

Strong Medicine Interview with Joe Blansfield, 10 June 2014

Miriam Rich: This is Miriam Rich, and today is June 10th, 2014.

I am here with Joe Blansfield at Boston Medical Center, and we are going to record an interview as part of the Strong Medicine Oral History Project. So could you begin by telling me a bit about yourself, your training background, and your professional positions?

Joe Blansfield: Sure. So I'm the trauma program manager for the Boston Medical Center. I work in the department of surgery, and I'm responsible for basically, all the aspects that makes this place a Level 1 Trauma center, and all of the managing of the trauma registry, the program improvement, the credentialing, the resource, the education, the -- all the pieces and parts of administrative and clinical that allows us to use the Level 1 Trauma center credential. I've been -- I've been here at the Boston Medical Center for 35 years. And the first 13 years, I worked in the emergency department directly in a variety of positions as a -- as a staff nurse, charge nurse, clinical educator, clinical nurse specialist, nurse practitioner. And then since the early 90s when the institution was going to make the commitment as the first in the city of Boston to be verified by the American

College of Surgeons became the trauma program manager to -- to sort of help with that process, and seemed like a good fit, and I've been doing that ever since.

Q: So what led you to be interested in this kind of work?

A: Well, I've always been interested in -- in anatomy and physiology and what makes the body tick, and well-- and wellness as well as in illness an injury. And -- and I've always liked nursing because it had the most latitude. And so -- so that was always an easy fit, and I was kind of, sort of gravitated towards emergency and trauma nursing because, I think I fit with many other clinical people in this -- in this specialty that we have a short attention span, and that allows us, you know -- you can do something for a patient in an emergency or trauma setting, you got pretty quickly -- you get pretty quick feedback as to what you're doing as whether it's working or not working. And - - and it's also very gratifying that when you do something for a patient who's in extremis that -- that you can actually make a difference for them.

Q: Great. Can you talk a bit about your background as a military nurse and how that compares to the work you do now?

A: So when I had been working at this institution for several years I was looking for bigger and broader challenges and

one's always looking to measure oneself. And so I said well, everything in the military and specifically, in the army is -- is predicated on -- on -- on larger venues and more austere environments, and so I decided to jump into that type of a pond and see if I could somehow swim through it, and navigate, and -- and how I would do in that. So -- so, it was -- it was a very good experience for me. So I started in the military 26 years ago, slowly worked my way up through the ranks as a junior officer retiring just this past fall as -- as a colonel and over the course of those 26 years had a -- a great -- vast amounts of associations in a variety of settings, been to six or eight countries, had two deployments, one to Kosovo, and once to Iraq where I actually managed a combat support hospital as the chief nurse and -- and saw firsthand the effects that when -- that the body gets when -- when -- you know, the wounds of war.

Q: Can you talk about what a typical workday here looks like for you?

A: There's really not one -- you know, when you're in a trauma and emergency care business that's one of the -- I think that's one of the draws for it is that there really is not one day that's exactly the same. You meet people on the worst day of their life, and you hopefully can -- can make

a difference for them. We certainly have routines everyday. There'll be rounds or there'll be standing meetings, and -- and things like that, but -- but pretty much, my day is sort of 50 percent clinical, going to some of the trauma necessitations [05:00], and -- and -- and trying to expedite, and facilitate patients through their -- through their care, seeing patients up on the floor, making rounds on all the units where patients are -- where trauma patients are, and the other half of my responsibilities is -- is the administrative side of it; cataloging the morbidity, mortality cases, making sure that standards of care were met and -- and following up on any shortfalls.

Q: So before April 2013, what were your disaster response training and protocol like?

