognition they received upon returning home—a truth borne out in historical accounts of Vietnam-era women veterans.

While The Women is a work of fiction, it is grounded in extensive research and largely mirrors the real experiences of American military nurses. The training, chain of command, field hospitals, and emotional isolation are portrayed with authenticity. Hannah consulted with veterans and drew on oral histories to build a world that feels true to those who lived it.

That said, certain dramatizations are in service to the novel's emotional arc and may compress or amplify real-world dynamics. Readers looking for a historical account should supplement the novel with memoirs or primary sources such as interviews archived in the Veterans History Project.

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BOOK REVIEW - THE WOMEN

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Ultimately, The Women honors the complexity and courage of nurses in war. It is a reminder of the profession's physical and emotional demands, and the quiet resilience required to care for others in the face of overwhelming pain. For modern nurses, the novel serves as both a tribute and a call to remember the legacy of those who paved the way.

The novel also opens a conversation about nurses and PTSD—both as caregivers and as survivors. Research has shown that nurses in high-stress or trauma-rich environments, such as war zones or emergency settings, are at increased risk for post-traumatic stress disorder. The science of treating PTSD in nurses includes trauma-informed care, cognitive behavioral therapy, and peer support models, while the art lies in restoring meaning, fostering connection, and helping nurses re-integrate their caregiving identity with their personal healing. The Women poignantly illustrates this duality, showing how nurses carry both the wounds and the wisdom of what they've witnessed. Please see trauma-related articles in this journal ('The New Face of Trauma' and 'Team Lavendar').

Recommended for:

- Nurses and nursing students interested in the history of military nursing
- Readers seeking a gripping, emotionally resonant account of women in wartime
- Readers interested in gaining insight into wartime trauma
- Book clubs or academic discussions on nursing ethics, trauma, and resilience

Want to share your reflections? Reach out to the OJNA Journal Committee - we'd love to feature your voice in our next issue.

MUSINGS

Reclaiming Palliative Care

By: Gila Zagelbaum RN, OCN

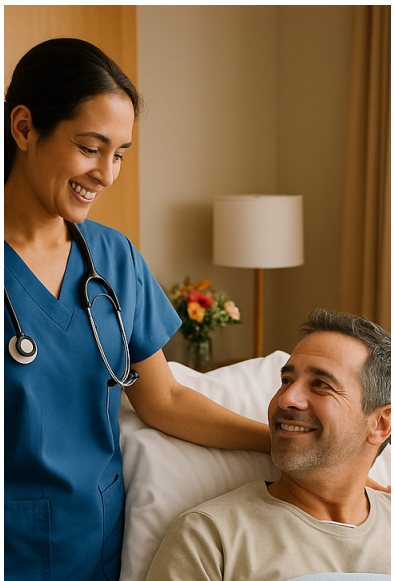
In nursing school, I learned about palliative care and hospice care. The purpose of palliative care is to help alleviate symptoms of both the disease and its treatment anywhere from diagnosis and continuing along the spectrum of care. Hospice care is a form of palliative care, but only for patients with a life expectancy of six months or less. Throughout my five years as an oncology nurse, I've seen hospice care called at the right time - when the patient stopped responding to treatments. The doctor would solemnly come in, inform the patient and family, and, then, hospice care would be consulted. However, palliative care was rarely called at an earlier stage - before it would be classified as hospice care. As a result, I believe palliative care has, effectively, been reduced in practice to just hospice care.

In my opinion, this outcome is a missed opportunity to improve the quality of life as patients undergo treatment. As an example, let me tell you about two patients I've been privileged to treat. Robert was a 60 year-old male diagnosed with multiple myeloma. His symptoms included worsening bone pain and incontinence from cord compression. Immobile, and receiving high doses of opioids, he was drowsy and severely constipated despite the oncology team's prescription of stool softeners and laxatives. Then there was Francis, who suffered from Acute Myelogenous Leukemia and was so severely neutropenic that she contracted an opportunistic fungal infection in her right eye and lungs. Ophthalmology and ENT were consulted to remove her right eye and some of her orbital orifice to mitigate the spread of the infection. Unfortunately, as neither patient was projected to die within six months, the palliative care team was not consulted.

