Strong Medicine Interview with Jeffrey Kalish, 8 April 2014

Q: So this is Joan Ilacqua, and today is April 8th, 2014. I am here with Jeffrey Kalish in Boston Medical Center. And we're going to record an interview as part of the Strong Medicine Oral History Project. Jeffrey, do I have your permission to record this interview?

A: Yes.

Q: Excellent. So as I mentioned before, we have three broad sets of questions. The first are background, the second have to do with the Boston Marathon, the third have to do with the aftermath and the year after. So to begin with, background questions. Could you tell me a bit about yourself.

A: Sure. So I was born in Miami, Florida, but eventually made my way up to the Northeast. I went to college at Harvard University, and then medical school at New York University School of Medicine. I knew I wanted to become a surgeon, and I did my general surgery residence in training at Boston Medical Center. At that point, I figured out I wanted to do vascular surgery. So I did some research, and then ended up doing a fellowship in vascular surgery at Beth Israel Deaconess Medical Center, also in Boston. And it was at the completion of that fellowship that I came

became an attending back at Boston Medical Center where I've worked as an attending ever since.

Q: Excellent. So what is your official title here at Boston Medical Center?

A: I'm the director of endovascular surgery at Boston Medical Center, and I am an assistant professor of surgery at Boston University School of Medicine.

Q: All right. So what does a typical day look like for you here, then?

A: A typical day as a vascular surgeon. I think it depends on whether it's an operative day or a non-operative day. But on an operative day, we handle all the variety of issues that can come about with blood vessels. So other than the brain and the heart. We'll do surgeries for strokes, we'll do surgeries for aneurisms, we'll do surgeries for leg bypasses. We also deal with dialysis work. On non-operative days, we'll be see patients in clinic, seeing patients in the hospital, doing outpatient vein procedures. So kind of touching everything, if you will.

Q: So you kind of talked about before, on Marathon Monday, is that a day that you typically work?

A: Myself, I typically do not work Marathon Monday because my wife is a runner for a Dana Farber charity. And so for us, that's actually been the past few years a special day of

taking off for me, and the kids are obviously out of school, and we spend the whole day tracking her down on the racecourse, and trying to find her at multiple points, and then seeing her at the finish line.

Q: Excellent. So on last year's Marathon Monday, was that what you did?

A: That is exactly what I did. My wife had a friend drive her out to Hopkinton. I got up with the kids, and we typically start out in Natick. We have a certain spot that we watch her. And this year, she was running at a pretty decent pace for her. And so we -- after seeing my wife, I took my kids for lunch, and then drove back to where I live in Brookline. And then our next usual stop is to go see her at Cleveland Circle, right when she rounds the bend there. And this year in particular, I was going to take my nine-year-old daughter into Boston. So as soon as we saw my wife, I gave my five-year-old to my in-laws, and I took my nine-year-old on the Green Line, and we headed into Hynes Convention Center.

Q: Excellent. So when did you know something had happened at the marathon finish line?

A: I would say as soon as I was outside of Hynes Convention Center and I was making my left onto Boylston Street, for the first time ever, I noticed that there were people

walking towards me, as opposed to what usually happens, where I'm walking with everyone into the, you know, closer area for the finish line. So that seemed a little bit strange, but I didn't really think anything of it. And as I kept making my way down Boylston Street, that was probably within the first few minutes after the bombs had gone off. When I definitely knew something was out of the ordinary was when I saw -- and heard, more specifically -- about 20 police cars and ambulances rushing down Boylston Street. That's when I knew something had changed drastically.

Q: OK. So you had your daughter with you at this point. What did you do?

A: The way we typically arrange this is I meet (clears throat) -- I meet one of my wife's friends, who also has a daughter, and this is usually our routine. So our cell phones weren't working, but our text messaging after about a minute or two was working. And eventually, we were able to coordinate to the point of making [05:00] our way towards each other right near Capital Grille, which is on Boylston Street. And what I did was gave my daughter to my wi-- excuse me, to my wife's friend. And basically, that first 10 to 15 minutes was spent trying to just figure out, or at least confirm, that my wife had not gotten to the

point of the finish line, which I did not expect based on her time. But obviously, given what was going on, I just didn't know where she was specifically. And that was probably the next 15 or 20 minutes of trying to figure that out.

