Episode 48 – When the lights (and water) went out at Mission Hospital

Intro music: 0:00

Podcast introduction: 0:10
Hospitals are open 24-7. That's what they do. And communities invest tens of millions of public and private dollars, so medical care is available, no matter what, through illnesses, injuries, global pandemics and natural disasters. But what happens when a hospital is in crisis itself? No water. Spotty power. Scant supplies. Thin staffing levels. And precious little of the technology that is so much a part of modern medicine. Dr. Julia Draper found herself in this exact situation last September, when Hurricane Helene descended on Asheville and the rest of western North Carolina. And she and her colleagues? They just kept calm and carried on as the patients kept streaming in. This is Jean Fisher Brinkley, Communications Director for the North Carolina Medical Board, and this is MedBoard Matters. Thank you for joining me. In late September we mark the one year anniversary of Hurricane Helene, which now ranks as the state's deadliest and costliest hurricane of all time. NCMB is recognizing the anniversary by checking in with a selection of licensees in western North Carolina. Over the next few weeks, we will publish a total of four podcast episodes reflecting on Helene and the dedicated physicians and PAs who lived and worked through this storm of storms. We begin with Dr. Julia Draper, who was just starting a seven day shift in the Family Medicine Department at Mission Hospital in Asheville when Helene's heaviest rains started falling.

Interview with Dr. Draper: 1:48
JD: My name is Julia Draper. I'm a family medicine physician. I work as a faculty physician for MAHEC, which is Mountain Area Health Education Center. We function like a hybrid community academic center. So, we are a residency program, among other things. But for MAHEC, I work both in our outpatient family medicine health centers as well as at Mission Hospital.

JFB: So, as you know, we are going around North Carolina or Western North Carolina collecting stories from some of our licensees. Could you just sort of set the scene? Where were you sort of when the storm hit, and in particular where you were sort of when the power went out and all of that, you know?

JD: Yeah, absolutely. So, the first day of the storm, I was still working outpatient and was there when the rains hit so hard. We had to close the clinics and convert to telehealth. And then the next morning, around 5 or 6 a.m., I drove into Mission Hospital to start my normal seven day stint of inpatient work covering the family practice service. And that morning, that Friday morning, the kind of second day of the heavy rains, the streets were wet but adequate for me to get to the hospital themselves. And then a few hours after I started my shift is when the Swannanoa and French Broad River started really flooding such that, you know, just about a quarter mile of the hospital, and then for a mile, starting a quarter mile south of the hospital, and then for miles was completely flooded to the rooftops of that entire Biltmore area, such that from the southern side, the hospital had become isolated and only accessible by boat.

JFB: So, this happened while you were?

JD: Yes, I could yes, I could see it happening from my office on the seventh floor of the Mission Hospital. I could see the floodwaters rising up to the rooftops of the buildings and that Biltmore Village area.

JFB: Okay. Could you explain how a seven-day shift works?

JD: It's very complicated on the family medicine side. So, you know, our family practice service covers inpatient adult medicine. So, what people think of as internal medicine. We also cover inpatient pediatrics, newborn care, and then our family medicine, labor and delivery patients as well. So during the daytime we see and round on all of our patients. And then at nighttime where they're full time newborn coverage, our residents are that we supervise. And then we also as attending physicians, we cover our patients all day and all night for, labor and delivery as well as throughout the weekends. And then we're there for, you know, 12, 14 hour shifts during the day and then as needed at night as well.
JFB: Wow. So, 12, 14 shifts every day for seven days straight. Wow.

JD: Yeah.

JFB: That's, that's fun. So, you were just starting that. You know you drove there when you drove in. Did you have any inkling that you might not be able to get back home or?

JD: Not at all. We had been told that the rains were heavy and that to ensure that we would be able to be there to cover our shifts, we had been offered call rooms to stay out at the hospital before the storm, to just ensure that no one was going to miss their shifts, but I had worked at Mission Hospital several times before when there were, like, kind of minor floods. And we would have to go around some of the Biltmore Village area flooding. And so, I felt pretty confident that we would be okay. And honestly, my attention was focused on all of my loved ones in Florida who were in the direct path of the storm. So, I was worried about them and their safety and losing connectivity with them. So, I hadn't at all thought about our area. No one I know had thought about preparing for our area. No one had any sense of how serious the damage was going to be here in Western North Carolina.

