AN INTERVIEW WITH DR. DEBORAH KUHLS

BARBARA TABACH

DECEMBER 29, 2017

REMEMBERING 1 OCTOBER

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PREFACE

Dr. Deborah Kuhls, M.D., F.A.C.S., is a tenured professor of surgery and chief of the section of critical care. Dr. Kuhls is program director of the UNLV School of Medicine's Surgical Care Fellowship Program and medical director of University Medical Center's Trauma Intensive Care Unit. Her expertise and passion for teaching medical students, residents and fellows provided a steady foundation at UMC on October 1 as injured attendees of the Route 91 Harvest Festival began arriving.

Dr. Kuhls spent her childhood in Wisconsin, the daughter of a farmer and his wife, a nurse's aide. Her medical education includes: Medical College of Pennsylvania (now Drexel University School of Medicine; general surgery residency at Albert Einstein University at the University of Maryland; a fellowship in critical care and trauma at the R Adams Cowley Shock Trauma Center at the University of Maryland. She has resided in Las Vegas since 2000.

On October 1, 2017, Dr. Kuhls was in the midst of ending her day shift when the call came in that there was an active shooting on the Strip. UMC was told to prepare for 50 – 100 victims. Immediately, she and Dr. Syed Saquib, who had just coming on duty, were reacting to the situation. She remained in the trauma center while the UMC emergency physician set up an area for triage outside.

Dr. Kuhls describes the sequence of events within the hospital, assessing the injuries, and working with the medical personnel, including Dr. John Fildes, the director of UMC trauma. She lists the variety of people who joined the effort, including, among others: military surgeons, nurses, respiratory therapists, administrators, ICU staff, and those who transported the injured to the hospital. She details steps taken, from identifying patients to participating with the media.

She is a professional and justifiably proud of the UMC team she belongs to. She is also a human being, who reveals a tender side when talking about her drive home later in the afternoon of October 2 as she passes the blood donor center on Charleston.

ORAL HISTORY RESEARCH CENTER AT UNLV

Remembering 1 October

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Barbara Tabach 12-29-17

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Today is December 29th. This is Barbara Tabach and I am sitting with Dr. Kuhls.

I'm going to ask you say your full name and spell it for us.

My name is Deborah Kuhls. That's D-E-B-O-R-A-H. Last name is Kuhls, K-U-H-L-S.

Explain to us just in general what your position in the community is.

Within the UNLV community I'm part of the School of Medicine, a tenured professor of surgery. I'm chief of the section of critical care; I work as a trauma surgeon and I also manage the Trauma Intensive Care Unit at University Medical Center. I'm also trained as a general surgeon, so I do take emergency general surgery calls. I am UNLV School of Medicine's representative to the group on Women in Medicine at the AAMC [Association of American Medical Colleges]. I'm just starting in that role, so I haven't had a lot of activity, but I have been doing a lot of thinking and researching on that.

It's fascinating what your career is and to be dealing with trauma and critical care and all of that. We talked that maybe we'll get together and do a subsequent interview. For today's purposes we'll start talking about Remembering One October. Tell me how you learned about what was going on, the shooting across from Mandalay Bay.

As I mentioned, I am a trauma surgeon, and when we take call at UMC, which, by the way, is Nevada's only Level One trauma center and Nevada's only pediatric trauma center, we take in-house call. We take in-house call with a team of residents, particularly general surgery residents and emergency medicine residents, and we have what we call acute care surgery fellows who we also work with who may or may not be on call that specific day. We have actually the U.S.'s first acute care surgery fellowship and we have three fellows per year.

On One October I was on trauma call during the day, and that's a shift that is normally from seven a.m. to seven p.m. What those times demarcate is the times when we are responsible

to accept new patients. Even though my shift was to end at seven p.m.-- that just means that I would not be receiving new patients. But it had been a very busy day and especially towards the end of the shift. I was still in house actually when we first heard about the active shooter on the Strip. It was a little after ten. We were still taking care of patients that we had seen during the day, getting them admitted. I think there was one or two that were being discharged. Sometimes we need to wait for official radiology reports and so forth and then observe the patient clinically to see if they need to be admitted or not and, if so, to what level of care. So we're doing all of those things all day and then through about ten. We were almost finished with the disposition of our daytime patients. I was on call with residents and we were as a team still there. There was also a team that started at seven p.m. that also had a trauma surgeon and a team of residents, as well. There were actually two trauma surgery teams on call.

We work in an area that's a little different than most hospitals. UMC has a hospital within a hospital concept, so we have an emergency room, operating rooms, CAT scan, angio suite where we can sometimes stop bleeding without an operation, and a fourteen-bed trauma intensive care unit that are in kind of a separate but connected building. In addition to that we have a main emergency department that is located several hundred yards away that is for adults. We have a pediatric emergency room, as well, that's in the same building as the trauma center but on the third floor. That's kind of important as we talk about One October because within the trauma center we really focus on trauma and gunshot wounds would be some of the high acute traumas that we would see. So we're staffed by the team that I described, plus there's a full-time emergency medicine attending and that person may or may not have a resident working with them. That's kind of the staff that was there.

Physically how many people does that include on a team?

Physically I would have a team, including myself, of three to four. The 19 had about the same. There was an emergency physician and I do not believe that she had a resident with her. In addition, we always have a resident in the Trauma Intensive Care Unit, which is in very close proximity to what I'll call trauma resuscitation. Trauma resuscitation is like a trauma emergency room, so I may use those two terms synonymously throughout our talk.

I was still taking care of patients from the daytime when I heard that there was an active shooter on the Strip. Basically, a nurse came in from trauma resus to say, "We've just been notified that there's an active shooter on the Strip." We were not quite ready to go home, anyway, from taking our daytime. When that nurse—and I believe it was a female—said there was an active shooter and she said, we're going to get at least five to ten patients, we immediately knew that we weren't going home. I would say one or two minutes later she came back with, "We're getting fifty to a hundred."

So after the first notification, I was there. The night trauma doctor was there; his name is Dr. Saquib. We were both there, so we started to plan a strategy for how we would manage even five to ten very seriously injured patients. It requires a lot of care. After the first notification, we were there and we let our Trauma ICU resident know that we had possible multiple injured people or casualties coming to us. Then we have another team of surgery residents in house; they're called emergency general surgery. So we notified them after, again, the five-to-ten notification, and we notified anesthesia—we have in-house anesthesia for trauma—that we were getting potential multiple seriously injured patients and for him to notify his backup anesthesiologist. When we got notified that there was maybe fifty to a hundred—that was literally, it just seems like, two or three minutes later—we have a unit secretary in the trauma resus area and I asked her to call an internal disaster. That fifty to a hundred patients, not

knowing how injured they were, could really overwhelm our normal resources. So that was done. As part of that our trauma director was notified.