Q: And so did you find her right then? Or...

A: No. What happened is we ended up triangulating phone calls, where I called my parents in Florida, I called my in-laws who were at my house with my other daughter, and I basically told them that I don't know where my wife is, but I'm assuming she wasn't near the finish line based on her time. And that as soon as anyone hears, they should just call me, because obviously my wife doesn't run with a phone, so she would have had to find someone with a phone. So at that point, my initial reaction was to keep heading into Boston and just find my wife. I had already given my daughter to a friend. And it was at that point that I got a phone call from my in-laws saying that they heard from my wife. She's OK, and she was going to head home, and she would just walk home. So I immediately then went back to try to track down my daughter, and I figured I would just get her and then figure it out from there. And it was at that point that I really figured out what was going on when the -- my parents started calling with news reports from

Florida, and when the hospital, my residents called me and really alerted me to what was actually happening. So they -- they pretty much said, "We know your wife is running. Number one, are you OK?" The answer to that question was yes. And then "Number two, if you are OK, can you actually come to the hospital, because we're expecting a massive influx of patients, and many of them may need vascular surgery," which is what I do.

Q: So how did you get the hospital?

A: So at that point, I actually had my daughter again, and I was able to, again, find my friend, offload my nine-year-old. And the finish line was only about a mile and a half from Boston Medical Center. What I did was start getting I -- I initially got in my friend's car, and figured that would be my quickest way to get to the hospital, but there was massive gridlock. And so what happened was I ended up getting out of the car, figuring I could walk there faster than the car could take me. And unlike my wife, who is a runner and is in great physical shape, I am not the most physically fit individual due to my profession and time constraints, so I started walking, but happened to cross a group of pedicab drivers, and literally walked up to the group of pedicab drivers and said, "Hi, my name is Jeff, I'm a vascular surgeon at Boston Medical Center, and I need

to get there right away. Can -- can one of you help me?" Luckily, someone helped me. Off we go. And I made it pretty quickly.

Q: So what was it like when you -- or rather, what was going on at the hospital when you got there?

A: I purposely did not stop through the emergency room when I got to the hospital. So when I was on the way, I essentially was calling my office and saying that I needed someone to meet me downstairs. I needed them to bring me my surgical glasses. And I got dropped off at a specific location, I met someone from my office, and then I basically bypassed the emergency room and went straight to the operating room on the second floor. I will say that by the time I got there -- which must have been around the 3:30 or 3:45 timeframe, I noticed that it was eerily quiet all around Boston Medical Center. There was no one really walking around, everyone was inside, there were no cars anywhere. And I just made my way straight to the operating room to the charge nurse to find out where should I go? Where do they need someone with vascular experience?

Q: And is that part of your disaster management plan? Is there a person generally in charge that you would check in with? Or...

A: So the hospital has multiple disaster management plans that are centralized through our command center. And that command center was operationalized and functioning on the hospital end in terms of trying to get surgeons in, trying to get anesthesiologists here, keeping workers from leaving until essential -- essential tasks were undertaken. But in terms of our disaster plan within the operating room, it's -- it's pretty much well known that we just should go talk to the person in charge, and that person's really the person running the operating room. And there's two versions of that. One is the actual [10:00] operating room nurse that has a command of everything that's going on in terms of the operations scheduled, where personnel are located. And then there's the anesthesiology attending, who also is manning the anesthesia group. So my instinct and default is always just to go to the charge nurse and have them direct me to where they think appropriate.

Q: So -- and I'm not sure if I'm allowed to ask this. Did you end up operating on people immediately?

A: I did. So they sent me into room five. There was a general surgeon that had started an operation on a gentleman that was presumed to have significant vascular injuries. And my surgical partner was already in another room operating on another patient with a vascular injury.

There were multiple orthopedic surgeons that were dealing with traumatic amputations, and just cleaning up wounds, and getting them ready for another stage of an operation. So I was sent into room five, and there was a gentleman there already who had injuries to both legs, and so I assumed control of that operation once we had figured out what was going on.

