

Strong Medicine Interview with Andrew Ulrich, 19 May 2014

Q: [00:00] OK, this is Alyssa Botelho. Today is May 19, 2014. I'm here with Dr. Andrew Ulrich in Boston Medical Center and we are going to record this interview as a part of the Strong History -- Strong Medicine Oral History Project. Do I have your permission to record this interview?

A: Yes, you do.

Q: Great. And so if you could just begin by telling me a little bit about yourself, where you grew up, your medical training, and then how that got you here to BMC.

A: Sure. So I grew up in the New York City area, in the Bronx, and spent my entire childhood down there in the New York area, in New Jersey, and then went off to college in Vermont, University of Vermont, and spent four years up there in college and then a couple of years afterward having no idea what I wanted to do in life, and then found myself back in New York at Columbia University's post-grad program, pre-med program. Spent two years there doing all the pre-med courses that I didn't do in college. And then [coughs] -- excuse me. Then was accepted to and went to Albert Einstein College of Medicine back in the Bronx and spent four years there. And during my time there sort of tried to figure out what I wanted to be within the world of

medicine. Found myself one day doing a rotation in the emergency department at Jacobi, which is a great teaching hospital in the Bronx, part of Einstein. And found myself enthralled with that field, having never learned about -- heard about it or knew anything about it. And decided that's what I was going to do and ended up getting into an emergency medicine program up here in Boston. But did my first year, my internship year in New York down at St. Vincent's Hospital, which no longer exists, and then came up here and trained in emergency medicine at what was then Boston City Hospital, which was the city hospital of Boston. Did my training here and then stayed on and have been here ever since.

Q: Great. And your official title at the institution is?

A: Let's see. My official title today is executive vice chair of the department of emergency medicine.

Q: Great. And what does the job look like on a day to day?

Typical day?

A: It's whatever nobody else wants to do. It really is. I'm responsible for the overall operations of the emergency department here at Boston Medical Center. I oversee the clinical operations. I certainly oversee other aspects of some of the training programs. Working hand-in-hand with my chair, we really oversee all aspects of this emergency

department and how this emergency department works with and interacts with the rest of the institution of Boston Medical Center.

Q: Great. And have you worked Marathon Monday before?

A: I have worked just about every Marathon Monday, either here in the hospital, the emergency department, or sometimes I'll work at the finish line or at the medical tent at the finish line.

Q: So for several years?

A: Oh, I'd say probably of the 1a-- I've been here 25 years and I probably have worked 20 of them.

Q: And what does a typical day in the ED look like during Marathon Monday?

A: So a typical day in the emergency department on Marathon Day is a day where we anticipate getting an increased number of patients, but those usually are runners or runners who have been, you know, affected by running 26 miles. Depending on the weather, depending on the conditions, we will see anywhere from eight to 10, sometimes as many as 20 people who come in having either finished or nearly finished the race.

Q: Right. And could you go back to April 15 of last year. If you could speak a little bit about how the morning began, when you knew something had happened, and then what took

place in the department in the --

A: Sure.

Q: -- hours.

A: It's been well-written and everybody's heard a lot of the -
- sort of the events that occurred that day. From our
perspective here, it was like any other Marathon Monday.
There's a lot of work that goes into preparing for what we
anticipate to be, you know, any number of an increased body
from patients, from runners. So we have some programs in
place to help track these runners and it's done through a
coordinated effort citywide.

Q: By bib numbers?

A: Correct. By bib.

Q: OK.

