Strong Medicine Interview with Maureen Fagan, 13 May 2014

MAUREEN FAGAN: [00:00] So, OK, so I'm Maureen Fagan. I am an OBGYN and family nurse practitioner by trade. I also have an MBA, and I have my nursing doctorate. I'm from New York, initially, and I moved to Boston in the mid-1980s. When I came here I had, for 17 years, an OBGYN specialty practice, with -- primarily with teenage girls, and then I moved to Brigham and Women's in 2000.

And when I came here, I initially was in charge of a large OBGYN ambulatory specialty practice of 16 different specialty practices before I moved and was recruited in 2009, to become the executive director for the Center for Patients and Families. And at the time, time was called Patient and Family Relations. And we were responsible for the compliments and complaints of the whole hospital. We are regulated by CMS, and by the joint commission to provide a forum for patients and their families to speak in their own words, about what's happening to them at the hospital. So whether it's a complaint or a compliment, it is mandated that there -- [0:01:32]

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FAGAN: [00:00] -- compliment, it is mandated that there is a group that actually captures that.

So that's -- that, I started in 2009, and I also then was charged by our chief nurse, who became our chief executive officer to actually create a whole patient and family centered care unit, and to move the hospital toward creating a patient and family centered care paradigm. So if you think a little bit about what is that, primarily hospitals, inpatient facilities, and ambulatory care is structured around either the physician, or the hospital system. And the opportunity exists to actually change that paradigm, so that it's structured around patients and/or family members. And we tailor our content knowledge, and our processes around how they can basically take up that knowledge better. We are treating them with dignity and respect. We are transparent in all of our interactions with them. We invite them to participate with us about their loved one, to the extent that they can do that, and to the extent that in whatever way, it is promoting health for them. So on whatever level that would work for them, and that we actually incorporate at some point, patients and families onto our meetings, into our advisory councils.

A huge paradigm shift. So that was the work that I was tasked to do, and this is now three years later.

The actual day of the bombing, I was --

ALYSSA BOTELHO: Oh, oh, but first, if you could -- if you could sort of talk about what a typical day looks like for you?

FAGAN: OK. A typical, normal day here --

BOTELHO: Yeah.

FAGAN: -- in patient -- OK.

BOTELHO: Mm-hmm.

FAGAN: So a typical, normal day in Patient and Family Relations, and in the Center for Patients is unheard of. There is no such thing as a normal day. You can have a quiet day, or you can have a crazy day. But there's not really anything in between that. Patients and families can come down from the inpatient units and speak to us about a problem. And we invite them to come in the middle of a conflict. We ideally would like to be able to understand what the problem set is from their own voice, and then to go up with one of our representatives and help.

BOTELHO: What kind of conflicts would you encounter?

FAGAN: It can be any kind of conflict, but one of the most common conflicts are issues around end of life. So if you think that we have about 1,000 deaths a year here, our biggest book of business is cancer care, and the downward spiral of cancer. So you are a cancer survivor, but you are now still facing the ramifications from the chemo and from some of the different aspects of cancer, or your cancer returns at some point.

Many of the conflicts occur when either the family is not on the same page about what to do with their loved one, or your loved one can't really speak at all, and you have to remember something about your loved one. So there wasn't a plan that the loved one talked about, the patient actually spoke about, and you're in conflict with either your siblings or your family of origin. That's one type.

It can also be that you don't understand what the different providers are talking about. You could have -- you have a primary care hospitalist, but then you also have four to six different specialists, and three specialists are saying something is the matter, and two specialists say your parent is fine. And you can't really understand what they mean by all of that. So there's not someone there that

actually can take all of this incongruent data and somehow put it together in one synthesized format.

So -- and the pace is very quick. And the messages can be fleeting. And what we said we were going to do this morning, now that we have these labs back, now we're not going to do that, but we -- you don't understand why, necessarily. So there's a lot of communication issues, care and treatment issues.

And then also issues of attitude. I understand what you're saying, but the tone of your voice, or the inference of what's happening to you makes me not want to trust you. So those are the normal kinds of things that we deal with every day.

And we do have patients that actually will [05:00] come and be very happy with us, and say how wonderful we are, and that they want us to tell the providers that. And they want -- they're incredibly grateful to us, and they want us to be able to relay their thanks. And that could be, too, if, after their loved one has died. So it doesn't matter the outcome, what really matters is the experience of the patient and the loved ones; how we created the experience

for them, and how we connected with them during this experience for them. Those are the normal days for us.

And a lot of times, when we're saying, "This is the way it has to be," we're not really coming down on the side of the patient of the family member, per se. Which is why we specifically say we're not the advocate for the patient, we're not the advocate for the family. We really are mediators, and loss-mitigators. Understanding where we technically went wrong in this situation, and being able to write that, and then saying also when we can't do something, and why we can't do that.

BOTELHO: Got it.