Q: And so did you spend the rest of the day working on one person? Or did you move around?

A: So I happened to have a patient that required a very extensive, and the longest operation for all of the ones that we did at Boston Medical Center. So I only operated on one patient that day. We got control of the bleeding blood vessels in both legs, repaired what needed to be repaired, did as much damage control surgery as we could, and essentially just stopped bleeding to try to prevent any ongoing bleeding, which could lead to him dying right in front of us. When I had walked in initially, he was actually undergoing chest compressions and CPR, and he had actually coded or arrested because of all the profound blood loss. Fortunately, the anesthesia team and everyone in the operating room was able to get him back, and then I was able to control the bleeding. So that was a successful operation. Took a few hours to ultimately finish

everything that we needed to do. And at that point, all of the other operations had already been completed for part one.

Q: So for an event like this where you have suddenly lots of trauma cases going on, had anything -- had you -- had ever had an experience like that before?

A: The individual case and the individual management was something that our hospital was very well accustomed to, because as a major level one trauma center in Boston, we deal with traumatic injuries all the time. We deal with profound hemorrhage, and bleeding, and life or death on a minute by minute basis. What was different this time was the volume of simultaneous life-threatening situations, which is exactly the same problem that every hospital in Boston faced, about how to simultaneously manage multiple life-threatening problems.

Q: And so obviously, that went well. You didn't lose anyone.

A: Correct.

Q: You had a great healing response that day. Have you updated your plans to account for something like this happening again?

A: I know in the after-action reports that our hospital did in all of their meetings, and talking to the other hospitals, we -- excuse me, we definitely modified a lot of the

systems that we imposed during a mass casualty situation, some of which has to do with patient tracking, family notification, and things of that nature. But we also made sure to streamline the process of how to communicate with as many people as possible in a very quick period of time in terms of centralized lists of surgeons, alternate contact information. Basically, someone knowing where all of our specialists are at any one time, whether it's a weekend, a holiday, etc. So we've coordinated those kinds of efforts to basically take even a delay of a few minutes out of the equation to streamline the process as best as possible.

Q: Excellent. So when you finished that surgery that day, how long did you end up staying at the hospital?

A: I would say I got back to my office somewhere in the range of eight or nine o'clock, after I had had a long talk with the patient's family. And at that point, I was fortunate in the sense that my surgical partner was still here. So he had finished his operations, and getting things cleaned up a little bit. And we obviously talked about what was going on, and again, I didn't have a car here, a way to get home, so he actually drove me home probably around 10 o'clock at night.

Q: [15:00] So how did the rest of that week play out for you?

A: I remember, as I was getting my ride home on Monday night, I was talking with my partner, and basically saying that as I saw what was going on -- or not saw, but as I heard what was going on in terms of the volume of patients, that I didn't think we were out of the woods yet, because I knew that there were multiple damage control operations that had been done that were not the definitive operations. And that usually relates to amputations and other damage control surgeries that need a second look, or a second, or third, or more operation. So what we decided that night was that since two of our partners were actually away that week. It was school vacation week, and they were both gone. I would handle the trauma and the Menino campus, and my partner would handle all of the other vascular surgery issues, whether they were mine or his, at East Newton campus, and we would divide ourselves up to not double the work, but also to streamline our ability to coordinate everything. So I started sending emails out to a bunch of the trauma surgeons and orthopedic surgeons when I got home, basically saying we need to somehow coordinate our information, and what the decision was on behalf of the trauma service was for everybody involved that was going to be dealing with this was to meet at 7:00 a.m. on Tuesday morning, and basically discuss what we knew about every

single patient that had come in during the course of that day. And it included not just the surgeons and the anesthesiologist, but it included the SICU nurses, any floor nurses taking care of patients, any of the social workers or patient advocates. Any of the liaisons, basically. And so we all sat there at 7:00 a.m. on Tuesday morning, and essentially debriefed each other to get a more accurate list of what everyone's injuries were, and what the next steps were for operations. And what it allowed, and what it engendered organically, was the ability for the correct person to take over the correct patient. Instead of keeping it with whoever happened to be the first surgeon who operated on someone, it engendered a workflow whereby, as a group, we decided who would be best served to handle that specific person's next problem, and their issues going forward.