A: As we've progressed technology wise it's gone from, you
know, just names to writing down numbers to now the numbers
are actually a part of the bib number. So we have -- you
know, a lot of coordinated effort has gone into over the
years of really developing a disaster response concept for
the run, for the race. Because, you know, we look at it as
a disaster when we see that many more patients because of
the event. So like any other [05:00] Marathon Monday we
were prepared for our normal influx of patients. I
remember it was a nice day but not a terribly hot day, so

we weren't really anticipating a lot of runners. We thought we would just get a normal amount. And I was actually working here a normal shift in the department, which started at three o'clock. And then right before I was about to start my shift, right around 2:57, 2:58, I was called on the phone by one of my colleagues who had gotten a phone call from one of our other colleagues who was working the finish line as a volunteer, as a medical volunteer, that said, "Something just happened. Be prepared." And that was our initial warning. Very soon after more information trickled in. In this day and age, as I'm sure you'll learn through this whole exercise, a lot of the information exchanged now occurs through the social media, which is great in the sense that we have much earlier access to information but it's also uncoordinated. It's not monitored. So we were getting quick trickles of information from a number of different sources. And one of the things you have to be careful of is to sort of jump and react before there's some official word. But in this case the official word came relatively quickly after the first - - you know, the information that we got from our colleague out in the field -- out in the field. But in the timeframe between that initial phone call that something's just happened, get ready, to when we got our official word

probably was in the range of eight to 10 minutes. In that eight to 10 minutes we already were preparing for the influx of what we didn't know was going to be a volume of patients. And as the official word came down, it really may have been even longer than the 10 minutes. We were already well in the works of preparing for any possible number of patients.

Q: And in terms of those preparations, did you move staff, move equipment? And then about how many patients did you see?

A: So, again, being that we didn't really know what it was, we presumed the worst, luckily. And, you know, I will say that there -- you know, a lot went into this citywide response and there was some unbelievable work by some unbelievable people throughout and I think we all as an institution, as a city take great pride in how things handled -- happened and how it was handled. But I think a lot -- also luck played a huge part in this and I think it may have come out in some of your other interviews and maybe hasn't. But the fact that where it occurred, when it occurred, how it occurred, the day it occurred, the fact that it was, you know, Monday -- Marathon Mondays are generally a holiday here in Boston, so a lot of the normal activities just weren't in place. So so many things went

into the fact that we were able to, as an in-- as a department, as a hospital, and as a city, gear up incredibly quickly to handle what turned out to be a very significant load -- volume of patients. So what happened here was as soon as we got, you know, this initial comment that something's happened, and then quickly other information that said it was a significant real event, we were -- you know, we have trained plenty for active -- for stuff like this. People here are very attuned to being able to respond immediately to a change in scenarios. And the hospital was not overly filled with [coughs] nor-- everyday normal activity, so we were able to empty out very quickly. So we moved people, we moved patients and staff from the emergency department. We brought staff down into the department. And within about 20 or 25 minutes, we were ready for whatever hit the door. And then in that 20 or 25 minutes is when the first patients really started to come. We received our first patients under 25 minutes from the time we heard -- first heard anything. Probably even under 20 minutes. I don't remember exactly at what point. But we got patients from ambulances before we were even notified from the official -- what we call CMED or the rad- - the sort of centralized control situation. We received patients before they even said you'll be getting patients.

And that -- and then over the next really about 40, 45 minutes, [coughs] excuse me, we received 23, 25 in that range, patients, most of which were very seriously -- critically injured.

Q: And these were a lot of limb injuries?

A: So what took place, as we all now know, was there was one and then very quickly a second device that exploded [10:00] that was on the ground. And within those devices were projectiles. In one of them were rounded metal objects. In the other one was sharp objects. But they were ground based. So the majority of injuries, the vast majority of injuries, were below the waist. And they were injuries that result from not only the blast itself but also the projectiles flying at high speed. So most of the people we saw had lower extremity devastating injuries. There were a couple of injuries that resulted from the blast, which -- one person had a significant head injury and there were some others. But what turned out to be the vast -- the huge -- the biggest problem for this was lower extremity injuries.

