

Strong Medicine Interview with Stanley Ashley, 28 April 2014

Q: [00:00] OK, great. So this is Emily Harrison, and today is April 28th, 2014. I'm here with Stanley Ashley in Brigham & Women's Hospital, and we're going to record an interview as part of the Strong Medicine Oral History project. Dr. Ashley, do I have your permission to record this interview?

A: You do.

Q: Thank you. So my first question for you is about yourself and your background. Could you tell the listener a bit about your training, how you came into the position you're in right now, and especially any background you may have in Emergency Response Training?

A: So I'm a General Surgeon, who sort of [as?] through my career, did more and more administrative sort of things; and I've been in this Chief Medical Officer role for three years. A big component of my career I did trauma call and led trauma teams; but when I came into this role, I did take the Emergency Response online courses that are provided.

Q: And could you talk about where you did your educational training?

A: Cornell for medical school. I did my training in surgery at Wash. U.

Q: OK, and what years were those?

A: I finished medical school in '81, and I finished surgical training in '89.

Q: OK, and how did you move into Trauma Surgery? How did you choose that (overlapping dialogue; inaudible)?

A: Well, I wasn't -- I'm basically a GI Surgeon but when you come out of training in an academic medical center, you usually take -- call for a whole lot of things, and I did trauma at Wash. U. I was at UCLA for a while where I did trauma call, and then for a while when I came here, I did trauma call. It wasn't my major focus. It was just (pause) they always needed people to be the trauma surgeon on call.

Q: (laughs) And you were willing. (laughs) Did you have any particular training as either a trauma physician or as this administrator position you now hold that you feel came to play?

A: Well you know, at the time I trained, there was nothing specific for trauma. If you did General Surgery Training, you were the trauma surgeon and you had all those qualifications. I did have critical care certification. When I finished training, it was just becoming a sort of --

it's an added board on top of General Surgery and -- and most people that do trauma now do kind of a Trauma/Critical Care Fellowship, so.

Q: And were there any sorts of coordinated response procedures that you were exposed to or trained in?

A: Not -- (sigh) not really. Multiple trauma -- I mean, I -- Barnes was kind of inner city St. Louis where you could, on an average night, see multiple gunshot wounds come into the Emergency Room, but there wasn't any specific training.

Q: Yeah. So it was just experience or the context you were in, you learned how to do -- was there?

A: Yeah.

Q: So then, if we step into pre-2013, so move forward a bit to the Brigham and to -- and you were in this position you're in now in 2012, for example?

A: I was.

Q: And so what did the Marathon Monday look like for you in 2012, for example?

A: Well, (pause) I'm not sure I remember that. I could have been away. (laughs)

Q: (overlapping dialogue; inaudible) so significant. (laughs) Yeah.

A: I don't remember that. I often go to Florida this time of year. (laughs)

Q: Yeah. Congratulations. (laughs)

A: My mom goes down (laughs) there. So I could have been in Florida that Marathon Day.

Q: OK. So to give the listener a bit of an understanding then of what you do generally in your position on a -- on an average day, could you talk a bit about that?

A: Well, so there's a whole -- there's sort of a range of things that sit under the Chief Medical Officer's office. Risk and compliance, credentialing, those sorts of things. [05:00] Pharmacy sits under me. So it's a range of issues, and then there's sort of a role that is kind of -- I think I would say that I sit between the docs and the hospital administration and sort of advocate for both with the other. It's that kind of role, so I meet with all the chiefs. I'll meet with a group of docs, I'll meet with people that have some issue that -- around the hospital mostly related to inpatient care that's a problem. Quality safety.

Q: Could you give an example of that kind of?

