Strong Medicine Interview with Tracey Dechert and Peter Burke, 17 June 2014

ILACQUA: [00:00] All right. This is Joan Ilacqua, and today is June 17th, 2014. I am here with Dr. Peter Burke and Dr. Tracey Dechert in Boston Medical Center. We are going to record an interview as part of the Strong Medicine Oral History Project. Drs. Burke and Dechert, do I have your permission to record?

BURKE: Yes.

DECHERT: Yes.

ILACQUA: Excellent. So as I had mentioned, my first question is basically background, and if you would like to go one at a time, tell me a bit of how you got to Boston Medical Center and what your title is here now?

BURKE: So my name is Peter Ashley Burke and I am the Chief of Trauma Services here at Boston Medical Center. I've been chief since 2008. My training in surgery was at the New England Deaconess Hospital and I stayed on there for approximately 10 years and came over to Boston Medical Center to do trauma in 1999. I've been here ever since.

ILACQUA: Excellent.

DECHERT: My story is a little different. My training started in Philadelphia where I did medical school and I did my

residency training at the Medical College of Virginia in Richmond, did fellowship in trauma and critical care at Penn in Philadelphia and then came here for my job. So this is my fifth year here in Boston. I had never been to Boston before other than for brief trips and I came to Boston Medical Center for the job and to join a group that took care of patients the way we do it here as a safety net hospital.

ILACQUA: Excellent. And what is your title here?

DECHERT: I am Assistant Professor of Surgery.

ILACQUA: Right. Excellent. And so on a typical day at Boston Medical Center, what would that look like?

BURKE: So we have a kind of a group approach to this and we take care of all of the patients who come to the hospital with urgent or emergent general surgical needs and we also take care of all the patients who come to the hospital for traumatic reasons so with a traumatic event that leads to their need for -- to be seen by the medical community. So we have a large or broad kind of approach to this kind of patient population, which we call it acute care surgery or emergent general surgery and trauma.

DECHERT: So we function as a group, which is really nice because our job is so varied. So one day we would be maybe the attending in the surgical ICU and we would do that for

one week and then another time we might be in the operating room doing cases all day. Another day we might be in the clinic seeing patients there, seeing patients on the floor, seeing all the consults in the emergency department and in the traumas. So our job is very varied depending on which week what job we have or the day of the week.

BURKE: But as a whole, we -- and as a group we provide all that -- that level of care 24 hours a day, seven days a week. It's different from an elective surgical practice where you have a process where you see patients in clinic and organize their operations and perform their operations, get them through their operations. This is more of the 24 hour business.

ILACQUA: Excellent. So on a typical Marathon Monday, what would your job look like?

BURKE: Well, we would be the usual. We would be providing all these services. Marathon Monday is historically we would get some patients from the marathon, usually patients who are, you know, who had injuries related to running the race. Generally those are fluid, you know, patients who are dehydrated or have other issues related to running 26 miles in one go. But -- so we always get a few of those patients but the general process is to keep those patients at the scene and deal with them there, so we don't get a

lot, but they just (inaudible) around the city in an organized fashion so...

DECHERT: It's usually a quiet day --

BURKE: Yeah, it's usually --

DECHERT: -- because a lot of people have that week off, you know, with the kids if they have spring break, so a lot of people with families take that week off. People also sometimes take that day off. So in general it's a quieter day than some of the other days [05:00] it's because it is like a holiday.

BURKE: It's a pseudo-holiday in Boston --

DECHERT: Pseudo-holiday.

BURKE: -- in that everything is open in the hospital but usually not running at 80 or 90% capacity because people aren't here or they are doing other things. They are out watching the race or something. So that actually has bearing onto what happened last year.

ILACQUA: And so last year were you both working that day?

BURKE: I was in -- I was in Nevada when the bombs went off at a surgical infectious conference so I was able to get an airplane out and get back here. I got here about midnight, but Tracey was here from the beginning. Or, no, you had gone home and come back or something.

