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Lake County Orthopedic Surgeon Dr. John Cowin Rushed to Help Victims of Boston Marathon Bombs

The following article was written on April 17, 2013, just days after the Boston Marathon bombing.

By Eloísa Ruano González

Instincts took over for Dr. John Cowin, a prominent Lake County orthopedic surgeon, when he heard the bombs go off at the Boston Marathon — he immediately jumped over a barricade and rushed to help the wounded, including one of the three spectators who died.

"It looked like Iraq after an IED [improvised explosive device]," the 65-year-old Cowin recalled Wednesday. "There were people without limbs everywhere."

He and his wife, Anna Cowin, a former state senator and Lake schools superintendent, had been standing near the finish line waiting for their daughter, Lynda Nijensohn, to complete her third Boston Marathon when they heard the first blast down the street. John Cowin said terrified spectators bolted toward them, so he pushed his wife toward the barricade to prevent her from getting stampeded. That's when the second bomb went off across the two-lane street from where they were waiting. John Cowin hurried to help the wounded, his wife following closely behind.

"Immediately I chased after him," said Anna Cowin, 66. "I wasn't going to leave him alone — for one. And two, I knew some stuff [first aid] and thought I could help him."

She tended to people with minor injuries and helped load them onto ambulances, while her husband ran to help those with more severe wounds sustained in the blasts, which killed three people and wounded at least 170.

> "It looked like Iraq after an IED..."

John Cowin said he was among the first doctors on the scene. The first man he came across had lost part of his leg in the blast, he said. The doctor handed his belt to someone to wrap around the man's leg

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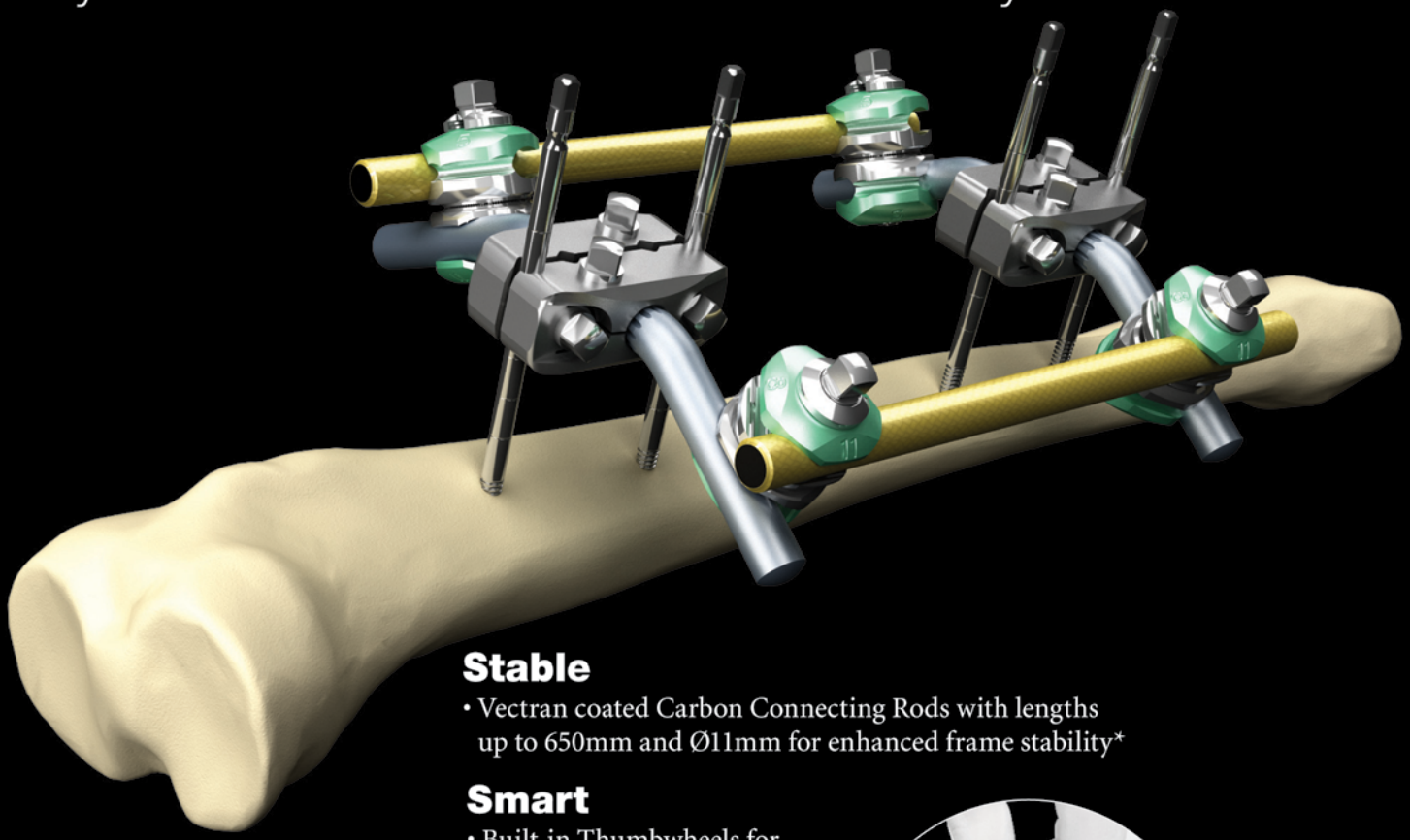