A: Well, I think the disaster training is -- is something that people give a lot of lip service to, but what I've -- I learned from my military side is that everybody has these little battle drills, everybody has little -- little disaster drills that each individual or each section or each department may participate in, but when you have a disaster that the really -- the mass casualty disaster is the batter drill for the entire institution. And, I think that's important to note because it -- it -- it really

stresses and exercises every facet of an institution. So whether you're a housekeeper, or whether you're a dietary aid, or whether you're a trauma surgeon you're involved, and you have to step up, and everyone needs to know their role. So a mass casualty disaster really stresses and entire institution, and it -- it's important for everyone to know what their role is. And sometimes, those roles may -- may bend a little bit and stretch a little bit depending upon the needs of the day.

Q: What are some of the challenges of coordinating things at an institutional level?

A: The two common themes that I think from all of the experiences that -- that I've had civilian and military is that crowd control and communication are always challenges. I don't care whether you've been doing it for a year, or you've been doing it for a decade. Crowd control and communication are -- every time we review our experiences in an after action report and say OK, what could we do better, what worked well, what would we do over again. The two common themes that always come out is well, it was too crowded. Too many people were in the wrong places and not enough people were in the right places. And so you can always get better at that and -- and communication; communication both verbally and in written -- in written

form in terms of patient records. So you have, you know -- communication needs to be closed-loop, it needs to be two-way, and -- and it has to -- is has to flow seamlessly. So those are two shortfalls that we know going into a disaster we have to be mindful of, and -- and if we do our jobs right, we don't have to talk about them as much in our -- in our after action report.

Q: So in the time that you've been at Boston Medical Center, had they activated a disaster response plan before April 2013?

A: Sure, we -- we do disaster drills a couple times a year and we have had real disasters of course as well. Things from building fires or train crashes or, you know, whether a T derailment, or a school bus crash, or something of that nature, but the marathon bombing was a little bit different in the sense that -- that -- the worst -- there were not just a number of casualties that we saw, but the number of casualties that were gravely injured.

Q: OK. Well, let's -- let's talk about that day, April 15th, 2013. How did the day begin for you?

A: The day for me -- I did come in early that day as we know it was Patriot's Day. And so I often call it sort of a fake holiday because the hospital is operating, clinics are open, the ORs are going, people are expected to work, but -

- but, you know, this -- it's -- it's a light day for the most part. So I came in and worked a half a day, and actually left around lunch time. I had some errands to run and so I actually left the hospital. So I really wasn't -- I -- I'd heard about what happened with the marathon bombings after I had already left for the -- for the -- I was on my way home running errands.

Q: What happened when you heard about them?

A: So of -- now I obviously called in and was in communication with people here [10:00]. And by the time I actually heard about it, I was already at home. And what happened after that was the hospital went to a lockdown mode, and -- and all of the patients that were -- that had already arrived were already brought to the -- to the various operating rooms. And I asked if they needed my services. So there's really no need for me to come back at that time, they said, and I thought to myself, rest up because tomorrow is when you're going to really be needed. So -- so I actually tracked from afar, and communicated with the people that were here, but actually, there was no need for me not being a trauma surgeon to come in because all the surgeons and all the patients were tied up in the OR, and all the staff were -- and were already in place in the ICUs. So -- so I

knew my coordination requirements and abilities would be taxed for the rest of the week.

Q: What was going through your mind when you first heard about what had happened?

A: That it was disturbingly similar to my experiences in Iraq where improvised explosive devices were intentionally let loose in crowds of civilian innocent people. And I was -- I was sort of stealing myself for -- for the types of injuries that -- that I was not only going to see again, but people that had not seen them before were about to see. There's lots of sort of comparison when people say oh, sure I'm a trauma nurse or I'm a trauma doc and I work in a trauma center, and I've been doing it for a long time and I've seen -- I've seen lots of things. War wounds are completely different. So when you, you know -- when you see someone who has maybe have been run over by a train or -- or been, you know, shot multiple times with a handgun or things that are very horrific, they're still not the same as when you see someone who has actually been blown to pieces, and you see them -- you see them in large numbers. It's just -- it's a trauma scenario that -- that civilian people are not accustomed to seeing. So -- so I was -- I was reflecting back on that and realizing that -- that not just we at Boston Medical Center, but the -- but all of the

trauma centers in the city will be gearing up for something like they've not seen before.