JFB: So, are you originally from Florida?

JD: Yes, I'm originally from Florida, and all of my family and my in-laws still live there.

JFB: So, no stranger to hurricanes.

JD: Exactly very accustomed to hurricanes.

JFB: Yeah, just not necessarily in Western North Carolina. I don't know if you said, but how long had you been practicing in Western North Carolina for MAHEC?

JD: So, I did a lot of my medical training here in Western North Carolina. So, I went to UNC Chapel Hill for medical school that had a program out here in Asheville. So, from my first year of medical school, I was coming out to the Asheville area and all of Western North Carolina to train and rural primary care. So,

starting in like 2017, I've been working in Western North Carolina, at least intimately. And then I did all of my residency training here in Asheville, in Western North Carolina. And now I stayed as an attending.

JFB: That's great. So, you mentioned being in your office on the seventh floor, seeing the waters rise. When was it apparent that this was not just a little bit of flooding?

JD: It became apparent about halfway through that shift, that first day on Friday when we started to lose connectivity of everything, but including the electronic health record was the first thing to go down. So, it's not uncommon that we have some sort of, you know, brief downtime of the electronic health record. But this was all computers down, all systems down, with absolutely no warning throughout the entire hospital system. And then we started to lose our pager system. And unfortunately, the Pyxis system where nurses are able to pull meds. So, all of a sudden it went from everything is functioning normally in the hospital, even though we're watching the flood waters recede outside of the walls of the hospital to oh my gosh, no, we can't communicate. We can't put in orders, nurses can't pull meds from the electronic med dispensing systems. We can't get pages. It was. Yeah, chaos.

JFB: Chaos. Okay, So, I mean, what did you do? I mean, you must have been, you know, with a team sort of on the floor, wherever you were. How did you get together and say, okay, here's what we're going to do, because you still have inpatients. I don't know how well the hospital was. So, you were not empty by any means.

JD: Yeah. No, but, you know, I mean something that we still have plenty of patients, and were coming in by the hour, so we, it was a lot of just, like, physically running around. So, I thought about, okay, who are my sickest patients? And thankfully I had a list of our patients on paper, you know, who do we need to go physically talk to the nurse for this patient and find it on the floor and make sure that they're getting their medications, that the nurse can't see what medications they need to get right now because they don't have the computer to remind them and tell them what meds are due when. And so, a lot of running around to talk in person to find people and say, okay, what are the most important patient needs that I know of, of the patients assigned to me right now? Who do I need to make sure gets what right now? And knowing that the tube system's down and communication with the inpatient pharmacy is down, how do we make sure that we're advocating for, you know, physically running down and getting the appropriate medications? But we assumed that the network would be up and, you know, oh, a few minutes or a few hours. It ended up being, I think the next morning, like five or six a.m. the next morning when we finally got the health record back and working. So even though the hospital ended up losing power that day, the backup generators came back on rather rapidly. But for anyone who's ever worked in a hospital, when you lose power, even though the backup generators are on, that doesn't power everything. So even though we had some parts of the hospital that have the health record back on, that wasn't true for our work room. We're not on the backup generator, so we have to scramble and find places that we can put in orders throughout the hospital. And, you know, nurses are having to run around and plug things into the backup generator plugs and figure out what of all of our electrical needs within a patient room, which you could have, you know, at any time, ten different things plugged in in a patient room, how do you decide which ones are most important, which IV pulls need to be plugged

into, which outlets that are on the backup generator? So, there's a lot of chaos as you move to that backup power.

JFB: Yeah, and I would imagine potential for error.

JD: Yeah. And just not enough staff. You know, it's hard on a normal day. And then when they need to be running up and down the stairs to communicate with other parts of the hospital, and then also physically in each room figuring out how to plug in plugs, that's really very difficult staffing wise.

JFB: Yeah, I can imagine. So how long did you practice under those kinds of circumstances where you had communication was severely impacted like that?

JD: The first day was really the peak of that. And so that first afternoon and night and then we at least by the next morning had the electronic health record back up. And I believe paging ability back up so that we were able to electronically put in orders and communicate with the nursing staff again. And once we got the backup generator, we were able to have our nurses were able to pull medications again.

