Strong Medicine Interview with David Gitlin, 4 June 2014

ILACQUA: And we're recording. This is Joan Ilacqua, and this is June 4th, 2014. I'm here with Dr. David Gitlin in Brigham and Women's Hospital. We're going to record an interview as part of the Strong Medicine Oral History project. Dr. Gitlin, do I have your permission to record?

GITLIN: Yes, you do.

ILACQUA: Excellent. So, our first set of questions are really background on you. And to jump right into it, could you begin telling me about yourself, where you're from, where you went to school? That sort of thing?

GITLIN: OK. You want me to go all the way back? Or just my medical training?

ILACQUA: As far back as you want.

GITLIN: OK. Well, let's -- I can quickly go all the way back. I was born and raised in the Boston area. I was actually born in Brighton and lived on Comm. Ave as a small child. And with the schools around here, I am a graduate of the University of Massachusetts Amherst as an undergraduate, and in 1978. And graduated from medical school, also with the University of Massachusetts out in Worcester, in 1985. I did my residency in psychiatry at also, again at the University of Massachusetts in the University of

Massachusetts Medical Center from ’85 to ’88, and then did a clinical fellowship here at Brigham and Women’s Hospital in the sub-specialty area of consultation liaison psychiatry. That’s essentially psychiatric care of medically ill populations. And that’s pretty much what I now do for a career. I was the Director of the Consultation Liaison Services in emergency mental health services at UMass Medical Center after I finished my fellowship, from 1980 until 2002. And in 2002, I came here to Brigham and Women’s Hospital, where I continued to run the similar services here, we call the Division of Medical Psychiatry, which includes emergency services here at the Brigham as well. I am also the -- I’ve been the Director of the Psychosomatic Medicine Fellowship program here at Brigham and Women’s Hospital, and more recently, the Vice Chair for clinical services.

ILACQUA: Oh, excellent. So, what does a typical day look like for you here at the Brigham?

GITLIN: Well, being more of an administrator now, a lot of it’s spent in meetings. But when I have the opportunity to be more involved in clinical services, it’s spent often a mix of being in the emergency room, seeing individuals who present with acute psychiatric problems and illnesses, ranging from anxiety and depression to psychosis, traumatic

reactions, a wide variety of conditions. Often quite acute, suicidal thoughts or even suicide attempts, for example. The rest of the time in terms of patient care, is actually spent with medical patients. I always like to say the only place as a psychiatrist I don't work is on the psychiatric in-patient unit in the hospitals. I work on all the other floors with medical patients, who their medical care is either complicated by psychiatric illness, or for having an emotional or psychological response of either a new diagnosis, or dealing with their illness, complications of their medications, things of that nature. So that's what, often, a typical day would be like. I spend most of my time with emergency medicine physicians, internists and surgeons, not psychiatrists.

ILACQUA: So, would you mind if I ask how you got into being a psychiatrist? What led you...?

GITLIN: Yeah. Everybody's path is obviously a different one. I was a psych major as an undergraduate, that's kind of always where my interest in people is. And when I went to medical school, I came very close to being an internist. As I always like to say, I was almost wooed to the dark side, but I did not go quite that far. But always was very interested in the kind of interface between illness and people's reaction and response to illness. So, given my

psych background went into psychiatry, but always kind of trying to focus on the interface between medicine and psychiatry, and essentially what I do now. That's how I got there.

ILACQUA: Excellent. So, on a Marathon Monday, [00:05:00] in general, not last year, yet, do you usually work that day?

GITLIN: Yeah, it's not a holiday at Brigham and Women's Hospital. So as long as I've been here, at that point, I'd been here for 11 years, and I've always worked on Marathon Monday. Psychiatrically speaking, it's not typically a day different than any other day of the year. In the emergency room, you know, people would always prepare for dehydration, and a lot of other things. But, you know, we never would prepare psychiatrically for Marathon Monday. So it's usually just a typical work day for us.

ILACQUA: So, on last year's Marathon Monday, in 2013, how did that day begin for you?

GITLIN: Yeah, really no different than any other day. I was covering the emergency room that morning, my memory tells me. A lot of this is what my memory tells me. And we had a particularly busy morning there. Mondays are a different day for psychiatric emergency services, because -- and again without, I don't want to go too far astray here, but, you know, it's worth, you know, briefly

saying that we're currently living in a period where there's a very serious public health crisis when it comes to the emergency care of psychiatric patients. There is an enormous deficit across the region, and really across the country, an inadequate number of in-patient psychiatric hospital beds for people with acutely severe psychiatric presentations. And what's happening all across the country is, these patients are staying for very long periods of time in emergency rooms, and this has been written about all over, and you may have seen this, you know, reports of this in the news. And we've even written some literature on this, as well. There's a term for this called "boarding," we have psychiatric "boarders" in our emergency rooms right now. And it's very typical that the weekends are an almost impossible time to admit someone to a psychiatric unit. So if you come in on Friday or Saturday or Sunday, you know, with severe distress, depression and hopelessness, suicidal ideation and really need to be in the hospital, you'll often wait in the emergency room. By Monday morning, there may be, in any -- you know, in our emergency room here, typically three, four, five or more patients. That particular Monday, there were eight patients awaiting psychiatric placement, who had been there for varying periods of hours to days at that point, in our

emergency room. So, it was a typical Monday for us, maybe a little heavier than usual in terms of, you know, trying to, you know, care for these, you know, really suffering individuals who really needed the hospitalization. And we were both treating them acutely in the emergency room, which is not a great place, you can imagine, for someone with enormous distress or even psychosis. We had several patients who were quite psychotic in the emergency room that day. You know, that's a pretty intense, bustling place -- very hard for someone who's acutely psychiatrically ill. And, at the same time, trying to search the city, the region, for appropriate care setting for those patients. So it's one of our kind of typically busy emergency room Mondays that day.

ILACQUA: Mm-hmm.