A: (sigh) So I can tell you my day today. It's -- after you, I'm meeting with the Chair of our Board of Trustees, and I usually do that on a regular basis and talk about issues with the hospital. I then meet with the guy that runs our international office and talk about how that's going. I'm

going to the OR Committee. I meet with the chief of Emergency Medicine. I'm meeting with a gastroenterologist that they're trying to recruit. I'm meeting with everybody that works in the international office; then I meet with the CMO at the Faulkner, who reports to me. I meet with our Head of Marketing, and then we have a House Staff Quality Committee that I'm going to go to for a little bit.

Q: OK. So you have connections with people all over, informal and formal connections.

A: Yeah, I do a lot of sitting and talking. (laughs)

Q: OK. And so then, if you can tell me -- knowing all these people, having all these informal connections, I can imagine came into play significantly during emergency response of the marathon. Was there any other sorts of training that you were -- that you, in your position, did leading up to that day or before that day? Sort of how to respond if there's a (overlapping dialogue; inaudible).

A: You know, there are these online courses that train you for emergency, Incident Command, that FEMA puts together; and I took a bunch of those online when we did this. And we have drills periodically around various emergencies. And you know, there's a structure that play-in for Incident Command. We use a conference room that's down there by the cafeteria. We all have little bibs that we put on. I'm

the Incident Commander, I'm etc., etc. And you know, there's a formalized process that we all report there and talk about.

Q: OK, and had that been put into effect recently before the marathon?

A: Yeah.

Q: What was the -- can you remember (overlapping dialogue; inaudible)?

A: So I -- it was long before me. (sigh) I think there was some sort of Incident Command for quite a long time. I believe 9/11 was -- everything got ramped up across the country and we, like most hospitals, put a more formal structure and have done a lot of drills. I think that, you know, Oklahoma City probably was a start to some of that. But the number of drills have increased kind of across the last decade, and the Aurora thing was another thing that I think -- the group in the Emergency Department -- Ron Walls, who's the chief, but also we have a guy named Eric Goralnick who's sort of over our -- from a physician's standpoint -- over our emergency response structure. And Barry Wante, who's an administrator. That's his primary focus is those kind of things.

Q: OK. So then if we move into the day of the marathon then?
What -- can you just sort of describe what happened that
day and what you did? I think especially --

A: So --

Q: -- what happened from your seat, from your perspective.

A: (sighs) Yeah, that -- so it was, you know, a holiday in
Boston but we had a regular working day at the Brigham.
Having said that, it was vacation time of year. I think
everything was scheduled -- our schedule was light. And I
had one of my usual days, except I do remember that I was
actually thinking about leaving a little early that day.
When [10:00] the -- so they -- when somebody hears that an
incident that might be bringing a lot of patients to the
hospital is potential, they call it Code Amber. Barry
Wante, the -- and I was the administrator on call that day,
so I got a call from him that said there's been a bomb, we
don't know anything about it, we're going to call -- Stage
One means we don't know what's coming but we need to be on
alert.

Q: And that was pretty immediately after it happened.

A: It was right after the bombing but --

Q: Yeah.

A: -- pretty quickly. And I was doing a couple things in the
office. I finished those and then walked to the Emergency

Room. And by that point, the first patient had already arrived.

Q: So what were your expectations when you got the call from Barry that there was going to be -- that he was calling a Code Amber. I mean, did you imagine it was going to be --

A: Well, we didn't know anything about what had happened or whether we'd be getting any patients, so it was --

Q: Sort of open?

A: -- hurry up and wait.

Q: Yeah. And then once the patients started arriving, how did your -- I mean, were you -- could you describe sort of your feelings as you started to get a sense of what had happened?

