Strong Medicine Interview with Kevin Tabb, 22 April 2014

Q: OK. So, this is Emily Harrison, and today is April 22nd, 2014. I'm here with Dr. Kevin Tabb in the administrative offices of Beth Israel Deaconess Medical Center, and we're going to record an interview as part of the Strong Medicine Oral History project. Dr. Tabb, do I have your permission to record this interview?

A: You do have my permission to record this interview.

Q: Thank you. So, we're conducting this interview to create a permanent historical record of the Boston Marathon bombings and their aftermath. We'll spend much of our time together today talking about your experience of what happened that day, and of the days, weeks, months, year that followed. But we also want this interview to make sense to people decades from now, so we'd like to start by hearing a little bit about who you are, what your background is, what training you may have had in disaster management --

A: Sure.

Q: -- leading up to this.

A: Be happy to give you a little background.

Q: Thanks.

A: And it's, I think, particularly relevant to this subject. So again, my name's Dr. Kevin Tabb, I'm the president and

CEO here at Beth Israel Deaconess Medical Center. I'm relatively new in this role, and new in Boston. I've been here in this role and in Boston for two and a half years. Prior to that, I was in California at Stanford Medical Center as the Chief Medical Officer. Prior to that, in a variety of roles, but I spent most of my adult life in Israel, where I served in the military. I trained first as a medic, and subsequently served as a combat physician, and then went to medical school and did my residency in Israel, in Jerusalem at Hadassah Hospital Hebrew University. And therefore, I have had a fair amount of experience in dealing with the aftermath of terrorist attacks in hospitals; not as a hospital CEO, but as a physician on the ground, either at events themselves, or in hospitals and emergency departments receiving victims.

Q: OK. And this, that ties to some things that have been coming from other interviews, as Mass General, where they actually talked about teams coming from Israel to do trainings at Mass General --

A: Right.

Q: -- in disaster preparedness. Those were influential. Were you involved at all in those?

A: I wasn't involved in those specific training sessions of emergency management personnel here, although I, again, my

training was there. It's interesting that we have a number of Israeli physicians that work at this institution, so, like myself, were trained in Israel and had experience, including the head of the ICU, and now the interim chair of the Department of Anesthesia, and others. And I think all of those experiences certainly contributed.

Q: OK, so that's some background on you. And now, some background on sort of the baseline of Marathon Mondays for you. I know you've said you've just been in this role for a couple of years, but if you can think back to Marathon Monday pre-2013, what was that day like for you? What did you do?

A: Well, to talk about Marathon Monday, there is pre-2013, and everything that happened after, and it's a very different world. Marathon Monday in this city for hospitals, even prior to this event, in some ways, was always treated as a mass casualty event. The thinking, though, was very different. The thinking was, there is a potential for a large number of patients, probably low severity patients. And in previous years, we had seen that before. So it was only one year before the events last year where the Marathon was conducted in a heat wave. So, we saw a large number of patients with dehydration, and obviously we see that every year when the heat's worse. We see more of that

orthopedic strains, those sorts of things. And Marathon Monday is one of, I would say, two days in the year where we prepare ourselves for the potential for a much worse mass casualty event, and are on alert for that. And by "we," I mean here at Beth Israel Deaconess Medical Center, but I mean more largely throughout the Boston, [05:00] Greater Boston, community. So that would be the 4th of July, when we would also prepare ourselves for similar -- there's similar potential for these sorts of things to happen, large crowds gathering, and Marathon Monday. This Marathon Monday was no different than many others, until the bombs went off themselves. At this institution, Patriot's Day is a holiday. That's not true at every hospital, but it's true here. But, of course, we're a hospital. A holiday doesn't mean that we shut down, it means that administrative staff is not here, our clinics are not open, but our ED is open, obviously, for business, our ORs are ready. And we had staffing at a level that is similar to previous years for Marathon Monday.

Q: OK. And what was your role that day, so that people listening to this in the future can understand sort of what does an administrator do on an average Marathon Monday at the hospital?