GITLIN: Sorry, I didn't mean to go into...

ILACQUA: Oh, no, that was great. So, as the day went on, basically, when did you find out that something had happened? When did the day start to change?

GITLIN: Again, it was a very busy day, because we had so many patients in the emergency room. And I think we discharged a couple of them, but then a couple more people presented. So we had, as I recall, at the moment of time of the bombing, we had still eight people in the emergency room.

I became aware of it pretty quickly, in that we have a disaster preparedness system here. And in my role as Division Director, I'm pretty much the first person here who will be alerted from psychiatry that a disaster has happened, and time to respond. So, soon as I got an email from our Director of Social Work, you know, we were in disaster mode, I immediately went to the emergency room. I grabbed the Associate Director of the service, Dr. Sejal Shah, and said, hey, let's go down to the emergency room and figure out [00:10:00] what's happened. When we got there, disaster was in full-fledged mode at that point. Individuals had already begun arriving in the emergency room, and so we thought, like, all right, we're already behind the curve. Still, that was only about 20 to 25 minutes after the actual bombing, and I'm sure you may have -- you probably heard this story over and over again, but the unbelievable speed in which patients -- the moment from injury to arrival in the emergency room is almost unprecedented. It was, you know, for a horrible tragedy of that nature, it was the best of circumstances. And again, you hate to think of tragedy, best circumstances in the same sentence, they kind of don't fit with each other. But right at that spot, we had hundreds of emergency preparedness individuals not expecting to respond to that,

but they were right there. Ambulances. It was shift change, you know? I mean, again, you hate to have almost a gallows humor about things, but, you know, if you were going to tell someone who was going to create a disaster when to do it, do it at shift change of the hospitals, because you have two staffs. And every, you know, not a soul from the shift that was supposed to go off left, because everyone wants to help. So you have double staff immediately right there. You know, it's just -- it was a holiday, and so the traffic was nice and low. So people, as you've heard, arrived literally in less than 20 minutes to emergency rooms. So we got down there about 20 to 25 minutes into it, and only by walking into the emergency room did I then learn what happened, which was only maybe about 150, 200 yards from the entrance to the emergency room where our offices are, so we get to the emergency room very quickly. And it's, like, it's literally discovered as I'm walking into the emergency room.

You can imagine, fairly chaotic at the very beginning, everyone trying to wrap their heads around what is the extent of this, you know, how big is this? What does the nature of our response need to be? We were already beginning to deal with the security issues associated with

this. So, my recollection was even that early on, Boston Police were already there, starting to protect entrances very rapidly within that process. It was almost impossible to get in and out of the emergency room. And I'll tell you how that affected us in a bit. And so, very rapidly the process -- in the very beginning, it was a pretty chaotic situation. I did find the Director of Social Work. She was with a couple of the other social workers. And we immediately said, OK, let's start to conceptualize what are [inaudible] the needs be here, rapidly, obviously identifying there were patients coming in, and at some point, they're going to potentially need our resources in terms of emotional support. But that's not going to be the first thing most of the patients are going to need. You know, medical care comes first there, particularly with the severity of some of the injuries that were coming in. Families, however, were going to need emotional support. So we immediately started talking about how we were going to effectively mobilize and develop a way to do that. You know, this is what our social workers do best, and they are amazing at this. And they were already actively thinking this process, starting to think about where the command center, so to speak, for the families would be. You've probably learned we put that in the Bretholtz Center, which

is our Family and Patient Relations Center, and that worked very well. Our social workers rapidly manned that setting in that regard, and basically spent, you know, the next few minutes discussing with our Director of Social Work and our Director of the Emergency Room, you know, how we could be most helpful. Obviously, they're distracted. At that point, by the way, we already had, now coming into the emergency room, are ATF people with machine guns, and you know, you could imagine the scene that was going on there. Can I go off record just quickly for a second?

ILACQUA: Yeah, sure.

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ILACQUA: All right. And we are back.

GITLIN: OK, thank you.

ILACQUA: You're welcome.

GITLIN: So, as I was saying, relatively early on, you know, law enforcement started becoming a pretty active issue right in the emergency room. There was an individual of interest who had been injured, who they were concerned enough about, who was possibly somebody who was involved in this. It was a pretty intense scene in that room. I mean, you're talking about 8, 10, 12, you know, local and federal

officials, full SWAT gear, machine guns. So, it was hard for people not to start to get distracted by, you know, the growing awareness of the enormity of what's going on. But people were just staying so focused in their individual tasks at that moment, that I think -- we were almost behind the curve on this one. In fact, I was getting calls from the outside, people saying, "Do you know what's going on?" I kept saying, "Well, no, we really don't know." We were getting informed from the outside, even though we were at some sort of epicenter, we weren't seeing -- you know, the constant breaking news, except occasionally there was a television on in the hospital. I'll tell you about those as well. And so, we were very focused in there. We really tried to decide how we could be of most help, here, is really what it came down to. So, we -- patients really worked on (inaudible) at the front end. Families, we really worked on taking care of, and responding to them as they started to come in. It was complicated because families and patients were often one and the same here. And one of the very unusual aspects of this is, it's pretty rare that when somebody is in an accident, everyone they know is in the accident as well. I mean, obviously you have two three people in a car together, or something of that nature. But these kind of events, typically, they're

events. But when you come to the marathon, you come with everyone you know, and you all stay together. And so you saw families, you know, multiple people injured, and, you know, those stories have now been told, obviously. But it is different in that regard. Typically, if families come in saying, "What happened to my loved one?" And there, we had in Room 5 and 6, two people that -- or, that one was at this hospital and one was at that hospital, trying to figure all that out was hard. So getting families was, as you can imagine, a much more complicated than usual process. For us, the two other factors that rapidly came clear to us was, this was an incredibly intense scene. And we could see staff working so diligently and really working very hard, but, I mean, very quickly, the strain was apparent. And people were having a wide array of emotional reactions to what was going on. And so, we slowly, but surely, started to kind of touch base with people, where we saw people who maybe needed a couple of extra minutes, tried to provide that. Because Dr. Shah and I do this job that we do, the two of us, in particular, are the two best-known psychiatrists to the emergency room. They think of us as them, OK? In fact, I've often had it said to me about Dr. Shah, "Oh, she really works for emergency medicine, she doesn't work for psychiatry," you know? For