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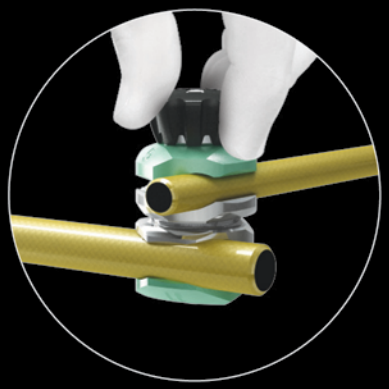

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- Single point of tightening for enhanced efficiency

*White Paper (NL11-NA-TR-2465): Comparison between the Hoffmann II MRI and the Hoffmann 3 Systems: The mechanical behavior of the connecting rods and a monoplanar bilateral frame. E. Wobmann, MSc; M. A. Behrens, MSc; S. Brianza, PhD; T. Matsushita, MD, DMSc; D. Seligson, MD. Based upon Biomechanical Test Reports from Stryker Trauma AG, Selzach; BML 11-072 and BML 11-059.

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Recruitment Resolutions: Avoid Common Hiring Pitfalls

Hiring the wrong employee will negatively affect the performance and profit of your practice. Fortunately, you can avoid the common mistakes made during the recruiting, interviewing and hiring process that can result in a bad hire. Read on to learn how.

Pitfall #1: Hiring too quickly and out of desperation. When a new employee is needed, a sense of urgency may be created to fill the position as quickly as possible. However, it's not beneficial to make a rash hiring decision, and doing so may hurt your office more in the long run. It can surely have an impact on your bottom line.

There is a significant cost associated with hiring and training an employee only to learn shortly after that he lacks needed skills. Not only will you find yourself back at square one, but you will also have the arduous task of firing and rehiring. This brings frustration, loss of resources and negative office morale. Never rush an interview or candidate. If in doubt, bring him back for another interview to determine if he is really the best fit for the position.

If you still feel that you have not found the candidate who is the "right fit" for your position, consider hiring a temporary employee. This can be very cost effective and allows you more time to seek your full-time qualified employee. Ask colleagues if they know anyone who is looking for temporary work, or reach out to a recruitment firm that focuses on your industry to assist with both your temporary and permanent staffing needs.