Q: And then so did you go in the following day, April --

A: So --

Q: -- 16th?

A: Right. So the following morning, all of the patients who were still mostly identified but there was still some confusion on that, so we knew that would be a challenge. And actually, we met here in this conference room, which we do our morning report each morning at 7 a.m. And so all of the -- the teams gathered here and it was a process of first of all cleaning up the list as we call our work list, trying to identify who was who, where they were, what their injuries were, and what the -- the overnight events and then making the plan for the day. The smart thing that I think happened that really began putting our best foot forward was that we just didn't have morning report with the trauma service, but we combined with all of the other services that were involved in the patient's care specifically the orthopedic service, vascular service, plastics, anesthesiology, as well as trauma and nursing. So everybody gathered literally in this room, and we all compared notes. And it wasn't just OK, who has what, but OK, now the plan for the day is who needs to go back, who

needs to have another operation, and in the process of doing that OK, who ortho and vascular could have a look at the same patient at the same time. And so -- so the operating schedule was being manipulated and crafted to maximize the economy of resources. So vascular and plastics oh, well this is too early for plastics so I'll -- oh, this, my case is going to be a big one, so you get the first OR or you get your -- your pick of the OR, etcetera. So -- so really that sort of collaboration and coordination of efforts really happened, and it was so successful that we did it again later that day at 5 p.m. And then sort of, we kind of instead of everybody rounded on the patients on the floors, but then all of the teams gathered in this conference room and rounded on -- and ran the list [15:00] everyday at 7 a.m. and everyday at 5 p.m. for the purposes of saying OK, how did the day go, what's the plan for tomorrow, and in the process of not just planning the operative day, but also determining any other issues that might come into play, you know, identifying family members, who are the out-of-towners, who had the bigger needs, you know, families that had loved ones at other institutions. So all of those sort of secondary, but equally important issues. Once the physiology was identified then trying to deal with the psychology of all of the individuals, and

this was a nice place to sort of bring it all together twice a day at 7:00 a.m. and 5:00 p.m., and that lasted literally for oh, at least a couple of weeks and 52 operations later.

Q: And -- and as you were doing these things were you following sort of a pre-instituted protocol, or was this largely improvised based on the needs that you're encountering in that incident?

A: Well, the -- I mean, I think medicine and -- and nursing is pretty protocolized already. And so there's a -- a sort of standardized approach to, you know -- how we organize our day, and how we organize, you know, patient care and, I think that was -- that was -- that was followed with each patient, but it was just expanded to involve all the other services.

Q: So -- so that level of coordination between services and -- and those meetings that everyone was having in here how -- how different did that make those workdays from a usual workday in as much as there can be one here?

A: Well, it made the day longer without a -- without a doubt. And -- and we didn't really elevate these patients to any special status. They -- they just had greater needs, and we still also had our standard service to run. So there were still people that would -- would have a motor vehicle

crash, or have a -- a broken ankle, or have an appendic--
an appendicitis, or -- so all of those patients were still
-- were still being cared for and managed as well, but they
didn't require the multidisciplinary approach. So -- so
sort of in a parallel way, we were -- we were doing the --
you know, the everyday care that happens in every hospital,
and then simultaneously, concomitantly we were -- we were
managing a multidisciplinary trauma service or a mass
casualty service, if you will.

Q: And -- and you had mentioned on Monday thinking to yourself
that you're about to see wounds that were, you know,
categorically different than those usually seen in civilian
life. Did that turn out to be the case?