the many years they've known me, but also in her short time here, as someone who's spent a lot of time there, we're like a member of the emergency room. And so it gave us this great opportunity to be able to touch base gently with people, not try to interfere with their work, but provide kind of gentle support. And it was a face that they constantly recognized, so they know we're psychiatrists, so they're willing to kind of, like, give it up, you know, in terms of their emotional distress for a second, and we helped get them moved back. That is something that played itself out over the next several days as well. And we provided a whole series of staff support options. And I think we played a pretty prominent role in the hospital's effort to provide support to the staff then over the next few days. But in those first few minutes and hours, we were able to be there and provide that. The other thing that we then provided was, we had this very bizarre situation of these eight primarily psychiatrically ill individuals, several of whom had been there, you know, in this very kind of distressing experience for hours and days already, and now this is happening. It was, you know, again, you don't want to exaggerate it, but it was a pretty bloody scene. You can imagine, this was not that [00:05:00] controlled an environment. I've heard people

use the term “organized chaos” over and over again, and that’s really what it was. But in terms of blood, there was a lot of blood in places that we don’t normally have blood. And there was a lot of energy, and a lot of excitement, and a lot of intensity. For people who are emotionally distressed, that’s not a good scene. And several of the patients were really struggling badly at that point. We, Dr. Shah and I quickly came to the realization, we needed to get those patients out of that emergency room. Not only did they need to get out of there, but that space needed -- you know, we needed to get every patient who didn’t need to acutely be in the emergency room, and these patients, you know, I wish we could have gotten them out of there before the marathon bombing happened, because it’s a terrible place for a psychiatrically ill patient to spend, you know, hours and days in. It’s traumatic in and of itself. So we went about the process of getting them out of the emergency room, and getting them someplace. We talked with nursing management, they had already kind of established, for the medical patients, a step-down floor that wasn’t being used, and staffing it, getting nurses there. Well, we ended up bringing eight psychiatric patients to this space. Well, we didn’t end up bring all eight, as it turned out, we then

got on the phones. You can imagine other hospitals, particularly let me say our own unit over at Faulkner Hospital, which was already receiving some patients in the emergency room, not like the Brigham, but they were receiving their own patients. We have a psychiatric unit over there. It was full, but they did everything they could to -- they got a couple of people, either created some space in the unit, we were able to get a couple of people there. McLean Hospital who's, you know, in our Partners network, were incredibly receptive. They had a unique experience. They were sitting there watching this all happen on the television, and they have strong partnerships with us and Mass General Hospital. But they're not -- they're a free-standing psychiatric hospital, they don't have an emergency room where they were going to be bringing marathon bombing victims. So they're like everybody else, then, watching this, even though they're a hospital. And I think they were, like, "We've got to figure out what we could do to help." And so when we called, it was like, "Oh my God, yes! Let us help you!" OK? We are going to create some beds, even though they were full. And I think they took four or five...

ILACQUA: Wow.

GITLIN: They took -- again, my memory, I don't want to distort here, but they were so helpful. And these themes, I'm sure, are things you've heard in a hundred different, you know, variations, as you've done these interviews. But people wanted to just figure out how to help. You know, people who -- I mean, they're good people, they're always good people, but, you know, on a normal day would be, like, "Well, I'm sorry, we're full today, we don't have any beds." You know, they're not going to move heaven and earth to make something happen, because, you know, it's not necessarily in the best interest of the patient they have there. But in a case like this, you move heaven and earth. And they did! And it was kind of a remarkable thing. And you know, in the days and weeks afterwards, I spoke with my colleagues at McLean, and we all reflected on, you know, it's amazing what you can do, you know, when it's the right thing to do. And so, we had this, you know, really unique experience of putting psychiatric patients, you know, really, first of all, calming them down, explaining to them what was going on. Imagine trying to explain to someone who's floridly psychotic, believes that the government is invading you, and all of a sudden there's ATF, you know, people with machine guns. It doesn't jive well with this. So we were spending an enormous amount of energy really

trying to help, you know, comfort and contain serious psychiatric illness in these poor patients, get them out of that environment and then continue to care for them. So we put them with the nurses on the step-down unit that was created for all variety of patients, were also incredibly welcoming. These are not psych nurses. They're, you know, we don't admit psych patients here, we're not a psychiatric unit at Brigham and Women's Hospital. So, none of our nursing staff here had any, you know, real experience with the primary care of psychiatric patients. But we kind of created a little mini-psychiatric ward, almost, there for a little bit. And they were wonderful! Calming, you know, understood the particular complexity for these patients. You know, working with us about appropriate treatment, including medications, that were necessary. And it was really -- [00:10:00] if I think back on it, just kind of remarkable how people make a good thing out of a horrible thing. It's one of the fascinating things about human nature. So that's what we were doing in those first few hours. The original question was – what were you doing in those first few hours? OK.

ILACQUA: Oh, that's fine. We can take -- the questions are just to --

GITLIN: I hear you, I'm sorry to get -- (clap)

ILACQUA: -- guide us along. Oh, no. So, what I am curious about, actually, is that you had mentioned that you were already providing support to the staff here. How did that begin to evolve in the days after the Boston Marathon?