Q: Right. And you have mentioned that you had a disaster plan in place. Did you deviate from that protocol at all? Were there challenges that you improvised for in those --

A: So that's a great question. Did we deviate. We used the

format and the structure of the disaster plan that was in place. And we -- again, we are somewhat lucky because we had at least a skeleton of that plan in place for the marathon itself, much less than was necessary for this response. But the model -- it was like we had already opened the door to it and now we just needed to pull the pieces out. We deviated in some ways in the sense that the plan of-- what we learned here, what -- not learned but what was emphasized, again, with this response, as with most disaster responses, is the one most difficult thing about it is communication. It's not physically doing things. It's not being able to handle specific volume. It's the communication that occurs between all the moving parts of the response teams. And in this specific event, the high volume and the speed at which these -- the volume and the patients hit us, it really affected our ability to communicate our actions to the command center and by -- back and forth. And so we went the path we normally do in kind of this response, is we opened the command center and then we staffed it with the appropriate people. But because the activity was so quick and so in-- so in-depth so quickly that we did a lot more without communicating than we would normally have hoped to. And one of the things we learned from this, which will come out, is tools

for better, faster communication. And being able to really be much more in tune with the command center as we were actively doing things.

Q: So did you implement any of those tool systems?

A: So there was a lot of learning from the event. There's been a lot of practice, a lot of reorganization. We've certainly taken -- taken from our response and said what, you know, could we do differently? What could we do better? Communication was one big thing that came out of it. The other thing is patient tracking. You know, as we, as society, and certainly health care has moved forward, you know, the IT world has really been a driving force and we're trying to get as much as we can within the IT world. And what really opened all of our eyes on this one was there may be times in the world where old school is better and going back to pen and paper in situations like this may in fact be the better way to do this. Because tracking patients through the computer system requires additional steps and additional personnel and it makes it difficult because the computer's not always following with the patient. But having pen and paper -- a piece of paper attached to the patient in a lot of ways is exactly what you need, that information from you. So sort of taking it -- that kind of information from this event was very

helpful. We, just like everybody else in town, has done an incredible amount of in-depth introspective work as to, you know, breaking down exactly what happened, what we did, what we learned from it, all the great things we did but some of the things we could have done better. And luckily we haven't really had to implement anything yet. We've had a couple of small events. We pro-- we've certainly done a lot of practicing and we've done a lot of hospital based, city based, even statewide based exercises that allow us to, at least on paper, you know, put out some of our new ideas and new concepts. But we have not been in a situation where we needed to implement it. And I'm not sure for most of us whether we will be in a situation again which will force us to implement to the degree that we did on this event.

Q: I've heard your comment about the patient tracking and patient identification echoed by others at other --

A: Yeah.

Q: -- hospitals. Sort of tracking [15:00] the movement of the ho-- of the patient within the hospital but also with family members perhaps at other hospitals.

A: Yeah. Citywide it was a very, very unique situation. This was an event which brings people from around the world. A lot of them are unfamiliar with Boston. Patients were

taken from the scene in a situation which allowed for them to survive but also minimized the ability to appropriately track them. So it was a matter of trying to connect people with patients to hospitals and not knowing initially who was where. And it really created a very unique situation and a lot of the energy spent -- one of the great aspects about here, and I'm sure other hospitals had the same thing, which... You know, those of us who took care of the patients get all the credit in a lot of situations and I'm really proud for our people who are taking care of patients. But the behind the scenes stuff that happens for this exam-- perfect example, dealing with the family, dealing with, you know, the political part-- parties. Dealing with all the other aspects of trying to sort of -- they're more than just the cuts and bruises concept. Was remarkable and people were really doing incredible things. And we learned a lot about that, too, which we had always thought about, I think, to some degree, about sort of the family center and, you know, how to deal with some of the non-medical aspects emergently. We had always talked about that. We had always thought about it in -- sort of in the role of the disaster response. But we never actually practiced it to this degree and it helped us understand some of our limitations there, as well.

Q: Right. And just to make sure I get that detail. You said pen and paper, you know, putting -- putting paper on patients and writing notes on them. What were some of the details that you would be writing on these -- patients?