DECHERT: Yeah, I worked Sunday on call, which means I stayed here until Monday around 11:00 or noonish so I was here for maybe whatever -- is that 30 hours straight. And then I was going to go home to either sleep or eat or eat then sleep or -- I hadn't yet figured that out. So I left here around noon time maybe with even the potential I was thinking about maybe going to the finish line because I live in Boston and it wasn't too far from where I live and I thought about it that day. But it was a little chilly so I thought -- and plus when you are tired and up all night, you tend to be cold easily. You can't regulate your body temperature when you are tired. So I decided not to go and was going to go to bed instead, which I never did.

ILACQUA: So did you get home and then come back?

DECHERT: I got home and came back. Yeah. I wasn't home very long.

ILACQUA: And did --

DECHERT: And then I heard -- I was just eating something and going to go to bed and then one of my residents, who was on vacation in New York texted me saying, you know, "What's going on in Boston?" Nothing is going on in Boston. And then it sort of struck me maybe I should turn on the TV because I noticed I was hearing helicopters and I just thought it was from the race and then I saw the explosion

on TV. And at that time I didn't know what it was other than just something bad, you know, was it a gas explosion, you know, something. Either way I figured I should come back to work and then, also, as I was walking to come in I was thinking about 9/11 because there, you know, a lot of doctors were ready and no one came, so I was thinking are we going to have that same issue here. Where we're all coming and preparing but yet no one will come.

BURKE: Right.

DECHERT: Didn't work out that way either.

BURKE: I was walking through the lobby of this hotel and then all of a sudden it was there, so right after it went off and then I went to the concierge and they got me -- you know, it was the next flight out, which was really great. And because for a trauma surgeon this is, you know, when this happens you don't want to be -- you want to be here. This is what, in a way, what you've been training for for your whole life to a certain extent, or one part of it anyways, and so we needed to get home and it was -- we got on this airplane and then I was stuck in the back and I was talking to Beda on the phone saying -- he was a surgeon here telling him -- asking him what was going on, he was telling me (inaudible). So the people next to me overheard me and they arranged with the stewardess to let me get to

go to the front of the plane to get out the minute it landed so I got -- didn't have to wait for the whole plane to unload. So I got right out and got a cab, got here I think about midnight and we were still operating on people and there were guys with guns outside the hospital. That was weird. But the security people knew me so I was -- I got -- was let in and then I just started to help, you know, do the -- a couple of the operations that still needed to be done and then just to sort of get organized because, you know, the first day was really important. A lot of important things happened but this process went on for weeks in terms of taking care of these patients because they -- the nature of their injuries were that they had, you know, multiple operations and 60 or 70% of all our patients had more than one operation so that was just the nature of their injuries. Their soft tissue injuries. So they -- it started and then it kept going so you needed to be -- we needed to be very organized and sort of had to change the way we did stuff, which was interesting. Not a lot, though. Our system worked pretty well for being able to deal with a lot of injuries all at the same time. We have a pretty busy -- trauma service is pretty [10:00] significant types of trauma. A lot of -- you see a fair amount of penetrating injuries. So we have some sick

people all, you know, all at the same time and so it worked out, but it did take some organizing on our part, which worked pretty well I thought. But Tracey was here for the initial -- I don't know how many operations you did, but --

DECHERT: I only did one that day because I then was more organizing, like, after that operation and we had enough surgeons so then we just went around trying to get everyone settled in the sense of, you know, how many patients actually came? Where are they all? Are there some -- some still in the ED? Are there some -- there are some in the operating rooms. There are some in the ICU. Like, trying to make sure we had track of everyone. It can be a little chaotic, as you can imagine. A bunch of patients all coming at once and you could easily not have the right identity of the person or have two names or two medical record numbers for one person or the wrong one and then, you know, just trying to sort of make sure you know whose all here, are they all accounted for, has everyone had the care they need? Is there anyone still somewhere in some back part of the emergency department that, you know, people haven't noticed? So that -- so I did one operation that day of a bilateral amputations and then was able to sort of just be kind of an organizer and make sure everyone was where they needed to be.