GITLIN: In many ways, I think we were probably, in terms of who did help most as a group of people? I guess I'd like to look back and think we were more helpful to our own staff than we may have been to patients and families. I think we did a good job of patients and families. But they had a lot of other supports coming to them, a lot of rallying around them, from lots and lots of resources. It was, you know, food and clothing being flown in from all over the country, from other hospitals and support. I mean, it was just the outpouring from the region in the country was unbelievable. And so, in some ways, despite the horror and the tragedy, the families were getting support, and we provided some. And same with the patients, although the patients were so ill in the beginning, and that didn't really become more, you know, important until days three, four, five, even a week or two out. But our own staff, I mean, it happened (inaudible). So we did a whole bunch of small group and large group meetings with numerous disciplines that were more actively involved in terms of, you know, orthopedics, certainly in emergency

room staff, surgery staffs, and across multiple shifts. We came back over several days to this, even a week out we did this. And we partly did this as a coordinated group. So, within that first 24 hours, we were able to identify, and partly because it's part of our disaster preparedness, a group of people who were more focused on the emotional and psychological health of affected individuals; patients, families and staff, and a lot of, you know, we knew the patients and the families were getting, you know, the care that they needed, that we were able to provide at that point. But we wanted to make sure that we then provided it to the staff. And so you're talking about our employee assistance program leadership, and our social work leadership, and our nursing leadership. You know, us in psychiatry, and just had an enormous outpouring. We were able to establish with great support from the Director of our Ambulatory Clinic, Dr. Jay Baer, who was able to rally all of our providers to say, any staff person wants to see us, we will create some time to see them. And any family needs, and so all of our individual providers, therapists, psychiatrists, etc., made themselves available. People were terribly traumatized in the first few days. I wrote, you know, a number of prescriptions for sleeping medications type of thing, because you really had to help

people kind of cope with this, and well, some people have concerns about, oh, you shouldn't medicate people who are traumatized, my personal belief about that is that's crap. People are so hyper-aroused, sleep is a critical factor. You're not talking about putting people on medications for weeks and months. We did, you know, people two or three nights worth to help with their sleep, and anxiety that they were dealing with. But then, also spent a fair amount of time in the family center meeting with families, things of that nature. I'm sorry, but getting back to the staff --

ILACQUA: That's OK.

GITLIN: -- we provided this as well. And this leadership group, we met every single day. We provided a wide array of things, we created a staff kind of event thing that people could come to, where they could get mental health, including things like Reiki and massage, and a whole slew of things. And we spent a great deal of time -- one of the things that we actually had to kind of re-emphasize, even to our own mental health leadership, at that point we kept trying to make a point that was made very strongly by our Director of Psychology, Dr. Megan Oser, was that there's some old theories about how you help people deal with these acute events. They fall under this term of "debriefing."

And the old theories of this [00:15:00] were, and really still a lot of people hold to these, is that, you know, you get people to talk about it, and just, you know, relive the event and, you know, that's how you get it out. There's very good data now that suggests that's not -- that doesn't help people and may harm people, may cause increase in the long-term development of Post-Traumatic Stress Disorder. So we kept trying to get people to say, that's not how you help people, OK? And people are going to talk a little bit about it, but don't encourage the "reliving" experience. What we really try to encourage is being healthy. That, you know, this has been a difficult time, but what's most important is to do the things that you normally do. Get a good night's sleep. Don't stop eating right. Get some relaxation in there. So, if you swim, go swim. If you -- don't get so focused on this that you stop living your life. Spend time with your children and your family and your -- and as much as it seems impossible to ask, try to maintain some normalcy in your life. If you're struggling with it, come to us, we can help you with it. But don't relive it and relive it. One of the things this led me to do, -- everyone had their own little personal crusades. You may remember during this time that there was this incessant news loop going on over and over again, replaying

it -- first of all, there weren't that many images, but they kept playing the same, you know, 12-second or 30-second loops on every station, you know, over and over again. You'd get to the nationals, and the same loop is going on. And it seemed like every TV in the hospital was on replaying this. And I kept saying, "This is not healthy." It's on in the ER, it was on in the patient room. I spent much of the first several days, after the first day, I spent, like, half my time going and turning off televisions! This was my personal crusade in the hospital. It wasn't a healthy thing to have, is a constant, almost -- you know, it was becoming the elevator music of our institution! We had enough reminders. And so, you know, those were almost like recurring traumas, particularly in the patient rooms. You know, I just -- even patients I wasn't taking care of, I would wander into patients' rooms and just turn off the TV and leave. You couldn't switch the channel, because it was on every channel. So, we tried to diminish this kind of constant reminder and constant barrage of this information, as a way of trying to get the health -- I think it was helpful to people. I mean, obviously, you know, staff would have to say ultimately whether they feel like they were cared for

collectively, but I think that was an important part of what we did.

ILACQUA: So, as the week unfolded and we headed toward the lockdown on Friday, did you maintain this -- did things change? Were things sort of the same? Crusades?

GITLIN: Yeah, things settled down. I mean, right. I mean, so you've got a good sense of the ebb and flow in the hospitals there. Monday was organized chaos, so intense, so exhausting, many of us didn't leave until pretty late at night. I mean, we were just in constant contact there, came back very early in the morning. But over the Tuesday, Wednesday, Thursday period, we really started to see, you know, a kind of a settling down, getting certainly not into a "normal" routine, but a more regular routine. Being able to think about, you know, OK, how can we help people over time here? And well, we talked about -- as I said, you know, the leadership group met every day, you know, led by Barry Wante here, who is our Director of Preparedness, and in the emergency room by Eric Goralnick, who really was leading the medical efforts in that regard. But it was starting to settle down on Tuesday, Wednesday and Thursday, as much as it can with armed guards, you know, at your front door. You know? It just had that feel, like, when you look at videos of what goes on in, like, European

countries all the time. You know, they've got armed guards standing at corners, or something. It's just not how America is, you know? So that was a little complicated, but you got a little bit used to it, and it settled down. And I think by Thursday, we may not have even had, you know, armed individuals at the doorways. And they, you know, weren't closing them. And that first day, by the way, I had mentioned to you we had a problem with getting in and out. Of those patients we were able to get out to other hospitals, we actually couldn't get them out of the hospital for a while!