I would say Dr. Saquib and I were working together, so we would notify different people, so I'm talking about he and I working together, what we did. We also notified our fellows. I think we notified one fellow and that fellow notified some of the other fellows, so they came in. Our fellows are fully trained and board-certified general surgeons, so they already have training in trauma, but they're at UNLV School of Medicine and UMC to get two additional years of training; one is a one-year fellowship in surgical critical care for which they take boards and pass, and then the second year is more operative for very complex trauma and emergency general surgery. So we called them in. One was out of town and I think we were initially unable to reach one, but we had at least four fellows in. We actually have a graph for when people came in.

Some of our trauma surgeons are active duty military. UMC has a joint training program called SMART [Sustained Medical and Readiness Trained] with Nellis Air Force Base.

What does SMART stand for?

It's sustained military...training...I forget what the A stands for. I always have to look that up. It's basically sustainment of training for war, and the closest thing we have to war in the United States is a trauma center.

So we notified them. Once we notified them, they have a separate system that they activate, and so they called all of their staff who were related to UMC and, number one, asked them if they were okay, and I believe it activated them to come to UMC.

I am visualizing that you're talking internally and that the staff just is increasing each moment as you get more information.

Exactly. As we called the internal disaster—again, this is just a few minutes into the process—I

called the anesthesiologist to call all of his anesthesiologists in from his group. That's just what I recall of the planning. That went on really early and really quickly. Literally within, it seems like, a couple of minutes of that...I remember starting to text a fellow to come in; midway, in comes several patients. We didn't have much time between notification and when the patients started to come in.

Because I was technically off duty, I hadn't really noticed which emergency medicine physician was there, but I don't recall—and I didn't talk to her until a couple of days later—I didn't recall even seeing a nighttime emergency physician, and the reason I don't recall that is that as soon as we were notified, she actually, outside of UMC, right outside of our trauma center, set up the triage area. She took nurses with her, set up IVs already attached to IV fluids, stretchers, wheelchairs, security. We also have an emergency medicine residency program, so I believe she activated some of those to set up a triage area outside of UMC Trauma Center.

Like in the hallway or where is it?

No, outside, literally outside. I have some photos I can share with you. So there's an area, it's not the main entrance of UMC, but a side entrance off of what used to be called Goldring and I think it's been renamed recently. I don't know, Street of Hope or something like that.

But like on the sidewalk?

There's a street and then there's an area where ambulances would pull in. So the ambulances pulled in. So right there they set up a triage area right outside of the sliding glass doors that go to the trauma center, so she set that up.

Patients, though, simultaneously arrived at both our trauma center and, again, several hundred yards away, our emergency department, so they came to both places at one time. Now, there's separate staff in both areas. I didn't go to the main emergency department. I stayed in the

trauma center. So I don't have great information on that but can give you some resources if you want to follow up there.

That would be great, yes.

Our emergency physician set up this triage area outside. I later talked to her about my perception, because in the middle of all of this, you sort of lose track of time. I remember asking an internal disaster be called and was starting to text a fellow when literally there was a barrage of patients that came in. The initial group arrived in the back of a pickup truck. The triage team outside triaged, of course, the most serious into our resuscitation area.

I should say even before they arrived, once we got notification, we moved all of the patients who were in our trauma resus area. We have kind of a back area that's like an overflow ICU and a recovery room. So we moved all of them back and I want to say there were a half dozen people that we moved back there. So we had twelve beds available and we can double book and use hallways and stuff like that.

I want to say the first group of patients...We went from, it seemed like, zero to ten patients in five minutes. By then Dr. Saquib and I were there with our residents and the other residents who came to help us. The first ones in unfortunately included some that were not alive, and so we had to quickly assess them. By that time we had, I think, at least ten patients who were triaged to be seriously injured; meaning that they had gunshot wounds to the head, neck, chest, abdomen or back. But when somebody is lying supine, you can't really assess the back. And extremities, only if they appear to be profusely bleeding or had a tourniquet on or something like that; above the knee, above the elbow typically are where you have your serious bleeding.

Her name was Dr. Hughes, she triaged the most injured to come to CS. What I didn't realize until later is that she was actually using—there's a fairly long hallway between the trauma

center and the main hospital; that was her area where she kept the less injured for assessment a little bit later, and she had a team of emergency physicians that were doing that plus taking care of the people who arrived in the emergency department.

Again, I was back in that area working with Dr. Saquib on what we felt were the most seriously injured people. I'm not sure why, but I assessed the two people who arrived dead. I think because I was the senior surgeon—I've been there for about seventeen and a half years now—that I think the nurses just called me to the areas where they felt they needed the most senior person. I remember one young lady who was dead. She was intubated by our anesthesiologist who is just one of our—they're all really good, but he's super experienced. He works trauma a lot. He likes to take care of injured patients. He intubated her and she had been down in the back of the pickup truck for an unknown period of time. We do some initial maneuvers that could really allow someone to be quickly revived. In the case of mass casualty, our thinking has to be different than it is in a regular trauma situation where we might only get one or two patients in. We have to do the greatest good for the greatest number of people. She did not appear to be survivable, so we did initial maneuvers in case there was something that was easily reversible and then we pronounced her dead. We didn't learn until later that she was actually shot in the back. When people come in and they're in extremis, we don't actually flip them around. The main thing is to get an airway, see if we can get a pulse back, give them fluids, sometimes blood. We'll decompress their chest with needles and so forth. There are some initial maneuvers that we're all trained to do. Unfortunately, she was not deemed to be survivable.

Very quickly thereafter, there were multiple other people who were shot. Dr. Saquib was assessing them along with residents. Then I remember I was called to another bed that was—none of this is super far away, but it's around the corner and not one of our main usual

resuscitation rooms—another patient who was dead. He was shot in the neck and the torso. Again, he was intubated. We had done several procedures on him to try to bring life back to him and we were unsuccessful, so we pronounced him dead.