BURKE: Yeah, that's I think another thing that's critical kind of observation is that when you have mass casualties like this or a bunch of patients all at the same time, you need some people to do the operations, some and then but you also need somebody and a few people to be organized about it, making sure people are getting what they need. Otherwise, you know, surgeons are good at, you know, doing operations but one of the things that other places got into trouble with was that the surgeon in charge who is making decisions about who does what when would go off and do an operation, you know, get stuck in one operation then their focus is only on one person and they can't be focused on all of the -- the whole process of making sure that everybody is getting what they are needing. And the other thing that was interesting was, you know, we had a lot of surgeons who came to help. All of the surgeons came and they said, "What can I do to help?" And so we had plastic surgeons, and oncology surgeons, and breast surgeons, all helping and all -- and we needed them in the beginning, but they are not trauma surgeons so much and their gestalt about how to do an operation is a little bit different than what these patients actually needed, which was kind of a staged approach. They didn't need a definitive operation. They needed enough to start the process, stop the bleeding,

get -- take the dead tissue away and then they needed to be resuscitated and brought back another day. So -- but plastic surgeons and oncological surgeons they don't think like that so much because that's not what they do. So one of the things that we had to make sure was that those, you know, we give advice to these -- our colleagues and make sure that those processes were happening and it actually worked out really well because -- and everybody helped, you know. The orthopods were critical, the vascular surgeons were critical. It was, you know, a great, you know, one of the things that we do really well here is collaborate with each other at Boston Medical Center because I think this is -- my bias is that we have a -- we don't have as much resources as some places so we have to make do to a certain extent. Not that -- everybody gets what they need. Don't get me wrong. But, you know, there's a lot of collaboration with -- amongst ourselves and trying to get the patient exactly what they need when they need it and so that really worked out and I think trauma services actually is a good example of how that works is we do a lot of different things. We need help from a lot of different people. And they help us when we need it, which is good. And that's the expectation here, so that's kind of cool.

ILACQUA: That's excellent. So as the week started to play out, how did the week play out really?

DECHERT: So the week was different then the normal week in some ways. In a lot of ways, things were going on, you know, somewhat normally. The big part that was different is that we needed to take care of this influx of patients and do multiple operations on them and that's where we needed to be working closely with orthopedics and vascular surgery and us. So what we did was we met every morning to discuss the day, so we had a list -- similar to what you normally have as a patient list, but this was marathon patient list. So we had 19 admitted patients, so everyday we would go through all 19 and what -- where they were. They were in the ICU; what did they need? They needed another operation. Was it going to be today or was it going to be tomorrow, and how are they doing and what's happening. And then we'd [15:00] come up with a plan for all 19 and then at the end of the day we would meet again. And that would also involve anesthesia because in so many issues were related to the operating room. So that way every day we made the plan for everyone, who needed to go to the operating room, how people were doing, and then we just kept doing that every day for that whole week. And then on top of that or next to that was the usual work that was

still being done and that's where other people were helping so cases that we would have done ourselves, now that we can't be doing them because we are doing this, you know, other surgeons helped out and took out someone's gallbladder or, you know, took out an appendix. We are doing some other things so we can focus on the marathon patients. And then otherwise we still needed to round in the ICU and see all the patients we needed to see. All the patients on the floor. One of our partners whose focus that week was the floor, it took her hours to round because every room she went into, you know, sometimes you might be in there 5 or 10 minutes but this week, of course, in each room she would go in it was, you know, a half hour conversation possibly or more. And it's just hard, so she would take hours a day just to round on the patients on the floor.