Q: So then -- so personally, what were you thinking and feeling while this was all happening? (laughter) It's a huge question. (laughter)

A: (laughter) I'll be honest, I was thinking in a total blur. I -- at that point, I hadn't really processed with my wife, I hadn't processed with my daughter, I just really hadn't taken the time to focus on anything else out of the hospital other than going home, getting sleep, and then

coming back. And I really didn't process any of it in terms of feeling or concerns for days, because that next three or four days, the role that I assumed was one of doing the completion amputations, because as a vascular surgeons, we do the majority of the amputations at Boston Medical Center. There was one orthopedic surgeon here that does amputations, and so he also carried forward with two of his patients, and dealt with all of their aftermath. But I inherited three other patients that would eventually need more operations and amputations. And so my focus on Tuesday through Friday was essentially stabilizing my very sick patient, because he needed to return to the operating room multiple times; coordinating the timing of the amputations for my other three patients that I inherited from some of the other surgeons. And to be totally honest with you, call responsibilities didn't stop. So that night, on Tuesday night, I remember getting called in for a terrible motorcycle crash, and a patient needed a vascular surgical bypass to try to save his foot and ankle. And that was just the normal, everyday trauma that our hospital experiences on a weekly basis. So it was really just a blur of trying to stay fresh, stay focused, and deal with myself and my family later.

Q: So you have described the events in the questionnaire I sent you as being life altering and career altering. And when did that start to sink in?

A: [20:00] So I think the first time I verbalized my whole story was sometime that weekend, when I was able to sit down with my wife for the first time, and we were able to reconnect pieces that really were so fragmented. And then I also talked to my best friend who still lives in Florida, and just kind of laid it all out there from start to finish. And I didn't understand and appreciate the career altering part at the time. I knew it was life altering because it was a major event, not only from a personal and family related issue, just because Marathon Monday is a very big deal for our family, a big deal for my wife, my kids and I love watching. But I knew that this was probably in some way going to shape the way that I think about these kind of issues and the patients that I take care of. Trauma in general, vascular trauma more specifically. But in terms of when it all coalesced, and when I realized how profound of an impact it had on me, that was, to be honest, months in the making as the process unfolded.

Q: So you had also mentioned that you earned the E.J. Wylie Traveling Fellowship from the Society for Vascular Surgery.

Could you tell me a little bit about that, and what your plan is with that?

A: Sure. Very early on, in the course of these traumatic events, and the bomb injuries, we recognized that although we may do trauma and civilian trauma every day, and although the injuries may be things we already know how to handle, we fully recognize that there's many more people out there with more experience than we have. The military, for all of the reasons that we understand, deals with these injuries a lot more commonly. They've developed their own best practices, and they're more rooted in the battlefield and in bomb-related injuries, as opposed to what we might deal with on a civilian level. So very early on, we had constant communication with some of our friends who were military surgeons. We had asked them questions if we needed advice. We had asked them for their input if we wanted to know their best practices. And we tried to model our standard of care guidelines based on what the military does in exactly these types of situations. Whether it be the handling of the wounds, the multiple surgeries, whether it be the infectious disease issues that come about in terms of post-exposure prophylaxis. Whatever the issue was, we were in constant talks with fellow surgeons that we know from the military. As the months went on, and as many

of our patients either progressed to getting prosthetics and walking again, or as many patients progressed to a level where they needed more input and more decisions to be made, I -- I realized the inherent value of the constant communication with the military. I realized that there are plenty of people out there that know a tremendous more information about this topic than I do. And for me to be the best surgeon to help my patients in the best capacity, it would require me to get the best information. So the idea I had was basically centered on having a better view of what the military does in these situations. There are three centers that the military sends their amputees to in the United States: Walter Reed in Bethesda, Maryland; San Antonio, Texas as the Center for the Intrepid; and the San Diego Naval Medical Center. In my path along the way, I was fortunate to meet some of the military surgeons that deal with these issues for the combat veterans. And through these contacts, and through these discussions, I started learning little snippets of best practice. But what I really wanted to get was a full overview of how to do this better, how to take care of our amputees on the civilian side -- whether it's just at Boston Medical Center, or whether it's changing practice patterns at the city level, or even in other civilian sectors. And so