ILACQUA: Oh!

GITLIN: So we had gotten McLean Hospital and Faulkner [00:20:00] to accept these patients, to an actual psychiatric unit, which is really where they needed to be. But then we got this complication of, they wouldn't let us take anyone out of the hospital, it was in lockdown. And so we had to go through channels, and I had to get the Director of Preparedness, and you had to get to the Chief of Security who is, you know, a friend of mine, we work together pretty regularly. When someone gets agitated in the hospital, you know, we work together with Security around those kind of, you know, responses. And so we had this great helpful thing, and we couldn't get people out of

the hospital! So that was a funny twist on things. But then, you know, we were able to get people out reasonably after a while. We went through the procedures with the federal agents finally letting us get patients to other hospitals, so, but that settled down. And then Friday struck, and it started all over again. And it was this, you know, for many people, in a sense, it's almost like re-traumatization, it's happening again, and what's going to go on? People were feeling unsafe. You know, it's these kind of veiled messages, not so much from the hospital system, but from law enforcement. Well, if you leave the hospital now -- we're not telling you you can't leave, but you leave at your own risk, kind of thing. And so, you can imagine how that message translates to staff. And so nobody left. And it got pretty intense around here, and kind of re-awakened some of the trauma. We did see, I think, a number of staff and family, you know, really kind of struggle that day, because it just was a re-awakening of their own kind of emotional trauma of four days earlier. So that's how we -- I mean, obviously, I think there was this enormous sense of relief when, you know, when we heard that they seemed to have captured, and then obviously, in retrospect, they did. I guess that's how it kind of played itself out at that point.

ILACQUA: Yeah. So, I don't know how good an answer I'll get from this question, but how long do you think it started -- it took to get things sort of back to a more "normal" pace around here?

GITLIN: It is a complicated question. Part of the answer is that it was different for each person. For the large majority of people, I think they got back to a basic sense of normalcy, you know, within two to three weeks. It was always there. We were kind of constantly getting messages. I remember in the first day or the second, every 15 minutes, there was a message that went over the, "We're still in the amber alert stage for..." And it's like, oh my God, it's like the televisions! Do we have to do it every 15 minutes? That kind of thing. And we were trying to see if we could settle that down, again, but it's kind of re-traumatizing experiences. The majority of people, including patients and family, and we were getting more involved with patients and families at that point, except for the patients and families, we were getting back to a greater sense of normalcy on the staff side. But there was still a number of individuals for whom they couldn't get back to normal, you know? And why it is that somebody's response to a horrible trauma, and, you know, this severe intrusiveness to human life and limb, they get stuck in it.

It's a complicated process. There's some neurobiology of brain structure, but much of it actually relates to people having had traumatic experiences far pre-dating this. And again, we didn't try to pry out of people what those experiences were, but I think for many of the people who struggled to get past these things, it has nothing to do with they're not strong enough to get by it, or some negative thing. But that the biology of their brains and their emotions have been conditioned by past traumas. And that when a new trauma occurs, it can kind of bring somebody back to, you know, a previous state of their own personal trauma. And that can be hard to get past for some people. And so I think we had some staff struggling with that, some people that had a hard time getting back to work. But for the most part, I really think in that two to four week period, we started to get some sense of normalcy back. I don't know if that answered your question.

ILACQUA: Oh no, that's great. You don't have to answer exactly my questions. They're just sort of...

GITLIN: You're just stimulating conversations.

ILACQUA: Yeah, topic points.

GITLIN: Yeah. I mean, I think as a psychiatrist, we're focused on very different things. And then the orthopedic surgeons were [00:25:00] focused on, you know, do we need

to go back to the OR here? Can we save the limb? You know, the emergency room staff, obviously their energies in this went down very rapidly. But, you know, they had been, you know, such an intense epicenter that they needed a lot of the early staff support more than any other group. But then it kind of moved, you know, to the trauma surgeons, and the orthopedic surgeons became, really, where the action was happening. And there, it was really, then, about people's lives. We spent a good deal of time with families, obviously, more at that point, trying to provide all the support they can. Again, I can't say enough how unbelievable our social work department here is, and how they really individually all kind of took a family and got to know them, and particularly our trauma social workers and orthopedic social workers were really working overtime. You know, several of our staff on our psychiatry consultation service got involved with individual patients. You know, and it was nice to break it all up, but I'm glad that it wasn't just one or two of us. I've got a fairly large staff, and so everyone had one or two or three patients that they were involved with, trying to provide support. And some of that was around even brain trauma. Some patients were delirious and quite ill. But then also, just dealing with what's happened. I was amazed at the

resilience of the patients. People were, much more often than not, were not stuck in, "Oh, this terrible thing has happened to me, what am I going to do?" It was a much more, "I'm going to beat this," kind of thing. And it's very interesting. You know, people are amazingly resilient people. I went to the one-year event downtown a couple of months ago now, I guess, right? And just blown away by the resiliency of these individuals, young people, I never would have been as resilient as they were when I was 20, 25. Just remarkable! People somehow can take something horrific and make it somehow something they grow from. Again, the healthy side of human nature is a remarkable thing. I mean, the ugly side of human nature is another story altogether. As psychiatrists, we see plenty of that, as well. But, yeah. I'm just -- I've been -- you know, as a psychiatrist, I see a lot of bad stuff, you know? And a lot of people doing a lot of bad things, and people struggling with substance dependence, and lots of other things in life, and serious psychiatric illness. You know, you get kind of inured to emotional suffering, you know, a little bit as a psychiatrist. I mean, as much as you want to help people, I've seen people suffering emotionally every day, particularly in an emergency room. And so, I always like to say to people, it takes a lot to move me

now, you know? I'm not an easily-moved person after 25, 30 years of doing this kind of very intense--intensive psychiatric care, you know, in emergency room settings and severe traumatic event settings. But I was really quite moved by the resilience of the people involved. It's more than I have been in a lot of things in life, so... I'm not an easily-moved person actually. I'm a tough nut.