BURKE: Yeah, it added some other aspects to things that we don't usually have to deal with so much. The media and huge amounts of family and things that made it, you know, made it a little bit different, and dealing with celebrities and famous people and things and how to organize that. It was very interesting. You know, and then there is some physiological issues that we learned about kind of sort of on the go. And one of the resources

that was really incredibly useful was the -- from the armed services they have a they, you know, they do a lot of this, taking care of people who are blown up by -- in Iraq and Afghanistan and so they've written best practices and they were incredibly helpful for us about what to avoid so we didn't have to reinvent the wheel. You know, and there things like all of these patients or the vast majority of them had an acoustical injury. An injury to their ear. So we, you know, it took a little while to get the ENT [Ear, Nose, and Throat] guys to figure out that they needed just to see everybody. But they did and they were really great at that. And anybody who got -- anybody who was admitted had some sort of fragment injury so they had pieces of whatever blown -- of the bomb or the surroundings or whatever blown into them and so they had all these wounds from that. And really, the reality is that some of those fragments that are in people are from other people. So they are biologic and so they all have basically a blood exposure so we had to make sure that they had access to Hepatitis B vaccines and whether, you know, tested for Hepatitis C and HIV if they wanted. So those are things that we don't usually do on your average trauma patient who gets run over or falls off a ladder. So that was different and that took a little while to get going. And we sorted

that out really quickly on the fly and one of the things that for me was helpful was I have some colleagues who had been in-country in Iraq and Afghanistan and I called them up and said, "So what do we -- what's with this?" And they said, "Oh, go to this web page and it's right there. And don't -- and we've got to worry about the -- all of them are going to have ear injuries and, you know, you have got to worry about these infectious issues and don't close any wounds and damage control kind of approach," and all of the things that we did and it was -- so it was -- great not to be having to figure this out all by ourselves. So it was good for patients that way.

ILACQUA: I'm actually -- I'm curious. You had mentioned that there was a lot of media, a lot of security – did you have celebrities at Boston Medical Center? There have been a couple -- the president was in town but I didn't think that was over here.

BURKE: President drove right by us, you know, I was very sad about that. But what I mean celebrities is, I guess, is that famous people wanted to help and so they came to see the patients, politicians, and actors, and football players, and hockey players. And that was sort of an interesting process, at least for me, anyways. I sort of had an epiphany about famous people. I mean, usually --

you know, every now and again famous people would come around to see trauma patients or whatever and they sort of get in the way. You know, this is about the patient, their disease and getting them better. But the reality was this horrible thing had happened to these people and they were feeling, like, put upon, and rightly so. And then these [20:00] famous people come and see them and there is all these people who everybody thinks is really, you know, important are coming to see them. And I swear they would just -- they would make these patients feel like they were important again, and it was cathartic and helpful for them psychologically. So I would just -- the football players would come in and I would just get out of the way and say, these guys are doing more good than I'm doing and I'm coming in and talking to them, seeing and looking at their wounds but these guys are coming in and working on the spiritual aspect of their getting better. And that's another big thing is that all of these patients had a, you know, a significant psychological, you know, injury or if not, you know, something that really affected them and that was something that we were very cognizant of and gotten, you know, our resources involved on many levels. I mean, we have here -- because of the nature of what we do, a community violence response service, which is focused on

patients who are victims of violence, you know, and their families and, you know, or victims of -- if a family member is a victim who has been murdered, so we have a resource that looks at and helps these patients and they were very involved in all these marathon bombing victims. And I think that was another thing that was -- makes them different from the usual kind of trauma patient. Although, trauma patients all have these issues. There was just a lot of the same thing all at the same time so it just brought into more focus than I think, you know, each one of these was, you know, every trauma patient has a little bit of this. You know, certainly those psychological aspects of being hurt. I think it's very hard on people.

ILACQUA: So you had mentioned that it took several weeks to begin to heal these people, to get that process going and a lot of times we think about this event in terms of the week that started with the marathon and ended with the lockdown and that was that. How long did it take for things to get back to a sense of normal around here?

DECHERT: Probably it was over a month, I would, say because we still had patients for a month.