A: Well, it was very quickly obvious that it was a major event. I walked down into the Emergency Room, and there was kind of blood along the floor. And they brought in (clears throat) the first patient; and as I was there, they were wheeling other patients. The Emergency Room was already relatively full, and so I walked up to the Incident Command Center, which is kind of right above the Emergency Room. And I believe Nancy Hickey, who is one of the charge nurses, oversees the Emergency Room and things upstairs, was already in the process of arranging to take patients from the ED to empty beds upstairs. And because it was a

Monday, we were very lucky. We had -- you know, where often occupancy is over 100% late in the week, but on a Monday it goes down. And one of the ICUs was empty, and then there were patient floors that were open. And Nursing really did an incredible job just coordinating getting the patients that were already in the emergency room, and there were a lot -- we -- on that day, we get a lot of dehydration and chest pain and things runners, etc. So they're already moving those patients upstairs. Eric McDonough, who's our PR Communication person was there as well and several other people were there; but it sounded like everything was happening so I went back down to the Emergency Room.

Q: And then were you working there as a surgeon, or were you overseeing --

A: No. I tried to help kind of coordinate things. Because we were not on holiday and it was a holiday, kind of everybody was here. It was right at change of shift. So there were tons of docs, and kind of as the patients were coming in, sort of every doc from everywhere appeared at the Emergency Room. We really did have a crowd control kind of issue.

Q: Oh, [care for riders?]. (laughs)

A: Yeah. They had a typical at that time on a Monday afternoon, we had six or seven ORs empty downstairs. The

chief of Trauma Surgery and kind of the physician that oversees the emergency room, I mean oversees the OR from the anesthesia standpoint and does kind of patient flow, both came to the ED. And the chief of Orthopedic Trauma came to the ED. So they were all there with members of their teams sort of trying to figure out what each patient needed. We were very lucky in that there weren't a whole lot of people that were really critically ill. There were only a couple that needed to go to the Operating Room right away because of bleeding or something. There were mostly extremity and mostly leg [15:00] injuries, and only few of them really bleeding. So there wasn't that big a time thing.

Q: Is that a difference than what, than the patients who arrived at other hospitals?

A: No. It was across the -- you know, this was not like a lot of trunk injuries with big, huge blood vessels. It was bones and it was soft tissue, but very few of them really needed to be operated on immediately. So I think most of us would say that it was incredibly lucky that everything -- having said that, I would say that people did an unbelievable job, but mostly without being asked if -- going where they needed to go, moving patients upstairs to make room in the Operating Room, etc.

Q: And as you said, you were sort of helping out down in the OR? What were you doing to help out there?

A: Well, things like -- one of the hardest things and at -- we had not -- I think we have done some things to fix this since then. Patients rolled in. Getting them registered, getting their names, figuring out who had what. You know, there were groups of docs that took each of the patients but sort of communicating between them and figuring out who was the next one that should go to the Operating Room was a problem. We didn't have any really very well organized way of all that information flowing centrally. So I ended up walking around, as did the chief of the Emergency Department, as did the chief of Trauma and the chief of Orthopedics, and the chief of -- and the anesthesia flow guy, Hugh Flanagan, trying to figure out how we coordinated those things.

Q: Yeah, and so this is a interesting question because this was a citywide event. Common things happening in multiple different centers. How did communication happen? And you talked about just what happened here within the Brigham. How did communication between hospitals happen? Where did that come up?

A: Well, so there is this citywide emergency response; and that went through Barry Wante. He was talking with other

hospitals. The triage itself from downtown. EMS was there right at the Finish Line. There were a lot of docs there from -- I mean, all the -- you couldn't have a better setup to do this.

Q: Yeah, yeah. And as the day was playing out and the week was playing out then, how did communications between -- within the hospital and the media or general public continue?

A: So most of that communication -- so Ron Walls, who's the chief of the Emergency Room, Erin grabbed him to communicate to all the media that was outside; and he did most of that. Erin and her group did most of our internal communication. And then you know, there was an effort to sort of provide enough information that people weren't too anxious but not violate HIPPA things and all that kind of stuff.

Q: And can you describe then, over the course of this week between Monday when the bombing happened and I think Thursday when the city was locked down, what sorts of procedures that had been in place were sort of tested, tried and true, and which were -- which do you feel like it was clear that some change needed to happen? You mentioned a communication issue?