A: So a great example is one of the patients came in and had known previously malignant hypertension, which is a life threatening entity which occurs if you get the wrong anesthetic, medicine. It's not something which you could look at somebody, says you have, it's something you have to know about them or they can get really... And one of the patients involved in this event had that. And his wife was racing to try to make sure that everybody who saw this patient and knew this patient had that. We ended up taking a piece of paper that said malignant hypertension and taping it to the patient. And that was -- that was life thre-- saving. It was critical. It allowed for the people downstream -- because in normal circumstances I would be able to pick up the phone and say, "The patient you're getting to take to the operating room has this entity. You need to know about it." But there's such cha-- you know, so much going on that the ability to communicate that is threatened. So finding a way to ensure that the next person downstream gets that information is critical. So that's one aspect. Another aspect is simply making sure

you're identifying the correct patient. We were really good at it. Other hospitals in town were not quite as good at it and there was at least one, if not more, very, very sort of catastrophic mix-up or the wrong person was identified and it turned out that there was a death. Very -- you know, I'm sure everybody knows about it. And it was -- it's -- you know, could have happened anywhere. It didn't happen here. We were very lucky. But that's something where you need to make sure... And, you know, making sure that you have the absolute basics in place is very helpful. And the pen and paper is very basic.

Q: Right. How did the presence of news media affect you guys?

A: So the immediate response is -- was, you know, very -- was really -- for the emergency departments and certainly for our emergency department, really the critical emergency response was over in 90 minutes because in that timeframe we were able to identify the patients that needed to go right away to the operating room and even some to the ICU and the ones who were left behind we were able to quickly manage and stabilize. So from our perspective, the emergency department, the immediate crush was really 90 minutes to two hours max. Then the secondary aspect of the disaster, which is the hospital's response to the ongoing care of these patients. And not to minimize that, but that

does take place outside of the emergency department. But also, it then became how the institution dealt with the sudden influx of everything. Even before -- I mean, you know, certainly news media was big and it was big very quickly. And we as an institution made a very quick judgment to not par-- not partake with them immediately. And there was some --

Q: Pushback.

A: -- pushback from the media. [20:00] We as an institution probably didn't get the recognition publicly in the first 12 -- four to eight hours that other institutions do but that was a decision we made consciously because our primary number one goal is to take care of patients. We would have time to deal with them later. Another really big problem instantaneously was law enforcement. This was an event that --

Q: I was going to ask you about that, too.

A: -- you know, was very public and clearly was very intentional. And in this day and age, was very scary because nobody knew exactly what it was at first. [coughs] There was an incredible immediate influx from the law enforcement contingent that was part of this and they all wanted to start their job immediately. And that meant talking to victims, talking to anybody. And we have our

job to do, they have their job to do, and sometimes they're not 100% aligned. And one of the things that we're -- that I did -- so I ended up, just to go back a step, I sort of was here already and then I quickly took on the role of overseeing the entire response, emergency response. So I was the point person for most of the stuff. Certainly was the initial patient care and then that transitioned to the media and the law enforcement and families and everything else. Probably why you got connected to me. So, you know, the media was at least buffered for a few hours because they were kept away a little bit. The law enforcement was instantaneously on us and in us and part of us. So one of the things we did was to sort of cordon off an area where all law enforcement went. And one thing we did, I did, was say, "OK." There were 19 or 20 different agencies present. It was really an amazing response. And I said, "You can't all go in there." And so, you know, create teams of three or four, one person per agency, and we can take a team to a patient and then we can move on, and another team to another." So we organized their input so that they weren't running amuck amongst us. And we worked very closely with them. Our public safety people helped considerably with that. So we -- so we interacted with them very quickly. I will say it's come up in a lot of these conversations, and

a lot of these meetings and interviews and studies that have been done about sort of the law enforcement and the other side of it, which was, you know, staff and hospital safety. And I will be perfectly honest. It never crossed my mind. I never thought about, you know, did we need to setup a threshold. Did we need to prevent people...? It's just not what I think. And, you know, in hindsight it may be a mistake. It could have been a mistake. But my thought was how do I get patients in, not how do I keep people out. I let other people worry about how to keep people out. So working with the law enforcement, at least from my perspective, was helping them get to the patients. I have heard other people talking about working with law enforcement, to how to setup perimeters and how to -- and that was not something which I was at all conscious of or was not something I was worried about.