FAGAN: So that's a normal day.

BOTELHO: That makes sense.

FAGAN: Yeah.

BOTELHO: And have you worked on Marathon Monday before?

FAGAN: Oh, every Marathon Monday I've worked.

BOTELHO: Every Marathon Monday.

FAGAN: So, it was --

BOTELHO: And what does it typically look like?

FAGAN: So a typical Marathon Monday, depending on the weather is very -- is a lot of fun. OK? So number one, it's an easy day to commute. Right? So right away, you're getting

some perk, here. So you don't have to negotiate traffic, everyone else is home, it's -- everyone is happy. There is an air here, in New England -- and not being from New England, it's really cool to watch it, because we didn't have anything like this in New York, right? Certainly not to this extent. Certainly not to having this level of cheering that happens along the marathon route, and tailoring the message that you're going to give to someone, based on the town you've come from. Right? So, in coming here, it was something that I did. Either -- I took it off a lot, when my kids were younger, just so we could see it. And when you're standing in the marathon, it's incredibly powerful to, like, see how happy people are, like, that are watching it. But then also how happy people are that are actually in it. So that's really cool.

Now that I worked -- now that my kids are older, and they can go by themselves, I would come and work here. And being from the Center for Patients and Families, we would all be able to -- we all kind of waited, because we'd know, generally, probably, depending on how hot it was, we would be getting probably anywhere from, like, 15 to 50 people in an afternoon, primarily around hypothermia. And our role was basically to be able to understand who are these

people? And if you turn the bib over, there's a lot of content data on that bib, and whether you wrote in sharpie or not, that was not water-soluble, you could actually, like, get to know -- like, you could figure out who they were. You could figure out who their contact, who their loved ones are.

So we pract-- you know, we would, a, practice all the time, right? But we would also be the -- we got used to it. And we got used to the flow, coming in. You know, you would see the people that were least well-off come in first, and then you would see the people that had much more experience come in a little bit later. And two years -- no, the year prior, it was really hot here. And it was like 90, hot. Right? And so we had -- and they were asking people not to run. So it was kind of like, "Aw," you know? But people still wanted to run. But a chunk of people didn't run. So -- but the group that we actually got, we didn't know who they were. They were way too hot; they came in with core body temperatures of 108 to 112. So we -- they weren't -- they didn't make sense at all, obviously, the ones that could even talk. They were in delirium, and we basically just hydrated them the whole time. And so, being a nurse, I could actually be in with the nursing group as well, but

also be able to run back and forth to my group, to be able to run interference for what do need now? Who are these people? And what was interesting then is, you got to a certain level of hydration and -- *poom*! They came back, because they had so much reserve that they could talk again, and you could tell whether or not they -- you know, people who you sort of thought, oh, they don't look American -- they could be from another country. They're -- you know, they might not be able to speak English, but [10:00] then when they came back, they could almost all speak English. Right? Like, they were all, like, they came right back. They came -- when I say "right back," six hours, right? And boom, they were all back. So that was kind of cool, watching that. So, you know, you kind of practiced, and you -- it was fun. It was just a fun day.

BOTELHO: So you belayed off in between the team of nurses at the ER, and --

FAGAN: Mm-hmm.

BOTELHO: -- sort of the front of the hospital, and then you also worked with your group in your office --

FAGAN: Right.

BOTELHO: -- getting more of a sense of --

FAGAN: Well, the office would move over.

BOTELHO: Would move over? I see.

FAGAN: So we would come over. So we can deploy anywhere, in the hospital, right? And we can stop our general shift of whatever we're doing, which is the normal people coming up and down, and go into problem mode, where, you know, when we have a hurricane, when we have a lock-down. When there's any kind of event, we all know how to pull together to create an incident command. And in that incident command, you are -- you have other jobs. So you suspend your normal daily operation. You'd take -- you know, there's someone back at what we would affectionately call "the ranch," giving you, like, what's going to happen right then, to all these other folks. We're just going to queue up all you problem sets, and work on them tomorrow. And then -- so we can deploy all the way over in the ED.

BOTELHO: So it's a team of nurses and other -- other mediators, who --

FAGAN: Right.

BOTELHO: -- who work with the nursing staff, but have --

FAGAN: Yes.

BOTELHO: -- take on additional roles, when they're needed in --

FAGAN: Right.

BOTELHO: -- certain incidents.

FAGAN: Right. So there's 12 of us altogether. And you work not just with nursing, but you work with physicians. We

work with attorneys. We work with social work. We work with risk management. You know, we do -- we work with a lot of different -- we work with everyone, no matter who you are, we'll work with you, because we're the point people that come in first when there are opposing sides, or the front people that come in first when there needs to be some sort of repatriation between your family and this person here. Right? So, there can be people calling and saying, you know, I don't know where my loved one is, but the bus just crashed, and you know, were they on there? So that call would come to us, right? Who are you? Who is your person?