Pitfall #2: Acting too slowly to hire a qualified candidate. Conversely to hiring too quickly, problems also arise when you take too long to offer employment to a qualified candidate. Some hiring managers are hesitant to hire the first candidate who interviews with them, even if that person is a great fit for the position. Setting standards of wanting to interview at least 30 candidates before you make your final decision can also have a negative effect on your search.

Chances are good that if the first candidate you interviewed was amazing, your competitor with whom they are also interviewing will think so, too. In the end, your competitor may end up making an employment offer before you are even done conducting all of your 30 interviews.

Pitfall #3: Focusing solely on personality. Just because you got along great with the candidate and can picture yourself going out to lunch with her every day does not necessarily mean that she is the best candidate for the job. Of course you want to like your employees and have a good relationship with them, but not every member of your team will be your best friend.

Focus on the candidate's job skills, not just her personality, but don't forget too that hiring employees with varying personalities and backgrounds is a great way to bring new concepts to the table when brainstorming for business ideas.

For more information on resolving common hiring pitfalls, see www.orthopreneurpub.com. Or, scan this Quick Code with your smart phone to take you directly to the article.

ORTHOPRENEUR
EMPOWERING TODAY'S ORTHOPAEDIC SURGEON

Refresh Your Trauma Skills (part three of a series)

As a civilian orthopaedic surgeon you may never need to manage more than one level-one trauma situation at a time or may never face a natural or man-made disaster. If, however, such a situation did occur, would you know how to most efficiently and effectively save lives with the limited resources at hand?

The Disaster Preparedness and Trauma Care Toolbox, comprised of published, peer-reviewed articles, course materials, newsletters, and an interactive, case-sharing blog, is a valuable resource that brings together the combined experience and knowledge of the Society of Military Orthopaedic Surgeons (SOMOS) membership. These surgeons are well-versed in the care of the combat wounded as it applies to humanitarian assistance and disaster relief. The *SOMOS Core Curriculum* and *Critical Skills List*, key components of the Toolbox, are derived from the objectives of the Combat Extremity Surgical Course, a program taught to military surgeons prior to deployment, and are presented in conjunction with the Wheeless' Online Textbook of Orthopaedics (www.wheelessonline.com/ortho/12821).

The following excerpt comes from the *SOMOS Core Curriculum* Extremity Soft Tissue Care and Amputation in an Austere Environment section which details austere environment amputation procedures and soft tissue care.

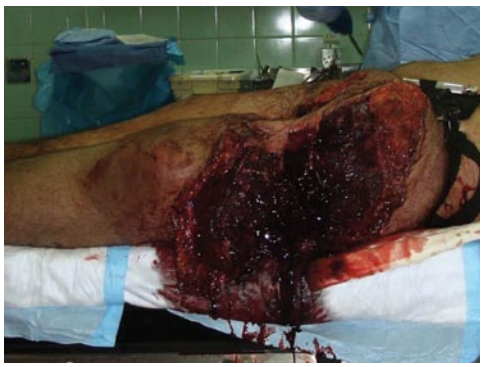

Figure 1. Combat-related open femur fracture. *Courtesy of Joe Hsu, MD, Iraq.*

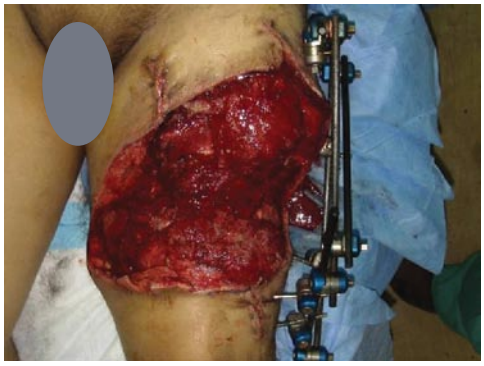

Figure 2. Combat-related open femur fracture post debridement and stabilization. *Courtesy of Joe Hsu, MD.*