Meanwhile, I'm assessing other patients who are alive and talking, and Dr. Saquib was helping to assess them, too. But the next patient I was called to was a patient that our anesthesiologist was unable to intubate. She was shot in the head. So I performed an emergency airway procedure on her neck to get an airway on her and was successful doing that. I worked with one of our senior residents and we secured that and then we moved on with her assessment. We had assumed that the bullet had gone into her brain, which is the usual course, but since the shooting occurred—I think it was on the thirty-second floor, if I remember correctly—it actually had a downward trajectory and had gone through her face and her mouth and that's why anesthesia was unable to intubate her. So we moved on to her and then she got admitted to the ICU.

Then we basically evaluated everyone else. We decided who then—I think I forgot to say that initially when we were notified, we asked our OR techs to open up all the Trauma ORs and we notified the main operating room that is, again, several hundred yards away and they have—I don't remember how many operating rooms, at least eighteen main and then they have some other operating rooms—to open up rooms. I don't believe there were any cases that were going on at that time. So they called in OR nurses and OR techs and they opened up rooms. At one time we had eight operating rooms working at one time.

I as a senior surgeon actually sent Dr. Saquib to the OR. He and I had never had a previous discussion on his disaster training and I just felt I was the senior surgeon so I should oversee who needed to go to the OR first, who needed blood or whatever, and so I sent him to

the operating room first. Then as other surgeons came in, I sent them to the operating room with patients that appeared to be in most need of an operation.

When Dr. Fildes, who is our trauma director, came in, he opened up the main operating rooms pre-op and post-op areas, as well as we have a same-day surgery area; he opened up all of those beds, as well. I didn't think to bring the total number, but we had an additional emergency room that would handle about fifty patients plus the emergency room that has, I think, fifty-nine beds in it. We actually probably close to doubled our ER beds. Then I triaged other surgeons. Those areas that are not normally emergency rooms, we staffed them; an emergency physician was there, an anesthesiologist was there, and one or more surgeons or surgical residents were there assessing them because they were deemed to be less injured, and, also, we had expected patients who were not yet dead but not expected to survive, so we needed an area to give them comfort; it's usually pain medicine and so forth. Those patients were intubated; they were on a ventilator to keep them as comfortable as we could. Then the people who were less injured, they were assessed and then reassessed just to be sure that we knew what their injuries were. Then they would get X-ray studies and so forth. If they decompensated, they would be upgraded.

That's where I can remember at least one of our military surgeons. I actually put her in charge of one of those areas. She did a phenomenal job. She worked with one of our regular trauma surgeons and with residents, as well, to be sure that none of those patients needed an operation or if they did, if it was urgent or whatever. But I think the initial triage that was done by our emergency physician was outstanding because we didn't really have many patients who changed in terms of their status.

That's one of the observations is that the mortality afterwards...

Basically the people who didn't have survivable injuries were either essentially dead on arrival or

soon thereafter.

All this you're describing happened in what period of time would you say?

I don't have a definite time frame yet. The time that people arrive, there's a manual logbook that's kept and then our admissions people then register them. I don't have an exact time frame, but we got a hundred and four patients within probably two hours. There were probably a few that came later. Patients ended up going to trauma centers and non-trauma centers. Remember, the roads were closed. The freeway was closed, which is the main access actually to UMC. We ended up with a hundred and four patients, but we felt we had the capacity for at least double that number of patients.

I had a number of military surgeons who came in. Our medical intensive care unit that doesn't normally care for acute trauma patients, their trauma director notified me towards the morning that they would be happy to take and transfer patients who didn't have immediate operative needs and so forth. Nurses came from UMC who are employed. Everybody. This happened at a time where a lot of people were awake and they heard about it. I don't know if it was on the news. I'm not sure how quickly it made it on the news.

There was, yes. There was like a crawl going across.

Yes. So people just came in. Nurses came in. Respiratory therapists came in. Administrators came in. Surgeons came in. Surgeons were called in all over the city to care for patients who required surgical intervention to save their lives and some of them were very seriously injured that went to other hospitals, especially those that were self-transported. They will always go to the nearest hospital and overwhelm that hospital. That's just part of disaster mentality, if you will. They all did the best that they could. They got into taxis and Ubers. And then the ambulances, from what I understand, there were more ambulances in operation that night than

maybe ever in Las Vegas. But, again, they had people that weren't even assigned to duty that came in, EMTs and so forth, and then they took patients to where they felt was the best place to take them to.

Those who were qualified or trained, self-volunteered and checked in because they knew the need was increasing.

Right. I think they help at the scene, too.

Yes. It's just amazing to try to visualize what sounds chaotic—or in my mind sounds chaotic—but, at the same time, when you describe it, the organization that takes place. I know this is your training, but have you ever experienced anything that was remotely like this?

It's not unusual that we'll get five to ten patients in a half an hour, forty-five minutes that are seriously injured. We've had bus crashes that have brought in at least dozens of patients at one time. I would say for me this was the largest scale casualty that I've had to help and actually direct, if you will.

Dr. Fildes came in and then he was obviously in charge. He opened up the other area that I described. We worked together on who needed to go to the OR, who needed to go to the CAT scan the worst and stuff like that. Then he left and left me in charge again. It was kind of an interesting situation because people just naturally looked to me. So the residents would come up to say, "Oh, Dr. Kuhls, this is going on. What do we need to do here? We need to get this patient blood." I'd quickly go over and take a look. The nice thing about our trauma center is that it's compact so we can keep an eye on things pretty easily.

Through the night various dignitaries started to come. Our chief of staff, Dr. Carrison, was there. Dr. Fildes, our trauma director, was there. I distinctly recall going to the ICU when it

looked like the other patients were relatively stable, going to the ICU to check on a couple of patients and I ran into the mayor coming into the hospital. I didn't realize she had her security guard with her. But overhead, literally at the same time, is that there is an active shooter at UMC. I forgot to mention this earlier, but we were told about the active shooter, five to ten, and then fifty to a hundred or more, and then we heard that there may be a second shooter at the MGM. We were thinking that this was maybe an orchestrated kind of multi-location and a real terrorist attack. That just kind of upped our ante for we definitely needed to be on internal disaster and activate our disaster plan.

Going back again to encountering the mayor, she was coming in the entrance where patients usually come in. I heard, "Active shooter in the hospital." The one nice thing about our trauma area, it is pretty secure. I said, "Okay, I've just been told there's an active shooter. I'm taking you to the Trauma ICU and you need to stay there until somebody comes to get you." I didn't realize she had her bodyguard with her, which I didn't realize. But I said, "You both need to just stay here." I said, "I have to take care of patients and you need to stay here because there may be an active shooter and we don't want you to be harmed." I think I said to a nurse say, "This is the mayor, just find a place for her to sit down and so forth, and I'll have someone come in and talk with her." My first priority always has to be patients and she understands that very, very well.