ILACQUA: Well, I feel that's a recurring theme in the interviews, anyway. A lot of people who are very not easily emotionally swayed by things, talking about their experience with this event.

GITLIN: And you know, maybe you're hearing that more, particularly, I know if you're talking to a lot of doctors and nurses and health care providers --

ILACQUA: And trauma surgeons.

GITLIN: -- I mean, when you do this for a long time, again, you, say, like anything in life, you do something for a long time, you just get used to it, so there may be parts of lots of jobs out there, you know -- I met this young man who climbs telephone poles for Verizon, and he goes, you know, 200 feet up in the air to change the reception. It's like, "Oh my God, I can't dare -- how the hell do you do that?" You know? And he's like, "Oh, I've been doing it for years and years. I don't even think about it anymore."

But you know, there's a moment, you know, there's a period of time, when you're kind of, like, this is intense. And then, you know, if you don't somehow figure out how to get used to it, if you don't insure yourself to the intensity of things, then you get burned out. And you can't live like that. [00:30:00] And that's kind of what drives burnout for a lot of people. But if you do get used to it, then you maybe go a little too far sometimes, but doctors see, you know, trauma and pain and suffering every day. You know? We care about people. I honestly truly believe we really still care about people, but we don't --maybe we don't have that intense emotional reaction to suffering. You know? I think sometimes people worry that doctors are heartless. I think sometimes we worry that we're getting heartless, you know? But I don't think that's it. I just think it's necessary to be able to be able to be in there to help people with their suffering. Otherwise, it would just be too intense, and you wouldn't be able to do it for very long. So finding that balance. So, I think you may hear that story more from doctors and nurses and social workers, and healthcare providers, because, you know, they get inured. And then it's, like, wow, so, it's remarkable what people's resilience is.

ILACQUA: So -- I, let's see exactly what I wrote for this question. We've kind of gone over it a bit, but, so you're part of the Disaster Preparedness plan, you're locked into that very large systematic structure here.

GITLIN: Now, I'm going to say something here -- I hope I don't lose my job after I share these kind of things. Yes, we have a Disaster Preparedness plan. It's a well-thought-out plan, it's -- but you know, you can't plan for a disaster! It's the reality of disaster planning. Because no two disasters are the same! You know, there's no disaster plan for a bombing where people arrive 18 minutes later in an emergency room, because you can't plan for this! I mean, so the generalities of the disaster planning? Yeah. We were there, and the good parts of it is that, all right, you need to call these people, and you get this group together, and, you know, these people think about what's our next steps, and stuff of that nature. But it's not like there's some fixed algorithm of, you know, "You're going to do this, and you're going to do that," and, "Tuesday you do this, and on Wednesday..." It's just there is a tremendous amount of flying by the seat of your pants, still. And making decisions that aren't part of some preparedness plan. And so, yes. I was part of the

Disaster Preparedness team, but don't kid yourself that it's like a well-oiled machine, you know?

ILACQUA: Well, I was kind of curious if your individual response, if what you and your team did, you know, fell into line with that, and really how you've changed it, and how you've changed your perception of it, maybe, since last year?

GITLIN: So again, I guess my answer would be fairly similar to what I just said, which is that, you know, it gave us boundaries and curbstones about how to think and how to be prepared, and how to act quickly, kind of things. But the specifics of the actions themselves aren't within the plan in that regard. I think because it felt like that organized chaos, that a lot of us thought, OK, when this is all done, and the dust has settled, and we're going to go back and complete rewrite the disaster preparedness manual because, you know, it was organized chaos, and chaos shouldn't be part of the process. And you know, we did some changing and this, did some work on it, but not as much as I thought there would be, because the reality is, it got us ready enough to be able to respond. People, when the, you know, "This is an amber level..." Everyone kind of knew what that was, and it got people moving and thinking. And so, it allowed us to be able to be as good

as we were able to. I think if it wasn't there, maybe we wouldn't have been as good. And people would have lost lives, and people would have lost limbs that they didn't otherwise lose. Staff would have been more stressed out. We wouldn't have responded to families, you know, our security people wouldn't -- all the different moving parts wouldn't have kind of been in the right places. And we were. Remarkably. I mean, again, I think, you know, it's hard to feel it from the inside of a hospital, and I mean I -- in my particular job, they live kind of the epicenter of a place like this, in an emergency room. It's central to my job, which is not true for most psychiatrists. You know, I'm not a psychiatrist that has a patient come in at 1:00 and 2:00 and 3:00, [00:35:00] that's just not what I do. I live in the emergency sense. For those of us who live in that world, the perception that people had of how we did, we can't step out and look at how we did quite as differently as people -- it does seem, though, to us that the perception is, we were remarkable. And I think we kind of were. It just didn't necessarily feel remarkable internally to us, I don't think. It think it was, we were doing our jobs, you know? And a preparedness plan makes it easier to do your job, you know? I don't know if that makes sense.

ILACQUA: It does. It makes sense. And my other sort of question that, there was a hard segue into it, you had mentioned before that you had provided disaster support after September 11th to airline passengers.

GITLIN: Say it again?

ILACQUA: OK, so you had mentioned that after September 11th, you had provided support to American Airlines staff people.

GITLIN: Yes. Yes, yes. Yes.

ILACQUA: Did the -- I'm curious, and actually, you mentioned before we started the interview, that when this event was happening, when the marathon was happening, you flashed back to 2001.

GITLIN: Yeah. Yeah.

ILACQUA: And I'm wondering, were there parallels there? Did you...