BURKE: Right. We had one guy who got 11 operations and, you know, spent two weeks in the ICU and, you know, another couple weeks on the floor so, you know, it was ongoing. He

got, you know, we had this meeting every morning and every afternoon and, you know, after about a week we didn't need to do that so much because there was only like seven or eight active patients and, you know, we had a handle on it and, you know, it was interesting because you had to -- you created this marathon bombing sort of service in a way, but it just was in sync with the rest of the service because, you know, the reality was people were getting shot, stabbed, and run over and we had to take care of them at the same time. And that sort of was interesting in a kind of dichotomous way because yes, we had business as usual and we, you know, we take care of a section of society that -- whose opportunities are limited to a certain extent and so they are, you know, and then we have all these patients who are, you know, come from the same part of the world I guess so it was (inaudible) with these two populations, you know, going on at the same time and there was a huge amount of attention towards the bombing patients and it sort of -- we, you know, got into this kind of -- every patient is the same and it was hard not -- that was one of the things that we probably all of us felt at the end, you know, in the midst or sort of towards the end of this said wow, you know, we did a really good job taking care of these patients on multiple levels and they got a lot of special

care and what we really should be doing is that we should be doing that for everybody regardless of what they look like or how they got into whatever trouble. So and I think that, you know, if I can take anything out of this whole process was that, you know, a new standard of, you know, we really raised the bar about how incredibly great we could -- how well we can do with taking care of patients. We really did a great job and now we just got to do that for everybody, every day. Not just when people get blown up at the marathon. So that's, you know, so it was enlightening in that way. There is a new standard in my mind of how we should do things. We'll see.

DECHERT: But I don't want it to sound as if we as practitioners don't take great care of our patients. It's more like I think in a society -- societal --

BURKE: Yeah, no, right, right.

DECHERT: -- level and a hospital-wide or a city-wide level, you know --

BURKE: No, I think that's an important but it's not about --

DECHERT: -- the people at the bedside. If you work here, you don't care what the person's story or background is or whatever. [25:00] You take really good care of them, but now all of a sudden you have all these people providing things for your patients that doesn't normally happen.

BURKE: More resources.

DECHERT: So the next thing you know, people are donating all kinds of stuff, you know. It's like, well, why doesn't that happen all the time? Because tragedies happen every day. Just not as much media attention or any media attention, but it's still a tragedy for that person or family. So that was the hard thing to see or adjust to or try to wrap their head around that --

BURKE: Right. I agree with you. It's sort of like, yeah, we think we do a really good job every day but we really -- the whole system just like was unbelievably good at it, and we should do that everyday for everybody I think.

ILACQUA: You kind of already answered this but did you change sort of your … disaster management to deal with events like this? Did you or -- let me think of a better way to phrase that… reflecting back on this, what would you have changed if you were going to treat an event like this again?

DECHERT: Well, some of it's more mundane but yet important. Just even, like, as the patients come in, how do you identify them and that is a -- all the hospitals sort of struggled with that where being able to know --

BURKE: Who's who.

DECHERT: -- who is who. You can't just assume that the handbag with the person is theirs, or you can't assume the wallet

in their pocket is theirs. They might not be able to tell you and talk to you. And just -- just a nice way of... Whereas everyone comes in, they get a name -- not their name, necessarily -- you know, "Patient 123456" kind of thing. Having it be organized in that sense, where you'd have a chart that's sort of a disaster-type chart. So some of it's kind of simple stuff like that.