A: Oh, absolutely. On -- in both regards, I think that --
that the wounds were -- were very severe, and were -- and
it was unsettling to many of the staff members as well.
So, and you could just see it in their faces and hear it in
their voices when -- when the -- you know, and -- you know
-- and certainly like the nurses in the surgical ICU, the
average -- the average tenure of the surgical ICU nurse
here is over 20 years. And so in 20 years working in a
Level 1 trauma center like this place, they've seen quite a
bit. There's no question about it. And -- and -- and it
was still -- it was still unsettling for them. So -- so

they -- they certainly needed an opportunity to decompress and an opportunity to have a bit of a catharsis. And -- and, I think that was -- that was noteworthy, and not always expected from everyone else because the wounds were -- were so devastating. So for example, we had -- we amputated seven limbs on five patients. So and obviously, that means that two patients had bi-lateral lower extremity amputations. And just taking and -- and these -- both of these patients came in with bilateral limb loss. We didn't lose -- we didn't take their legs. Their legs were off when they came here. And so for that -- for somebody to lose a limb by itself is very physiologically damaging, I mean it's a big hit to the body physiologically as well as psychologically. And for that to happen to both legs was -- was even -- was even more of a -- of a substantial impact. And -- and [20:00] these patients you have to remember were disoriented, were confused, were in shock when they arrived, and they were -- they were brought briskly to the operating room, they were put to sleep, and they were awakened in the surgical ICU. And to -- to have someone awaken them in the surgical ICU and not knowing whether they have one or two or no limbs lost and they were brought to the surgical ICU on purpose so that they could be kept on a breathing machine, and kept comfortable, and

pain free and -- and physiologically resuscitated until the sun came up the next day, and -- and everything was under control. And then -- and then for them to be awakened and then to be confronted with -- with their devastating injuries was, I think was -- was the smart and humane thing to do, but none the less it was -- it was no easy task.

Q: Do you think your military background specifically informed the way you provided care or acted that week?

A: Absolutely. I think that it -- it prepared me a little more because I was able to fall back on those experiences, and it allowed me to be a resource for -- for many of my colleagues in the institution. For example, I was very -- very proud of the fact that my year in Iraq we collected data as all combat support hospitals in Iraq did or Afghanistan and submitted our data by requirements to Fort Sam Houston in -- in San Antonio, Texas, and the Institute of Surgical Research. And from those clinical practice guidelines were promulgated and those clinical practice guidelines were pushed out and that became the standard of care for the military. So those are online, and we actually went to those and -- and downloaded them and printed them out. And so -- so everything from care of amputations, care of acoustic trauma, debridement of war wounds was very helpful for people that may not have had

that experience. So -- so even though we -- we weren't a military hospital, we were prepared to practice with an eye on how military handles similar types of injuries.

Q: And -- and do you think that insight from military medicine would have been accessible to this practice if -- if there hadn't been someone like you or presumably some of your colleagues with military backgrounds?

A: I think -- I think everyone would have come around to that because one of the things that we did is we -- we certainly shared with other institutions from our experiences as early as feasible. And in the process of doing that, we just by -- just by calling around and trying to find where all the other family members were that were -- that -- that got separated in -- in the move out to the trauma centers. So, I think -- think many of the military experiences would have been shared eventually at all institutions. And unfortunately, because we've -- our nation has been at war for over a decade, there are professionals in all of the trauma centers that have had some opportunity to -- to gain some of that experiences as well.

Q: What was the communication and collaboration like between different medical centers in Boston during that week?

A: It was pretty transparent, I'm -- I'm happy to say that we certainly called around to our colleagues, everyone from

the CEO of the hospital, the patient admitting, to the clinical providers, or to the family members themselves were calling around. Could it have been more organized, could it have been more efficient; absolutely. And, I think that's one of the lessons learned that we -- that we took away from it, but there was a -- there was a real push for us to help our patients. And part of helping our patients was not only helping them clinically, but helping them emotionally and that was trying to find, you know, the -- where a -- where a father or mother's children were, or where a husband, or a wife, or a mother, or father so trying to -- trying to reunite displaced families. And so we -- everyone did that with a fair amount of zeal. And probably bent the rules a little bit as well in doing so, but it was all -- it was all in the interests of just, you know -- just trying to put people's minds at ease and to lessen anxieties.

