Episode 49 – We're being public servants

Intro music: 0:00

Podcast introduction: 0:09
You might think that a church parking lot in a small, single traffic light town isn't the ideal place to practice full scope family medicine. Dr. Benjamin Gilmer would likely disagree. In fact, he might say that such a town is exactly where a physician should hang out the proverbial shingle, especially if there isn't a single medical practice to be found there. This is Jean Fisher Brinkley, Communications Director for the North Carolina Medical Board, and this is MedBoard Matters. Thank you for joining me. This episode is the second installment in our podcast series *Remembering Helene*, which shares hurricane stories from a selection of physicians and PAs in Western North Carolina. It's the medical board's way of marking the one year anniversary of Helene, which the western part of the state is still very much recovering from. I had the opportunity recently to speak with Dr. Benjamin Gilmer about his experiences helping to run a pop-up medical clinic in the Buncombe County town of Swannanoa in the immediate wake of Helene.

Interview with Dr. Gilmer: 1:18
BG: My name is Benjamin Gilmer and I'm a MAHEC faculty member in Asheville, North Carolina, I'm the clinical director of our Rural Health Initiative and Rural Health Fellowship.

JFB: Perfect. So, Doctor Gilmer, when we invited you to share your story, you said, "Rural health and global health. Not that different." Could you explain what you mean by that and tell me how it kind of set the stage for your work during Hurricane Helene?

BG: Sure. Yeah. For years we've seen the similarity between global health and rural health, and it's one reason why we've incorporated it into the experience of our residents in Asheville. And it's been an opportunity that's allowed both faculty and residents to continue finding sort of the joy of medicine, because it creates an atmosphere in kind of under resourced settings where providers have to work in teams. So, the teamwork is supremely important. And being adaptive and having, you know, an open mind about how you approach challenging situations in under-resourced settings. Our work has been in Honduras over the last 25 years. So, we've been taking groups of learners, students, residents, faculty in an interdisciplinary way down to rural Honduras, where we've been taking care of the same villages there for 25 years and have a real relationship with them. So, you know, when we think about our rural communities, another line and of course, means like 80 out of the 100 counties in North Carolina are considered to be rural. We see many of the same problems. You know, we see problems with transportation. We see problems with access to health care resources. We certainly have seen a greater number of challenges like accessing obstetrical care, both here in Eastern and Western North Carolina, but also in very rural Honduras. It gets, it's a challenging place. There's only one place in the whole region where…where they do C-sections, for example. But, you know, I think from an educational perspective, rural and global is very similar because you have to be creative in solving problems and, you know, identifying how to use resources differently. And, you know, ultimately you have to be more public health minded. And that really means thinking about the health of the community rather than the health of the individual at some point. And how do you do that? How do you provide, you know, resources to a community when they're limited already? And so when Helene arrived and we responded

as a community to the health care needs and social needs and transportation needs and food scarcity needs of our community, it really became very clear that, you know, what we were doing was, like, very similar to our work in Honduras.

JFB: You mentioned you take care of several communities in Honduras. What specifically do you do?

BG: So, in Honduras, we work with a system called Shoulder to Shoulder. And it's an NGO that actually hybridized with the government of Honduras. And so, we actually employ the doctors who work in the public health center. And we take care of all of the small towns that are in that county, basically. So, there we do everything like we do obstetrical care, women's health, acute care. But really, most of you know, global and rural medicine is about relationships and chronic disease management. So taking care people's diabetes and their hypertension and the, you know, run of the mill infections and dermatologic things that they have, like those were the burden of the developing world, you know, where food scarcity, hunger and malnutrition really affect people's chronic diseases. And that's the same thing we see in rural spaces where we do see malnutrition issues or certainly poor nutrition that contributes to metabolic syndrome. And diabetes and hypertension. And you oftentimes have to be a little bit more creative about how you approach those diseases when you don't have all of the tools in Honduras, we certainly don't have all of the, you know, pharmaceutical tools to do what we do in the States. But in rural America, where, you know, people live two years less than the general urban population in America, which is still astounding to me, they also lack the same tools. You know, it's harder to have access to physicians because of the relative porosity of primary care access to many, you know, rural places. So, you have to be really creative about how to access those things. How do you get a specialist, like if you are trying to get someone into rheumatology and you live in Murphy, North Carolina, you may have to go to Tennessee or Georgia or drive all the way to Asheville, where there's a six month wait to see rheumatologist. The same is true in Honduras. If you need a rheumatologist, you will likely never see one, but you would have to drive like six hours to the capital city and spend, you know, the trajectory alone is like more than what most people make in a month just to get there. And in this, you know, those barriers are very real there, and they're very real here. And they became augmented after the storm where the systems, you know, started to break down like the transportation is, you know, the most glaring example or just having fresh water.