III. Extremity Soft Tissue Care and Amputation in an Austere Environment

- Factors that affect care options for different patient groups
  - Patient groups
    - Locals, detainees, foreigners/soldiers, those with evacuation options
  - Determining treatment plan
    - Must take into account follow-on care after initial treatment
      - Rapid evacuation
        - Patient must be stable
        - Treatment to provide definitive care team with the most reconstructive options
      - In-country care
        - Treatment plans tailored to in-country resources
- Debridement (Figs 1 & 2)
  - Indications
  - Wound evaluation and skin incisions
  - Muscle and subcutaneous tissue evaluation
    - Indicators to determine muscle viability
  - Osseous evaluation
  - Irrigation
  - Postoperative care
  - Surgical steps
- Austere environment amputations
  - Two patient groups
    - Early amputation – nonviable limb or severely injured patient unable to tolerate limb salvage
    - Definitive amputation – patients without access to higher levels of care
  - Goals of initial care of severely injured patient
    - Preserve life
    - Prepare patient for evacuation
    - Leave maximum number of definitive treatment options
  - Possible indications for early amputation
    - Extremity injury characteristics
    - Systemic characteristics
  - Surgical technique

To review the section in its entirety, visit: http://www.wheelessonline.com/ortho/12787

Disaster Books:
Gain Knowledge. Be Prepared.

With several outlets available to expand your disaster preparedness knowledge, there is no excuse for why you shouldn't be informed. We compiled a list of popular books that give a more detailed analysis of disaster preparedness, response, and awareness.

Americans at Risk: Why We Are Not Prepared for Megadisasters and What We Can Do

Irwin Redlener, author of *Americans at Risk,* is an acclaimed scholar on disaster preparedness. In his book, he explains his position on the nation's inability to properly plan for a "megadisaster," and then offers ideas on changes that can be made to increase safety. Redlener brings his expertise from the National Center for Disaster Preparedness, where he is a founder and director, into his explanation and examples in the reading. The course of action for five natural and man-made disaster scenarios are highlighted for not only the government but the public as well.

Catastrophic Disaster Planning and Response

In this publication, Clifford Oliver fills in the gaps in emergency management education and compares the necessity for larger-scale catastrophe plans vs. plans for smaller-scale emergencies. Other topics include: historical catastrophic events, defining catastrophes, legality associated with government responses, and planning strategies for emergency managers.

Acts of God: The Unnatural History of Natural Disaster in America

As a U.S. historian for more than twenty years, Ted Steinberg has worked on many publications which focus on the intersection of environmental, social, and legal history. In his 2006 book, *Acts of God: The Unnatural History of Natural Disaster in America,* he chronicles a provocative history of natural disasters in the United States. In the revised edition, Steinberg analyzes the failed response to Hurricane Katrina and reveals how the decisions of business leaders and government officials have caused greater losses of life and property.

Handbook to Practical Disaster Preparedness for the Family, 3rd Edition

Arthur T. Bradley, a parent and NASA engineer, decided a book needed to be written that prepares families for the dangers they face. He began to assemble his first edition after the tragic events of 9/11, and after three years of research it was released. The 440-page handbook emphasizes practical preparations for natural disasters like earthquakes, tornadoes, hurricanes, floods, and tsunamis; as well as high-impact global events such as electromagnetic pulse attacks, radiological emergencies, and solar storms.

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Did You Know?

After an explosion, triage and lifesaving procedures should never be delayed because of the possibility of radioactive contamination of the victim; the risk of exposure to caregivers is small.

Centers for Disease Control and Prevention

Healthy Summer Foods

Summertime offers an abundance of fresh fruits and vegetables to enjoy while staying healthy. Yahoo (shine.yahoo.com) compiled a list of some of the top summer foods to try. Here is a sample of the top foods and why each is beneficial to your health.

Corn – Grill up a cob and enjoy the secret health benefits of the two main antioxidants found in corn – lutein and zeaxanthin. These antioxidants not only help filter out some of the sun's damaging rays by forming a macular pigment in your eyes, they may also help lower your risk of developing macular degeneration later in life.