A: On an average Marathon Monday at the hospital, the administrator is at home, having the day off. And that actually has changed. I can even mention this year how it was different, but in previous Marathon Mondays, it's a hospital holiday, and as such, I'm at home with my family. We chose to go and see the Marathon, not at the finish line, but near our home where the Marathon passes, in Newton. So, I was not at the hospital, and not in touch with people at the hospital. And neither were any members of the senior administrative team, until it went off. Now, we have, every day of the year, a senior administrator on call. So there is somebody who carries a beeper in case of an emergency, and that emergency could be many different things, on Marathon Monday and on every other day, holiday or not. I was not the administrator on call, so I was at home with my family.

Q: OK. So then, in 2013, on that Monday, can you recount your experiences of what happened? Especially what you, in particular, did on that day?

A: Yeah. So, being new to Boston and new to the Marathon, we went, my entire family, to go see the Marathon as it passed by, near our house. We watched and cheered on runners, including runners from Beth Israel Deaconess Medical Center, for about an hour and a half, and got home at

around 1:30. The first indication that I had, personally, that something had happened, was that the father of a classmate of my daughter's -- my daughter was a senior in high school last year, and the father of a classmate of my daughter's called her in a panic, stating that a bomb had just gone off, that he was in an ambulance with his daughter, a friend of my daughter's, and they believed that they were on the way to our hospital. Could I do something to help?

Q: Hmm! That's very personal.

A: Before she was able to answer, the phones cut off, and she wasn't able to get back in touch with them, and they weren't able to get back in touch with us. So that's the first indication that I had, two or three minutes after the bombs went off. Within a minute or so, I had already, after that, I was contacted by the senior administrator on call. Our Chief Nursing Officer, Marsha Maurer, who was also serving at the time as the inter -- no, our Chief Nursing Officer, saying that she was on her way into the hospital, and that it looked bad.

Q: OK.

A: And she didn't know much more than that. So, that was my first indication of what happened.

Q: OK. Now, you've talked about having been in situations where this wasn't something out of expectation, out of the ordinary, before. So, when you had that first indication from your daughter's message that a bomb had gone off, did it seem credible to you? Did you feel like you went into a particular mode of practice [10:00] that you knew? Or did you feel like you were caught off guard?

A: Well, it certainly seemed credible to me, although the truth is, that I did not imagine that I would face a similar situation to what I had faced in Israel here in this country. And these situations were very similar, the idea that two bombs went off within a very short period of time, very close to each other is very common in terrorist attacks, and one that I had seen frequently. Not one that I had given a lot of thought to, or imagined would happen in this country. But as soon as I heard, and while I was hearing from the Chief Nursing Officer, and the TV was on at that point, and I was getting dressed ready to come in, and it was clear to me that this was going to be an event similar to ones that I had experienced. Although, at that point, I really had no idea -- none of us had any ideas as to the magnitude. Clear to me, from the very brief interaction that I had with our Chief Nursing Officer, who was a very calm person, that when she said that this looks

as if it's going to be very bad, that this was going to be serious.

Q: Mm-hmm. So, you were then getting ready to come into the hospital, you came into the hospital, what happened at that point?

A: So, I came into the hospital, and I came in through the emergency department. And what I saw was a typical scene for events like this in an emergency department, which is what I would call organized chaos. And so there were a lot of people, and a fair amount of noise. But people were doing the things that they should have been doing. Specifically, that means that there was a trauma surgeon who was the event officer, in essence, who was triaging, making sure that people got the right care in the right place. Patients were all in the right rooms, and other patients were being cleared out, or had already been cleared out of the emergency department. I spent a relatively short amount of time in the emergency department personally, because it was clear that it was under control, and functioning as you would expect. People knew what their roles were, and were doing them. The Chief of Emergency Medicine had already made it in by that point. So I headed up to our command center, which had been opened almost immediately after the event. And I spent a good

amount of my time over the coming week either in the command center or making rounds throughout the hospital.

Q: OK. And who else was in the command center with you there?