JFB: So where were you when the storm hit?

We live about a mile and a half from the French Broad River. We were very close to the river. We were no danger of…of the water reaching our house or anything. But-

JFB: So, you were at home?

BG: Yeah. My family was at home and. And we, you know, I think like most people, we didn't we didn't anticipate very well what was coming. We did fill up the bathroom the night before, and that was the recommendation of my mother-in-law to do so. Otherwise-

JFB: Filled up the bathtub with water.

BG: That's right. Otherwise, we never we've never done that before and thought it was kind of a silly idea at first until we started tracking, you know, the radar. As the storm approached Western North Carolina, realizing that it was going to hit us, you know, squarely and that the winds were going to be 100 miles an hour, and that we had already had 20 plus inches of rain in the days that preceded the storm. So, we were we were a little bit naive in terms of how to anticipate what was about to happen. And no one fully understood until the day after what the reality was.

JFB: Absolutely. Hindsight is very much 20/20. So even though obviously you could tell, hey, this storm is going to be a lot worse than we expected, did you still, you know, go in to work? At MAHEC?

BG: So, the day after the storm, there was no access anywhere. We could not get a car out of our road. The roads were blocked off in every direction, and the next roads after our road were blocked off in every direction. So, there was no way to get out, literally, unless you chain sawed your way out. And so, it took about 48 hours before I was able to get out with my…my motorcycle. You know, at that point I had to, you know, jump over logs and spot trees with my dirt bike just to get out to the clinic to see what the damage was, because the small clinic where I work at called King Creek, is right off the King Creek, and there's terrible destruction out there. But luckily our clinic was okay. But we soon realized there was, you know, no power anywhere and there was no water anywhere. And to run a clinic, you have to have power and water. And so, we knew at that point that we were going to be down for a while, but we didn't know what anybody else was doing because there was no cell service. The only way to communicate with people would have been to walk to their homes. And so eventually we did kind of walk out to see what was going on in the neighborhood and with our friends, but we didn't know what was going on in terms of MAHEC or even what was happening at the hospital. You know, I mean, meanwhile, the residents and students and faculty in the hospital were sort of sequestered there. They were just taking care of the hospitalized patients because there was really no traffic coming in and out of the hospital. If you if you were there, you were sort of there until we started to mobilize a little bit and realize, you know, really searching for the need for what MAHEC could do. And so, the first need was to take care of the shelter clinics. And so that was our first kind of collective effort to take care of a lot of the people who were on respirators and CPAP machines overnight, and people who needed electricity to survive from us.

JFB: Right. These are the high medical needs, folks.

BG: That's right. The high medical needs.

JFB: Okay. So, at some point in all of this, you started to hear that Swannanoa was really in need. How did you hear that?

BG: So, we got a tip from one of our faculty who had received a call from someone out in Swannanoa. And you know, of course, that everybody was so focused on what was in front of them and not realizing the massive destruction that took place in all the counties surrounding us. You know, they were equally as bad or worse than we were. And so, you know, your vision becomes very myopic during these events.

And then we decided, okay, we need to go do an exploration mission to see what's going on up there and what services they have and how we could be of help. So, we drove out to Swannanoa, and we were just humbled by the destruction.

JFB: Wow. Can you describe what you saw when you went there on that little recon mission?

BG: So just approaching off the exit from I-40, you could look down towards the river and see that it was just wide open, you know, before there, it trees lined all along the river and…and, I mean, it looked like a bomb and had gone off everywhere, like houses had slid off their foundations. You know, tractor trailer trucks flipped over, still lining the roads, the carnage of homes and shopfronts and…and cars just laying everywhere, like-

JFB: Wow.