GITLIN: Yeah, yeah. I mean, obviously I've given you one of the parallels which was -- that was, you know, and I think it may have been true for other people working in disaster settings, at that point I was running an emergency room, and I remember very vividly, you know, coming down the hall to the emergency room and a lot of people knew. There was a TV outside the emergency -- the mental health part of the emergency room that I ran at UMass, and all these people gathered around the TV, and that's how I discovered what

was going on. You know, we then, we all provided a lot of support that day at the hospital. But nothing was -- different disaster, different story, as we were saying. Nothing was coming to our hospital in Boston at that point. But I had pretty strong relationships with the two physicians in Massachusetts who were connected to disaster planning for the state for the MEMA, the Massachusetts Emergency Management -- I don't know what the "A" stands for -- you know, but -- and I knew them well, in part because they were both also the kind of psychiatrists that I am, and so we knew each other, from these things. One of them had worked out of UMass, John [Ewok?], and so I got in touch with them, and they said, oh, the Red Cross is trying to set up some stuff. I talked to the Red Cross, they said, "Yes, we really could use your expertise. We're setting up some command stations down at Logan Airport. Would you come down?" And I did. So I spent three days at Logan Airport back in 2001. Again, organized chaos. You know? It wasn't, like, who knew that this was going to happen, and who could plan for -- how do you support airline staffing? I provided counseling and support to, a bunch of, strangers at that point, but many of whom were good friends with, you know, the American Airlines staff who got killed on a couple of the planes. And by the time

I got there on Day 2, it was very interesting, I had never been in the bowels of Logan Airport, but there's this whole underground system that the employees and the airline employees know about, where they're kind of going -- they're not necessarily walking the concourses with us. There's a whole underground system there. And at the American Airlines place, it was this huge memorial that had been, you know, kind of like when you see out in the street, or exactly what was at the marathon bombing site, but down there, you know, candles and pictures and memorials to the fallen individuals, who were their friends and colleagues. Very different experience of the trauma than this was, for example. But yeah, so I did that for three days, and you know, it's much more not, you, being at the epicenter of something, but again, you kind of want to do your part for things, if at all possible. And you know, the emergency psychiatrists have some role in this. So that's what I did back then, and that was a long time ago, but I did that for three days at Logan Airport.

ILACQUA: Yeah, did you see a parallel to that sort of care happening here? That's really what I'm curious about.

GITLIN: Yeah...

ILACQUA: It's OK if there's not.

GITLIN: Oh no no no, there's absolutely -- are parallels here about -- but the parallels are more around the general concept [00:40:00] of people being traumatized by unspeakable loss. And particularly, I think, that parallel of loss being done to them. The sense of vulnerability, and what does it mean about the world we live in? And is it ever going to be safe? And while people weren't talking about that directly, there's a different vulnerability there than if I was in a car accident, or an ongoing thing. I think I remember very much that second day at Logan Airport, there was still a sense of, is there another shoe to fall, here? Same thing with the bombing. This isn't over, necessarily. And so, I think there's something about the nature of huge things being done to a society that were different. I don't think it was -- it didn't feel quite as central to me, you know, the 2001 events as last year's events. But I can imagine in New York City, I have many colleagues who lived in New York City and worked in New York City, and, you know, they talk about the events there, you know, as a, you know, massive marathon bombing kind of experience in New York City. So I think I'm sure there are some very serious parallels. And I got a lot of calls from my colleagues in New York that day, you know, text messages, "Hey Dave, how are you doing?" "Been there,

done that. Let me know if I can be of any help." And that was pretty impressive. People kind of knew, who had been through it, just something to do. And you know what? I know I'll do that for the next person who that happens to as well, so...

ILACQUA: Hmm. So, I have one more question before we get to, you know, how has the last year unfolded. But I'm kind of curious, because actually, a lot of people that I've talked to are not native Bostonians in any way. They either grew up elsewhere and came to school here and ended up here doing residencies, or something to that extent.

GITLIN: Yeah.

ILACQUA: Do you think that living here and being part of the Boston community affected your view on how things happened? My official question is, do you think your role as --

GITLIN: (laughs)

ILACQUA: -- healthcare --

GITLIN: Your "official question," eh?

ILACQUA: -- my "official question." Do you think your role as a healthcare provider differed from your role as a member of the Boston community?

GITLIN: Yeah, that's interesting. I don't know that I've ever thought -- I don't know if I've thought about this question. You're asking me a question that I haven't put

my brain to here on this one. I think it's not, for me, different. My identity to this community is as my role as a doctor and psychiatrist in the community. That's how I kind of define myself as part of this community. And I've never been, let's say, an overly-active community-involved person in politics and things of that nature. You know, my interest in those areas have been more in a psychiatrist organizational level nationally and internationally. So, my identity has always been kind of as a physician, when I stop and think about it, so it doesn't tear apart that well -- I think if there's one thing about it, is that -- and, you know, again, every community has its own identity. The "Boston Strong" identity that came up just so fast, it was such an interesting thing. But yeah, there's something about being a Bostonian that, you know, it's just, like, you know, I'm not going to let that bother me. You know? Get out of my way, you know? I mean, it seems so obviously to me that we'd just be, like, no, no way you're going to knock us down on this one. I can't say I guess I related to it, because I was so focused in my role as a physician that I wasn't connecting as part of the community. In some ways, I wonder if other physicians have said this to you, or other healthcare providers have said this, we were so focused internally here that I felt a little disconnected.

You know? I was saying, I mean -- that first day, I was here pretty late. And my wife was calling, and, you know, other people were calling, and I was, like, "So, tell me what's going on," you know? I wasn't that connected. And I think I still felt pretty insulated -- I was so focused here, that in some ways I felt like maybe I was less connected to what was going on in the community in that regard. So, I was more just thinking about how I was affecting people, you know, rather than -- because I was taking care of so many people. Did that answer the question?

ILACQUA: Yeah, that was great.

GITLIN: OK.

ILACQUA: So, [00:45:00] my last set of questions, and I have kept you -- it's been about an hour, which it doesn't feel like it's been an hour, but --

GITLIN: Yeah! I'm chatty.