Q: There was one, perhaps two other hospitals that actually entered a lockdown state.

A: Yes, there were a couple. One was at a hospital where somebody was concerned because there was a knapsack left and they emptied the building and blah, blah, blah. And then another one did it because it was, I think, part of their routine disaster response. We did not. We certainly worked with our folks to help control access and we kept

what -- people who... You know, we did our best. And we did a very good job of keeping people out who didn't belong here. And then we did subsequently go into a very, you know, much more controlled environment where there was armed guards and soldiers in our front doors and it was really a different experience. And yes, you know, I'm not -- I don't want to say that we didn't as an institution think about that but as the person running the emergency response part I was not primarily thinking about keeping people out. I was thinking about how to get them in.

Q: Right. Let's see.

A: So just to follow-up on the media part. So we subsequently -- over -- about, I would say, a good two to three hours afterward is when we started to have a little bit interaction with our -- with the media contingent and it was, you know, structured, our people controlled. Media was in a room. We went to the media. We spoke to them and what limited stuff we can give them. And then [coughs] really over the next two, three, four days we had a lot more scripted controlled media input and media contact where there was, you know, really some news conferences and it was much more -- after we got our hands around it we were able to really do a much more formalized system. But the initial part was really, [25:00] you know, when I get a

chance I will come and then say nothing after.

Q: But there was a statement sort of later that evening and then your media team helped coordinate --

A: Correct.

Q: -- much more.

A: Yeah. And then it really became a very coordinated --

Q: Between patients.

A: -- and that became much more with other people in the hospital and everything else, yeah.

Q: Right, right. And did you communicate with other hospitals on that date?

A: We did eventually. We didn't initially. We were much more involved at that -- but we were getting input all along because Boston is very well setup with a network about how information exchange with the citywide/statewide --

Q: Is that all part of the C-- CMED?

A: It is, yes. So we know when they were involved. So we were getting information from the field. We also were getting information as to where patients were being sent and stuff like that. There was conversations offline, behind the scenes, about tracking down families and stuff that were occurring in our family center but not -- I did not reach out to and talk to anybody from another hospital until at least a day later.

Q: Right. I see. And then how did things change in -- in that week? You've mentioned it before. But more controlled, news media --

A: [coughs]

Q: -- law enforcement still present --

A: Yeah.

Q: -- sort of around the perimeter.

A: So, remember, that was a week long event.

Q: Right.

A: It wasn't just the one day event, right. So from the medical aspect of it... You know, the emergency department, again, within -- by four hours later we were back to essentially normal activities. The hospital dealt with the -- you know, the significant patient care issues of these, you know, nine to ten really critically inpatients and what we got to do with them and that was much more of an ongoing process over a number of days and weeks. What became the focus over the next -- for -- from the hospital's perspective was media and VIP access. That was a really, really big part of what happened over the next -- literally a week or so, where there was so many people -- governor -- the politicians and celebrities and athletes and everybody who wanted to come and see the victims, talk to the victims, somehow be part of this, you know, in a good way.

I'm not saying it was a negative way. But it really created a lot of additional difficulties for the people here, the staff here because, you know, we had to do what we were doing on a day to day basis. The hospital had to do what it was doing and still, you know, take care of all these patients and all these other patients who weren't part of this event. Yet -- and then it opens the door to this continuing parade of individuals, people, and stuff like that. So that really became a big part of what happened over the next three, four, five, six days. So much of it was positive. And I'm not trying to paint a negative picture. The people -- the outreach for support from all over was just amazing. People were sending things. People were calling and asking what they could do for us. You know, we were getting donations of fruit baskets and pizzas delivered from all over. You know, it was amazing what people were doing. You know, people were donating their services, whether it was, you know, limo rides for families to get to the hospital. There was just an incredible, you know, outreach of support. And luckily a lot of that was coordinated outside of the emergency department. I didn't have to deal with that. There was like two or three people whose sole job everyday was coordinating. "You know, we want to send you this or give

you this." But it did -- it was additional, you know, activity that we don't normally deal with. And that was the focus over the next, you know, three to four days, five days.