So in that realm, when there's some sort of incident command that's happening -- and when it's called. When you actually -- it's a code Amber, and you actually have an external code Amber that's called. So something is coming from the outside. You suspend the normal operations, and we go into this mode of, what is our task? What are we expecting? Is it coming in through the ED? How big is it? Who -- where are the loved ones going to come from? Are they going to be phoning? If it's an airline crash, then they're going to be phoning, they're not going to be here. If it's a marathon, they are going to be here. Right?

BOTELHO: Right.

FAGAN: If it's not -- they're not going to be here, where is their country of origin? Who and where is the embassy for that country of origin? So there's just all of this -- you've got these variables that you work on all the time, depending on what is the problem? So each time --

BOTELHO: (inaudible)?

FAGAN: -- is a different problem set. So a real day, of the real marathon? Not just --

BOTELHO: Yeah, if you could talk about sort of the morning, what you were doing that morning, and when you heard the news and --

FAGAN: Yeah.

BOTELHO: -- what happened in the hours after?

FAGAN: So the Friday before -- let's just prep with queuing the scary music, here. The Friday before, I was going away to a conference. And I was taking my second-in-command of this away to the conference. And so we gathered everyone together, and we said, "Monday is the marathon. It looks cool. We already know what the weather is going to be. The weather's going to be good for runners, 45 to 60." So we are not -- you know, we already know for incident command, there is not any kind of alerts, and we also get FBI reports of what they're considering is some sort of

code alert, right? And anything greater than a yellow -- higher, toward red -- is bad. OK? It means some-- they know something is out there.

So it was at a yellow, which it normally is at. It never stays at a green. So we basically said, "OK. We know, pretty much this is going to be a pretty routine day. We know it's going to probably be a weather that -- you know, if anything, but the weather looks good. And we're just going to be in Annapolis, which is only -- it's a direct flight back, heaven forbid there should be a problem. So let's just run through what's going to happen." And everyone said that. And we basically, at the end, they joked to us, "Well, you know, like, both of you are going, so who's going to be in charge?" And we'd say, "Well, nobody's going to be in charge. I'm going to be in charge. You've got my cell phone, you have Kristen's cell phone, you know, so -- you know, we're just a phone call away."

So we fly down. And we are in the -- at the hotel. And it's, you know, gorgeous, and we're at the cons-- we're at the National Institute for Patient and Family Centered Care. It is our premier conference, right? And I'm bringing a large delegation of senior thought leaders from

[15:00] here down to help change this paradigm that I was talking about.

And the morning is come -- the morning is basically where the host hospital is showing you their advisory council. And on their advisory council, just interestingly enough, is a mom who is Muslim. And she's an amazing speaker. So she's their patient advisor, and she's a mother of two young daughters. And her one daughter has had several bouts of cancer, and -- brain cancer. And then it comes back again. And she's telling us her story. And her husband is a physician in this hospital. And she tells this long version of the story, and really -- and this is part of the conference, and I'm thinking, "She is an amazing speaker." She's in full, beautiful, Muslim garb, OK? But just breathtakingly beautiful. And she's got on a burqa that is yellow and gray. And it's so -- she's -- and it's all spring-like. Right? It's yellow flowers. I mean, she was just beautiful, absolutely beautiful, right?

So she tells us the story, and she's a really strong advocate for her daughter, and she's a real -- and what happens to her is that, basically, people are profiling her, because she's Muslim. They think she can't speak

English. They think all these things that are basic patient and family centered care tenets, right? After the morning is over, so now it's noon time, I say, "I have to talk to you." Her name is Halla. I said, "Oh, Halla, I have to talk to you. This has been so interesting, and we're trying to recruit more Muslim patients and family members, and she's like, "Oh, this is so wonderful," and, you know. And I said, "Do you know anybody in Boston? Do you? --" "No, no, but we'll work on this." And so I was talking with her, right? It's time to go into something else, but I'm just thinking, she's just way too interesting.

So I can see on my phone that my group is talking in the lounge, and they're waiting. And when that happened, I can see that my -- all of a sudden, my phone is going crazy. Right? Like, Kristen's calling me to come over right away, and I'm seeing work is calling me, and I'm, like, I'm getting texts, and then my son wants to know where I am, and my son is in Buffalo in college. And everyone's -- and I'm like, what's happening? I said, "OK, just a minute, something is happening. And so I have to just go see -- to the bar." She's like, "Oh yeah, no worries, no worries." I run to the bar, and I can see on the TV screens that

there's -- they think there's been a bombing. And so we're watching it.

So now the ED -- head of the ED nursing is with me. The vice chair of ED is with me. I know, right? Oops. And then, the VP of HR is with me. And then I have all these executive directors with me, and we're texting everybody, come into the -- come in here right away. I call right back to work to say, "OK, we're in Annapolis. You know, we can see this --" then, when we're talking, then goes the second bomb off, right? And then you see -- and we're watching CNN. And then you see that there are these continuous false -- now we recognize that they're false -- bombing spots, throughout the city. Right? And my family is, like, freaking out. And I'm saying, you know, "I can't talk to you. I can't talk to you now."