ILACQUA: -- oh, and that's fine. That's -- so, my last set are really about how the year has unfolded, and how we came around to the anniversary. And these questions are pretty general. We had talked about the sense of normalcy here, and the sense of normalcy in working.

GITLIN: Yeah. Yeah.

ILACQUA: So really, well, we could skip straight to April. How did this April turn out for you?

GITLIN: Well, you know, I tend to be a person who moves on pretty quickly, OK? It's just my nature. I don't tend to hold on to things, so I probably got back to normal quicker than most. And you know, it's hard to say completely forgot about it, kind of thing, but pretty rapidly, it didn't intrude upon my thinking, you know, hardly at all by the time the following April rolled around. So I remember, when I first was starting to see people were -- that events were being planned, and I was asked to participate in a couple of things, it was, like, "Oh my God, it's been a whole year?" You know? It's, like, I forgot about it, you know, except in the unconscious ways that, you know, events incorporate themselves in your way of going about the world. Because I think I tend to be a person who doesn't hold onto things, you know, I was, like, you know, I get it, a lot of people need to remember. I don't have that much of a need to re-experience and remember. It's just not who I am. But I recognize that other people did, and I wanted to make sure that I created the environment to be able to do that, and started to participate in that. I've had, for me, the more of the unique experience of this is a more powerful thing than I'm used to experiencing. Again,

I'm not a person who's easily moved by the world events. You know, I try to be helpful, I try to be supportive. But I'm more of a person who takes care of other people. And I don't ask, or necessarily need, even, to be taken care of, and I certainly don't ask for it. And I just kind of go on with my business. But I was, I remember feeling emotionally kind of affected by it all. But I guess for me, it's really kind of been, and I was sort of saying this early on, I've become a much greater believer over this last year in the concept of resilience. You know? And for me -- and I use the word a lot now, and I've used it here today. I've used it a lot more in the last year than I did before. I used it before -- it's a concept of understanding how people deal with the world that's important to a psychiatrist. I mean, we spend our lives trying to understand what people -- when you asked me, "Why did you go into psychiatry?" You know, my "cute" answer about that always is, people pay me to be nosey, you know?

ILACQUA: (laughs)

GITLIN: It's like, what better job could there be than being a psychiatrist, you know? I get paid to just be nosey, you know? But yeah, you spend your time trying to understand how people cope with things, how people deal with things, and what gets in the way of people dealing with things,

what interferes with coping. And around illness, that's a constant question we're trying to deal with. What do they bring to the table that will help them deal with this? What skillsets have they never developed? What coping mechanisms that they never developed that's going to really get in the way now, because you need to cope with this thing, you know? And in psychiatry, you know, in these last, you know, few years, this concept of "resilience," we used to be more focused on illness, you know, what makes you sick. But there's a lot to be said for what makes you well. You know? And what allows you to deal, to go on, in the face of, like, you know, kind of overwhelming impenitence. And places where some people just lie down and stop. I'm done, I've had it, I can't take it anymore. This last couple of months, you know, this last April, it just reinforced to me this concept of, oh my God, people are amazing. It's this thing, this resilience thing, [00:50:00] that is just a remarkable human quality. You know, and again, I'm not a person who really is politically moved by that kind of thing, but the human nature and the human spirit is a pretty remarkable thing. You know, I'm a biologist by nature. I mean, as a psychiatrist, I tend to think about neural circuits, and, you know, this emotion is in that part of the brain, and, you know, this is clearly

this, that's a frontal phenomenon, you know, and I think about where brains get injured and that's why you're reacting this way. And, you know, that's where my daily world is. It's hard to say, you know, how do you put all of these electrical connections together and you get things like resilience? A soul, you know? People have heart. And that's a little hard to understand and explain, but it's a pretty remarkable thing about people. You know, I feel badly for people when they struggle, but I am increasingly impressed. This event has led me to be substantially more impressed by people's abilities to tolerate things. I don't know if you've had a chance to hear some of the talks that some of the victims gave at the one-year anniversary event, but oh my God. I mean, I was about as close to moved to tears as I'll ever get! I'm not a (inaudible), and I'm not a crier by nature. But yeah, I was welling up. It was really impressive. And even, you know, the peripheral politicians -- I always think politicians are politicians, they say the right things and all that kind of stuff. But even you could tell they were moved. You know, Walsh and Patrick, I was really impressed by -- you could just tell, he was sincerely moved by it! Now, so much so, he went off script again. He stuck his foot in his mouth, oh, I think, a couple of times. And I

said, "I can't believe he said that." But still, it was coming from the heart, you know? And he just, you know, you could see that this just taps into people's true sense of the goodness of people. And, you know, it is remarkable how when sometimes people do terrible things to other people like this, that any of them -- and it sounds trite -- it brings out the best in people. That's a funny thing. I don't know that -- I'll retire as a psychiatrist, and I'll never fully understand that concept, you know?

ILACQUA: My very last question --

GITLIN: OK.

ILACQUA: -- is basically if you have any other thoughts or stories that you want to share with me?

GITLIN: I think I shared a bunch of stories with you here, today. I think you got all of my stories. No, I think that's pretty much it.

ILACQUA: Yeah. That was, you know, it's a little dorky to say on the tape, but that was a very powerful final recollection to end on!

GITLIN: Yeah. I went home and hugged my kids a lot more, too. My kids are grown, but I still -- I sought them out and hugged them, and I wish I could maintain that level of love 24/7, you know? So it's funny, it brings out things like love, and it's -- I can't -- and other than that I can't

think of anything. I was nicer to my wife for about a week or two more. That's about it.

ILACQUA: Well, excellent! So, thank you so much! For speaking with me today.

GITLIN: Thank you! I appreciate the opportunity. Whoever listens to this 40 years from now, look up my family for me, OK?

ILACQUA: Oh, excellent!

GITLIN: All right.

ILACQUA: All right, and I'm going to shut off the recording.

END OF AUDIO FILE