JFB: So, what were you hearing and seeing during that first day of chaos? I mean, what were your patients, how were patients reacting?

JD: I think patients I think we're in part shielded from it, and that we were, you know, trying to not make them too anxious and say, hey, you know, we're going to get that to you as soon as we can. You know, please be patient with us as we're running around trying to come up with new protocols and find where that medication might be that you need. So, I think we were asking for a lot of grace from our patients during that time. It was when the water stopped working, which was shortly thereafter, that there was even more communication with patients of, you know, I'm sorry, we don't have any running water for you to wash your hands with or a toilet that you can flush in your room if you even have that accessible.

JFB: Yeah. So, I was getting to that because that has been a major theme. As I mentioned. You know, we've been having conversations with physicians and PAs across Western North Carolina. I think every single person has mentioned water. A huge, huge challenge. Can you go into a little bit more detail about how that impacted staff and patients in the hospital?

JD: Oh, yes. I think people highly underestimate how important water is for a hospital system. I mean, there's a things that one thinks about to start with the, you know, handwashing, toilet flushing, not having the ability to do that for over a week was, really difficult, even when the hospital was doing everything they could to ship in bottled water and, a few days in they were able to get us these trash cans of non-potable water that we could at least flush toilets with, and just making sure we had the minimum of, you know, keeping patients hydrated and keeping our staff hydrated. But knowing that there's no ability to wash off, shower, wash hands. But I think that the things people don't think about of not having water, that means no ability to sterilize instruments. And so, for instance, I had a patient come in during that time who had an active upper GI bleed, who was vomiting blood and had dropped his hemoglobin low enough to require a transfusion. And we were able to get the transfusion going for

him. But when I called the GI team to say, hey, can we get this guy in endoscopy for an active upper GI bleed? They said we've got four endoscopy kits that are sterile, and we don't know when we're going to be able to have sterile instruments again. It could be days, it could be weeks. And they basically asked, do you think your patient should get one of the four kits left? We had no protocol for deciding who gets the very limited, sterile equipment left over and working on the labor and delivery floor, I had, you know, a patient come in and labor. We had very limited sterile supplies for our deliveries. And so, you know, I'm used to delivering a baby with a table of 21 sterile instruments. And now all of a sudden, not only do I have to protect myself knowing that after a delivery, I can't wash my hands or wash my body, which is, you know, very common to get all sorts of things on one's body during a delivery. But I don't have my 21 sterile instruments that I'm used to working with. Instead of having 21 instruments, I was given two umbilical cord clamps that are plastic to use as my hemostats and everything else I need during a delivery, and had to, like, really communicate closely with nurses and bargained to be able to get even a pair of needle drivers to repair a second degree perineal laceration for this patient. So, a lot of difficulty with just not having access to sterile supplies that we’re used to being able to autoclave and re-sterilize throughout the day.

JFB: Wow. That sounds stressful.

JD: Yeah.

JFB: So, what was going through your mind? I mean, it must have felt in a way, like you were going back in time.

JD: Yeah. And I had worked in emergency departments previously during hurricanes where we're down for a couple of hours, maybe we lose our lights, maybe we lose our electronic health record, but we just have the few dozen or a few hundred patients in front of us. But a hospital as large as Mission Hospital with hundreds of patients with more flooding in at every moment, so to speak. It's really remarkable how many backup protocols one needs to figure out how to triage, how to make good use of limited resources across this just massively complex system.

JFB: So, I want to come back to that, about the protocols and what you learned out of this. But I did want to just ask, how long were you there? And I guess I should preface my question by when you're doing a seven day stretch like this, do you go home every day, or do you stay at the hospital for a few days and how did your routine have to change? Because you were in the midst of a huge hurricane, catastrophic flooding, etc.?