A: So I think our communication group did a great job. Unfortunately, there was huge amount of anxiety. There probably was -- you know, we had Elizabeth Warren and the Mayor, and Michelle all came. I think the patients themselves got a little tired of all the media attention? There were some -- you know, some caregiver would post a picture of them and one of the patients on Facebook --

Q: Yikes.

A: -- you know, and that kind of thing. It tend -- not a lot of that happened, but there were clearly some issues around HIPPA kind of things. There was so much attention. I [20:00] think it was -- it was definitely an unsettling week. We had one ti -- where there was a parked car outside one of the entrance, and we locked the doors because we were concerned that that might have a bomb and - - there was a person of interest in the Emergency Room at the same time all the patients came in, so there were FBI, State Police, City Pol -- too many policemen in the Emergency Room in addition to thousands of people. All those things -- you know, you would say we could have done a little better, but most of them worked out.

Q: Yeah, yeah. I want to follow up on a couple of those threads. But the first one is this mentioning of Facebook, because the event itself had -- people would say oh, social

media plays such a big role in how we respond, how quickly we can respond now. You're bringing up another side of social media, which is where privacy of patients meets social media and --

A: Yeah, I --

Q: -- can you talk a little more about that?

A: -- don't think it helped much with this event. It was ju -
- you know, everybody was Tweeting everything, everything that's happening in the hospital becomes public knowledge immediately, everything that's happening outside.

Q: So when the hospital noticed that there were some issues, HIPPA violations or potential HIPPA violations going on, how does the hospital respond to that sort of thing?

A: I believe what we did was make some broadcast emails about the issues that -- to remind people. Yeah, it gets lost, what we usually do in kind of the whole event of that week. It was a little surreal, the whole thing, so.

Q: Can you say more about that?

A: Well, the lockdown and people -- it just didn't (pause) -- you -- nobody knew really anything who these people were, what it meant, shootouts in Cambridge and -- that -- it was -- I think everybody felt unsettled by it.

Q: Yeah. I think so. Do you think that the -- on the Thursday, when there was the lockdown, how did that affect what was happening at the Brigham?

A: Well, I don't -- (sigh) I mean again, it was an odd day. People who are -- with a hospital ID mostly came in on that day. (pause) And it felt like the city was shut down, and we weren't doing everything normal.

Q: And can you talk a bit about the sort of divergence from normal, if there are specifics, even in what you specifically were doing that day?

A: Well, I think a lot of elective stuff with -- patients didn't make it in, etc. or those parts of things. So the hospital's much quieter than under normal circumstances and (pause) --

Q: OK. And then if we want to look forward sort of through the year that came after that week, what sorts of changes to hospital procedures came about as a result of the marathon? What sorts of talking happened between hospitals?

A: So I think that (pause) you know, there was tons of presentations by people about what we did. Internally, we had a lot of debriefings. Out of those came some specific sort of changes. We had a registration system that assigns a medical record, if we don't have the name and information, we call them Unknown Male, Medical Record

Number such-and-such. That made it very hard with X-rays and things to figure out who was what. So we're adding a color code to those things. We now have a concept that we're going to use Bornstein Auditorium as the place where everybody goes so everybody doesn't come to the Emergency Room so there aren't these huge crowd control issues. We have a plan to assign a group of people to help with that communication rather than the Incident Commander and the Trauma being the ones that walk around and try and triage things. [25:00] We -- so there were some points where some of the equipment we ran out of, so there are cassettes for plain X-rays -- there were a lot of plain X-rays; they ran out of cassettes at some point, so we now have more cassettes, etc. I think those were sort of the main things. We've done -- so the Head of Trauma has a plan, and I don't know how far along they are with this, to give the General Surgery Residents who do most of the trauma stuff more of the Incident Command Training. The thought was that that isn't a usual part of residency. It's something you get when you're in an administrative position, but I think the recommendation has been made that they do those online courses and maybe -- so I think we have not systematically enough included the residents who

really are a huge part of our care model in the drills.