A: So there are a set of defined roles, there is the administrator on call, which happened to be the Chief Nursing Officer. We have our Head of Emergency Operations, who sort of -- she coordinates it all. There is a liaison to the Emergency Department, to each of -- the Department of Surgery, there are communications people, there are people from social work. There are people from IT. All of those people have assigned roles anytime that we open the command center, really, for any emergency.

Q: OK. And so from the command center, you have a view of what's happening in the outside world, outside the hospital, a view of what's happening inside the hospital. What's your role in the coordination of that information? And how are you sort of managing all of this information at once?

A: I think that there are formal roles, and there are informal roles. The truth is that the CEO has a relatively small formal role. There's an administrator on call who's running the event, so to speak, there are liaisons with each one. There are, at the same time, a large number of informal roles that a CEO takes, in a position of

leadership; making sure that things are progressing as you would expect them to, that we have everything that we need, providing support to people in the command center, but also people throughout the medical center, and doing things like cutting through some levels of bureaucracy that exist. An example of that, which I think really sort of exemplifies what went on, is that shortly after I got there, [15:00] I got a phone call from the CEO of Boston Medical Center, Kate Walsh. And they were facing very similar issues to what we were facing. And what she said was, is that they had a victim there who was married to somebody else that they could not find. And they were trying to get information, and the family was there, did not know where the spouse was, they suspected that the spouse was in another one of the hospitals. And the normal communications were not working, because they called at lower levels, and were told we can't give out protected health information. Which is silly, which is true, the letter of the law. But clearly, you need to be able to solve those things. So, to cut through it, she just picked up the phone and said, "Can you find out if you have the husband of so-and-so?" And within, you know, 45 seconds, I was able to find that out and let her know. And that's an example, that's just one example. The fact that the CEOs

know each other, and have each other's phone numbers on our cellphones, makes a difference. It's not in the Emergency Management Handbook. It's not part of the plan. But it's something that exists. And I think that there were many examples, not just of that, but of everybody's figuring out how to do things that weren't in the book --

Q: Right.

A: -- that really made the difference. So it's important to train, it's important to have procedures, and it's important to figure out what to do when you don't have a procedure for something.

Q: Right. And so how, I think this is actually a really, really fascinating aspect of disaster response, is, you can be trained in certain things, but then there's the certain creative element, because a disaster is a disaster because it's unexpected, and unpredictable.

A: I think that's really what differentiates a great response from a OK response. Clearly, nothing will work if you haven't trained and don't have a procedure and a policy, and can't follow those things. So that's table stakes, as far as I'm concerned, and you need to have those things in place. And I think we did those things, and by "we," again, I mean all of the hospitals in Boston, and did them well. I think, though, additionally, it was that

additional creativity which was really impressive to me, it was something that I remember from Israel. And it was one of the things that I was the most worried about and had the most skepticism of.

Q: At what point? In general.

A: Sort of as the event unfolded. Because in Israel, people are known for figuring out on the fly what to do. You learn that in the military. We, here, tend to be more "by the rules." I didn't run into that, I ran into a great sense of, let's figure out what we need to do and do it. What are some examples of that? I'll give you two examples. One is, because of the nature of the event, a number of our folks in the emergency department figured out that there was still a concern that one of a number of things could happen. That one of the injured being brought in in the ambulance would be one of the terrorists and have explosives on him or herself, or that the explosives used would have some level of radioactivity in them, would be dirty bombs. That wasn't written into the manual. But they quickly set it up so that all of the ambulances were stopped a distance from the entrance to the emergency department, and members of our emergency department required that all of the injured be exposed, so they could see they were not wearing a vest. And we had somebody from