Tomatoes – Want to protect your skin in the hot summer months? Eat more tomatoes. Beta-carotene and lycopene, substances found in this vegetable, help protect skin against sun and UV light damage. Not only does lycopene help protect your skin, it has also been shown to strengthen and repair your bones.

Watermelon – Staying hydrated is key to good health. Hydration keeps your mood stable, memory sharp, and body cool. If you don't want to just drink to stay hydrated, try watermelon – it's 92 percent water! In summer months, copious amounts of the delicious fruit can be found at grocery stores or local markets.

Raspberries – According to a study in the *Journal of Nutrition,* eating more fiber may help prevent weight gain or even promote weight loss. One of the main benefits of eating raspberries is they are a great source of fiber so eat more of this delicious fruit and gain less.

Blueberries – These berries have the highest antioxidant capacity of all fresh fruit. Because blueberries are rich in antioxidants, eating them boosts your immune system and helps fight muscle fatigue. Their tangy flavor fits well into summer recipes.

Tart Cherries – Looking to rev up fat burning and decrease fat storage, especially in the summer months? Scientists at the University of Michigan Health System found that consuming tart cherry juice can do both because of the anthocyanin found in this fruit. Not only will tart cherries help you slim down, they also help with post-workout pain and restless sleeping.

For additional foods and tips for healthier summer eating, visit Yahoo's Healthy Living page.

Employee Benefits That Won't Break Your Budget

Employers that offer attractive employee benefits are more likely to retain good, productive employees. The problem, as you know, is that employee benefits are expensive. On average, the total cost of benefits to employers was $9.48 an hour per employee in September 2012, or nearly 31% of total hourly compensation ($30.80).*

Smart Employee Benefit Options

What can your practice do to attract and retain talented, hard-working people without adding significantly to your overhead? Why not consider offering "soft" benefits? Work-life programs, also known as "soft" benefits, are intended to improve employee satisfaction, increase productivity, and reduce absenteeism. Some of the more widely appreciated and common work-life programs include:

- Flexible work arrangements
- Compressed workweeks
- Time off for school functions
- Employee assistance plans
- Recognition awards

Several of these programs cost very little to introduce into the workplace. Offering flexible work arrangements and giving employees time off to attend functions at their children's schools aren't costly to implement. Likewise with compressed workweeks. They do require scheduling changes and some flexibility on your part, but the payoff may make the effort worthwhile.

Non-monetary recognition awards can run the gamut from recognizing an "employee of the month," to awarding special parking places to high-performing employees, to simply writing thank-you notes.

Contact Us

For more information, please call a member of our Health Care Team at 317.472.2200 or info@somersetcpas.com.

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**Bureau of Labor Statistics, U.S. Department of Labor*

The One Fund Boston, Inc.

Massachusetts Governor Deval Patrick and Boston Mayor Tom Menino have announced the formation of The One Fund Boston, Inc. to help the people most affected by the tragic events that occurred in Boston on April 15, 2013. To contribute to The One Fund Boston, visit onefundboston.org. All other inquiries can be sent to: info@onefundboston.org.

Dr. John Cowin *continued from page 1*

to ease the bleeding. He then came across an injured woman cradling her dead 8-year-old son, who later was identified as Martin Richard.

"I will never forget," he said. "She had her arms around him."

Emergency responders were trying to get the woman into an ambulance but she continued to hold onto her son, Cowin said. He added, "She said, 'Let me stay with him a little longer.'"

The other two victims killed were identified as 29-year-old Krystle Campbell of Arlington, Mass., and Lu Lingzi, a Boston University graduate student from China. John Cowin said he ran to try to help Lingzi after tending to a man who lost a foot and his 3-year-old son, who suffered a small cut to his head. People were administering CPR when he stepped in to try to clear Lingzi's airway until she could be loaded onto an ambulance.