And I call -- my cell, for some reason could come through. Not everybody's cell -- I had AT&T. So the cell could get through to Boston. So we said to one of the folks, "Go up to Incident Command; say where we are. We're in Annapolis. We will come back. But leave it open. Leave the phone open, so that I can hear what's happening, and we will be able to let you know, like, what we should do next." And

so they're like, "Absolutely, no problem." But by the time they got upstairs, they'd pulled down the cell towers. So then we lost all communication with everyone.

So that was probably, by now, around 2:30, quarter-to-three, and Kristen got Heidi, Josh, and I. So, the ED physician, the Ed nurse leader, the head nurse --

BOTELHO: And what are their last names, just for the record?

FAGAN: Heidi -- Heidi Crim, who is the nursing director for the ED. Josh Kosowsky, who's the vice chair for the ED. And myself. She got us seats back on -- by this time, there was no airspace now, over Boston. So -- well, Heidi and Josh got the first -- the last two airspaces, still being able to land at Logan. And then I come into Rhode Island. So we all got in that night, [20:00] like we came in probably around 9:00 that night, back to Boston.

Before we came in, I huddled with all the group that was there, to be able to explain, "I have to go back, even though I'm supposed to be your host here, I have to go back. And this is what you need to do; these are the people you need to see, while you're down here at this conference, and this is what -- these are the different choices you need to go to make sure you guys see this, and

you other guys see that." So really kind of lock that into, this is the work that has to happen while I'm away. And you can do the work while I'm away, and you can email me tomorrow about what you need to do, but I have to go back. And Kristen stayed down, so the second-in-command stayed down, and I -- I went up.

So that is Monday night. I fly back. I get into Providence, and I mean -- I think what you have to hear is that there was probably, when you think about it, three horrible minutes of two bombs. And then all of the things that happened afterwards were primarily people doing, like, amazing things for one another. Right? (snaps) It's still very like, it's emotional.

So I get back, and waiting for me in Rhode Island is Kristen's dad's driver. Like, he -- so -- and he's, you know, like, I do not drive in limousines. Right? Like, this, like -- (laughs) why is my name -- why is that man holding my name like that? And so her -- his driver drove me all the way back home. So an hour and a half to drive back home to Boston. I'm like, "Wow, that was, like, totally really nice." By the time I got in, it was about probably 2:00 in the morning. And then the next morning,

so the day after the bombing, I get in probably -- I'm there around 6:00. And it's calm, except that when you come in -- and I'm walking up the hill from our parking garage -- there are Secret Service, and the bomb squad, and like SWAT teams that are guarding the front and guarding the ED, and there are tobacco and firearm and the ATF people and the FBI. And everyone's in full garb of all of that. Right? So, let's say, like, over 100 of them, right? All around. And they let you pass. You had to always wear your badge, but they let you pass.

And I came in, and the first thing I see, at, like, 6:30 in the morning is our chief executive officer coming down with a list. Like, she doesn't come into our department, right? Like, this is not her world. But she basically was just running interference with everyone, because it was also spring break, so many people were gone that week. There weren't -- everyone kind of, who had kids who were in public schools went on break. And everyone had Monday off, right? So, a lot of people were away. And she just happened to be one of the people that were not away. And so she was actually kind of in the trenches with us, which was kind of cool, to watch somebody that basically is your

external representation for Brigham and Women's be part of the team.

BOTELHO: And the name of the CEO?

FAGAN: Is Betsy Elizabeth Nabel. So -- we call her Betsy. So just basically running interference with everybody else, right? And by this time, people were initially out of the OR. So when you -- and we got a lot of reports, like, hourly about how everyone was. But my role then, as the executive director for the Center for Patients and Families was to basically meet all of the patients, and then to meet all of these families. And what we didn't recognize what was going to happen was, we were going to be -- we were a media event. So there was this media event piece that was something that, as we reflected upon it a year later, now, something that just -- you would never see in your lifetime, necessarily. Right? Like, things that we saw, things that happened to us that transpired over that week, were one of those iconic moments in your lifetime where you would say, "I never saw this level of a wound; I never saw this level of a problem." You know, you could have a terrible bus accident, but intentional violence like that, and being able to wrap your head around the concept of the intentional violence, and [25:00] then to see how young those young men were. I mean, for me, it was hard, because

I have children that are that age. So to be able to juxtapose my kids with those boys, too -- I call them boys -- was an amazing juxtaposition, right?