Q: [25:00] How did the rest of that week unfold through to the Friday when there was the Shelter-in-Place order?

A: Yeah, it didn't get much better. So, I mean on top of it all we were -- we -- we were inundated with support, I mean which of course, was a wonderful thing. But the inundate - - inundation of support ranged from the politicians, ranging from, you know, the president, the governor, the

senators, the mayors, the congressmen, the athletes, the celebrities. I often, you know, I made the kid -- I kid around that I didn't know who Bradley Cooper or Kenny Chesney were prior to this event, but I know who they are now. And one side of me was that the -- I was often jaded that these folks that came to see us were often there just for a photo op, and -- and I'm happy to say that I've changed from that position because when I saw that how they made both patients and staff feel special than they felt better about themselves. And so, it made the staff and the patient's morale improve. And so, it was -- it was wonderful. And, but the most important visitors that I recall were veterans themselves that had suffered limb loss that found us. That we didn't reach out to them, that they just found us and they came in as a peer visit to -- to, you know, just -- just comfort the patients that had -- that had serious injuries, just giving them the confidence that life goes on, they'll get better, they'll get back to a new normal. So that all happened, but that was also a fair amount of work in coordinating and trying to manage all of these -- these sort of extracurricular activities. And then Shelter-in-Place order comes about on Friday, and I had already gotten to work because, you know, any time you're going to have a seven o'clock meeting, you just

don't show up, you have to prep, you know, and sort of clean things up and -- and prepare for it. So I was already here, but none of my staff was able to make it in. And -- and they were -- they were, even before the Shelter-in-Place order came out with the manhunt in full swing, they were fearful to -- 'cause one lived in Cambridge, and -- and they just weren't sure whether they were going to be comfortable coming in. So I said, "Well, whatever you feel comfortable with." So just -- just -- just stay home. And so the Shelter-in-Place came out and -- and I didn't know how long I was going to be stuck here, but it -- it all worked out. So we had enough resources and again, the hospital was very -- very supportive. Anything we needed was -- was certainly made available, but they made for very long days, and they made for very exhausting days, but very gratifying days.

Q: How long was it before the pace of work for you returned to something more like normal?

A: I think it took a full two weeks. And, I think that's important. It's important to keep in mind because you have to -- you have to pace yourself, and even when you're doing a -- in a mass casualty operation, you can't -- you can't have your entire staff go full out because people will drop. And if you -- and if you're going to be doing this

as a sustained event, it's important to do a couple of things. It's important to get some separation. Even if it's, you know -- we were fortunate that people were able to go home, even though it was late at night and even though it was an early morning the next day, you didn't get a chance to go home. You got to go into your own driveway, and go into your kitchen, and go to your own bedroom, and you had a chance to get a little separation. That was important. It's also important to make sure that people you -- you rotate and rest people, 'cause if you don't again, you're not going to be able to continue at the same standard of care that you expect -- expect. So to -- to get some separation and to -- and to -- and to rest people as much as possible really was a difference maker I think in helping to do that sustained level of performance for a couple of weeks.

Q: And do you think in general Boston Medical Center was successful in understanding [30:00] and implementing those kinds of considerations?

A: I think so. Pretty close, you know, halfway through that period of time we did our own after action review with our own department, we did one with the entire section, and we did one institution wide. And then actually, we met with our counterparts. So all of the Level 1 trauma medical