BG: You couldn't drive a straight line down the road, you know, you had to dodge trees that were hanging out and cars that were still like halfway in the road, stoplights that were not working, people that were just like, shell shocked, literally. And so, we tried to discover the different pockets of Swannanoa and wanted to have a better understanding about what medical services were happening at the time. And we could hear the helicopters that were beginning to fly in and out of the Harley Davidson store that was right in the epicenter of Swannanoa. And so those search and rescue missions were ongoing. And then we discovered a small group of athletic trainers and a nurse who were kind of congregated at the First Baptist Church, like, which is really the epicenter of the community. And they had a little tent up, and we stopped to see how what resources they had and what they were trying to do, and discovered very quickly that, you know, that we could be of great service to them because they didn't have any physicians in as part of their team. They were really just a team of like three. So, then we realized this was, you know, very proximate to a lot of the people in the community. And transportation was still very difficult. And so, we decided to set up a pop-up clinic. And for us, it was very natural because we just come back from Honduras a few weeks before and we just set up 12 pop up clinics and-
JFB: As you we're moving from village to village.

BG: Because we were moving from village to village. That's right. You know, we were kind of poised and ready to go. And one of the residents that was with us had just been in Honduras with us as well. And the pharmacist that was with us had been to Honduras multiple times. So, we were ready to set up a Honduran clinic, which is yeah, this is what we did in the middle of Swannanoa.

JFB: Right there in the First Baptist Church? Like where in the parking lot or?

BG: Just right in the parking lot.

JFB: Yep. Okay.

BG: So, we…we didn't have any rooms at first. We would use the church initially and then Quest Labs very generously gave us a brand new 50 foot van, and we install the van and we're collecting resources

from people like very generous people who are coming from all over the country to bring whatever they had to help the people of Western North Carolina. So pretty quickly, we had lots of resources, and we were not resource scarce. We…we actually had plenty. We had insulin and we had medications, and we had vaccines. We had an ultrasound. And then, you know, the beautiful part of kind of global health is just how ready people are to give. And so, you know, in rural health settings and in crisis situations, people come out of the woodwork. So and so we had orthopedic surgeons coming out and we had respiratory therapists and other clinical pharmacists and OBGYNs and, you know, all kinds of people who were-

JFB: Just people just hearing, hey, there's a pop up clinic and showing up and offering their services?

BG: That's right, that's right. So, it was it was a beautiful way to…to get to know other people in our community, some who we knew and others that we didn't, to create a true multidisciplinary like clinic. That in many ways is how health care should function. I used to work in France and said to sort of experience like how the French system works and, and it was very much similar to that, and that we had a multidisciplinary people all under the same tent who were contributing and really giving people. And then the patients kept coming. And so, we.

JFB: Yeah.

BG: We had patients coming out of the woodworks and some of them walked to the clinic. Some of them were driven by ambulances. Some of them were flown in in the helicopter. Some of them, you know, were brought in by their loved ones. Some of them showed up at four wheelers. Some of them showed up on bicycles, or side by side like it was a, you know, because transportation was so difficult. Like-

JFB: Yeah.

BG: Sometimes the military would bring people and then their Hummers, you know, to the clinic. So, we saw a little bit of everything.

JFB: I know there probably is no typical day, but could you walk me through a day in your post-Helene pop-up clinic there? What types of patients and what were their medical needs? Just a range of what you were seeing.

BG: Sure. We would start the day with team gathering and we would kind of collect our resources and see who was there for the day. We had one station that was set up for kind of rescue missions, where we would send one team of people out into the community to do like home visits. And these were usually like guided by people in the community who said, okay, this community has great needs they cannot get out at all. This assisted living facility has had no providers, lots of different sort of tips like that. So, we would have one team that would go out and we were in contact with one another through FM radio which was donated by a very generous person and from Georgia, and then the rest of us would divide up into our bus. So, we had three exam rooms. We had a full pharmacy that was set up in the cab

of the van. We had a respiratory station and sort of a physical therapy station. Some days we had a behavioral therapist who was on board with us. So, you can see like it was it's really a beautiful collage of-

JFB: Yeah.