JD: Yeah. So typically, when we're on service like this, we try to go home in the afternoon and evening if we can. And in theory, we have backup faculty who are available by phone to help our overnight teams with decision making from afar. But then we lost all connectivity. And so, I think our preceptors, who were supposed to be available by phone, weren't available, and we didn't know that. And so I attempted to leave the hospital briefly and was able to during that time, see some of our residents being like, some boats, like our police officers going in boats to try to rescue people from apartment complexes, where I know some of our residents live in those apartment complex and had to be rescued by boat from their

second floor apartments. And so, I was able to kind of briefly see the situation. And then found out, oh my gosh, no one's coming in to cover me. No one even knows that they need to come in to cover me or that they're not reachable. And so I had to head back to the hospital and, make sure that we had adequate coverage, which we do not uncommonly, when we're just on call for a stretches that long, but a lot of sleeping in the hospital and communicating person to person to make sure that we had good coverage.

JFB: Now, I believe you mentioned that you have a husband. You're married. How were you communicating or were you communicating with him during this time?

JD: I couldn't, yeah, I attempted once or twice to come home briefly to tell him, hey, I'm okay, but I'm gonna have to go back to the hospital. But there were many times where I just couldn't come home at all, and I couldn't tell him I'm not coming home tonight, or for who knows how many days. And it was difficult to come home because there was no gasoline. And all of the routes from the southern side of the hospital were closed off for, you know, weeks. And I lived south of the hospital. So it was a instead of a, you know, seven minute commute to the hospital, it's like a 35-minute commute to the hospital through all sorts of back roads without a GPS in the dark with trees down everywhere and like muddy highways everywhere and huge portions of the highways just completely washed out. So, it was pretty treacherous to even try to go around the whole city to get back to the south side. And I had limited gas and there was no gas anywhere. No one knew where we could get gas until eventually several days in the hospital was able to contract a gasoline tanker to come to the parking lot of our Sweeten Creek Mental Health Facility, just to fill out the limited number of gallons for each hospital worker who was trying to get to and from the hospital. Because it was so limited, the number of people who even could get to the hospital, so many people were trapped in their neighborhoods or trapped in their houses and couldn't come in for shifts. So not easy getting home.

JFB: Yeah. So, did you ever actually make it home?

JD: I did, I made it home several times that week. Some for, you know, 30 minute turnarounds and some where I got to stay home once we finally were able to figure out our coverage by speaking in person with people.

JFB: Okay. And was everything okay at home? Did your home have any damage?

JD: We were one of the very, very lucky ones that didn't have any trees down. Of course, we had no water and no power. I thankfully have a very resource aware husband who was, I think, drinking like two or three tablespoons of water a day to make our five bottles of water last a month. So, he was kind of cameling it. Wanting to preserve the resources for me while I was working hard shifts at the hospital.
JFB: Wow. I'm gonna ask a question. I don't know if I should ask it, but was there ever a time when you just thought, maybe I just I'm not going to go back like maybe somebody else can?

JD: Yeah.

JFB: Take care of patients because, you know, I don't know how long. I mean, I know you were committed for a seven-day shift, but these are pretty extraordinary circumstances. And there must have been so much temptation to be like, oh, can't do it. Can’t get back.

JD: It was definitely hard to leave my husband. In those really short turnaround when it was when I just wanted, when I was worried about his health and his safety, and when I just so desperately wanted a little bit of downtime. But then I thought about our residents. We have so many residents in the hospital, our family medicine residents. We always have at least three to five on internal medicine covering their services. On our residents are the inpatient pediatric service at the hospital. They are the newborn overnight service at the hospital. They cover at least 20 to 50% of the labor and delivery service at Mission Hospital. And so I needed to know that one of our faculty was there, looking out for our residents who did have to stay there and who were coming in and who were worried about their colleagues who they hadn't heard from, didn't know if they were okay. There was a certain point where it was my job, because I was one of the only ones there to run around the hospital and ask, hey, who have you heard from? Who is okay, who's not okay, who needs to be rescued and who can come in and who can't come in? And how do we make sure that we have adequate coverage? And how do we make sure that we're relieving the residents who are new to this and stuck in this situation? Some of them just a couple months into being a doctor. So, I was definitely I and I think our other faculty who were able to make it to the hospital were committed to making sure that they had the support that they needed.
JFB: Yeah, I can understand that, because you're not responsible just for providing patient care. You're responsible for overseeing the work of these residents and-

JD: Exactly.

JFB: As a resource for them.