directors and all the Level 1 trauma program managers conducted a city-wide after action review where we all got together. In fact, they all came here and -- and we were -- normally, it's a very competitive market in the city of Boston, and certainly among trauma centers because everyone holds themselves out to be the best. And -- and that's OK, that's a good thing, because when you have multiple choices everyone then wants to be competitive, and everyone wants to bring their A game. So, I think it's important to be competitive, because it does bring out the best in everybody. On that day though we all needed each other, and so we were all very collaborative. So it was in that spirit that we had a city-wide after action review where we asked everyone to come with the three things that they would do better, that they felt that they could improve on, and three things that they thought worked well that they would want to continue. And we had an independent arbiter, the state trauma chairperson. We asked him to facilitate the meeting. And we also had Boston EMS Medical Director and Superintendent there to provide the scene input. And so we -- we collected everybody's comments and turned it into an after action report, which is in the process of being published. So -- so, I think that's a little bit of leadership on Boston Medical Center's part. And in fact,

that collaborate -- that Level 1 trauma center collaborative is still in place today. And in fact, we're having a meeting -- we've been meeting every other month for over a year now, and so that spirit of collaboration is continuing as a direct result of this unfortunate tragedy.

Q: Can you talk more specifically about some of the points people brought up in terms of what they could improve on, and -- and what they felt had been done very successfully?

A: Sure, I think -- I think without a doubt, tourniquets were a difference maker. And tourniquets were somewhat controversial before, and tourniquets are still less controversial now, but still not completely unanimously supported. But tourniquets in our experiences were -- were a difference maker in terms -- terms of mitigating blood loss, and -- and -- and extending people's opportunity, and extending people's lives until they were able to get to a surgeon, and an operating room, and a blood bank. So even -- even a tourniquet that may not have been perfectly applied still slowed someone's blood loss such that they were able to get to a trauma center. So -- so as -- as a group, tourniquets were -- were a difference maker. And that -- that was one of the things that would be a sustain, and it would -- would be -- we would recommend doing again. Family support centers was a -- was a -- was also a

successful enterprise where we -- we were inundated with large numbers of families that -- and it was just -- just sub-optimal to have large numbers of families waiting outside the ER, waiting outside the -- the operating room, or the ICU, or somewhere else. So we -- we took our best conference room, we -- we equipped it with telephones, and computers, and food, and -- and water, and drinks, and allowed people to -- to communicate amongst themselves to -- to -- to -- we actually went over to Best Buy down right around the corner here and bought power strips and cell phone chargers for every conceivable cell phone that's out there so people were able to be kept in one location, they were able to charge their phones, they were able to communicate with each other, and they were well looked after. So that was a hit as well.

And so in terms of some of the things that we could do better, I think the patient tracking [35:00] was -- was universally less than ideal because some of it was the nature of the event that we didn't really stand up our disaster response until we were -- we were really starting to receive some of our first patients. Because things happened so quickly, and there was the sort of fog of war situation because if you recall we didn't know whether this

was truly a bombing, or whether this was a transformer that exploded, or fireworks that had gone off, or the JFK building was on fire at the same time. And so while we're getting this sort of -- these mixed messages, our first patients were starting to show up. So by the time we had confirmation of what we had, we were already at the beginning of it. So then we obviously stood up our disaster response, but by then some of the patients had already come -- come through and were on their way to the operating room before we really had a chance to do proper patient tracking. So -- so patient tracking is -- was -- is something that we certainly are now looking at to do better as well as the abbreviated medical record. We learned that because we have an electronic health record like most institutions do these days, the electronic health record doesn't hold up it's -- hold up well in a mass casualty response. And so -- so we had paper records, but the paper records were not designed for large numbers of casualties, because they're multiple pages, or multiple sheets, or multiple forms. So as a result of the Level 1 trauma center collaborative, we've developed a one-page record that has physician notes on one side, nurse's notes on the other side. It's got the universal department of public health tracking information on it, and we are

looking to standardize that across the city at all the Level 1 trauma centers so we'll have an abbreviated disaster record that will come as a result of this -- this experience.

So just off the top of my head those are a couple of things that we felt did -- we did well with, and a few things that we could actually do better with.

Q: Interesting. Can you talk more you -- you know, put out a phrase fog of war? How -- do -- do you think there are ways to make decisions better and more quickly given that in these situations information is not certain, you're not able to confirm information instantly always, I mean are there -- are there better ways of -- of acting quickly in an event which by -- by it's nature sort of takes everyone by surprise?