BURKE: Well, I think that's -- you know, one of the lessons that we learned. You know, all of the level-one trauma centers got together and just discussed these things -- this observation that there was this disconnect about where people went, because there were so many centers. And, you know, the only thing we know -- the next disaster, the same thing is going to happen. People are going to be taken to different hospitals, and you're not going to know where they are. So we need some methodology to get that information back out to the -- to some cen-- to the Department of Public H-- to some central place, so that -- so Uncle Joe can find out where his brother went as quickly as possible. And, you know, one of the things that really brought this home to me was that there was a father we had here, and he had an operation. And he wakes up from his operation and says, "Where's my four-year-old?" And nobody could tell him where his four-- whether his four-year-old

was alive or dead or where he was, for about five or six hours. Now some of that is because we get in our own ways with HIPAA and all these things. But it was horrible, because we added another injury to this poor guy -- a psychological injury, that he worried about where his kid was. And it took us a while to do that. And we should be able to, in this modern world -- to be able to do that better. And one of the things I'm hoping to get out of this with the collaborate -- the level-one collaborative, is a uniform process -- the disaster form that Tracey was sort of describing -- that'll have a part of it that describes a person, you know, as a 50-year-old female with blonde hair and blue eyes. And that -- you may not know their name, but at least that'll be somewhere centrally, so if you're looking for your mother who's a 50-year-old blonde-haired woman, at least you'll know that they're most likely here, rather than... You know, and then, as you get better identification, you add to that, and it's an ongoing thing, so people will know where to do. Because that was, you know, another thing that was different than usual. Was the amount of -- you know, the family kind of support that we had to gear up to, and do. And we had to have a big -- create a whole place where the families could go and wait and find -- to try to find out what was going on. And you

had to feed them, and you had to make sure that they had internet connections, and you had to make to -- need to -- they had phone chargers and things that you don't usually think about. So, we had a lot of things we learned. But I think that -- you know, if we could figure out how to make sure that everybody knows where people are going, that'll be better. Because that's -- you know, that's what the -- you know, in some cities where there's only one trauma center, it'd be easy. But here, we have six or, know... So they're -- you know, it's going -- you know that it's going to be spread around. And that's one of the strengths, but also one of the weaknesses that, you know, brought up a -- you know, the -- you know, a consequence that we didn't [30:00] really think about as much as we should have. So that, we learned. So, learning -- that's another -- you know, something good can come out it, maybe. We can do better next time. That would be good.

ILACQUA: I'm also wondering what kind of support did you have for your own staff?

DECHERT: There is a ton of support, because we -- at a hospital, of course, you normally have social workers and chaplains and people who do, you know, psychology, psychiatry. All that's already here. And for the staff, as well as -- more so for the patients, but, you know,

there's employee health, and there's things in place. So, all of that was already in place, but then it all just was stepped up, as you could imagine. So there were group meetings. There were meetings that were, sort of, voluntary, of anyone who wanted to come throughout the whole hospital. Then there were, sort of, department meetings. Then there were individual meetings. There were... I mean, (laughs) there were so many kinds of meetings.

BURKE: There was a lot of access, I think.

DECHERT: And availability of social workers and different types who would -- you know, could help and meet with groups, or whoever would need anything. Like, there was no way anyone could have said, "Oh, I didn't have an option to (laughs) talk to someone if I wanted to." So it was on all different levels, which was nice. You know, like, the CEO of the hospital has a meeting, but that's a big group. You know, but then -- so they also had small groups. We had social workers come and talk to just our division of Trauma. So, you know, it's a group of 8 or 10 of us that day. So, all kinds of support, yeah.

ILACQUA: OK. I'm also curious -- you had mentioned, actually, a really strong sense of community and collaboration across

departments here. Has that evolved or changed since the marathon?

BURKE: No, I think that's always the way it's sort of been, to a certain extent. You know, there's always exceptions to that rule, but most of the time --

DECHERT: Yeah.

BURKE: -- you know, there's that... That's something that's -- that, at least in my experience, is one of the strengths of Boston Medical center. You know, just sort of that kind of approach to... Then, specially, to trauma patients. You know, we take care of trauma patients here, so the expectation is that, even if you are a left-colon surgeon or a right-ear surgeon, that when I - when we need you -- because that's what that patient needs -- you'll come and help, even if it's in the middle of the night. So everybody just says, "Oh, OK. This is part of the deal." And, you know, OK. And I think that camaraderie and that sense of community, sort of, really was played out well.