JD: Yeah, yeah.

JFB: So when you were at the hospital, you talked about, you know, you don't realize until all of the things that you normally depend on are gone, like the EHR or the sterile instruments and things like that, or the automated medication dispensing machine.

JD: Yeah.

JFB: That you have to figure everything out. I want to be clear that this is not something that the hospital could have or should have prepared for, because I don't think anybody could have predicted, you know, just the level of damage. But that said, I wanted to ask if there were lessons learned during this that affected sort of how you manage things going forward or if you do things differently just in case, because you've now seen this is what it's going to be like, or this is what can happen if these systems fail.

JD: Yeah, I think that's a great question. I think this experience has certainly had me consider my reliance on technology. And I think medicine is becoming increasingly hyper a technologized. Because of the

pressures on providers to be more efficient. It's harder if our productivity requirements are more and more each year it feels. It feels impossible to be the level of efficiency that we're required to be without so many of these technological tools. But when I think about, you know, no one saw this coming, and all of a sudden, we had no phones, no GPS, no Wi-Fi, no water, no power, no pagers. We had just given up our old pager system a couple of years ago at the hospital, and we are 100% reliant on technology for the care that we provide, with no training on what happens when the systems go down. And I've worked at other smaller rural hospitals that do have plans for that because they're more used to occasional power outages. They do have clipboards and paper charts in the janitor's closet, ready to go for when systems go down. But in a system this large and this complex, we take for granted and this like close to downtown, honestly, we take for granted just assuming that the technology is always going to be there. The backup generators are going to cover what we need, or we'll be able to get water back soon. And so, I think we all need to think about our reliance and technology, and especially as we start to have more like AI incorporated into our work. And almost all of our clinical resources be searchable exclusively online, I think we need to think about like, do we still need to have paper charts? Do we still need to have paper textbooks? Do we need to make sure that we, as clinicians, are staying sharp and not needing technology to give us the answers to our clinical questions throughout the day? I think it leaves a lot for us to think about in terms of our reliance.

JFB: Yeah. So, you bring up a good point. What did you do about medical records during that time when you didn't have EHR? It sounds like it was mercifully brief, but-

JD: Yes.

JFB: You still, you know, have to keep documentation is everything.

JD: So, I think a lot was just writing notes to ourselves on paper and then back charting later, which is usually what we do for HER downtime. I think a lot went uncharted, you know, medications were given that, hopefully a nurse wrote it down and back charted it later. But if that nurse is on shift for 72 hours straight and had to do that for hundreds of patients that night, it's a little unreasonable to expect that she accurately back charted all of those medications. So, you know, we do as much as we can in terms of keeping track of things and recording it later, but I'm sure a lot got missed to be honest.

JFB: And I know it just makes me think, you know, from the Medical Board standpoint, this what we do is when the Board investigates quality of care and looks at patient records and everything, it's looking to see were at least minimum standards of care met. During an emergency, that kind of goes out the window. And, you know, there is a recognition that standard of care shifts during an emergency because you can't do things in the way that you would if all systems were go in normal. So, it sounds like you were in that sort of a situation where you did the best you could.

JD: Yeah, exactly. I think we are all just out there doing the best we could.

JFB: Yeah. And, you know, as far as the water situation, you mentioned being covered in all kinds of fluids, bodily and otherwise, not being able to wash your hands. I assume that means you weren't able to shower. I mean, how long did you have to go in those circumstances?

JD: I was lucky that I was able to get home enough to be able to at least pick up some clean scrubs. The hospital was great about providing us lots of hygiene kits so, you know, powder shampoo caps and clean underwear and mouthwash and toothbrushes with little bottles of water so you could brush your teeth with a bottle of water and lots and lots of baby wipes.

JFB: Yeah.

JD: Have a shower-

JFB: At least wiping down. Yeah

JD: Exactly. Yeah. It was just lots of wiping down. And then, like, lots of alcohol based sanitizers. But yeah, I think me and so many of our colleagues went eight plus days without a shower.

JFB: Oh, my goodness, I can imagine that. It must have felt like heaven when you finally got to shower again.

JD: It was a big deal. I have never been so pleased when I watched, I think it was the National Guard pull in shower trailers into the parking lot so that our staff could sign up to get showers and in trailers in the parking lot. Yeah, it was a really big deal.