It was hard for me to keep defensive about who they were, when I could see that they were so similar to my kids, right? In age, in just kind of their quirkiness. Right? You could -- once you started to see them on the screens, you could see that, so, you know, and from my perspective as a nurse, it was really hard to hate them. Right? As terrorists. Like, I didn't have labels for them, right? So, that was hard. And that was, I'll tell you, a minority viewpoint. OK?

But when you think about that day, the whole second day was basically coming in and a very, very few -- I would say almost no one of the patients could talk, yet. Right? They were either in a drug-induced coma, or they were so filled with pain meds that they actually couldn't talk.

BOTELHO: How many patients came in to the ED that (inaudible)?

FAGAN: Thirty-nine came in, and 12 stayed. Twelve slept over. And most stayed for about a month to six weeks.

BOTELHO: And were -- and the majority of the wounds were, that came into this ED were...?

FAGAN: The majority -- so when you think about the bomb actually blowing up low, so it was in a -- they were in backpacks that were low to the ground. Most of the injured, unless you were a small child, most of the injured were to their torso, their legs; your hands, like your hands were down low. And only two of the survivors who happened to be husband and wife were actually -- got spray of the shrapnel to their faces. So most of them were low, and some of them were an amputation that occurred as a result of the trauma, and some actually required amputation after a while -- fingers, and legs, and ankles, and all different parts.

And I think that whole day was spent trying to listen to the family members and to really -- to basically listen, right? And at that point, I didn't really have a word yet for what I recognized in day three -- so the second day after the event -- was the word "terror." Like, we don't have -- we don't see terror on such a grand scale here. And so, when you think about it, you're used to -- quote-unquote -- intentional violence when it is gunshot victims or stabbing victims. And it could be a group, you know, which is a terrible thing to have happen, of like a group of kids. Three -- one to four, right? But to see that

amount of people, and to see -- it was young, middle-aged people, like people that were just coming to be -- people that were waiting at the finish line. So it was people that were primarily, happy families waiting for their loved ones. I mean, when you think about everybody's story, you know, what was happening. And then at some point, to be able to contextualize for patients and families what was this? How could people do this to other people? What is going to happen now? What is going on here?

And then we felt a -- so there was that, actually connecting and checking. But then we also started having relationships with who are the FBI people? Who are the State Police? Who are the local police? Who are the alcohol, fire, and tobacco arm -- fire... Alcohol, fireworks, and tobacco. It's like a whole 'nother group of folks. And then who are -- so all these people that wanted in, because these were people that they still hadn't found the perpetrators. So they wanted to still talk to the patients, and they wanted to talk to the families. And we really -- we really wanted there to be this sacred healing space first. I mean, that's some of the basic framework and tenet in patient and family centered care, when you're changing up this paradigm, you will get your opportunity to

talk. But it can't be right yet, because you're going to -- because, first of all, a lot of them can't speak yet. And second of all, [30:00] they're -- it's too soon for this family group to be hashing and rehashing. And most of the families weren't there. Right? Only a few, a few were young, were there, right? So --

BOTELHO: So, it was a lot of communicating with the families of the patients, if the patients themselves couldn't talk. And then with the law enforcement, and then with the physicians, and trying to --

FAGAN: Mm-hmm.

BOTELHO: -- to mediate those conversations --

FAGAN: Right.

BOTELHO: -- of who can talk to who when?

FAGAN: Right.

BOTELHO: What kind of care does this patient need now?

FAGAN: Right, right.

BOTELHO: All (overlapping dialogue; inaudible) --

FAGAN: And talking with Legal. Being able to say, "This -- we know we're not supposed to get -- you know, we know that the FBI can tell us what to do. But, you know, you can -- I'm going to tell you that he is unconscious, and you're going to have to believe me that he is unconscious. I'm not here to create some kind of a blocking between you and

he. I get that his wounds contain shrapnel and shrapnel is evidence. I understand that, conceptually. But his mouth isn't working. Right? Yes, he's got shrapnel in his face, but he can't -- he's unconscious right now. And they actually got that. They were very respectful in that way. But always wanting to come in. And so it was a lot of running -- so, you know, eventually there are some people that get to speak. And eventually they can pull down enough tape that they can see that there are -- where these people were, in this picture that was there. And then who was closest, and that's the people they want to talk to first.

So, it was -- once they're all awake now, a few days later, you can see that the media now wants to talk to them. And everybody's got a story. And then we start to recognize that you're split from your family. Who was in your friend group? And when you start waking up, you want to know where your mom is. You want to know where your sister is. And we recognized that, OK, you have a mom. Where was your mom standing with you? Can we go to other -- so now we run into all these HIPAA things, where, you know, this is a person that is, you're legally not supposed to talk about them. But you have a feeling that, like, their brother is

at the BI, and your mom is down at BMC. So then, it really was this very interesting dynamic of pushing the envelope with who are you trying to protect and why? And where is the loved one? So it was, for me, very interesting, because you bumped up to the very end of what's the rule, and what is the new paradigm of patient and family centered care? Why are you holding this information without letting -- you know, without letting their loved ones know?