So I went from the Trauma ICU where the patients actually appeared to be doing okay and I went back to our trauma resus area. Our chief of staff was there and I said, "The mayor is here." And he goes, "Oh, wow." I said, "I'm putting you in charge of the mayor because I'm in charge of the patients." So he brought her over to resus. I can't remember, I think maybe Dr. Fildes had left at that point. But I said, "I need to go look at all the other patients in these other

areas." I said, "Okay, if you guys want to come with me, come with me." So we went down and we went around and then I checked in with the doctors and nurses and so forth in those other areas and talked with a few patients and they all appeared to be generally okay. Then I returned.

All through the night, we got a few transfer patients from non-trauma centers and not all of them were super seriously injured, but you don't know that until you study them for sure. But we got one very, very, very seriously injured patient in the wee hours of the morning—I want to say three, four or five in the morning; something like that—that clearly would have died had they not taken very quick surgical intervention.

I should mention that most people, unless they die of a brain injury, die of hemorrhage; they're bleeding, so some major blood vessel in their body or organ was bleeding. In trauma surgery we can take care of both organs and blood vessels that are bleeding, but the real specialists at what we call vascular surgery are vascular surgeons. In Las Vegas that is usually provided by a specialty called cardiothoracic surgery. Our cardiothoracic surgeon was in all night and well into the next day operating and saved multiple lives, along with our trauma surgeons. She is the only female cardiothoracic surgeon in Southern Nevada and maybe in all of Nevada. I'm not sure. That one transfer patient we got, we just look at as very, very lucky to be alive and amazing that that person survived to get re-triaged to our hospital.

Throughout the night—I don't know how the dignitaries heard; I guess they get phone calls or whatever—the governor came, the attorney general came, several of the county commissioners came, other people from the board at UMC came and the chairman of the board came. As they came, luckily Dr. Carrison was there, but he wasn't always there. Actually, I think I took the governor around without him, or maybe he joined us then; I don't really remember.

I almost made rounds with the people who are really serious to say, is somebody

decompensated? They got enough blood? Who's next in line for the operating room? And so forth. A lot of patients, unless they were really unstable, meaning that their blood pressure was really low, we would have time to do CAT scans and so forth, although we did far fewer CAT scans than we normally do that night just because if there was an initial question that they need to be in the OR, we just took them to the operating room. But I was always circulating.

Literally, I just walked in there and the governor was there. I mean, the governor and the attorney general was there. I had met the governor before, so I said, "Hi, Governor Sandoval. I'm Dr. Kuhls." Basically I knew who's there. I said, "We're doing okay. We've got more than enough resources." Then I kind of did a similar thing with him. I said, "I've got to go check on patients, so why don't you just walk with me." So I took him around. I took three or four groups of people around.

You stayed in constant motion, it sounds like.

Constant, constant motion. I had been in constant motion since seven a.m. the prior day.

When did your day end?

At seven what we did—this is another benefit of having this joint military-civilian partnership. I've worked with Thailand's military. I've done a lot of trauma training and a lot of disaster training and have trained others. This will be a little bit of a digression.

No, that's good.

Early on, when I moved to Las Vegas, we had a Thai pediatrician, a pediatrician who was originally from Thailand. He stayed in close touch with people in universities back there. He asked me one day, "How would you like to go to Thailand?" I said, "I'd love to go to Thailand." I had been there once previously when I was young and just traveling as a tourist and it was one of my favorite countries. I said, "Sure, I'd love to go." He said, "They want to learn about trauma

and so forth." That's typical. In a lot of the temperate areas infection is the original threat to life, parasites and so forth, and they can actually kill people in huge numbers. But once a country gets that under control, what ends up popping up as the greatest threat to life is traumatic injury. It's in our country, as well. Up until age forty-three, the single largest cause of death in our country is trauma. Most people don't know that and we need to do a better PR job about that.

I went to Thailand and after my first trip that great tsunami, if you remember, that hit me maybe two weeks after I returned from my first trip to Thailand, and so we offered to do disaster training over there. We trained actually their military in disaster training. It's mostly through simulation and actors, people playing injured people, and that's how we train until you get a real disaster. I did disaster training over here, too. So I'm well trained in it, but I had actually never been in something that you would say was a disaster because the definition of disaster is when the needs of the patients exceed the normal capacity of caring for them. I would say even though UMC is a very busy place that has huge capacity, unless we had called in all these additional resources, which we did, the initial numbers, a hundred people coming at once would exceed our normal capacity, so that's why we called internal disaster and had other people come in and open up other areas of the hospital for the less injured and so forth.

It sounds like all that training really came into play.

Totally.

It's fascinating how prepared. It's sad, but I'm grateful to hear that.

It's very sad, but I was very grateful that I had all of that training. While it takes a long time to totally analyze results, it looks like we did as good of a job as we could have. I'm sure there were really good reasons that the freeway was closed, but that impeded the transfer of patients to us, I think, because we felt literally we had double the capacity.

I had digressed and you had asked me a question about when did I get off. What happened is we had a fresh team coming in, in the morning. I should say among our residents, some of them were working several days in a row. I was actually at the end of a series of days. This was on a Sunday. Sunday was my last day of three or four days on call. But some of our residents were going to have to come in the next day and I had kept them there. Remember, we had two teams that night. So at some time we released them and I don't remember exactly what time. They came back and then we had some fresh residents who hadn't been on the next day and a trauma surgeon who had not been on the night before and an ICU doctor who I think actually we did call in, but he stayed for ICU rounds and so forth and took back several patients for operations the next day.

I guess the reason I digressed from that is that by then we had several military surgeons in. We didn't use all of them, actually. I was feeling kind of bad; they got up during the night and we had more people than we needed. I released anesthesiologists at two or three in the morning because several of them we would need the next day for takebacks. UMC canceled elective surgeries and I guess notified the surgeons of that. But still we had a number of takebacks and we were still operating through the next day even on primary things that didn't require an operation right then and there but the next day. So we had what the military told me was a military style sign out, and I took that as a great compliment.

I mentioned that I think our medical ICU people had agreed to take people, so I had gotten a text message, I don't know, six or something, from one of our MICU attendings saying, "We can take some of your patients." And hospitalists who would take the non-ICU patients if they didn't require surgery and blood and all of that. Then one of our military colleagues who is in charge of the Pulmonary Critical Care Fellowship program, he actually came in and he said,

"Would you mind if I'm part of your sign out and we can take"—I forgot what he said—"We can take a dozen or somewhere patients if you need us to." So on our service already in the ICU, we had had many patients who were already there before One October. Some of them were just getting off the ventilator and other things. They literally took a dozen patients from us.