DECHERT: And I think it was nice that a lot of people work really hard here, and, you know, got recognition or attention for the work -- you know, the hard work that they do --

BURKE: Yeah.

DECHERT: -- throughout all the different parts of the hospital of, you know, "You do a good job." Which was nice, of course, to hear that one in a while --

BURKE: Yeah.

DECHERT: -- and get that sense. So it just strengthened probably what we already do and have here, and the fact that it was kind of -- people were paying attention.

ILACQUA: Good. So, I'm going to kind of circle around to my last set of questions. We've talked a lot about marathon week, changes here. As the anniversary came up this year, did you do anything to commemorate that? Was there anything going on here?

DECHERT: You got -- that was you. I just worked, you know?

BURKE: Yeah. (laughs) I had to give some talk.

DECHERT: He's like -- yeah, he would give a talk.

BURKE: You know, they're always trotting me out like some, you know... So, you know, there was a recognition of the fact. And, again -- then, of the community. And it was good, and necessary, I think. You know, and I spoke to the issue of, you know, this new sort of standard of what, you know, the best level of care should be for everybody, and this was an opportunity, I thought. And, you know, I think that, to a certain extent, you know, this -- there -- you get a little, kind of, bombing fatigue after a while. Just

there's so much attention paid to it, you know? And so, it was -- people were not ready to move on, and you know, we're not going to forget about it. There was too many lessons learned, and it was too powerful a thing. But we need to sort of put it into context with the rest of what we're doing, in taking care of, you know, the patients that need it now. And, so, you know, it was a -- sort of, a little bit of closure, I think, to --

DECHERT: Mm-hmm.

BURKE: -- a certain extent, you know?

DECHERT: And what was nice, too, is that the marathon occurred again, and then there was, you know, Team BMC, just like there's a lot of teams that are running and raise money for good causes. And that was nice, because there was sort of, you know, let's take it this year. And it was sort of a celebration of life and hope and all those types of things (laughs) of, you know, just thinking about the good stuff that's out there, and the good people that are out there. Because if you think about it, it was really two guys [35:00] that were kind of -- you know, two guys were bad. And, like, how many hundreds if not thousands of people (laughs) -- or hundreds of thousands, you know, just were good --

BURKE: Yeah.

DECHERT: -- at the response. So, that marathon being run again, and then, with the different teams, and raising money, and the support they got. And some people who were victims last year were very much involved in being in the -- on the team, and trying to, you know, raise money for the cause. It -- so that was all really nice to see, and that was definitely a part of, you know, being able to have some closure or some sense of, you know, "OK, this is --" You know, "We're going to -- things are going to be OK, and we'll move in."

BURKE: Right, and sort of moving away from the fact that there was these people who would do this to other human beings, but more to sort of celebrate the fact that there are all these human beings who will do good for other people. I mean, all of the people that we got, got -- basically, their lives saved by what happened to them at the scene. So, bystanders and EMS, they put tourniquets, you know, ties and short, and wrapped up their legs, stopped the bleeding enough so they didn't die, and they got here, and then we could save them. You know, if those people had run the other way and not, you know -- people would have died. More people would have died. So it was a -- you know, it's -- in a way, you know, a testimony to how wonderful humans can be. Yes, there are some bad ones.

But there are a lot more good ones. (laughs) You know, for those of us who have offspring that's important. You know, and -- you know, for all of us. I don't mean -- you know what I mean. (laughs) But any-- it's really -- you know, it gets -- if you -- they wanted -- you know, people go, "I can't believe the world is like this." And I say, "Well, the world is like this. But there's more good in it than there is evil," in my mind. Now, that may be half full, but that's the way I choose to look at it. So -- and that came out -- that's what's going to be left behind. Now, if these people who did this thing -- they're going to be forgotten. It's going to be about the city's effort, and the -- all of this stuff that people did to make these people -- put them back together again -- to make them whole again, as much as we can. So, that's a powerful thing.