JFB: That's great. Can you think of any specific interactions you had with either patients or fellow staff at the hospital that stand out in your memory, in particular from that time?

JD: You know, I think a lot of my time that week was spent on the newborn service, on the newborn floor, the mother baby floor, trying to help our nurses on that floor figure out how to safely discharge patients when they didn't know where to find formula. Their house may have just gotten flooded. They have no clean water or food in their home. They don't know how to even get home without knowing, you know, where one can get gasoline to put in their car. I had one particular patient encounter of a family who had moved here recently from Guatemala, and they delivered their baby. They had food insecurity at baseline, but then their house got flooded and they didn't know anyone. They didn't speak the language. Their baby required formula feeding, and they had no car seat, no ability to communicate with any of their friends or family to try to help them find a car seat or food for that matter. The mom had been in labor for three days prior to coming in with basically no food or water for three days throughout her laboring process, and then delivered this baby, who understandably, we were having trouble controlling the baby's blood sugars and getting that baby to gain weight with the limited formula that we did have on hand in the hospital. And then incredible nurses on the mom baby unit, you know, usually we have case workers there and all sorts of social workers who can help make sure that these families are hooked up to care that they have food resources and car seats for their baby, and all of the

safety and security measures that they need. But, you know, our main food bank had been flooded. All of our safety net resources were flooded. We didn't have case managers who were able to get to the hospital. We didn't have our backup charity groups coming to bring in car seats. And so, these nurses banded together and asked their friends to bring in their old used car seats and were taking food from their personal supply to give to this family, to make sure that they could eat. And, one nurse figured out she lived nearby to this patient and drew paper maps of here's how to get on foot from your house to my house if you don't have enough food for you or your baby and you need to walk to my home to get shelter and food, and it was just a lot of people banding together like that of just making sure everyone has what they need. And just, you know, going way above and beyond, to make sure that patients were safe when they left the hospital, which, you know, eventually we had to get them out because we were filling up.

JFB: That sounds incredible. You know, we've talked about just how stressful this was. Obviously, like, burnout is a huge issue in medicine. It gets even more difficult to keep going, you know, when there's a crisis like this. How is the mood in the hospital? I mean, how were people doing? It sounds like they were just doing these incredible things, you know, coming through for each other and for patients. But at the same time, it must have been really difficult, too. Was there anything happening to support you and the other staff at the hospital?

JD: Yeah. There was a lot that the hospital was doing in terms of providing just logistical support in terms of, you know, here's some gasoline, here's food. I think a lot of staff members were understandably really stressed about their kids, like their kids not having access to these things and them having to be locked in the hospital and not being able to communicate with their kids or make sure that they're kids had what they needed or like how to talk to their kids about, you know, we had some nurses who said, hey, on my way into my shift today, there were bodies on the side of the road that my kids saw, and I had to explain that to them and then go in for 72 hours straight of a shift. You know, that's a horrible thing to have to do as a parent. And so, I think, you know, people were understandably stressed, but they also knew that everyone around them was going through the same stressors. And I think when these disasters happen, people just band together and are especially supportive and, you know, I think there's a lot of just kind of a campy spirit of like, it feels like we're camping in the hospital and, you know, we're just going to lean into that. And my hair is eight days greasy, but you're all just going to accept me for that. And, I guess we're going to do the best we can.

JFB: Right, right. And so is yours eight days greasy.

JD: Yeah. We all smell bad. Yeah.

JFB: Oh, wow. Okay. Fair enough. I was going to ask, you know, just personally, how did this experience affect you or change you?

JD: I've never been much of, a like a disaster prepper, but I certainly think more about that now. I yeah, my only Christmas present I wanted this year was a solar and or hand-crank powered hand radio to be able to keep up with the incredible radio reporting that's happening, which was the only way it felt to

keep in touch with all of the different communities that had been hit and where the resources were getting pooled. That's how we were figuring out, you know, what pharmacies are open, who has what formula, where can one get food or gasoline? And where are the community meetings happening to talk about next steps? So I definitely keep water on hand, now, I, have lots of solar lights and chargers and radios and, and then just generally someone who now kind of acknowledges that this could happen anywhere, at any time and that our sense of, oh, you know, hurricanes happen but usually we can get the lights on in the next couple of days and kind of clean up from the storm, that that's maybe not the case anymore with these storms that we're seeing now. And it's a whole different level now, what we could be facing in the future.