We did a sign out on all of the people who came in overnight first. As I was rounding in these different areas of the hospital, I was getting stickers or their fake name or their real name—If they can't talk to us, we give them a fake name—to be sure I didn't forget anyone. *This is the patient; this is where they went to the operating room, not; they went to the ICU; they went to the floor*. We went through every single patient. All the residents were there who had been on all night with me and then the day team was there. We went through every single one of them and that took us well over a hour to do that and to the best of our ability what needed to be done.

When you get that many patients in, your ability to document what was going on with them was very minimal, and so a lot of the dictations and so forth needed to be done during the day. I took care of dictating the two initial people who died. After a while, when you would take care of so many patients, you're always concerned about maybe forgetting something. So we did that.

Then I was relieved then of clinical responsibilities and then Dr. Fildes came in. He was already requested to give press interviews, so we all walked as a group over towards the Shadow Lane campus. There was one news, and I don't even remember who it was, that was interviewing over there. They had gotten permission from the gas station to set up in the gas station parking lot and that's where we were interviewed. Then we were asked to walk over towards Delta Point on Tonopah, and I want to say there were twenty radio and TV. Usually the PR people at UMC will be there and they'll tell us who to talk to and stuff, but it was overwhelming for them, too, so

they just said, "Talk to anybody you want." So we were all interviewed. We weren't quite sure who should talk and so forth. After a while it became apparent, if we felt like giving our story, we gave our story and that's kind of how it worked out.

Then we saw at Delta Point where—I don't know if you drove over that way at all—it was set up. I have some photos that I can share with you; they set up a temporary blood bank there. That's where I thought we were actually going to meet. I was thinking there would be a little bit of media in the building. They were all over the street. But anyhow, I walked in the building expecting to see media, but there were literally five hundred people waiting in line inside and out. They had set up food for them because sometimes after you give blood you feel dehydrated and not so good and everything. They had all that set up in Delta Point for people giving blood. It was almost overwhelming how quickly it had gotten set up because this is like—we did our first interviews at around eight-thirty. It must have been nine or nine-thirty that we were doing the other interviews I remember water bottles all over. I thought that was mostly Delta Point, though, the blood bank people.

Then I started to get calls and texts from the American College of Surgeons saying that the Wall Street Journal, New York Times, NPR, everybody wanted to talk to somebody at UMC. I was texting John Fildes to see—he's the trauma director. I'm not the trauma director—to see if he wanted...He wasn't even answering me. So I just went ahead and I did phone interviews, I want to say, for about the next four hours on behalf of the American College of Surgeons and UMC and the UNLV School of Medicine, sort of all kind of lumped together.

Then I drove home around three in the afternoon. I drove home on Charleston and as I approached the main blood bank donation center, which I hadn't even really put this together, there were all kinds of police and everything there sort of redirecting traffic and then we have

those signs that lanes were closing. I thought I was coming up onto a motor vehicle crash. There were literally thousands of people at the main blood donation, so much so that they were actually stepping out into the street and we didn't want to hit them. Cars, right? We were down to one lane in that area and we were being asked to move right along and not slow down the traffic. I wish I had had a camera because I'm just like, *wow, this is just overwhelming, the number of people*.

You had just come from what they were giving blood for.

Yes, yes. It was bizarre. I really thought it was a motor vehicle crash. When I saw the blood donation at Delta Point, I really knew that the community was activated, but it almost seemed like ten times the effect at the main blood donation center. I'm like, *this is really impressive for our city or any city.*

Then I went home. I had had, I want to say, about a hundred text messages and E-mails. I went to sleep mid-responding to an E-mail and then I slept until sometime the next day.

What were your messages? Were they people checking on your well-being?

Yes, a combination, but there were also a few—I'm trying to think how I knew about this one person. He may have e-mailed me early or texted me. He was a physician from Colorado asking if he needed help; that they would come down and help us. Somehow I got his message even before I was at home, so that must have come along with a request from the American College of Surgeons. Our chair of the Committee on Trauma called me—I'm sure he had probably called Dr. Fildes, too—to see if there was anything that the American College of Surgeons could do for us. There was a lot of outreach. In the trauma surgery circles, we're all very much in touch with those who have served in other mass casualty events. It's almost like a community within a community. Most people were reaching out just to make sure we were okay, just offering their

support that they knew it was a really difficult time for us, all positive. They would say, "Oh, sorry to bother you, but..." It ended up being really comforting. It was very cool.

You're a human being and you're dealing with this on a regular basis. It's your training, but the density of the tragedy is in your hometown.

Yes. It's kind of funny because I really think we as healthcare providers...There's not really a good term for it, but we need to limit our emotional involvement at the time, so kind of the emotional consequences happen much later. But in that regard, I would say that the emotional support is just phenomenal. Dr. Netski, who is our chairwoman of psychiatry, she and others around the city offered support for everyone—victims, including emotional victims, healthcare workers and so forth, UMC. Every employer has to offer employee assistance, but I know that they flew someone in specifically to be at UMC a couple of weeks or something like that. They have people around the clock. So there was a lot of good support for us. What ends up happening to healthcare workers is it really doesn't start to surface until later.

So the next day I came in. I went home on Monday. It would have been Tuesday. We had a session with our residents. I think we canceled our normal teaching, but we had someone there, I think it was Dr. Netski, from psychiatry just starting to talk through what happened. Residents, fellows and attendings were all there. It was very helpful and people shared some things. But I think for trainings, I think they're always concerned about appearing to be too emotional or week or something like that. So they requested a second session without the attendings present the following week, which was absolutely fine, whatever they needed.

Then that Tuesday after that session, I'm trying to think what I did, but I know I went to the hospital. What had happened from the time I left on Monday, into Monday night and so forth, I think individuals, as well as companies and casinos, they brought all kinds of food and other

support items. As I am told, actually the whole block around UMC just had water bottles. I think there was something like twenty thousand cases of water bottles, so that was there. Food, I mean, thousands of pizzas. A casino donated blankets, largely for families. Most of these people, most of the victims didn't have ID on them and they dropped their cell phones, so we had no idea who they were. The families actually had to go from hospital to hospital looking for loved ones.