Imagine with me, had the palliative care team been consulted, here is how their treatments potentially could have proceeded. For Robert, the palliative care team could have helped alleviate his symptoms of constipation with diet change, massages, and by introducing a new pain regimen rather than just prescribing more opioids. If the palliative care team had been called, perhaps he would not have had to tolerate his uncomfortable symptoms - a bloated stomach, constipation, and extreme drowsiness - on his own. For Francis, perhaps the palliative care team would have helped her adjust to the loss of her eye and helped to improve her quality of life during her recovery. Instead, she was left to adjust on her own. Worse still, in Francis's case, her chemotherapy was eventually discontinued, because the infection continued to spread. The doctors determined that no other treatments were available and it wasn't until then, the team was finally consulted to offer hospice care.

While palliative care cannot change the ultimate outcome for patients, it can help manage their symptoms better in the earlier stages. Should the patient recover and survive, the quality of their recovery and subsequent life could be enhanced through the care they'd receive during their treatment. If the patient will ultimately die, palliative care could still help mitigate the suffering during their treatment before the doctor issues the terminal prognosis. Instead, it seems to me, palliative care has been reserved for hospice situations, while patients who have not reached that point, take on extra suffering as a result.

My goal in highlighting this issue is to reclaim the label of palliative care. Currently, in my experience, patients confuse palliative and hospice care, leading them to reject offers of palliative care for fear of the belief in the implication that they are going to die soon. I believe this confusion is a missed opportunity for nurses to help improve patients' quality of life, by bringing in a medical team to manage their symptoms more effectively, regardless of the final prognosis. Rather, if we could educate our fellow nurses and medical professionals of the opportunities the palliative care team could offer, we could improve the quality of care our suffering patients receive.



Gila Zagelbaum RN, OCN is currently a clinical research nurse at Georgetown University. She received her BSN from Rutgers University School of Nursing in 2020 and is currently pursuing a masters degree as a family nurse practitioner. She lives in Silver Spring, MD with her husband and son.

CASE STUDY

Calcium Channel Blocker Overdose Leading to ECMO

Jessica S. Nooriel DNP, CPNP-AC

This case study briefly describes the presentation of a young teenage woman to the emergency department (ED) after intentional ingestion of an unknown number of amlodipine tablets and her subsequent clinical course and medical management in the pediatric intensive care unit (PICU), including cannulation onto veno-arterial extracorporeal membrane oxygenation (VA-ECMO). Evidence-based recommendations and guidelines are shared regarding the management of calcium channel blocker ingestion and its secondary clinical effects.

A previously healthy teenage female presents to the ED with her parents due to lethargy after intentional ingestion of an unknown number of tablets of Amlodipine, a blood pressure (BP) medication. On initial exam, she was found to be profoundly hypotensive (BP 40/20), bradycardic, and somnolent yet arousable. Further history reveals prior suicidal ideation and attempts as well as depression and generalized anxiety disorder. She was immediately taken to the trauma bay due to the need for immediate care and concern for rapid clinical deterioration secondary to amlodipine overdose.

Amlodipine is a non-dihydropyridine calcium channel blocker (CCB) often prescribed to patients with chronic hypertension. Its half-life is approximately 30-50 hours and has a large volume of distribution (2L/g). Refractory hypotension is the major toxic effect of amlodipine overdoses, often due to vasodilation and impaired cardiac metabolism and contractility [1]. Patients may also present with bradycardia and loss of inotropy [2]. Due to profound vasodilation, perfusion becomes impaired, and tissue ischemia and lactic acidosis may be seen. Additionally, the blockade of calcium channels in other tissues (i.e., pancreatic beta cells) may have other adverse consequences as well (i.e., reduced insulin release, prompting significant hyperglycemia) [1]. Due to the negative effects stated above, calcium channel blocker poisoning is a leading cause of mortality [2].

In the ED, the patient was found to have EKG abnormalities (PR prolongation, bradyarrhythmias), hypotension, and non-diabetic hyperglycemia. She was promptly given a normal saline fluid bolus followed by the initiation of multiple vasopressor drips (epinephrine and norepinephrine) for her blood pressure, calcium gluconate, and bicarbonate. Initially, she was able to maintain her airway with fair oxygen saturations, however as her saturations dropped and she started to develop acute hypoxic respiratory failure, her level of respiratory support was escalated from nasal cannula to a non-rebreather mask before rapid transfer to the PICU.