ILACQUA: So, I have, I think, two more questions left, and then we can -- we can wrap up. I'm curious if you think that you're --personally, if you've changed as a result of treating people after this sort of traumatic event? You mentioned that you treat trauma patients every day, but had anything like this ever happened to you in your career before? Have things changed since then, on a-- on a personal level?

DECHERT: So, for me, I would say this event -- I have not been as a trauma surgeon, involved in a mass-casualty event before this. And there aren't many that happen in our country, luckily. So, you know, you could go your whole career and not have an event like this. But -- so, this was my first. And I think what this did for me is just, you know, we get tired. We work hard. We work long, long hours. And sometimes you just -- yeah, I get tired of fighting the fight. (laughs) And this just kind of gets you going again, and gives you, you know, invigorates you and gets you back on your horse, or like try to... You know, so that you would have the passion to do what we do, because it can be thankless, you know? A lot of times, because you're here in the hospital at 3:00 a.m., no one cares. There's no actors and things -- people and athletes coming and celebrating, you know, the work we're doing (laughs) at 3:00 a.m. on a Wednesday. But the passion to keep doing the work, the passion to educate people. People now seem to have a better sense of what it is to be a trauma patient -- to be a trauma doctor -- to have some tragic event happen to you. People seem to know a little more about what all that means. So, to educate, you know, just society at large; to educate medical students as they come through and they're learning to be doctors, about all

of this... So, yeah, I guess, in that sense, I am more passionate about it than ever.

BURKE: Yeah, that's a good way to think about it. Sort of the quintessential moment for a trauma surgeon -- this mass-casualty thing. And we see mass casualties, but most of them are for -- they're not, like, for premeditated mass... So, it's different. And even though we see patients hurt in the same say in terms of massive soft-tissue injuries from... But this was from people doing it. So it was different. And so, that was an interesting kind of insight. And just the idea that, you know, all of this [40:00] stuff that we do has meaning, you know? Because we can really help. And it's such a privilege to be able to help. Not that many people get to do that, so we're really lucky in a way that we are allowed to do that. I find -- at least the way I think about it, it's really... And it's -- you know, the i-- (laughs) you -- it's 3:00 in the morning on a Wednesday night, and the people are shooting each other, and you're taking care of them, and nobody cares but you. It gets -- it can be tiring. And having this moment -- this kind of a re-- you know, this kind of s-- this recognition that, yes, what you've learned and how you do it really makes a difference, is -- was great for that -- you know, this rare event.

ILACQUA: Mm-hmm. Well, so, finally, are there any other thoughts or stories that you'd like to tell us, that you'd like to have recorded, that I didn't ask about?

DECHERT: There are so many stories that...

BURKE: Yeah, and I think that -- the one thing I think it's important realize, that it's -- you know, we did -- you know, we as practitioners, we did a really good job. But it's all about the patients and how strong they were. You know, they're the ones -- they're the -- the ultimate survival is about them, and their ability to do that. We can put stuff together, but it's all -- you know, these people were strong, and tough. And they were survivors. So, again, we just sort of helped. It was great, great, great to be able to do that, for us.

DECHERT: Yeah. I can't think -- I mean, I -- like I said, there's tons of stories. But, at the same time, I -- you know, all the different patients and those little snippets of things that happened throughout all that time that are good things to have -- to have been part of it, whether it's -- you know, it's not exactly newsworthy, or something that necessarily was covered in any of the media or in any way. It's just these little pieces of stuff that happened along the way, that are -- yeah, that are -- you kind of will always remember.

ILACQUA: Mm-hmm. Well, excellent. I just want to thank you both for your time, for speaking with me today about this project. And I'm going to turn off the recorder now.

DECHERT: Excellent.

ILACQUA: Great. Thank you.

END OF AUDIO FILE