A: Sure, I think that -- well, just you have to understand there were -- there were people that were at the scene, docs and nurses that were at the scene that were unsure of what was going on. And everyone has a smart -- smart phone. There were runners that were at the scene that were docs and nurses from various institutions, and there were spectators that were docs and nurses and other health professionals that were also at the scene and everybody had

a smart phone or access to one. So everybody's communicating with each other and everybody's communicating with the hospital. Hey, guess what happened, guess what I think what happened is -- this is what I'm seeing. And so simultaneously people are -- are -- the authorities are collecting that information and trying to make their best assessment and then push that out with authority. So you have all of this that's swimming around while you're waiting for a proper declaration to occur. So -- so the nature of it is -- is going to be a little difficult to really hang your hat on. We have a saying in -- in the -- at least I had a saying in the military that all initial reports are false because that's just the nature of what they are. You should not discount them, but sort of like the gossip wire, you listen to everything, but you have to decide what you're going to take action about. So which of these reports are actionable, and which of these reports you want to just pay attention to because you know that -- the -- clumped together, they'd be maybe very meaningful. So you pay attention to everything that's going on with you and you gear yourself up for it. And then by the time a proper declaration occurs, it's not the first time you heard it or you have enough -- enough circumstantial evidence that you're prepared to act. I'm not sure that

was exactly the response you were looking for, but that's how it plays out.

Q: Do you think things like smart phones and the really intense social media activity that surrounded this event sort of [40:00] changed best practices and strategies for assessing and confirming information as quickly as possible?

A: I think we would be foolish to discount it and, I think the only way -- it certainly has changed, yes, absolutely. And what we need to do is we need to figure out how to leverage that -- that technology so that we can use it to our advantage whether it's, you know, having a proper network, or a proper channel, or -- or texting photos of the actual scene to multiple sources so everybody's seeing the same thing at the same time. So, I think there's opportunities for improvement in all of that. I'm not smart enough to figure out how that technology should work, but, I think we would be foolish not to -- not to exploit it. So, I think -- I think that smart phone technology is certainly here to stay and only going to grow, and -- and we need to find ways to incorporate it in a secure and smart manner to benefit everybody.

Q: Are there any other particular lessons or insights learned that you'd like to talk about?

A: The only thing I think I would add would be that it -- it -
- it was one of those events that everyone will remember
where they were and what they were doing, you know, much
like 9/11, or much like when the first man landed on the
moon, you'll always remember where you were and what you
were doing when that happened. And for the -- you know,
for the time that happened as a result I'm -- I'm happy to
say that, you know -- that I was at Boston Medical Center,
and I was happy to say that the city of Boston really rose
to the occasion, and -- and really became an -- became an
exemplar of -- of -- of how to do things well. We weren't
perfect that day, and, but -- but and -- and we were a
little bit lucky as well, but, I think we were both lucky
and we were both successful.

Q: For you personally as well as for Boston Medical Center,
what was the 2014 marathon day like for you guys here?

A: It was spectacularly boring. So we're happy about that.
And, I think we sort of were hoping -- well, we were
definitely hoping for that, and we were sort of expecting
it as well. So, it was actually very -- clinically, it was
boring, but it was also very moving in the sense that the -
- that we had a very, very thoughtful and poignant
anniversary where the -- the institution recognized many of
the staff. The -- many of the patients came back, and --

and thanked the staff as well here at the hospital, as well as there was a huge number of staff that were runners for team BMC. So from the clinical side, it was pretty uneventful, but from the -- from the anniversary side, it was a -- it was a really nice, positive time to -- to react and reflect.

Q: So are there any final thoughts or stories that -- that you wanted to share?

A: Well, I think -- I think you were pretty good at hitting all the highlights. So thank you very much.

Q: Great. Thank you very much.

A: OK.

END OF AUDIO FILE