BOTELHO: There were other interviewees as well who talked about the trouble of identifying people who came in and corralling family members who might also be injured.

FAGAN: Right.

BOTELHO: So that was a problem that you guys also dealt with --

FAGAN: Right.

BOTELHO: -- on your team.

FAGAN: There were so many interesting different problems that a lot of -- that you would never have thought, right? But the volume of people, and the variables around, who is your family, and what -- and the fact that this was a crime scene, along with being a sacred hospital space, right? So, if you hold out this concept that there is such a thing as a sacred healing space; and yes, it's a hospital; yes, it's as big as a city, right? Sixteen thousand people? There are towns smaller than that, right? That work in two

city blocks. Yes, it's this juxtaposition of all these different things. It is also a crime scene, and we haven't caught the perpetrators. And so, trying to be able to weigh all of these things with -- and then, the international community came in and said, "I am from Poland; I am from Italy; I am from China; I'm from Japan. I am the ambassador, or I am sending my embassary [*sic*], and we want to know, in your hospital, do you have nationals that have run this that we need to tell our people about?" OK. Is there a rule for this? Right? So you start thinking about, OK, I could answer that question if you phrased it differently, right? So let me help you understand, I have American citizens here, just American citizens here. Like, does that help you at all? Is that what you're looking for?

So, they were so respectful of us, though. It was, like, amazing to watch the amount of respect for the organization, respect for the commonality, but also the community of people that [35:00] to do good. Right? In the aftermath of all of this. And now, by this time, we recognize that there are people that died. Right? So by this time, you recognize there are four people that are dead. They are young. And they are parts of family, and

the other parts of family are other -- like, so the media is showing you these connections of people, right? And making the story be human.

And so I just -- I found all of that very interesting. There were some -- I think if you had to say, what were -- what would we take away now that were different, we would be much more media savvy, because there were people in the media that recognized where to sit and look like being a family member, so that you could just listen to what everyone was saying, kind of get your own lay of the land, as a interloper. And then just take someone else's flowers and go up into a room and pretend you were a loved one. Right? So that happened. And that kind of inexcusable behavior that is -- for the sake of a story -- is something that is just incredibly, you know, horrific, right?

I remember telling that to my son, who is a communications major in college, and he was saying it to his professor and to the students one day when they were talking about the ethics of journalism, and he said, "Well, this is what happened at my mother's hospital." And they were just horrified by that. But that kind of a lesson shows you in today's world, when there is such a thing as terrorism.

When there is such a thing as big, intentional violence. Where do you draw the line in the new rules, right? So, even that, I thought there was some good that came out of that.

BOTELHO: So your team, and I guess the hospital's PR team, media relations team, did you -- did you work together, in talking with patients if they were willing to talk?

FAGAN: Mm-hmm.

BOTELHO: If so, who they interviewed with?

FAGAN: Right.

BOTELHO: Were you part of that --

FAGAN: Yes.

BOTELHO: -- responsibility? OK.

FAGAN: Yeah. So, so basically, Erin McDonough, who's our VP of PR, and I teamed together to be able to understand who all of the different patient and family members were, and was there any kind of story that they wanted to portray, and if they did, how would they want to portray it? Because the media was contacting their families at home. Or contacting their families by waiting outside, or as they walked from one hospital to another, so some folks had loved ones in different hospitals and they kind of profiled who they were and then asked them out on the street. So, we tried to be able to understand who does want to talk to

the media, who doesn't want to talk to the media? Who wants to talk to the media around who does, what are you going to say? What if they say something that you don't want an answer? You don't want to answer that.

So that was Erin's role, to actually do the prepping of them, and my role was to actually ask them, is this something that you would want to do, knowing that when you open this can of worms, you open it, and they can find you on Facebook, and they can find you -- you know, they can -- they already can figure out who you are, because they are connecting with whomever on Facebook. So they're good at this, right? They're using social media to get one of you. And then they're going to broaden their capability to talk to you. And I think that was something that a lot of people didn't recognize. And so, my role was to basically say, "You can still be private. And no matter what, we would never want to do this if you don't want to do this. This is, you know, we're in uncharted territory right now. And we don't want you to do anything that you're uncomfortable with."

BOTELHO: Right. And just before we keep going, I wanted to backtrack, and make sure that we hit -- in those hours between 2:30 and when you got on the plane and got to

Providence, at 2:00 in the morning. When you were relaying questions, and challenges by phone, what were some of the things that your staff, your team, here at the hospital, asked you for guidance about in those four or five hours? What kinds of conversations were you having?