Key initial aspects of any ingestion work-up include a brief history, thorough physical exam, consideration of type of ingestion (acute vs chronic, presence of co-ingestants), and initial exam to provide immediate stabilization [3]. In this case, the patient's history, provided by the parents, revealed no coingestants, and the patient's exam was notable for hypotension and bradycardia and Glasgow coma score of 10.

The patient was transferred to the PICU and ultimately intubated for lack of airway protection. Her lactate was found to be 7.5, indicating decreasing end-organ perfusion, and due to continued hypotension, she was placed on two additional vasopressors for hemodynamic support at maximal drip rates. Other medical management included: methylene blue, high-dose insulin bolus and drip, lipid sink, plasma exchange to remove albumin-bound CCB, continuous renal replacement therapy (dialysis), and a continuous calcium infusion. It was decided that since she remained vasoplegic despite maximal medical management, she was to be cannulated onto VA ECMO for both respiratory and cardiac support. At the time of cannulation, she was in refractory vasoplegic shock with an acute kidney injury (AKI), metabolic acidosis, and poor end-organ perfusion.

The initial approach to CCB ingestion patients like this starts with fluid resuscitation, intravenous volume expansion (using bicarb-containing fluids to correct the lactic acidosis) and the ABC approach. Poison control should be consulted for guidance as well [3]. Multiple pressors are often initiated, as above, though this treatment is often ineffective as the primary issue underlying the hypotension is not hypovolemic shock but arterial vessel relaxation [1]. Atropine may be considered for hemodynamically significant bradycardia [2]. Depending on how soon the patient presents after ingestion, orogastric lavage and activated charcoal may be considered [3]. Calcium is routinely given as a type of "antidote" to CCB ingestions, though the noted response to calcium infusions is usually not adequate. Glucagon may be considered for inotropic effect on the heart, and high-dose insulin infusion is initiated as well for glycemic control [1]. High-dose insulin therapy itself is recommended by the American Heart Association and has also been shown to have a direct positive cardiac inotropic effect. Given its lipid solubility, CCB ingestions have also been known to be treated with lipid emulsion or methylene blue (nitric oxide inhibitor); raising serum lipid levels can raise the total volume of distribution which can aid in reduction of serum levels of the ingested CCB [1,2].

Ultimately, if the above management strategies cannot adequately support the heart through the metabolism and excretion of the CCB, the patient may need extracorporeal life support via VA ECMO [2]. One adult study by Finn, et al. [4] reported an average time of ECMO due to CCB overdose to be 4.3 days. Reported survival rates of patients placed on VA-ECMO due to refractory cardiogenic shock after CCB overdose is 77% [2]. This type of life support may be lifesaving for patients with pump failure refractory to maximal medical management [2].

The patient in this case remained on ECMO for four days total. With improvement in her vasoplegia necessitating less vasopressor support, maintained hemodynamic stability, and improved AKI, she was de-cannulated successfully and extubated shortly thereafter. Once she achieved full medical clearance, the psychiatry consult service worked on transfer to an inpatient psychiatric facility for continued care.

Jessica Nooriel DNP, CPNP-AC is a pediatric critical care nurse practitioner based in Atlanta, GA. Her clinical interests include graduate nurse transitions, medical education, and quality & safety improvement.

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Alya Shor is a nursing student at Hunter-Bellevue School of Nursing, a former combat soldier in the Israel Defense Forces, and a current first responder with Magen David Adom, Israel's national emergency medical and disaster response service. She serves on the Youth Leadership Committee at Save a Child's Heart, an Israeli organization providing life-saving cardiac care to children worldwide. Alya is passionate about bridging Jewish identity, global healthcare, and nurse-led advocacy.

Mitchell Silberberg BSN, RN, PHN is a new graduate nurse based in Los Angeles, CA. He earned his BSN from California State University, Fullerton, and has a previous Bachelor of Science in Public Health from California State University, Northridge. He currently works in a SNF/Rehab and will be starting an RN residency this Summer. Outside of work, he enjoys spending his time with loved ones, hiking, and reading.

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