Arriving in Incheon, South Korea, after a long flight from North America, there's not much to indicate that I'm halfway around the world from where I started. The atmosphere is sleek, modern, and relatively interchangeable with that of any large air hub. As I sit on a bus, inching toward Seoul through a landscape of tidal flats, jagged mountains, and scores of Kias and Hyundais, the realization that I am in a very different place begins to slowly set in. But it's when I step off the bus into a neon-fringed street buzzing with energy that I become fully aware that I am in Korea.

Streets like these, on which restaurants, clothing shops, and any imaginable small business are packed together into even the smallest nooks, are the heart of the frenetic, commerce-driven metropolis of Seoul. Vendors stand by bubbling trays of spicy rice noodles and fish cakes a few steps from chic “fusion” restaurants. Scantily clad “ad models” dance on the sidewalk to booming techno music announcing the opening of a new electronics shop, while families casually stroll by, unfazed. Throngs of young people crowd the streets. Everyone seems to be on their way somewhere. And everywhere I look, there are neon lights.

Standing in the midst of this flood of sensory input, there is no mistaking the fact that I am very, very far from home. So as we strolled through Seoul, it came as a surprise when Hopkins nursing student K. Olivia Robbie mentioned she has been most impressed with the similarities, rather than the differences, in health care between Korea and the United States.

In many ways, the health care challenges that South Korea faces mirror those of the United States, says Robbie. “Doing research in another country, you realize that the health care challenges in the United States are not isolated issues.” Among the most pressing issues are rising health care costs and an increasingly elderly population.

A fellow in the Minority Health and Health Disparities International Research Training (MHIRT) program, Robbie is in Korea examining the challenges the South Korean government has encountered in containing costs associated with its national health insurance system. She points out that between 2000 and 2006 health care expenditure in Korea grew 10.7 percent per year, more than twice the average rate of other developed countries. The problem is compounded by an aging population. By 2050, Korea is projected to have the fourth largest proportion of elderly citizens in the world, due in large part to the current birthrate, which ranks as the lowest in the world.

Under the guidance of Dr. Il Young Yoo, the MHIRT program faculty adviser at Yonsei University, Robbie is conducting research that addresses problems in South Korea’s health care system. She is joined this summer by...
MHIRT fellow Cathy Handy, a student from the Johns Hopkins University School of Medicine.

Under Yoo’s guidance, Handy and Robbie have been investigating ways to reduce health care expenditures by streamlining care for a percentage of the Korean Medicaid population, known as “over-utilizers,” who visit a health care provider more than 365 times a year. Their project builds on the work of Dr. Eui Sook Kim, also a faculty member at Yonsei University, who discovered that 64 percent of Medicaid recipients “over-utilize” health care.

This population is made of mostly elderly, poor, and unmarried or widowed women. Seventy-nine percent have had less than six years of education, due in part to the Japanese colonization of Korea (1910-1945), under which women were barred from receiving an education. They experience a high incidence of chronic illness, including diabetes, hypertension, arthritis, COPD, and depression, which can lead to visiting multiple doctors who prescribe multiple medications. Many have difficulties integrating the care they receive. The result is fragmented, disorganized, and expensive care that can harm as much as it helps.

Handy and Robbie’s research began in Baltimore, when they met with Professor Miyong Kim, a MHIRT faculty mentor from the Johns Hopkins University School of Nursing. The team decided to focus on care management programs, in which a health care professional assists patients in coordinating their medical care, guiding them to appropriate informational sources and outside services, as a possible solution for the Korean “over-utilizers.”

At Yonsei University, Handy has written a comprehensive literature review of successful care management programs in the United States and around the

Quick Facts:

- Number of MHIRT fellows since 1999: 100
- Projected number of fellows over the next five years: 40 undergraduate and 10 graduate students
- Participating Universities: Johns Hopkins University, Winston-Salem State University, North Carolina A&T State University, and Brown University
- Research Sites: Gothenburg, Sweden; Newcastle, Australia; Durban, South Africa; Cape Town, South Africa; and Seoul, South Korea
- Program Goal: MHIRT Program Director Fannie Gaston-Johansson, PhD, RN, FAAN, looks forward to “greatly enhancing our capabilities to contribute to the pool of competitive baccalaureate students who enter graduate or doctoral degree programs in the biomedical, bio-behavioral, and clinical sciences.”

Olivia Robbie, accelerated ‘09, received hands-on international nursing experience in Korea this summer.
Robbie is synthesizing Handy’s work with Dr. Eui Sook Kim’s data to create a sample program addressing Korea’s unique needs.