our security department looking under the ambulances to see if there were any explosives there, and we brought out a Geiger counter. Those were things that were, again, not in the manual, but they are now, and I think were the right thing to do. Another very different type of example has to do with the way that we treated our patients. I mentioned that when I walked into the emergency department, I saw a young trauma surgeon who was acting as the Incident Commander, partly because I'm relatively new, and we have 13,000, and I don't [20:00] know everybody, and I had not seen him before. He was very impressive to me. He looked like he was about 13 years old, but he was doing a great job. He was there, he had been on call since the morning, and he was making sure everybody got what they needed, got the treatment. At a certain point, he went upstairs into the ORs, operated on a number of the injured. And then late that night, was rounding on all of the patients that had been injured, who were spread throughout the hospital. And as he went from bed to bed, he stopped at the bed of a young woman who had been injured enough to have been hospitalized, not so severely that she needed to be in the ICU. And he asked her if she was OK, if she was comfortable, if she had everything that she needed. And she said she was, and she did, she was OK, and everything

was fine, except up here. And she pointed to her head. What you have to understand is, this guy's a trauma surgeon, so his first thought is --

Q: What's wrong with your head?

A: -- you know, like, is she bleeding up there? She's got a bandage -- and of course, that wasn't what she meant.

Q: Yeah.

A: And he quickly picked up on that. And he stopped right there and thought about it, and thought about whether we were, in fact, doing everything that we needed to do for our patients. You know, this is -- this guy's been there since early in the morning, operated on a number of patients, taking care of dozens, and yet stopped and thought about it, and within six hours had organized a multi-disciplinary team of trauma surgeons and orthopedists and nurses, and social workers, and all of that is relatively normal -- but he also added in somebody from the Department of Psychiatry and a chaplain from the Department of Spiritual Services. And they, that multi-disciplinary chain, which had not existed before, continued to round on all of the patients for the rest of their stay, and then, not only that, but when we built out the clinics for these patients to come back for these follow-up visits, the multi-disciplinary team was there for them. And that's the

kind of, I think, incredibly creative and different thinking that doesn't appear in the manual, that changed all of us and changed the way that we think about our patients and treating our patients. And those are the kinds of things that make me, you know, really proud. But it had a tremendous effect on our own staff, as you can imagine. And to this day, I think that there are a fair number who were profoundly affected by the experience of taking care of patients that had been injured in this way, by that number of patients, and also by the unique fact that at this institution, we received both of the suspects, in addition to the terrorists. And there are a couple of -- so, one story, which sticks in my mind, the day after -- I was speaking to a nurse the day after the event, and she had actually been -- volunteered at the finish line, which she does every year. So, the medical tent, we have a large number of people, doctors and nurses, who volunteer every year to provide services at the finish line, medical services at the finish line. And they expect to see sprains or blisters, or dehydration. And she was something like 25 yards away from the explosion, and she took care of a number of the victims, right as they were injured. And about 45 minutes after the explosions, she got in one of the last ambulances that was heading back to

the hospital, came back, was in the emergency department, worked into the evening in the emergency department, went home, came back the next morning. And what she said was, that she cried the whole way in coming in because she knew that she couldn't do that when she was here, because she needed to be strong for the patients. And I think that many of our caregivers experienced something similar, so.

Q: Were there innovations in how to provide for the needs of caregivers also? Let me just check the timing.

A: Yeah, I think that we gave that a lot of thought, and from very early on, provided [25:00] both formal and informal ways for our caregivers to have their needs taken care of. So, if you think about sort of the mental health needs, we have mental health services available for our caregivers. That was available before. What we found is that most -- one of the most effective ways was to provide peer-to-peer support, rather than formal mental health intervention. Many people were more comfortable with that. And so we enabled and did some training for peer-to-peer support as time went on, that was particularly effective. And that was different and innovative. And then there was, I think support that was there, not what you think of as mental health support, but there was all kinds of different support. Another story that I distinctly remember is the

day of the lockdown, which was in and of itself a unique event, obviously. I was going floor to floor visiting all of our -- as many people as possible, patients and staff, and I got a phone call from a board member who said that she was worried about us. And I said, "Well, you really don't need to worry, because we've never been safer. There's a huge amount -- we've never had this many law enforcement." We had everything from Boston Police to SWAT officers, all sorts of law enforcement were there. She said, "No, no," she said, "I'm a Jewish mother. I'm worried that you guys don't have enough to eat, because there's a lockdown, and how is the food getting..."