FAGAN: Right. So, we -- they were basically saying, you know, what do you want us to -- do you want us to all go to the ED? Do you want us to -- how do you want to deploy us? Where do you want us to be deployed? And so, my messaging was basically that, this is going to be so big that you have to deploy with [40:00] a team of people not just using us. You actually have to go to Chaplaincy, and you have to go to Social Work, and you have to team with that group of people, because you're going to take your group of six, and you're going to be able to make it be a group of probably 20 people that way. And that way, you can juxtapose -- you can be over at the ED, you can be outside, because right away, we had to go on lockdown, so no one could come in. So even if you were not involved in this bombing and you just happened to be out at lunchtime that day. You went out for air, and you came back after lunch, and let's make it up -- your loved one was here for three days. You were not allowed back in. So everyone coming back in had to be vetted that they were actually the family of a loved one

somewhere else in this hospital. So that meant that we had to be positioned outside. Plus we had to be positioned at the ED. And everyone at the ED -- no one had a name. So everyone was going to the OR with a number. And so -- and so even though you had a number, our job is to figure out who are your family members?

And it became clear -- so when you hear my staff talk -- three of the people were on the phone just taking calls from loved ones and families. And one of my staff actually tells the story that one of the patient's mothers that was calling was a woman that she knew. She knew the mom. And she also knew the daughter. And she didn't see the daughter in the ED yet, but she could hear -- she knew the mom. And the mom didn't recognize her, because the mom was so frantic. And at that moment, it became very real for my staffer person, because in the midst of all of this really powerful terror that went on, it became very real to her at that moment on the phone. So that was very -- that kind of shook her.

The staff wound up leaving around 11:00 that night. But what we did was to be able to understand where are the places that you need to be deployed outside the ED, the OR,

and then back in the Center for Patients and Families, because we're going to congregate people there. And then back up at the Command Center. So they got that right away; they figured that out right away, because at some point, it became routine, once we understood that there weren't going to be more people after the 40 that -- you know, 39 to 40 that came in. So after the first two hours, there was this lull. So they call came at once. Which was huge. That's not how you usually receive a lot of people. But then you recognize that, you know, because there's five level-1 trauma centers, everybody got sort of an equal amount of people that way.

BOTELHO: Got it. It's a -- all very interesting. I'm making sure that we sort of covered everything about the day itself.

FAGAN: Mm-hmm.

BOTELHO: Did you have any other communications with other hospitals or teams in Boston?

FAGAN: We communicated with the Department of Public Health. So, they offered their services to do anything that we needed. Because now this is as the week goes on. so this like Wednesday now, when they still haven't caught the perpetrators, but we -- so, we talked a lot with our risk management folks, and with the Facebook FBI. We got

assigned, actually -- so the FBI actually has people that are victim-assistance officers for the -- for acts of terrorism. So, while we didn't have acts of terrorism, they are used to that, right? So these were now a whole set of social workers who are FBI agents that come in and actually try and understand what is needed and when. So as it becomes less acute and more now into settling into what's going to be a long haul for everybody -- everyone's going to be here for at least a month, we're going to have reassess these ruins [wounds?] every few days. People are going back every few days for more surgeries, for skin flaps, for debridement. So people were going back to the OR several times during this -- several times in the first couple of days. And then several more times over the first two to three to four weeks.

And the FBI agents were actually the folks that were able to quantify what is happening, and quantify the level of severity of illness, and juxtapose it to other areas -- other groups that have had acts of terrorism. [45:00] So that was really good for us to be able to work with people that were quote-unquote used to this, right? Like, how are we doing? What do you think about this? And what actually I found to be somewhat rewarding, even though it was a

horrific situation, was the kind of compliments that we would get from the FBI and the state police and all the different kinds of folks that were in the legal world and the folks that worked in police work around how orderly everything was, and what a system we had for everything, and how, you know, when you think about the fact that, if you're taking shrapnel out of someone, that there has to be a chain of command that occurs from the OR to the surgical pathology department, and there had to be an FBI group in pathology, and in the OR. And they had to be always watching all of this. And their perception of how we did our work was amazing to them. So to be able to come out of your role as an FBI agent for a minute to say, "Wow, you guys are really good at this," in terms of how you are systematizing what you are doing, was kind of a like a nice break for a minute, to be able to say, "Oh, thanks." You know, that's nice to be able to hear from somebody that would be the recipient of our work.

Because when you think about patient and family centered care, it is the end user, the patient, that's saying "thank you for making the experience good." And now here's this FBI agent saying the same thing, right? "Thank you for making my experience of needing for me to do my role well,

like you kind of thought about all this from the end user's perspective. Wow." So it's kind of -- it's nice when you can actually see that happen, and hear these small little grateful bits of that.

BOTELHO: Interesting. And so, just finishing up, to give you some time to talk about what you've learned, anything that you've changed in the year since. The marathon happening -- you've touched on it a number of times, in our conversation already. But were there any changes that your team made, for sort of emergency response, disaster response since? Are there things that you've learned, things that you would do differently next time?