Using existing care management programs in the United States as a guide, Robbie’s sample program calls for care intermediary positions to be formed within the Korean healthcare system. Each intermediary would stay in frequent contact with a group of “over-utilizers,” tracking their illnesses and advising them on the most effective care plans.

As their knowledge of the Korean healthcare system broadened, Robbie and Handy were impressed by its quality, resources, and the speed with which it has developed. “I was amazed at all of the resources Korea has for its citizens—from free in vitro fertilization to large community centers for the elderly. There are extensive support services for all ages and socioeconomic classes,” says Handy.

Robbie adds that “Korea is a small country in which quality health care was unthinkable just a few decades ago. But today they have one of the best national health insurance systems in the world. Primary health care is incredibly cheap and accessible for Koreans, so many people seek treatment before their health problems become severe.”

Robbie, who plans to pursue a graduate degree in the next few years, says that her summer in Korea helped her to grasp the important role that nursing research plays in the field of health care.” As a MHIRT fellow, I have a better understanding of how nursing research impacts practice and, most importantly, patients’ wellbeing,” she says. “As a graduate student, I will continue to pursue international research and practice. Eventually, I hope to initiate my own projects on an international level.”

Although Robbie hasn’t entirely decided on the area of nursing she will pursue, she is sure that the perspective that she has gained while working at Yonsei University will be invaluable. During her time there, she interacted with nursing professors, nurse practitioners, Hopkins nursing alumni, doctors, medical and nursing students, and a public health group from Fiji, among others. “Returning to the US, I feel as if I have a wider view of the field of nursing and the roles that I might play within it. I feel lucky to have had this experience at a time when most of my classmates were studying for the NCLEX and narrowing down their job choices.”

Before receiving the MHIRT fellowship, Robbie was interested in working with underserved populations, but didn’t have a specific plan of how she might go about doing so. “Now,” she says, “my eyes have been opened. There are a lot of research opportunities out there that focus specifically on underserved populations. I understand now how urgent and crucial this research is for the well-being of entire nations.”

At some point, Robbie hopes to have the opportunity to return to Korea. “I’ve made some great friends. And Korean food is incredible—I’d return anytime for a meal with friends.” —Robby MacBain

To view more photos of Robbie and Handy in Korea, visit www.nursing.jhu.edu/korea
Our patients come from all over the country. And so do our nurses. They come to be part of the most professional, diverse and reputable nursing teams. They come to work beside the unequaled talent of Johns Hopkins physicians, nurses and staff. And they come for the benefits and unlimited opportunities for personal and professional growth.

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MHIRT fellows only live and work at their research sites for eight to ten weeks. However, the MHIRT program aims to instill fellows with a lifelong commitment to addressing health disparities on an international scale. For alumna Stacie Stender ’99, MSN ’01, the program has made all the difference in her choice of a career.

Before studying as a MHIRT fellow, says Stender, “I never had any intention of traveling to South Africa, let alone working there.” She applied for the program out of a desire to learn about health care issues that affect developing countries across the world, and conducting research in the poverty-stricken section of Cape Town known as Cape Flats represented an excellent opportunity. As a fellow, Stacie developed an interviewing tool with both qualitative and quantitative aspects to assess hypertension risks in black residents of the Cape Flats. She also taught a class on advanced practice nursing at the University of the Western Cape.

Nearly four years after her initial trip to South Africa, Stender returned as Clinical Advisor for the Columbia University International Center for AIDS Care and Treatment Programs (ICAP). For nearly three years, Stender lived in a remote region of the Eastern Cape, working on an HIV care and treatment program funded by the United States President’s Emergency Plan for AIDS Relief (PEPFAR), and supporting four district hospitals and more than twenty primary health care clinics.

In 2007, Stender moved back to Cape Town to work as Clinical Coordinator with a South African NGO, TB Care Association, on a project to integrate TB and HIV care and treatment. Since then, she has been busy assisting many small NGOs with projects around Cape Town. In January 2009 she will begin serving as an HIV/AIDS and TB Regional Technical Advisor with Jhpiego, an affiliate of Johns Hopkins University.

Besides introducing her to an unfamiliar country, the MHIRT program helped Stender develop an understanding of the social and political contexts that nurses in South Africa negotiate—an understanding that has proven vital to her work. However, she looks back most fondly on the personal connections she was able to make. “I met and befriended some truly amazing South African women as a MHIRT fellow, and my experience wouldn’t have been as rich as it was without them,” says Stender. “I also had the opportunity to get to know Martha Hill, who was my U.S. faculty mentor. She has been a great friend, and you could say that she’s been my life mentor, too.”

