Patient gives emotional thanks at Stroke Gala

METHUEN RESIDENT GASPAR “BUD” INTERRANTE loves to fish, play golf and spend time with his four grandchildren. Although Interrante, 62, leads an active life, he has experienced some challenges. Interrante lives with Crohn’s and Parkinson’s disease, and in December 2017, he hit another bump in the road.

While in the MGH Emergency Department (ED) for dehydration and diarrhea, Interrante began showing signs of having a stroke, including slurred speech, numbness on his left side and droopiness on the left side of his face.

Interrante recalled hearing his wife yell, “My husband’s having a stroke!”, but that was it.

“I don’t remember much after that, but I do know it took about two heartbeats for a full team to show up,” Interrante said during his emotional testimony at the sixth Annual Stroke Breakfast Gala, May 25. “I was taken to the OR and woke up in the ICU. I remember seeing my beautiful wife and family. Even though I lost most of the function in my left side, I knew I would beat this new inconvenience and test in our lives.”

When it comes to stroke care, “time is brain.” Every moment is crucial in treating stroke patients because the more swiftly they are diagnosed and a specialist administers tPA, a blood clot-busting drug, the less likely they are to have long-term disabilities and further complications.

“When every passing minute, 1.9 million brain cells are estimated to die,” says Natalia Rost, MD, director of the MGH Stroke Service and associate chief of the Stroke Division. “Giving IV tPA so swiftly has certainly contributed to preserving Bud’s brain and ensuring a good outcome.” This also serves as a bridge therapy until the clot is definitively removed.

During Interrante’s story at the breakfast gala, which honored him, his family and the entire MGH care team, he explained how his care enabled him to go home and see his new granddaughter, who was born shortly after he experienced his stroke.

“After two days in the ICU and three more on the seventh floor, I progressed enough to go home and see a new year with my family,” Interrante said. “Due to this amazing staff – nurses’ aides, therapists and doctors – I was able to see my (Continued on page 4)
Profiles in Education: Ann Jampel, PT, MS

This profile is part of a series designed to highlight the importance and impact of the hospital’s teaching mission and the work of the MGH Executive Committee on Teaching & Education (ECOTE).

Ann Jampel, PT, MS, education coordinator Physical and Occupational Therapy Services, shares her experiences.

**WHO DO YOU TEACH AND WHAT DO YOU HOPE THEY LEARN FROM YOU?**
My primary responsibility is the training and professional development of Physical Therapy and Occupational Therapy clinical instructors and mentors. Over time, I have come to learn that there is a skill set to serving as a clinical teacher that goes beyond the “science” of learning theory. It involves a dynamic decision-making process where the clinical instructor is engaged in determining what the learner may need to safely and effectively – and ultimately creatively and efficiently – provide the patient with what they need. My role is to help these instructors develop these teaching skills as a parallel process to ongoing decisions about patient care. It has been a privilege to work with staff and see them analyze, practice and evolve their clinical teaching skills.

In the last few years, I have been involved with an interprofessional group from the MGH and the MGH Institute of Health Professions that has developed and implemented an interprofessional model of clinical education on Ellison 8, Bigelow 11 and Ellison 12.

**WHAT MAKES YOU MOST PROUD OF YOUR WORK AS AN EDUCATOR?**
When I interviewed at MGH more than 30 years ago, the first interview question was: “Our current staff find students a real challenge, even a burden and most don’t enjoy working with them. What will you do to change that?” After talking with them and analyzing a bit of the “why” behind this, we put together a training program for clinical instructors to help them meet these challenges. Over time, staff have come to better balance the responsibility and rewards of being a clinical teacher. Today, staff seek me out to inquire about how soon they might be assigned a student.