I would say one of my early most difficult situations was on Monday morning. After we did our sign out and then we did the press thing, then there was actually a meeting with the disaster team and the incident command saying if there were any things that we needed to do or supplies we needed or whatever. In that interim time, the chief of social work asked me to speak to a family of a member who had died and that the patient had been identified by the coroner. So I met with the family and with the fiancé. They were saying that they were sure this was the person, but I treated the patient, I don't know, almost twelve hours earlier, meeting his family who came in from another state and the fiancé who had been with the patient. I explained that I was given information that the coroner had identified this is their loved one. I was describing to the best of my ability the wounds and so forth; that this patient essentially came in without vital signs, had been intubated, put on a ventilator, and that I had never talked to this person because they weren't awake. Well, the last time the fiancé saw the patient, he was talking and everything. So she said, "This isn't the right person. No, this is somebody else." And started to get argumentative with me. The social worker was with me, luckily. I said, "We've just been given that information and I need to share it with you. I saw him when he arrived and we did a lot of procedures on him to try to save his life." Unlike the first person I talked with, the second person we had done a lot of procedures on. It was really unsettling for me because people were just connecting facts that this was the patient and the patient's family and I was the doctor. I'm talking

to them and I was seriously questioning myself for quite a long time whether I had really given information to the wrong people. That was one of the more difficult things early on. All of that was the first day.

Then the second day was really just kind of catching up on things. We were still getting all kinds of media. I would say every day for that first week I probably spent on the phone four, five or six hours being interviewed and sometimes in person.

I'm the president of the Nevada chapter of the American College of Surgeons. I'm coming towards the end of my term. One of the things I wanted to give to our state was a statewide all-day meeting where surgeons, all of our residents and fellows, get together and learn about relevant surgical topics. So I had been planning this for months. That happened on October seven, which was Saturday. Luckily, we had done a lot of preplanning, but there's still a lot to do the last week. I specifically arranged my schedule so Sunday would be my last clinical day and I would have the week to prepare for that and other things, and, of course, that just evaporated. But we went ahead. Somebody asked, "Do we want to cancel?" I said, "No, no. This is one of my things I want to leave as a legacy and I think it's really important to get people together."

There is a program called Stop the Bleed that American College of Surgeons, along with several other national organizations, has designed. That happened after Sandy Hook where all the children were killed in the elementary school, and so that's one of the outgrowths to mass shootings. We had already started to train in Nevada and as part of that day I had arranged for a Stop the Bleed course in the morning before the main program and at the end of the day after the main program. We had people RSVP. I had maybe ten people RSVP for the morning and ten for the afternoon; something like that. I don't know how many people were registered, over a hundred. We had over a hundred attend the main meeting. So as people were arriving at the main

meeting, they were just kind of sitting around and I said, "You know, there's a Stop the Bleed course going on right across the hall." We used the Sim Center. I said, "We just went through a mass shooting and we would like you all to be trained. We know you as surgeons know how to use tourniquets, but we want to train you as instructors." Literally that was standing room only both morning and afternoon.

On Thursday—I don't know if you know Paul Joncich. He used to be a Channel 8 TV anchor and he's been hired by the School of Medicine as director of media relations. I had just gotten to know him literally two or three weeks earlier. I called him because I figured this is such a main event. I spent most of my week being interviewed. I said, "I'm having a College of Surgeons meeting on Saturday and I am teaching Stop the Bleed and I'm getting as many surgeons from the state together as possible for this all-day meeting." I said, "What do you think about a press conference?" He goes, "Let me see. The vice president is going to be in town, but I'll put it out." So he kind of put something out. I approved it. He put it out on Friday morning. I forget; I have to refer to him. I want to say we had multiple TV stations there and we had multiple press, written press there. So I held a news conference during the lunch hour, which also there was a competition among the residents, like a Jeopardy competition for answering the right questions. We had a press conference for over an hour. We got TV and print, multiple, multiple prints as a result of that. That was one of the best decisions I made is to continue on with that and it verified that I had planned it well. I had no idea, of course, that we would need Stop the Bleed training and that would be so relevant to our own community, but it was hugely successful. The surgeons who came, they don't all work at UMC; they work all over the city. Most of them were called in at one hospital or another. Surgeons, we're pretty concrete; we're pretty direct; our emotions don't usually show on our shirt sleeve. But it was really a great time for surgeons to

come together, and so it was hugely successful.

Of course, not having any idea what my prior week would be like, I was also having—I forgot what we call it—it was like a governing board meeting that night at Oscar's where we're exchanging dialogues and all that.

Oscar's Restaurant?

Yes, Oscar's Restaurant. Isn't that so weird? So I decided I was going through with all of those plans because we just had so much to get done.

That probably was healthy, though.

It was healthy, yes. Very, very, very good for surgeons and the residents and everything to get together. We had a good program. Also, it was not about trauma. It was about other surgery topics. But I had a time when I gave my own talk, so I gave some comments about October One and my work with the American College of Surgeons and firearm injury prevention for a number of years and then how important it was to support the College of Surgeons in our political action fund, as well. It was as good as it could be in a sea of tragedy, is what I would say.

Of course, Wednesday morning President Trump comes. Everything was so secure there. There were two floors that he visited, one where doctor—

Two floors at UMC?

At UMC. He and every other elected official was there and then many people from the board, from UMC and the C suite at UMC. On one floor Dr. Fildes was in charge and the other floor I was in charge along with one of our other trauma surgeons. We got to meet President Trump and we got to meet all the other elected officials. They all initially went to one floor where President Trump was starting his time. President Trump and Melania and some of the physicians and staff from up there, they stayed there. The rest of the elected officials and some of the other people

came down to our floor. We had them there for about a half an hour, including the mayor and the governor and attorney general and everything. I had them as a captive audience, and so I talked with them about how I felt that UMC did, which I felt we did a really good job, and that our military-civilian partnership was very helpful. There is legislation that's actually still pending in the House and the Senate. In my office I had the bill numbers and everything. I'm also on the Advocacy Committee for the American College of Surgeons, so I'm texting my advocacy, "I need the numbers of the bills, their exact names and how much money is." Because it's to appropriate funds to encourage military and civilian partnerships. I had all of that there when they got there. So I said, "And I need your support on legislation that will encourage military bases to collaborate with civilian trauma centers." And I said, "This made a huge difference for us at UMC and I need you to support these bills." So they're all reading the bills. This afternoon I'll need to write—actually, my guy is on vacation until next year—but I am going to do a letter writing campaign for them to vote for these bills because they're going to come up for a vote after Congress returns, so I told them about that.