—RM
Five Nurses Receive First Nursing PhDs in China

Through a joint program between the Johns Hopkins University School of Nursing and the Peking Union Medical College (PUMC) School of Nursing, five doctoral students are the first Chinese nurses to receive a nursing PhD from a Chinese university.

“This is an historic moment in the health care of China,” says Marie T. Nolan, PhD, MPH, RN, associate professor and director of the JHUSON-PUMC Doctoral Program Partnership.

The first graduates—Gao Feng Li, He Zhong, Liang Tao, Liang Xiaokun and Li Yang—received their degrees in Beijing on July 9, 2008. All will eventually become faculty in the PhD Program at PUMC.

A hallmark of the joint program, funded by the China Medical Board of New York, Inc., is the requirement for each student to spend a semester at Johns Hopkins. While in Baltimore, the students participate in doctoral seminars with Hopkins nursing students, observe U.S. health care delivery systems, learn about the best of evidence-based nursing practices, and work toward finalizing their dissertations.

Two additional cohorts comprised of nurses from throughout China are now completing the program. The second completed their studies at Johns Hopkins East Baltimore Campus in fall 2007, and the third and final cohort is on campus for the fall 2008 semester.

—Diana Schudin

From Left: Graduates Dr. Tao Liang and Dr. Yang Li; Advisors Dr. Min Wei, Dr. Zheng Lai Wu, Dr. Marie Nolan, Dean Martha Hill, Dr. Chong-mei Lu, Dr. Shou Qing Lin, Zhu-Ming Jiang; and Graduates Dr. Zhong He, Dr. Feng Li Gao, and Dr. Xiaokun Liang

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From Left: Graduates Dr. Tao Liang and Dr. Yang Li; Advisors Dr. Min Wei, Dr. Zheng Lai Wu, Dr. Marie Nolan, Dean Martha Hill, Dr. Chong-mei Lu, Dr. Shou Qing Lin, Zhu-Ming Jiang; and Graduates Dr. Zhong He, Dr. Feng Li Gao, and Dr. Xiaokun Liang
Nurse Researcher Leads in Preventing Transmission of Drug-Resistant Bugs

Jason Farley, PhD ’08, MPH ’03, ARNP, is a man on a mission. This Johns Hopkins University School of Nursing assistant professor is working to identify, seek out and destroy drug-resistant infections in hospitals and in the community. And Farley believes this goal is best accomplished by translating sound nursing science into evidence-based nursing education and practice.

In an overview of the epidemiology, presentation, and treatment of drug-resistant infections in the Journal of the American Academy of Nurse Practitioners, he notes that the spread of methicillin-resistant staphylococcus aureus (MRSA) has evolved from a hospital problem into a community and public health concern about which clinicians—including nurse practitioners—need to be increasingly cognizant. Gleaned from a review of 40 years of research, he highlights current thinking about MRSA risk factors, the skin and soft tissue infections hallmark of community-acquired MRSA, and current best practices in diagnosis and treatment, providing a unique roadmap to understand, recognize and potentially prevent MRSA transmission.

With prevention on his mind, Farley and colleagues from The Johns Hopkins Hospital and School of Medicine assessed the effectiveness of two rapid MRSA screening tools among newly arrested men in correctional facilities. Their findings in the Journal of Clinical Microbiology suggest more research is needed on currently available rapid molecular assays to determine if they are sufficiently sensitive for use as screening tools for infection control decision making and clinical treatment. Farley highlights the importance of effective quick assays in a just-released study of MRSA colonization among newly arrested men in Baltimore City. The data, reported in the American Journal of Infection Control, found a nearly 16% MRSA rate, significantly higher than earlier estimates of community-based MRSA.

—Teddi Fine

Discussing Medication “Rights” Helps Prevent Drug “Wrongs”

On average, one medication error occurs each day for each patient hospitalized in the U.S. That translates to 1.5 million preventable negative drug effects each year. These errors most often occur at the point of drug administration—the last line of defense—with responsibility falling squarely on nurses and the patients in their care. That is why Johns Hopkins University School of Nursing researchers Jo M. Walrath, PhD, RN, and Linda E. Rose PhD, RN recommend ways in which nurses can better work with patients to strengthen their partnership to halt medication errors.