after discussing with the contacts I had made, and after putting together my proposal, I applied for a travel award through the Society for Vascular Surgery, which is our national society. And they choose one recipient per year based on their application to visit other centers in order to gain information to alter your practice, to define a career path for yourself, and to overall [25:00] just improve the communication back to our society of other things that might be out there, and how we can incorporate them into our daily practices. So I put together my application. I spoke to my military contacts. And I applied in early, I would say, March or so. Sorry, actually, it was January-February of 2014. And I received notification a few weeks ago that they had chosen me as the recipient, and what that would allow me to do is fund my travel and coordinate some of my efforts at the military centers so that I could bring this information back. Not only for myself as a career building opportunity, but to really increase the bridge between the civilian and the military of free-flowing information of how to make practices better, how to translate this better to our population of amputees, whether they be traumatic or vascular surgical etiologies.

Q: So you're using your experience at last year's marathon in order to change your career, to change how people react to events like this, provide care, which is great, which is a recurring theme with some people that I've talked to, taking this event and doing something more with it. So for this year, what are you going to be doing for the marathon?

A: So my wife is running again for Dana Farber. We are going to watch her in Natick. This time, it'll be a little more challenging to also see her in Brookline, and still have some way to get to Boston in time. But the plan as of now is to catch her there in Natick, then again offload my now-six-year-old, and take my now-10-year-old into Boston, and see my wife complete what she started last year.

Q: Do you have anything planned for the anniversary of the marathon this year?

A: Our hospital convened a committee a few months ago, because we recognized the drastic impact that this event had on the entire hospital setting. And the hospital brought together members from multiple specialties of physicians, nurses, psychologists, psychiatrists, social workers, people in the patient experience and patient volunteer sectors, as well as people from the hospital administration. And we've been discussing for the past few months of how to tackle the anniversary. It's going to bring many emotions to many

different people, and it's going to be on a complete spectrum and a full range of those emotions. So some people just don't want to think about it. Some people absolutely want to move past it. Some people want to dwell on the tragedy that happened a year ago. Some people want to focus on the celebration of how well we did. Some people want to dwell on the tragedy of what transpired. Because we know that that full range exists, we have basically planned a week's worth of events at the hospital, which are aimed at basically giving people what they need and what they want at whatever level they're at. So the day before the anniversary, we're actually hosting a flag raising to commemorate all the incredible work that was done across the hospital, coming together in this time of need, but also commemorating the fact that this is something that we -- unfortunately or fortunately, something that we do every single day. We handle victims of trauma, we handle patients and their families who have undergone trauma. We unfortunately deal with catastrophic situations that are life-altering for patients, and that can have lasting effects on staff. And so we wanted to commemorate not only the marathon, but also our everyday institutional goals. Then on the day of the marathon, we have other events that are much more commemorative nature

relate to the Marathon. On Wednesday of this -- April 16th, we've put together a wellness fair, which basically encompasses multiple ways that people can relax, take care of themselves, treat themselves, and that runs the full spectrum from the puppy van coming back to give people a little spark of life, prayer services, massage therapists, acupuncture, manicures, pedicures, whatever it -- whatever it was, we've kind of put it all in this area. And then we also recognize the importance of moving on and celebrating some of the things that we did do very well. [30:00] So we do have an enor-- a giant team this year running in the marathon, and we want to show support for them, because they're also commemorating what Boston Medical Center did, and we want to celebrate their triumph and their goals, which is to complete the marathon this year. So really, there's the full range over the course of the week so that we can get people where they are at, whether that's at the lowest point and they still need help, or whether it's at the highest point and they've completely recovered.