I had several other things that I told them about that related to disaster training. We really need to continue disaster training. We need to actually research how we did with objective measures so that we know areas for improvement, areas that we did especially well, things that can be improved in case this happens again. Las Vegas, not only is it a tourist center, but it's kind of an international destination that we have always been on the top ten list for mass casualties.

Is that in place to collect this information, this report of...?

We are very, very hopeful. Actually, the Department of Defense has a main research center in San Antonio, Texas, ISR, Institute for Scientific Research. They are the main office for much DOD funds for all branches. It's an Army Research Center, but they collect and do research for

all branches in the military. Actually, the head of that unit is a graduate of our Acute Care Surgery Fellowship several years ago. He called me two days after the disaster while I was going into UMC to prepare to meet President Trump. He called me on the telephone and said, "We would really like to research this trauma system-wide." I said, "I think that sounds like a phenomenal idea."

Again, this whole military-civilian partnership has been talked about with granularity of legislation and so forth for over a year. There was a National Academy of Science report in 2016 on how this would really help both the military and the civilians, trauma surgeons and the emergency medicine folks take care of injured patients both at home and in combat. This is a huge report I'm happy to send you. I'll inundate you with reading, how's that?

That would be phenomenal.

I spoke at a conference in April on this and took our commander of our SMART program with me; we were both there. I met...I think he's a colonel. I always forget their ranks. But I met Dr. Nesson, who is our former fellow, at that meeting again. I hadn't seen him for a long time. He was saying, "I really need to find ways that we can work together. DOD has a reasonable amount of research money." Then October One happens. He contacted me by phone, e-mailed Dr. Fildes, who was overwhelmed I think at that time. They are putting forth a grant to the DOD to research the entire One October event from pre-hospital, in-hospital and post-hospital.

Now, will that involve the other hospitals?

Yes, and they've all been cooperative.

The whole medical community can come together—

The whole medical community and the coroner's office.

—and report on this. That would be wonderful.

So UNLV...I've been working with the Office of Sponsored Projects and we have issued a letter of intent on this. I think it's highly likely that it will happen. Then each hospital, we're going to do our own research on how we think we did. But really it's taking a look—trauma is a whole system within the healthcare system. It's like a subsystem almost. We have three trauma centers in Southern Nevada. UMC is a Level One, Sunrise is a Level Two and Saint Rose has a Level Three. Then all the other hospitals should be able to care for trauma patients that do not meet what we call trauma field triage criteria. The CDC issues data, given how EMS would evaluate a patient based upon external injuries and vital signs, who should go to a trauma center because going to a trauma center improves survivability significantly, so they're going to take a look at it from that perspective.

But there were so many casualties, many of them self-transported to the nearest hospital, trauma center or not. The impression I have is those hospitals really rose to the occasion.

It sounds like they did, the reports that filter through. I try not to read too much. I want to learn this, not over read and biased position. But we've even had occasion where—

It's nationally known that within our College of Surgeons—I mean, the month of October just completely evaporated. I want to say before a week was out, the chair of the COT was saying, "Would you guys make a presentation?" And our meeting was in October, too, our national meeting; it was like the third week in October. So I organized us from UMC, UNLV, someone from Sunrise and someone from Saint Rose and we all talked. I'm in the process of writing that up in an article that is due by the end of the year, so that means next Tuesday.

This has consumed your life.

It's consumed my life.

It just seems like we all can learn from it.

It has consumed my life, but you know what? This is my professional life and I think we all did the best we could. What's really helpful emotionally is that very early on national organizations were saying, "This was handled really well in Las Vegas and this is an example of a good trauma system."

Because you really didn't have to outsource it to others, like your friend who volunteered to help. You didn't need to do that.

We had many, many people. The hospital got notified from some trauma center in Arizona and I think I got contacted by the same ones, but I'm not sitting down answering my E-mails; I'm busy taking care of everything else. But we had multiple offerings. What's a little unique about Las Vegas compared to some of the more densely populated states is for anyone to get here to help us, unless they're going to fly in, they're hundreds of miles away. I'll just use Philadelphia as an example. New York is ninety miles away, Baltimore; all this kind of stuff. We're here by ourselves. So a mass casualty is local for at least twenty-four to forty-eight hours even if you need outside help to really mobilize that. There are emergency credentialing procedures in place, like at UMC, so people who aren't credentialed could come in, in cases like a disaster like this, but we didn't need to activate that. That's where again that military collaboration, those people are credentialed at our hospital.

I want to talk to somebody from that perspective, too.

Dr. Snook. I'll give you a number of people that I think would be interesting depending upon how deep you want to go into this. I think Dr. Snook would be good. He's head of our SMART program. He and I just went to Washington again two weeks ago on this military-civilian collaboration, which I think it's going to get passed, which will provide funding basically to set up the infrastructure for it to happen. So I think you should talk to him. I think it would be

interesting for you to talk to Dr. Saquib. He was actually on trauma call at that time. Dr. Hughes, who is the emergency physician, who was there outside triaging. I didn't even know it was her. I talked to her several days later. I thought, *I don't remember seeing anybody from emergency.* It's because she was outside doing good work. Then there was the emergency physician in charge in the main ED and they actually received one of the initial casualties. They received a lot of people. Then I think we would be remiss not to include Dr. Fildes. He's our trauma director.

Absolutely.

I don't know if you want to talk to anybody at the hospital.

Oh, I would love to.

Like Mason, the CEO. Essentially, the bucks stops with him.

I think all those folks would be important voices to be in this story to learn from. We never know what a researcher is going to want to look at in the future, so the more that we with oral history collect the stories and experiences, this is valuable information for understanding.

You mentioned Stop the Bleed. If I'm correct, there have been trainings in the community now? My husband went to one. I wasn't able to go to one. But he went to one, but he never would have done that before, I don't think.

Yes, yes. We were just ramping up on Stop the Bleed training. Actually not all of the establishments in Las Vegas really wanted to be trained in that because, *oh, what does that mean about security? We want all of our visitors to feel safe and so forth.* But there is a lot that we can do. I can put you in charge of the person who is the national head of Stop the Bleed.

That would be good, yes.

His name is Lenworth Jacobs. He was part of the group that treated the children at Sandy Hook

and he said, "I need to do something." It will prevent people who are already injured from potentially dying. It won't prevent injury.

I don't know if you can address this, but one of the suppositions or feelings that you get through these interviews is that the mortality rate might have been higher if there hadn't been the first responders who were off duty in the audience there at the festival.

I'm probably not going to be your best person to look at that although it sounds like there were some really valiant...