In a descriptive, exploratory study published in the Journal of Nursing Care Quality, Walrath and Rose found that acute care patients vary widely in their understanding of and involvement in assuring the safety of their medication regimen. Nurses are well-versed in administering medications using the five “rights” (right drug, right patient, right dose, right route, and right time). By taking this process one step further—verbalizing the five “rights” to the patient during drug administration—nurses can raise patients’ awareness of and encourage their ongoing engagement in the process.

Walrath says “As nurses, we need to really hear and act on our patients’ concerns about their medication regimens and continuously encourage them to full participation.” Rose adds, “We cannot afford either to disregard what our patients are saying about their medications or to adopt a ‘one size fits all’ strategy.” By adopting the strategies outlined in their article, Walrath and Rose posit that nurses are uniquely positioned as the safety net to catch medication errors before they become potential patient tragedies. —TF
Nurse-Physician Team Finds Protocol Promotes Best Practices

Adoption of research-proven best practices in health care is slow and far from universal. Despite advances in knowledge and practice, little more than half of all patients are receiving recommended general medical care. Nowhere is the need for adoption of best practices in care more urgent than in the intensive care unit (ICU) where the difference between best practice and the current practice in many settings can be lethal.

According to Johns Hopkins University School of Nursing faculty member Cheryl R. Dennison, PhD, RN, ANP, and a team of critical care physicians and researchers, a known-effective, lung-protecting ventilation technique—low tidal volume ventilation (LTVV)—is far from the norm in ICUs treating patients with critical lung injuries. As part of the Improving Care of Acute Lung Injury Patients study, the team assessed patient- and ICU-related factors that might contribute to the use of LTVV among over 200 lung-injured patients on ventilators.

Reporting in Critical Care Medicine (May 2008), Dennison and colleagues found that only half of patients received LTVV, even though it has been advocated as a best practice for over seven years. One ICU-related factor—the presence of a protocol for LTVV use—was most strongly associated with the actual implementation of this lung-saving best practice for acutely ill ventilated patients in the ICU.

Dennison cautions, “The existence of protocols and guidelines helps, but it doesn’t guarantee that patients will receive evidence-based interventions. For that to occur, we need to effect system- and provider-level change at the basic teaching and practice levels and include all members of the treatment team.” —TF

Emergency room nurses can help save lives by being on the lookout for signs of attempted strangulation among women victims of intimate partner violence (IPV). Based on an analysis of medical examiner, police, and emergency room records spanning 11 cities over a six-year period, attempted strangulation was found to increase sevenfold the risk of becoming a subsequent homicide victim.

In the October 2008 issue of the Journal of Emergency Medicine, faculty members Jacquelyn C. Campbell, PhD, RN, FAAN; Nancy Glass, PhD, MPH, RN; and Phyllis W. Sharps, PhD, RN, FAAN; and other researchers report that women victims of completed or attempted intimate partner homicide were far more likely than other abused women to have a history of strangulation. In fact, prior non-fatal strangulation was reported in 45 percent of attempted homicides and 43 percent of homicides of IPV victims.

“Strangulation has only recently been identified as one of the most lethal forms of domestic violence,” says Glass, co-author and Johns Hopkins University School of Nursing associate professor. “When abusive partners use strangulation to silence their victims, their actions exert a form of power and control that can have serious physical and psychological effects on victims with a potentially fatal outcome.”

In addition to suggesting further research on this high-risk group of abused women, the authors recommend improved ER nurse and physician capacity to recognize and treat the soft tissue injuries associated with attempted strangulation.

Glass cautions, “This serious, potentially lethal, offense needs to be accurately and fully documented for possible future court action. Further, as nurses, it’s our responsibility to help safeguard the future health of these vulnerable women, as well as to recognize and treat their current injuries and trauma.” —TF
Bright Moments for Nursing on Hopkins Series

The ABC series, Hopkins, was a ratings win for the network and portrayed heroic medicine, catastrophic disease, and miraculous technology. Many of you were glued to your TV each week to watch Hopkins from a different point of view. Nurses, while severely underrepresented, had some shining moments.