Q: That's right.

A: You know. And of course I laughed, because we had plenty to eat. But what I also realized was, I had never eaten as much pizza as I had eaten that week!

Q: (laughs)

A: The dietary staff came in double and triple shift, without being asked, throughout the week, to make sure that everybody was well-taken care of. And I think we sometimes lose that in the discussions about these things. The doctors and nurses were heroic. But there are a lot of people here, and everybody was involved in some way, shape or form.

Q: Yeah, maintenance, everyone...

A: Maintenance, security, dietary services. It was really very unique. And none of those things are written in a playbook, either.

Q: That's what I was going to ask.

A: Yeah. Yeah.

Q: This manual, which sounds like it's sort of a flexible document that concretizes and then dissolves and then re-concretizes.

A: Yeah.

Q: But I was wondering how much the informal -- or, not the informal, but the auxiliary staff of a hospital, how much they are involved in any drilling or training that goes on.

A: They are involved in training to sort of -- not dietary services, for instance, but public safety officers are, or you know. But really, very peripherally, at best. And I think it took an event like this for us to have a full understanding of the larger impact. I would say there were things that I saw that I did not see in my previous training, or previous events. So, events like the lockdown were unprecedented. I'd never seen a situation where an entire city is locked down for a day. We have two hospitals that are on -- that are not physically next to each other, a block apart, so basically, people were frozen

into each of the buildings. And I went back and forth, but had to be escorted in a police car between the two institutions. But the lockdown had all sorts of effects. And then I went from floor to floor and talked to people. People were happy to do whatever needed to be done. Remember, though, that staff that were there could not leave, they'd been there all night; and could not be replaced, because staff were not allowed to come in. What that meant was, you know, there were people who had childcare issues at home. Somebody said, "I'm happy to do this, I left my medication at home, though, what do I do?" No, luckily, it's a hospital!

Q: It's a hospital! (laughs)

A: We have plenty of medicine. Somebody who said, who called the command center and said, "Well, I wear hearing aids, and my battery's running out," you know? So the command center dealt with all kinds of things like looking for a battery for a hearing aid, that you wouldn't think of.

Q: Yeah.

A: Small things --

Q: That's right. But big deals.

A: -- but are [30:00] all important.

Q: Yeah. Is there any, just thinking for future researchers, looking back, are there any records at the command center that were kept through the incident?

A: Yes. Absolutely. They're pretty meticulous records that are kept, and our Director of Emergency Management Services has all of those things.

Q: OK. So, somebody can look into the archives kept by that, if they're interested in that?

A: Yeah. Absolutely.

Q: OK, great.

A: Absolutely. But I think that was an example, the lockdown, of -- I don't know of any similar event, except perhaps in wartime, where that sort of things happens.

Q: Yeah, and then it's often inadvertent, that there's a lockdown.

A: That's right. Yeah, yeah.

Q: Not sort of a public agreement, which was always so strange about that day.

A: Right. Right. Yeah.

Q: So going back to this idea that there is a sort of prescribed way of responding that changes based on the realities that you've experienced, we've talked about things that changed in sort of an added, additive way, but what about things that you realized didn't work that day?

Procedures that, for lack of a better vision, fell out of the manual?

A: Yeah, I think that -- well, I don't know about falling out of the manual, but there were clearly many things that did not work as we thought that they would, or should. I think that there could have been a better prescribed method for interaction between the different hospitals. Again, luckily, because we all know each other, we were able to cut through it.

Q: Great!

A: But I think initially, that was a problem. I think there were issues around patient identification which are in the manuals, and still didn't work perfectly. There was a case at another hospital, but it could have happened to any of us, where a patient was misidentified because she was carrying somebody else's ID.

Q: That's right.

A: So I think that there were a number of things at that level. And then, I think many of us had hoped for a little better, faster flow of information from the city-wide command center.

Q: OK.