It's -- so there's a plan to do more of that.

Q: Yeah. It seems like the more people know what other people are doing, the --

A: Yeah.

Q: -- more (overlapping dialogue; inaudible).

A: You know, I think we were incredibly lucky in that it was a work day and nobody was working. If this had been 2:00 in the morning on a Saturday, there would have been a lot fewer people available. I think that we are working on kind of a cross-residency still, a system that people that aren't on call, we still have their phone num -- their cell phones. If they're in town, they could call them and say, "Come in," that kind of thing that we haven't been as systematic about as we should.

Q: When you said there's a recommendation or that the residents be more involved in Incident Training, but then where's that recommendation coming from? Is it --

A: It's coming from me. (laughs)

Q: OK! (laughs) I wasn't sure if it was sort of a national medical --

A: No, no. It's -- this is an internal thing. (pause) I -- there are issues that we haven't completely figured out, so if it was really hard to get here, there's something that

disrupted the transportation system or the road, how would we get docs that weren't in the hospital in the middle of the night? That's one we're thinking about that I don't have the simple solution to yet. But there's been a -- it's motivated a lot of thought about mass casualties, that sort of thing.

Q: Yeah. Well, I guess that's what I would like to ask you about now is sort of just general reflections on things that haven't come up in what we've talked about or things that you want to elaborate on. What do you feel like were the sort of significant lessons learned from that day?

A: Well, (sigh) you know, it -- again, it's unsettling and I think we (pause) -- the worry is that it went so well? That we end up more complacent about the next one. Or something much more major. It was so -- so -- you know, the fact that EMS was there, there was a medical tent that was right in the center of a city with more Level One Trauma Centers than anyplace else, a holiday but everybody in the hospital, the hospital relatively empty, change of shifts, every one of those things made this go unbelievably well; and you know --

Q: You mentioned that the nature of the injuries that were --

A: Yeah.

Q: So is that concern about complacency, is that something that you feel like is you, or is that a widespread sort of concern that you've been hearing in discussions?

A: Mmm, I (sigh) -- no. I mean, I think we mostly talked about what didn't work and what -- but you do worry about it. There were -- there was a ton of pride and a great feeling that we, as a city, had done a terrific job! I -- but in fact, we couldn't have had it easier really for what happened.

Q: Right. So you're saying that chance also did a great job.
(laughs)

A: That's right.

Q: Yeah.

A: I mean, I do think we were [30:00] prepared; but this -- the surgical phrase is I'd rather be lucky than good! And we were incredibly good and lucky in that. (laughs)

Q: Yeah. So is there anything else that you would like somebody who's learning about this event in the future to know, to sort of keep in mind? I think, especially some of the comments you're making that go against the grain of what the common narrative was that was told about the event, are -- I think they're really important to also hear and put on the record, so.

A: Well, I -- it really is just that, that we shouldn't back off on our drilling, we should continue to do everything we can because we could very easily be in a much worse situation the next time.

Q: And are other hospitals coming here to sort of learn from the Brigham about responding?

A: Well, I think there have been a huge number of -- not just the Brigham, but every one of the hospitals that have been involved with this have gone out and spoken about things, been invited on multiple occasions to talk about -- I -- so the Association of Program Directors in Surgery, which is -- you know, people that oversee surgical training across the country. I just participated in a panel where it was me, it was a trauma surgeon from MGH, and it was a resident from the BI talking about the response, what we can learn from it, what we should do in the future to -- to people across the country, and there have been hundreds of those kinds of things. Lots of publications on what happened and.

Q: Yeah. OK. Well, that takes us through the sort of arc of questions I wanted to lay out to you; and if you have anything else to say on the record, please feel free to (overlapping dialogue; inaudible).

A: I don't think I do.

Q: Then that will conclude the recorded part of this
interview. I thank you very much.

A: Thank you.

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