- Megan Quick, PICU, showed compassion to a beautiful infant undergoing cardioversion.
- Teresa DeVaughn, PICU, resuscitated a child and maintained a cardiac rhythm during transport to the ED. Hopkins also led to additional media coverage of Hopkins nurses.
- Rhonda Wyskiel, and Christine Gonzalez, MSN '07 WICU, appeared on the CBS Early Show.
- Megan Quick, PICU, traveled to New York City to be interviewed by ABC’s Dr. Tim Johnson, health correspondent.
- Joan Diamond, Nurse Manager in Obstetrics, appeared in a WMAR special with other nurses.
- Deb Baker accel. '92, MSN '97, Director of Nursing for Surgery, did a live interview on WYPR. The ABC series also increased interest among RNs in employment at Hopkins. During the series, job applications increased by 140 and web hits increased by 4,500, with 1,100 unique web visitors.
Magnet Drawn to Nursing—Again

Karen Haller admits to holding her breath the past few months. So, when the vice president of nursing and patient care services received the long-awaited telephone call on July 16 that the hospital’s Department of Nursing had once again attained the prestigious Magnet Recognition status, she says her reaction was one of “relief!”

“We knew we were well prepared, had marshaled our resources to host an effective three-day site visit, and were supported by the Hospital as a whole,” Haller says. “But it’s not over until you receive the official word.”

Led by Magnet coordinator Patty Dawson, MSN ’03 and her team of Magnet ambassadors, the department’s preparation paid off. The American Nurses Credentialing Center complimented the nursing department on its focus on retention, interdisciplinary teamwork, and creative roles such as wound care and patient safety nurses. Not only did the organization renew Hopkins’ status for another four years, it had no recommendations for improvement to offer.

The credentialing center awards the Magnet stamp of approval to just five percent of the nation’s roughly 7,570 hospitals based on their standards of excellence for nursing care, the 14 “forces of magnetism.” In 2003, Hopkins became the first and only hospital in Maryland to receive the designation for quality patient care and innovation in nursing practice.

“Nursing is a problem-oriented profession, so we are always asking, ‘What’s the patient’s problem and how can we intervene?’ or ‘What’s the unit’s problem and how can we make the system function better?’” Haller comments. “We rarely ask, ‘What’s right around here?’ Magnet allows us to think about what is right, good, excellent.”

Patient Safety Heroes
Save the Day

Many at Hopkins know the story of Josie King, the 18-month old who died at our hospital from medical errors in 2001. Her parents experienced overwhelming sorrow and intense grief, but were also consumed with anger. Mrs. King has said that anger can do one of two things to you: “It can cause you to rot away or it can propel you forward.”

In the years following Josie’s death, Sorrel and Tony King moved forward and created the Josie King Foundation to unite healthcare providers and consumers, fund innovative safety programs, and create a culture of patient safety. The foundation funds an annual patient safety research award of $10,000 during Nurses Week; and hosts a luncheon for our patient safety heroes.

Who are patient safety heroes? They are individuals who have actively prevented harm to our patients. The literature calls them “positive deviants”—those among us who do the right thing and are agents for good. Nine individuals were identified by their nursing departments as having been a positive force to make healthcare safer.

The Department of Gynecology recognized Sara Nakamoto—a first-year nurse—who discovered that a pre-mixed IV solution delivered to her unit had the incorrect medication label applied over another label. The IV bag actually contained the solution whose label was hidden, and was contraindicated for the patient. Nakamoto’s patient had impaired renal function, and could have suffered significant complications had the drug been administered. For this individual patient, Nakamoto was a super hero!

Kelly Creighton was recognized by the Department of Medicine for her work on improving the safety of patients on monitors. Creighton determined that 27,000 alarms rang on her 15-bed intermediate care unit every 24 hours—that’s one alarm every 3 seconds! Creighton worked with her committee and the Hospital’s clinical engineers to improve the situation, reducing “nuisance alarms” by 26%. Kelly literally took the noise out of the system, so that nurses could respond more quickly to patients in trouble.

For a complete list of this year’s Patient Safety Heroes, go to www.josieking.org/blog/.
Intensive Foresight


The nation’s first ICU emerged at Johns Hopkins Bayview 50 years ago.

A half-century ago, the offer of $150 to participate in a potentially harrowing medical experiment at the old Baltimore City Hospital, now Johns Hopkins Bayview Medical Center, was something third-year medical student Chester Schmidt Jr. felt was too good to turn down—even if it meant being injected with a drug that briefly paralyzed his diaphragm. “That was a lot of money then,” he recalls with a chuckle.

Schmidt, later the long-time director of psychiatry at Johns Hopkins Bayview, volunteered to let Peter Safar (1924-2003), then head of anesthesiology at City Hospital, use him as a guinea pig to test his new, groundbreaking methods for cardiopulmonary resuscitation. Such experiments, which subsequently earned Safar recognition as the “father of CPR,” were among the astonishing innovations in critical care medicine that he initiated at City Hospital—including the opening in September 1958 of the country’s first multidisciplinary intensive care unit (ICU).