JFB: Yeah. I mean, if I recall correctly, Asheville didn't get drinkable water back until, November, right?

JD: Yeah. I don't think our house, my personal house didn't get it back for like a month and a half, I think. And many people, I think we're two-ish months. Yeah.

JFB: Right, right. And that that's what happens. It wasn't like there was just some pipes, you know, destroyed. It was the whole water treatment plant was lost.

JD: Exactly. Yes, yes. And a water treatment plant that had planned for a hurricane that had said, not only are we going to be a highly effective water treatment plant, but we're going to have back up prepared. We're going to have a whole second system of six foot diameter pipes buried 30 feet underground for the event of the most intense storm you can imagine in even those six foot diameter pipes buried 30 feet underground were washed away, like, instantaneously. So even the most thorough, highly engineered backup plans were completely washed away. And that, to me, is that part that's astounding. Of like, wow, our even our best engineering was no match for this. Not even a true hurricane head on. Like a couple offshoots from a hurricane after a summer thunderstorm. Yeah.

JFB: Yeah. That's insane.

JD: Yeah.

JFB: Did you come out of this looking at your profession or your colleagues any differently? I mean, in a way, it sounds like it might have been affirming just to see everybody coming together and doing what they needed to do to take care of patients.

JD: Yeah, I agree that it was mostly affirming. I left feeling honestly grateful for my family medicine training. You know, family medicine doctors are trained to be highly adaptable and flexible and to know that we may not always have the answer, but we will try our best and we will make it work with what we have. And so, I appreciated that just kind of foundation of it's usually a chaos and we're just going to make it work. And honestly, I felt so grateful for the MAHEC system. My colleagues, especially in family medicine, and how we pulled together and created resources for our patients. You know, when the Buncombe County Emergency Resource Management Center had to create all of these shelters overnight for the thousands and thousands of displaced people, you know, they made an emergency

medical shelter that they started to staff with some of their staff and then, I think, quickly realized we do not have the medical staff that we need to staff this medical shelter adequately on top of all of the other shelters that we're staffing. And so, they asked MAHEC to step in to be the medical providers for that shelter. And I was just so touched and amazed to see the brilliance of my colleagues of just like within hours, just stepping into the emergency medical shelter, saying, okay, we're going to make paper charts. You don't have any, we're just going to make some, we're going to create a triage system. We are going to call our...our pharmacist friends who to work for MAHEC through our like, nonprofit, may have pharmacies and pull our charitable inventory and make pop up pharmacies here in the atrium of AB Tech. We are just going to create this entire medical unit that can serve hundreds of people who need to plug in their oxygen and have refrigerated medications and have access to medications who are highly medically vulnerable. And we are going to provide them with several medical providers, 24/seven for weeks and weeks until we finally get back up. And just seeing how many of my colleagues were there to step in to cover that shelter all day, all night for weeks, and to come up with all sorts of creative ways to ensure that our patients were safe and that we could decompress the hospital that was really, you know, hurting for resources and get some of those patients who didn't need hospital level care anymore, but did need a safe place to go and to plug in their oxygen or their CPAP machines or, you know, have medical supervision. So, I was really just in awe to see how brilliantly my colleagues were able to help support those efforts from the county.

JFB: Well, thank you so much. It just sounds like it was an incredible experience. As difficult as it was, it also just sounds kind of amazing.

JD: Yeah, it will definitely stick with me. It's in my bones now.

Episode closing: 35:52
That brings us to the end of Part one of our Remembering Helene podcast series. For more information, visit our show page at www.ncmedboard.org/podcast. And be on the lookout for the next installment of our series, when we visit with Dr. Benjamin Gilmer, head of Rural Health for the Mountain Area Health Education in Asheville. While Dr. Draper was helping to hold down the fort at Mission Hospital, Dr. Gilmer was practicing out of an RV in a church parking lot in Swannanoa. Thanks for listening. I hope you will join me again.