A: And they were trying, absolutely, but I -- again, I think around the lockdown, when the decision was being made, it

wasn't clear, would it occur? Wouldn't it occur? When it did occur, who was it supposed to affect? Should we send employees home? Shouldn't we? And each -- initially, each of the hospitals were told, well, you guys make that decision on your own. That doesn't make sense. That should be a centralized decision, and in fact, what happened was, a bunch of the hospital CEOs got on the phone with each other, and said, let's do the same thing, and agreed on it. But I think that could have been done better.

Q: And is that -- the Citywide Central Command, is that part of the Mass Department of Public Health? Or, who is that Central Command? The Governor's office?

A: It's out of the Governor's office.

Q: OK.

A: And again, I would say, that's a -- it's pretty -- they did a spectacular job, but that is, if we look back, if there's something that we need to work on, I think that's one of the things.

Q: Uh-huh.

A: The other I would say that I was surprised at the lack of coordination between the public safety personnel, specifically, at the lower levels between the FBI, the US Marshalls, the Boston Police, they did not work together

well. And here at this hospital, because we had the suspect, we frequently found ourselves in the middle of that.

Q: I see.

A: Now, those problems, actually, were very similar to what happened at the hospital level. Once you spoke to the people in charge, there was no problem. They figured it out among themselves, and they all went -- but a couple of levels below didn't coordinate together well.

Q: There was another question I was formulating as you were talking, was this sort of strange relationship between security and therapy, help provision and sort of security, was it a public issue, but here in the hospital you also had it because you had the suspect here?

A: Yeah.

Q: And I was wondering if you could talk about how those two sort of ideas butted up against each other.

A: Well, I'd say as follows. This developed throughout the weekend, and for us it was weeks, because the suspect was here for a number of weeks before he was discharged. [35:00]

Q: Mm-hmm.

A: Initially, we have our own public safety department, we have our own public safety personnel, and our own police

department. But that was bolstered by external folks around the event itself. And then, after the first firefight -- well, the first suspect had been brought here and died in the Emergency Department. The second suspect was still at large. There was fear among our staff, and I think to a certain degree, among public safety personnel that there was some level of risk to the hospital or to personnel here. I'm not completely clear why, but everything from, was it possible, and it turned out to be true, that the second suspect was injured and could potentially be looking for medical supplies too? Would we be targeted, or something. And there was a huge amount of security here, and it was necessary, and it was necessary at a couple of levels. It was necessary because you need to have security, and it was necessary to give our staff a feeling of safety and comfort. And I think they had that, because of that level of security. It required us to do things differently, we had to lock down all of the entrances to the hospital, and you could only get in or out one entrance. And it required us not to let families in, except in extenuating circumstances. And that's different for us. And then, we needed it because we were inundated with press. And that was quite difficult, actually. There were members of the press that were very invasive and

inappropriate. And there were plenty of members of the press who were great, but there were a number of instances of quite inappropriate and invasive behavior. We had a press member lie about who they were and get almost to the ICU. We had two members of the press offer very large sums of money to employees to get pictures of the suspect out, which is illegal. And generally, it was difficult to deal with.

Q: Yeah. I imagine that's not part of the manual, how to deal with press?

A: Well, it is, it is part of the manual, and there are roles within the command center that have to do with --

Q: Media management?

A: -- media management, communications, and press relations. So that is part of the manual. I think we were surprised at the level of intensity.

Q: Yeah. Intensity is probably a good word for that week, across the week!

A: Right.

Q: We've actually done a lot of talking about lessons learned, or changes that have happened. But just to give you a chance to talk on what you feel like are important points that we might not have talked about yet, changes in the

year following, maybe even having seen another Marathon coming, though, you have some reflections?

A: Yeah. Well, again, I think -- so, first of all, the things that we went through, many people in Boston went through. And the things that we went through were minor, compared to what the victims themselves went through, or the victims' families. It was somewhat unique for this institution, because we took care of the suspects, and that was not easy for some of the caregivers, a fair number of whom were the exact same caregivers who took care of the victims, and then took care of the suspects. And dealing with that was emotionally difficult. There was no hesitation. There was no difference in the level of care they provided. But you could imagine that it was emotionally difficult. We, at the hospital, got a fair number of death threats and other things --

Q: For caring for the suspect?