Since July, each of Johns Hopkins Bayview’s six ICUs—medical, surgical, coronary, neonatal, neuroscience and burn—individually has celebrated the 50th anniversary of their prototype’s creation and their own unique contributions to that heritage. The celebration culminated on September 26th with a day-long symposium at Johns Hopkins Bayview, featuring lectures by some of the premiere physicians in critical care medicine from around the country.

Philip Zieve, former head of Johns Hopkins Bayview’s department of medicine and chief of the center’s medical staff, was an intern at City Hospital when the ICU was founded. He recalls Safar as an “aggressive and charismatic” leader of anesthesiology “who believed that there was an opportunity for better respiratory care if the patients could be hospitalized in a single unit with nurses trained to care for people with severely acute problems.”

At the time, City Hospital was Baltimore’s major polio center, but once the Salk vaccine virtually ended the threat of polio, Safar saw the opportunity to transform the hospital’s four-bed ventilator unit into an ICU, Zieve says. It had round-the-clock staffing by an anesthesiologist, nurses and a surgeon, says Romergryro Geocadin, director of Johns Hopkins Bayview’s neuroscience CCU, and became “the template for what the ICU today looks like.”

The first ICU had just six beds, Zieve recalls. At today’s 709-bed Johns Hopkins Bayview, one of every six beds is in an ICU, says Jonathan Sevransky (head of medical ICU). Last fiscal year, 5,941 ICU patients were treated there.

In the Hopkins Hospital’s nine ICUs—neonatal, pediatric, cardiac surgical, surgical, medical, neuro critical care, coronary care, oncology and Weinberg—nearly 10,000 patients are treated annually, says Todd Dorman, vice chair for critical care. About 20 percent of the hospital’s 1,017 beds are in ICUs, he adds.

Today, hundreds of nurses and dozens of physicians, respiratory therapists, pharmacists and support personnel work in the two hospitals’ ICUs.

With people surviving longer with serious illnesses, “it’s likely that hospitals will become more and more devoted to patients who need life support,” Sevransky says. It is estimated that one percent of the country’s gross domestic product already is being spent on ICU care, he notes.

“At the end of the day, after all the hoopla,” says Geocadin, “if we can rekindle the zest of Peter Safar when he was at Johns Hopkins Bayview creating all of this, it will inspire people.”

—Neil A. Grauer
A day in the life of a DNP student at Johns Hopkins is like living in triplicate. There is the work day that can begin as early as 7:00 a.m. and can go as late as 9:00 p.m. There is the family life, which can include children, spouse, frail parents, pets, and home responsibilities. And then there are the academic requirements of the doctorate of nursing practice program, which take several hours each day, often tucked into a 5:00 a.m. or 10:00 p.m. time slot. As adult students—many of us not being exactly fit and under forty—this leads to a certain level of sleep deprivation, reduced exercise, and random acts of eating.

I am one of 25 students in the first DNP cohort at Hopkins. I chose this program to learn aspects of nursing theory and practice that may be additionally useful in my career as Chief Programs Officer at the American Nurses Association (ANA). Despite the hectic schedule, I know I am developing a new knowledge base and expanding a skill set that I have not had previous opportunity to develop.

The full-time program is taught in an executive fashion, with a full week of on-campus classes (that means 40 hours of class) twice during each of the first two semesters. We also have online lectures and presentations, writing assignments, and interactive class discussions using web based discussion boards and chat rooms. Our capstone project, which runs through all four semesters of the program, requires that we plan and execute a research question, discover an answer designed to lead to best practice evidence about the topic, and write a literature review and publishable manuscripts.

Who is crazy enough to take such a course load, work full time, and try to pretend to have some semblance of family life? Apparently, many of us working nurses! While there are 25 in my class, there is another group of DNP students who started one semester after us. We all have a master’s degree in nursing, and several students have MBAs as well. The class includes nurse practitioners, clinical nurse specialists, a nurse anesthetist, nurse managers and executives, nurses who are IT professionals, and policy developers.

At the end of the DNP program, each of us anticipates being able to improve outcomes for patients, regardless of our individualized focus and setting. We expect to exert a broader reach in improving care for one or more patient populations we serve, and to have learned and demonstrated that we can gather and apply evidence of best practice in the care we deliver and for the profession as a whole. It is what keeps us challenged to stay with the arduous pace of both working and learning.”