**TELL US ABOUT A MAGICAL TEACHING MOMENT.**
Recently I was working with an instructor and a student, and prior to seeing the patient, I asked the instructor what they hoped to see this student do during the treatment? The instructor was silent but after a few seconds said, “I know this patient and they will most likely present some behavioral challenges for this student. I think they are ready for this challenge, and I would like to see evidence of her listening to the patient and using the information to guide her decision making.” At the conclusion of the session, the clinical instructor was able to help the student see where this had happened successfully and where additional probing of the patient might have been helpful. It was impressive to see this instructor analyze what the student needed, both from an interpersonal and cognitive perspective, and then focus her feedback to meet this need. The student left the interaction feeling positively about her progress and with things to reflect on for the future.

**WHEN PATIENTS HEAR THE WORDS “TEACHING HOSPITAL,” WHAT DO YOU THINK COMES TO MIND? WHAT DOES IT MEAN TO YOU TO WORK AT A TEACHING HOSPITAL?**
A patient often chooses to come to an academic teaching hospital for assurance that the individuals providing their care are knowledgeable and experienced in the most current health care practices. I am not sure that they always know that they will meet team members who are in progressive stages of learning. In my experience, the best of a teaching hospital is working with an interprofessional team that is committed to understanding the complex needs of patients and works together to seek creative solutions to meet their goals of care. The whole is greater than the sum of its parts.

**WHAT DO YOU WISH EVERYONE KNEW ABOUT EDUCATION AT THE MGH?**
I wish that all students entering the MGH better understood the impossibility of knowing everything that they will need to manage every aspect of their patients’ care. I have seen more than one student experience an epic sense of “failure” when they don’t meet their own expectations and need to ask for help. Developing a sense of resilience is critical for the development of any clinician. I am humbled on a daily basis with the complexity of the questions that staff are trying to answer to meet their patients’ needs.

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Health care education at the MGH

**ON MAY 21,** 125 members of the educator community at the MGH gathered for a day-long symposium focusing on interprofessional health care education. Sponsored by the MGH Executive Committee on Teaching and Education (ECOTE), the event started with opening remarks by Keith Lillemoe, MD, chief of Surgery and ECOTE chair. International, national, regional and local faculty spoke on topics such as interprofessional learning and collaborative practice; teaching strategies for multigenerational workforce; diversity and inclusion in health care education; and a hands-on workshop for creating learner-centered presentations. The keynote presenter — Ian Curran, vice dean of Education at Duke-NUS Medical School in Singapore — stressed the importance of teaching for the point of excellence, not just competency in health care education.

“The ECOTE Symposium is great because it brings the multidisciplinary health care team together with a common interest,” said Maureen Hemingway, DNP, RN, a nursing practice specialist who attended the symposium. “To spend a day immersed in education topics that are current and relevant makes it a memorable day. I have already incorporated ideas that I learned there into my practice.”
Injectable opioids shortage: Talking points for patients

**THE MGH AND HOSPITALS** throughout the country continue to grapple with the injectable opioid shortage. In the coming days and weeks, patients, families and caregivers may ask about the nationwide opioid shortage. Here are some important talking points to help provide an overview of the situation at the MGH.

**Q: I’VE HEARD THERE IS A SHORTAGE OF PAIN MEDICATION. IS THIS TRUE?**
A: Yes. There is a shortage of one type of pain medicine. Opioid pain medicines that are given by a needle or directly into a vein are in short supply. Other types of pain medicines are not affected.

**Q: WHAT PRODUCTS ARE AFFECTED BY THE SHORTAGE?**
A: All opioids given by a needle or into a vein may be affected. Some of the names of these medicines are fentanyl, morphine and Dilaudid (hydromorphone).

**Q: ARE THERE OTHER PAIN MEDICINES THAT ARE NOT AFFECTED BY THE SHORTAGE?**
A: Yes. There are other types of non-opioid pain medicines that can be given by a needle or into a vein. Opioid medicines in pill or liquid form that can be swallowed are also not affected.

**Q: WILL THIS SHORTAGE OF INJECTABLE OPIOID MEDICATIONS AFFECT MY TREATMENT PLAN?**
A: It may. Our top priority is to provide you with the highest quality care. That includes helping you with your pain. Hospital experts have plans in place to use pain medicines that are not in short supply whenever possible. We will always check with you to make sure the pain treatment plan is working for you. If you have any concerns about the medicine you are getting, ask a member of your care team.