A: For caring for the suspect. There were a number of patients that were here that were upset at us for housing the suspect [40:00] in the same hospital that they were being taken care of. And so, I think, you know, that had its own effect. At the same time, the outpouring of support and love from the community for our staff was just unbelievable. And incredibly, incredibly important! The

story that I can tell about that is that, midway through that week, as you know, the president came to speak, and held a service at the cathedral. The night before he came, I got a phone call, saying that this was going to take place, and that they wanted to have a chance to give thanks to caregivers and law enforcement and others, and that they were giving us 100 tickets. And my initial response, I didn't say this to them, but my initial response was, oh, great. I've all this stuff going on, where am I going to get 100 people, and it's the last thing that I need right now to go over there. Well, what it turns out is, first, it was very easy to get 100 people that were interested, and we got a swath of people, from doctors to nurses to dietary services, to -- so that was a piece of it. The other was, we went over in the small Beth Israel Deaconess shuttle buses to the cathedral, and anybody that saw pictures, or was there, saw that as you got closer and closer to the cathedral, there were tens of thousands of people lining the streets. And there was not enough room for everybody to get in, so there were thousands and thousands of people lining the streets. And as we pulled up in these buses that had Beth Israel Deaconess Medical Center on it, and the staff got off, the crowd burst out into applause. For them, for the staff, it was a really

incredible moment. Many of them cried, and it was very, very important to them to see how much people recognized them. And I think that that level of support and recognition from the entire community continued on to this day, and was so important to our people here.

Q: That's actually a beautiful image, just (inaudible).

A: Yeah.

Q: So, this sort of takes us across the span of what I wanted to ask you about today.

A: Yeah.

Q: And before we conclude the interview, are there any other things that you would want to share with somebody trying to understand what happened that day, in the future?

A: We did an event a week ago, where we had seven of the caregivers involved talk about their own personal experiences. So, there was he trauma surgeon I talked about, an orthopedic surgeon, a plastic surgeon, ear nose and throat, a nurse (inaudible), and one of the victims who was taken care of also spoke there, as did Kevin Spacey, who came right after the event, and I was with staff. But very, very moving, very interesting. And we videotaped that. And I was -- someone said to me afterwards, a copy of that should be given, also, to you guys.

Q: Yeah. Actually, I'll ask you again about that afterwards, and make sure we get that.

A: Yes. Absolutely. So I think that would be interesting for you to see, and a different view on the events.

Q: And that actually brings up one other point that I think we shouldn't neglect to ask, which is, how learning happens about these things? You talked about how your own experiences, and Israel came with you when you moved into this position.

A: Yeah.

Q: Have staff at the hospital been doing any talking at other institutions either here in the US or elsewhere about...

A: Yeah. Absolutely. There's been a lot of that going on. I think many of us, or many of them, have been invited on numerous occasions now to talk with others in other cities around the world, about our experiences, what we did well, and what could have been improved on. The City of New Orleans recently called, as they were getting ready for Mardi Gras, and trying to figure out what we had done, and what they should do. And [45:00] they had mentioned that they had not gotten together as a group within the city to discuss it, and someone said on the call, "You mean you haven't gotten together this year?" And they said, "No, we haven't ever gotten together --"

Q: Interesting.

A: "-- as a group." If there's a single overriding important lesson, it's there needs to be drills, there need to be -- but people need to know each other. And it's important for the people that are in charge of the police department, and fire department and the hospitals, and to know each other and know who each other are, because that helps as much as anything else on events like this.

Q: Yeah! What a powerful idea, actually, that's -- you're the first person I've heard mention that, but these informal professional networks --

A: I think they are incredibly important.

Q: Yeah. OK. Great.

A: All right?

Q: Thank you very much!

A: My pleasure.

Q: So, that will conclude the interview, and thank you so much for your time!

A: My pleasure!

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