FAGAN: I think that there were many systems that were changed. What happened specifically around communications in general was to be able to report out many people want to know who is here. So we have to really tighten up who we can talk to, and when. And there should be some people like police officers, who should be able to be unblended to who is actually here. Because once you understand that your event is larger than on hospital, and you could have loved ones other places, what you need to understand is that you need to kind of widen your net around what you can and can't say to someone. And that there are other folks that have an interest in knowing who these people are, not

from a media standpoint, but from a communications stand point to loved ones. And that expanded. And then to be able to say to folks that never had something like this happen, what you're going to see happening is that there are going to be many people that need to know who these people are, and what is the matter with them, and it's not obvious to you yet. So, yeah, we did a lot of work around that. And we actually had a webinar as the folks that were communications experts that were coming from around the country. So the Brigham participated but other hospitals participated as well. Talking to the FBI, and talking to the federal government just around what were the problems that happened. And what were the rules that disallowed us to talk at a certain level, and what would you do to be able to lessen the burden of that, during a time that you could declare this is happening. So, you know, the governor can declare something, and during that declaration, you can have a different set of rules.

And so this is something that you need to think about because if you're gathering a large group of people to be at some kind of a big event, and you're making it be that kind of a variable, where you're going to have a lot more patients and families around, then that's important.

BOTELHO: Is there some [50:00] sort of declaration or alert that your hospital or the city's trying to put in place so that in the event of a crisis -- so, what I understand is, normally you can't tell somebody who calls in to the hospital if there's a patient here. You can't identify --

FAGAN: Right.

BOTELHO: -- and give out that information.

FAGAN: Right. Unless they -- you can say it if they are an inpatient and they give you permission to say so-and-so is here, and that is their condition. Right? Yes, we have so-and-so, it's this is their condition. But where no one could talk, coming in, all we had was people saying, "Is someone here?" So yes, you can't -- you can't say anything just then.

So there's that piece of it, but then there's also, during any kind -- we haven't had a time where we would disallow someone to come into the hospital. That's another sort of unusual event. Even in a --

BOTELHO: Like a lock-down.

FAGAN: A lock-down, yeah. You don't -- who has a lock-down? You don't have a lock-down, right? You can have -- you can say that they're -- we just wouldn't have a lock-down. Unless you had some sort of active shooter, somewhere in

the hospital. And you practice for that, but you know, that's obviously a practice. That never happened. But to be on lock-down, and then to have the city be on lock-down, so you couldn't get in at the end of the week, were just all kinds of interesting crazy. Because now you had patients that couldn't leave. Now you had to start giving people medicine. "Oh, you're on medicine? Oh you have high blood pressure medicine? Oh, we don't know when that -- oh, you need insulin? We don't know when we're going to let you out. Oh, we're going to have to get you insulin." Right? So all of a sudden, we became this community where, "Oh, we have to feed you. Oh, we have to -- you know, like, you can't go anywhere." So that was unusual for us.

So what we're trying to -- what we tried to explain to people was the two kinds of events, this intentional violence that caused this large event from happening, and this lock-down, are two areas where we have to be prepared differently going forward.

BOTELHO: Interesting. And if you wanted to know if there is a name of a project, a name of a plan that you guys are trying to put in place, just for the record so that researchers can look into it when --

FAGAN: So what happens now is that we work with the state of Massachusetts and our Command Center that's here at the Brigham and Emergency Management can work with the city of Boston, and can work with the state of Massachusetts. So those are already in play that's happening. Those -- so they talk to each other all the time, and they actually deploy a whole different mechanism for communicating who this patient is, and tagging them separately, based on where you found them and where they're going, and what's the matter with them on their system. So we already have that in place. And now -- so they're still working on that.

BOTELHO: Got it. Great. Is there anything else that you'd like to add?

FAGAN: Well, I think just in closing, the thing that I found really comforting to me is the woman that I told you about, Halla, in the beginning. She writes me the next morning, so now I'm home by now, and she apologizes, and she says her whole prayers of the day were so beautiful around how terrible this was of an event, and how having children herself, she thinks this is so horrible. And so, the -- she -- we still are good friends now. So the juxtaposition now of sort of meeting her, having her be with me when this happened, and then having her talk to me over the next

couple of weeks to kind of just, you know, never saying about the victims here of what happened, and the survivors of what happened, but to always be saying that, "We're praying for you, and we're thinking about you." And it was just such a -- to me, a beautiful juxtaposition of, like, where did we find -- what did we find ourselves in? And then, who is praying for us? I thought that was really beautiful. So, yeah.

BOTELHO: Great. And, OK, so that's the conclusion of our interview. There was a glitch at the beginning, so I'm just going to go back and say that this is Alyssa Botelho, and it is May 13, 2014, and I'm here with Maureen Fagan at the Brigham.

FAGAN: Yeah, you're welcome.

BOTELHO: I really -- [54:39]

END OF AUDIO FILE