"But I knew she wasn't going to make it," he said.

He said her friend, another student from China, was propped up against a fence with a shrapnel wound to her stomach. People from a nearby restaurant were using tablecloths to bandage her wound. John Cowin, who served as a military physician more than three decades ago and was stationed in the Philippines, helped load the students and other patients into ambulances.

"I've seen these injuries individually, but never like that. The ground was covered in blood," said Cowin, who wrote about the gripping and emotional experience in his first-ever Facebook posting after a friend insisted he share his story.

> *"This is not supposed to happen in America..."*

With all the chaos, Anna Cowin said she and her husband were separated. She said police were afraid of another explosion and evacuated the area. They were reunited hours later along with their 37-year-old daughter and her husband and two children.

Nijensohn, a cancer survivor, was running the marathon to raise money for the Dana-Farber Cancer Institute in Boston. She had passed the 25-mile marker and was 10 minutes from the finish line when police stopped the race, John Cowin said. He said she raised about $16,000 for her cause.

"This is not supposed to happen in America — here these people came out to enjoy the race and watch their loved ones," he said.

But as long as his daughter keeps running in the Boston Marathon, he said he and his wife will continue to attend.

"If we stop what we're doing," he said, "we're letting them conquer us."

Did You Know?

During the 2013 Boston Marathon, the B.A.A. positioned Disaster Management Administrative Teams (DMAT) that were located in Natick, Wellesley, and Newton. These tents were staffed with physicians and nurses that could offer a higher level of care to the runners. These tents unfortunately saw more severe injuries than anyone ever anticipated.

Boston Athletic Association

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Editorial: Preparing for Disaster

Natural disasters are not new, but as populations grow and the numbers of densely concentrated areas increase, the likelihood of mass casualties from hurricanes, typhoons, tropical storms, and earthquakes will continue to increase. Random acts of violence such as those that occurred at Sandy Hook Elementary School, the Boston Marathon, and the New Orleans Mother's Day shooting, from deranged perpetrators acting alone or spawned by terrorist organizations, have sadly become part of 21st century life. Mass casualties from indifference to safe practices, such as the recent building collapse in Bangladesh, are also a constant threat.

Our emergency departments here in the U.S. are well-trained. We have outstanding nurses and paramedics and accomplished physicians and surgeons. Emergency plans are in place in most hospitals, including large level-1 urban centers, medium-sized facilities, and small, rural hospitals. The aftermath of the Boston bombings is an example of the expertise of our medical personnel. Hundreds of individuals were injured, some horrifically, yet everyone who arrived alive in emergency departments survived. There is no question that we were also very lucky in Boston. The majority of the injuries were to lower extremities because of the ground level explosive force. There were very few head, thorax, and abdominal injuries, and those that did occur were less devastating than they could have been had the bombs been detonated at different levels. In addition, the bombing occurred at the shift changes for the receiving hospitals, which doubled the amount of available medical personnel on hand. The Boston area had participated in disaster drills and had benefitted from lessons learned from disaster conferences in 2008 and 2009, which included medical personnel and surgeons from London with experience in similar events.

None of this negates the heroic actions in Boston which are a tribute to the resilience of our medical workforce. However, the injuries in Boston were finite. There was no second wave of victims, the majority of injuries were lower extremity, and the disaster occurred during a shift change in an urban environment accustomed to trauma.

Based upon current accounts, standard of care was practiced in Boston with only minor compromises. For example, many patients were admitted without drug reconciliation from the emergency rooms to other floors in order to clear the emergency trauma bays. There were no major deviations from standard of care, and to our knowledge, no patients were treated expectantly.

The Boston bombing and other disasters teach us that we need to continue to prepare – to train in scenarios which maintain and/or modify or suspend standards of care, and to ready our health care professionals both medically and emotionally for overwhelming and sustained mass casualty events. We also need to pray that we never have to use this training.

L. Andrew Koman, MD