Q: That's really great. So I'm curious. We're nearing the end of our questions, but something has sort of arisen in my mind. In the past year, you've had to interview a lot about your experience, and talk to people. And I think I saw your name on a *National Geographic* premiere that's

coming up tomorrow. Is that something that you had any experience before this, being thrust in to the public spotlight?

A: No. I definitely have no experience with it. What I always tell people is that while I have a certain story, and my year has unfolded a certain way, I in no way am different than any other surgeon, nurse, caregiver, that provided exceptional care, and that worked and came together as a team to instill the most incredible outcomes for our patients that were possible. I happened to be at certain places at certain times, and be linked to certain patients and certain experiences that have led me into doing interviews, having discussions. And what that role has evolved in -- I call myself almost a figurehead for this hospital story. So every single person at Boston Medical Center was responsible for any of the things that people may think I have done. But everything that I have done is a manifestation of the teamwork, and the multidisciplinary approaches to ensure the best possible cases. And with that, or with me begin a figurehead, I have definitely evolved into someone that has no objection to talking to people about this, because I feel like our hospital story is a good one. It's a worthwhile story to tell, me just playing a very small part in that.

Q: Good answer. You could have fooled me. You're a very great speaker. So really, we're at the end of my list of questions. We hit upon a lot of them without me having to actually ask you. But before we wrap up, I want to make sure to give you an opportunity to tell me any other thoughts or stories that we may have glossed over, or not touched on. So --

A: Sure. One of the -- one of the greatest things that came out of this tragedy was a recognition on our end as caregivers of a few pieces of vital information. One is that we work better when we work as a team. And what that means is what happened organically on Tuesday, April 16th at 7:00 in the morning, where every single person got together, laid out the best communal plans, and assigned the appropriate person or people to handle the situation. That engendered, for me, the thought of extending our multidisciplinary care on multiple avenues. So what did I do? I brought back a lot of the people that had gotten together initially. And we have now formed a multidisciplinary amputation committee, but really focused on taking the lessons of things we did well. And more importantly taking the lessons of things we did not do well. And making it into hospital-wide practice going forward, so that everything we did back on April 15th

through May -- middle of May, when all of our patients had been discharged, we took that information, we took the lessons learned, and it now can affect positive change for all future patients that come to our hospital with the exact same problem. A traumatic amputation is a traumatic amputation. The loss that a patient and their family feels is no different whether it's the result of a motorcycle crash or a terrorist attack. The spotlight on patients may be completely different, but the individual patient loss is the same. And we learned a tremendous volume and breadth of lessons after that we're trying to enact for all future patients going forward. And I feel like we're going to have a really, really positive impact in minimizing the catastrophe that's already happened. So that was [35:00] one enormous lession. The second enormous lesson is if you took a snapshot of healthcare delivery team members, whether they're whatever from level of surgeons to nurses, any level, and you ask people why they were doing what they were doing, and you asked them again six months after the marathon, I truly believe that the marathon instilled in all of us the reason why we joined the healthcare delivery network, if you will. It wasn't to fill out paperwork, it wasn't to be bogged down with major economic constraints, major time constraints of having a clinic that's too busy,

not enough time for our patients, not giving families enough of their time that they're using or needing to ask questions. It's not rooted in the economics of healthcare delivery. It's rooted in making a positive change for a single person or their family. And at least for me -- and I know for many people that I've spoken to -- the marathon showed us what we can do. It showed us what we can do if we all work together, we step out of our silos, we come out of the boundaries with our specialties, we work together, and we basically make it a patient-focused and family-focused enterprise. The changes we can exact are limitless, and the reasons that we're doing them are far greater than what we might have thought the day before we set foot in that room and worked together as a team. So it's really engendered a paradigm shift in the way a lot of us think about healthcare delivery, to a point that's going to be such a positive impact on not only ourselves in keeping us rooted in the profession and not getting burnt out from all the constraints we're under, but also for our patients and their families, who really deserve the best possible care.

Q: OK. Fantastic. So on that note -- unless you have any other stories, which...

A: No, I think I'm good.

Q: You don’t have to. OK. Excellent. Then I’m going to officially shut off our recording, and I’d like to thank you for taking the time to speak with me today.

A: You’re very welcome.

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