**Q: HOW LONG IS THE SHORTAGE EXPECTED TO LAST?**
A: The shortage may last for several months or longer. Please know all care teams throughout the MGH are working to make sure you will continue to get the best possible care.

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Biothreat trainings provide year-round education and preparation

**IN 2015, THE MGH** was one of 10 hospitals in the country designated by the U.S. government as a special regional center to treat Ebola and other highly infectious diseases. Throughout the year, the MGH Biothreats Response Team continues to conduct educational exercises and training sessions, including sessions that refresh team members’ skills on properly donning and doffing personal protective equipment (PPE), as seen here, during this full-scale drill last December.

“With a growing number of Ebola virus disease (EVD) cases being reported in the Congo this year — including 25 deaths — we are glad that we have this robust program, and we are continuing to work with team members to make sure they are always up-to-date with current best practices and the latest knowledge in this field,” says Monica Staples, RN, clinical nurse specialist in Emergency Preparedness and PPE training manager for the EVD response program. “While the current risk for Ebola cases in Massachusetts remains very low, it is important that the staff within the MGH who are trained to respond to this challenging disease always feel educated and prepared.”

For more information about the EVD Response Plan, the MGH Hazmat Team and other Emergency Preparedness efforts visit, apollo.massgeneral.org/emergencypreparedness.
CDI graduation celebrates sense of community

THE MGH CENTER FOR DIVERSITY AND INCLUSION (CDI) hosted its annual Gala and Graduation May 11 at the Royal Sonesta Hotel in Cambridge, celebrating 43 graduates underrepresented in medicine across all MGH training programs. The event included remarks by CDI leadership members Elena Olson, executive director; Winfred Williams, MD, co-chair of the advisory board; Sherri-Ann Burnett-Bowie, MD, associate director; as well as remarks by Peter L. Slavin, MD, MGH president, and Tim Ferris, MD, MGPO CEO.

“The first word that comes to mind when I think about CDI and the Resident and Fellow Committee (RFC) is family,” says Utibe Essien, MD, a general medicine fellow graduate and past RFC chair. “From the welcome barbeque, to the community service events, to the mentorship offered through the CDI, my residency experience was transformed by being part of this family.”

The CDI sponsors groundbreaking initiatives and award-winning programs ranging from a summer research program for college and medical students, to a vibrant resident and fellow committee, to faculty development awards and cross-cultural education and trainings. “One of the most important things CDI does is to provide opportunities for trainees and faculty, such as the CDI Gala and Graduation, to connect with each other and create a sense of community,” says Olson.

— Stroke

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grandchildren, including a new 9-pound granddaughter born Jan. 3.”

But the coast wasn’t clear yet for Interrante. On Jan. 29, he received a call from the Cardiology Unit at the MGH explaining he needed to rush to the ED to receive a pacemaker. Specialists detected an issue through a heart monitor he had been wearing for 30 days.

Interrante plans on getting back on the golf course this summer and spending ample time with his grandchildren.

“From the bottom of my pacemaker-assisted heart, I’d like to thank you all,” Interrante said. “Not just for saving my life, but for giving me my life back. I am as good, if not better, than before my stroke.”

— McGill

(Continued from page 1)

“It is during this time they can further learn from, and share with each other, their experiences of medical school, their city, their country and their culture.”

On May 31, six HMS students traveled to Montreal with Semaan – who earned his medical degree from McGill – to learn about McGill Medical School, Canada’s medical and insurance system and to spend the weekend with their Canadian counterparts.

“Medical school can be a lonely and isolating endeavor on many levels,” Semaan says. “I wanted to address the isolation of ideas and culture. Medical training in any institution, no matter how universal one may think the science may be, can be fraught with institutional bias. What I hoped for was an exchange of ideas and experiences between these two institutions between cohorts that would otherwise not be exposed to each other.”