Q: Yeah, interesting. And -- and yes. You've touched on this somewhat before but just to give you the last note. If there's anything else you wanted to add about as the past -- as this past year has unfolded, another Marathon Monday has occurred, any changes of note or any -- any things that the hospital has sort of taken in that you'd want researchers to know?

A: So it's real-- that's a great question. I think this was a -- this was a one -- it was a life changing event in so many ways for so many people. Some of it is easily -- I don't want to say measured as much as it's very evident. You can physically see the difference. You know, there are people with no limbs who had limbs right before this. There was -- it's a city that's changed because it felt vulnerable and it was attacked at its core, as people thought, because this was a great event of Boston and stuff like that. So there's a lot of ways there's been some real physical changes. There was... I think this was also an event which, you know, for all of the horrendousness about it, the positives was how the -- how people came together,

the strength that people showed both -- I mean the patients are amazing but even the staff and the people -- you know, people did amazing things [30:00] because it had to be done, not because it was their job. And I think it created an incredible sense of one, of community that persisted for a long time. Like everything else, those -- good sense eventually wear off and normally... You know, when there are normal... When I say normal, I mean in the -- in the role that we do, we have specific events which people, you know, attach themselves to. And those... You know, a sense of feeling really good about something tends to last for a day or two, a week or something. There was something about this that, as you can imagine, that was so much deeper and more -- and grander than in others. That sense of togetherness, of oneness, of community lasted for a long time. And for some people it really lasted up until the anniversary of. And I think the anniversary brought back some negative feelings for a lot of people. So the hospital and the people who are really very involved with helping the staff go through the anniversary were very involved throughout. And I think that was something which was very interesting. It kind of really raised in everybody's eyes the importance of keeping staff healthy, of worrying about staff. And some people... You know, it's

very fun-- you know, funny's not the right word. But, you know, for a lot of non-clinicians, they struggled with the emotion of it far longer than a lot of the clinicians. For a lot of us, it's not that we see this every day. But we deal with stuff like this every day, maybe on a smaller scale. So we tend to get over it faster. And then -- so there was this sense, I think in some way, for people to not understand that and kept saying, "Well, you know, how did it change you? How were you affected by it? How are you different?" And the reality is I'm not. I don't think I am. I learned from it and I'm different in that way, because everything we do we learn from. But it hasn't changed me as, "Oh, my God, I see life differently now or anything." It was part of my job and I think for a lot of people it really was their job and they did a remarkable job at it. But it -- what was most impressive was how people responded and that really was different. So have we taken that forward? I would like to think we have. And I would like to think that people really, from that, understood that when we can -- when we have to we really, really can do something to that level. And I think that will stay with people for a long time. I think preparing for this year's marathon... You know, everybody very much wanted to just go back to normal and we were very close to

the old normal. But I think because this, you know, is part of our history bank now, that it's a new normal and we sort of said, "Oh, we're going to prepare like we always do every year." But I think we probably had in our back of our minds, you know, what if? And we got through this year and my guess, each year, that what if will get a little smaller, a little smaller and we will return back towards our normal, our old normal. But the other thing that it did do [coughs], which I think is very unique to Bos-- to BMC than any other hospital in town, was it brought forward a lot of -- a lot of... I don't want to say feelings but I think what it did was help illustrate the fact that we deal with violence everyday, much more than any other hospital in town. And we deal with victims of violence and we deal with families of victims of violence. And although it may be on a smaller scale and it may not be as public, it is the same violence and there are victims of it. And for a lot of us we struggled with why was it so public, why was it so supported, why was -- why was -- you know, why was all of a sudden people donating hundreds of thousands of dollars to us when there are people who, you know, had similar events a week ago, a month ago and they're on their own. And it gave us a platform to talk about that. And I think, if nothing else, that was a positive that came out

of --

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