A lot of military were there or ex-military.

Yes. Police officers, EMS who were off duty, it sounded like they really helped a lot. I can remember one guy that I've spoken about in multiple interviews that came in with a bullet up here in his thigh. Actually he's one of the patients that President Trump talked to. He said, "I have to be thankful for two people, the person who thought to put his belt on my leg, but he put it in the wrong location, and then the second person who knew where to put it." That was very cute. But I remember him coming in and that thing was on there pretty tight. He was one of the early ORs. I think it's really, really important.

I would like to put you in touch with people and also the people at the other trauma centers. I don't know people at other hospitals who are not trauma centers, but from Sunrise—someone is trying to call me; I think this is another oral interview. [Pause]

We'll talk another time about my work in injury prevention and firearms injury prevention. We're really trying to move the dial with the public health approach through the American College of Surgeons and I think we'll make a difference, but I think that is going to be a huge part of my career for the next number of years and I think it's really worthwhile. I was already headed in that direction, but this has crystallized it for me.

One of the other really shocking things—so there are two people in the College of Surgeons—there are many people in the College of Surgeons who feel really passionate about this and who have done a lot of work in this area. Dr. Lenworth Jacobs, you'd have to interview him by phone, but he's the father of Stop the Bleed. I'm sure he would be happy to talk with you. I don't know if he's exactly retiring or what. Anyway, the Connecticut chapter of the College of Surgeons is naming a lecture in his honor, an annual lecture. I'm going to be the keynote speaker for the first one in April.

Oh, wonderful.

He's a real good guy. He's one I'll put you in touch with. The other person that I think you might be interested in talking with is our chair of the Committee on Trauma. He really helped to define a public health approach rather than a political approach. The political approach has been churning for the last fifty years and has done almost nothing because it's so divisive. Is it okay if I send you a lot of reading material?

Sure, yes.

I'll send you a ton of reading material on this. You might want to read through some of it especially before you talk to Dr. Ronnie Stewart. He's in San Antonio.

What was really creepy about this for me—Dr. Lenworth Jacobs, he got involved because of the mass shooting and he did Stop the Bleed and he's done it valiantly. It went through the White House. It got all kind of endorsements early on from high level people in the U.S. Then the next two people who have been involved the most, at least on the surgical side, have been Dr. Stewart and myself. So we were hit here and really October for me was...I don't know. I was probably still in emotional shock over it and I had so many activities to do. We had our statewide meeting. We had the National Clinical Congress for American College of Surgeons and every

day it was something new that we just needed to jump through hoops and get done or talk to someone and so forth. It really wasn't until I took a separate trip to Boston in the beginning of November to the AAMC meeting to learn on group and Women in Medicine that that was a time when I knew that I would start to reflect on the experience. I was in a meeting and I got a text message that there was a mass casualty event near San Antonio. Dr. Stewart was the main guy there. He and I are the two people most involved in this in the College of Surgeons and we're hit just like one-two.

That's ironic.

It's ironic, yes. I actually had more of an emotional reaction to his because mine I had to be together and handling everything—not everything, but handling a lot of things. Dr. Fildes handled everything as the trauma director.

But it was show time for you. You were on.

Yes, yes. It was on for both of us, I think. He was only there for very few hours. It was part of more than a twenty-four-hour experience for me. It was just a different experience. But it just seemed really, really weird. But you should talk with Dr. Stewart. There's been a lot of press with us in it. I'll send you what I can. I haven't logged it all that well. Then after San Antonio, Dr. Stewart also was in USA Today and several other pieces of the press.

Something that I want to talk with you about just a little bit is I feel a need to capture all the press on this event and photos and videos. I don't know if that's in your—

Yes, it is part of the project. We have a digital arm of Special Collections and we are collecting whatever digital imprint there is out there. We have a person who is in charge of that. So you sending me anything or make a note of it, I will direct that towards her to make sure we archive that as well.

School of Medicine IT has set up—and we haven't really done much work with it yet, but we really need to—a shared drive that will be also owned by IT so that if the people involved in it leave, we have access to it, of our presentations that we give, all photos. We're going to try to have as much press as possible. I don't want to be duplicative. We need to have access to all this stuff for our presentations. I would say I have at least a dozen speaking presentations this next year and so do other people. We're setting that up, but certainly we should share it with you.

Yes, we should figure that out. The right person to talk to is not in this week, would be the director of our Special Collections. I would like to talk to Michelle about that and set up a collection and figure out how we can do that for you so that that material is available to anyone and everyone. That's not an issue. It's just a matter of what (indiscernible).

Can it be shared fairly quickly and stuff like that?

Oh, yes.

Because we might need to make a presentation next week.

I was going to say it's easy for me to promise that, but this is obviously very important to all of us that we do this in as an efficient way as we possibly can. Let me send her an E-mail. Even though she's on leave right now, she's responding to things like that. We'll find out what we should do to make that happen.

Then I will connect you with the people that I talked about sort of one-on-one is what I will do.

That would be great.

I think starting with Dr. Saquib who is on. Dr. Netski, psychiatry, you should definitely talk with her. She's part of victims' fund board as well.

As you're outlining, there are just so many layers to this and this is just looking at it through that lens. This is amazing. We figure this project will go for at least a couple of

years. Then there are always the people who will want to come back after time. As you mentioned earlier when you were talking, time gives you perspective and wisdom and thoughts that you need to share.

Yes. May is Trauma Month, and so we always have a trauma survivors' luncheon. I don't know what our plans are going to be. We're going to have a strategic planning session; we have one early every January. I don't know if we want to do something separate for the victims or if we want to integrate them with our survivors' luncheon, but we have a survivors' luncheon every year that I presume Dr. Fildes started when he became the trauma director here sometime in the 1990s where people who are severely injured who might not make it make it and they come back, they and their families come back for a luncheon. There is a little program. They have a time to speak and all of that. Caesars Palace hosts that for us free of charge.

I think that's really important. Totally unrelated, but through the Jewish project, I deal with Holocaust survivors and that type of trauma and go to their gatherings. There is this group. They're dwindling, but we still have a sizable population of those.

Do we?

Yes, we do in Vegas.

Of survivors?

Of survivors.

Oh, wow.

I just went to their Hanukkah party and there were a couple hundred people there.

Interesting.

It is very interesting. There are other scars that we take with us for a long time.

We'll talk about that some other time.

It's wonderful to meet you.

Yes, likewise.

Thank you so much for your time today.

You're welcome.

[End of recorded interview]