BG: Of providers who were there. And we had just about every medicine we need at like to take care of most people. And, you know, the patients were very just as they are at most, like rural clinics, like, if you're a rural practitioner in Western North Carolina or eastern North Carolina or in the Piedmont, you're going to see everything. So, we didn't see everything. We saw a lot of acute mental health crises. We saw people who hadn't been on their Suboxone for days or weeks. We were able to provide those things for them. We did a lot of acute care. We had some fractures that we, you know, diagnosed with ultrasound. We had pregnant patients that couldn't get to their OB providers. We had people who no longer had access to their insulin and so their sugars were in the four or five hundreds. We had pneumonias, we had bee stings, we had tons of poison ivy. We had I mean, there was literally like the gamut of family medicine, like, showed up, but yet we had women's health care, and we even had a woman from Nicaragua who showed up, and I happened to know, like one of her close friends from Nicaragua, because I worked there for a little while. And yeah, it was it was like true family medicine and the kind of family medicine that we train our residents to do, like to take care of the underserved, the complicated medical conditions that you see throughout rural America, to do both acute and chronic things and to even to take care of obstetrical things if need be.

JFB: Could you tell me about the more memorable patient encounters from that time?

BG: I think one of the most memorable patients for me was a guy who literally walked out himself. He was an older gentleman. He'd spent, you know, days like walking out, like he lived way, way out. And there was no way to access his home. And the choppers didn't know about him. They couldn't access his land. And so, this guy like, you know, eventually showed up and kind of walked into the clinic, and he was disheveled and hadn't had food or water in several days. And for him, he was memorable because I think it was just very hard to believe that, like this could be happening, that someone could be, like, truly isolated for days in the United States of America without any access to transportation or health care like that. It was like it was it was a stark reminder of like what we were confronting in this moment. You know, when you're kind of in it, it's hard to see outside of your eyes. He was that. He was a reminder that there were still people out there that maybe who had not been accessed. And he was cold. And this was like October, and the temperatures were dropping. And some people, well, most people didn't have any heat. And if they did have heat, it was like a kerosene heater. And…and the kerosene was running low. And, it happened to be a very, you know, a colder like October. And like as we were getting into mid-October and late October, it was getting quite cold. And so, we were able to take care of this guy and kind of connect him with resources and get him a blanket and a place to stay and treat his blood pressure. More than anything, that he was just a reminder of just how dire like the needs were for some people.

JFB: Yeah, I can see that. What were some of the biggest challenges during the pop-up clinic there? The way you're describing it, it sounds kind of idyllic in a way, you know, but surely there were challenges.

BG: Yeah, you're right. In some ways it was idyllic. In some ways, we were practicing the medicine that we loved to practice the most. You know, to be like proximate to patients and not be-

JFB: Fiddling with the EHR.

BG: And, yeah, the EHR, the systems like we were just with the patient's taking care of them. And that's like the most beautiful, you know, most rewarding part of medicine. But, you know, ironically, the first biggest challenge that I confronted as like, Medical Director was all the people who were showing up with resources. So, these were people driving from like Arkansas, West Virginia, Florida, Georgia who were just bringing resources. And we were trying to figure out what to do with them. You know, some of them we would use, others we wouldn't. And so, trying to have an understanding about where we could store the resources, how we could share them with others. Like, I never imagined that that would be a problem, but it eventually became a laborious act because there's people driving through the parking lot all day long with trailers of stuff, and we had to figure out, like, what to do with them. And we didn't even know, well, like, you know, what other people needed. And we were just a little section of our county. We didn't know where if there was like a mass storage place somewhere else where people were storing things. So, we spent a lot of energy just trying to manage resources.

JFB: Yeah, so what did you do? I mean, you had all this stuff piling up.

BG: We piled it up. We piled it up and started learning where other people were, you know, having resource centers where they…they would take things in and kind of distribution centers. And so we, we discovered some of those. So we started sending resources to some of those places. We started meeting with a local group. Swannanoa is kind of interesting because there's…there's not a mayor's office. There's no like it's not incorporated per se. And so, just people in the community were stepping up as leaders. And so there's a like a leadership meeting every day. And we would go attend that. And as the medical arm and just wanted to learn from them, like if they knew where we could send resources. And then soon we kind of incorporated ourselves with the Buncombe County Community Paramedics. So, they were a great resource because they got to hear all the briefings from the…the county EMS and the other counties that were part of those briefings. They were super helpful for like transportation, enabling us with vaccines, connecting us with the greater region in a way that we hadn't done yet. And so that was a really great resource that helped us to start thinking about the more collective in our region and how to share some of these resources.

JFB: How were you getting clean water?

BG: So, my family didn't have water for 56 days, and we would get water wherever we could get water. We would boil water, we would iodine water. We would try to go to, you know, as soon…if somebody had a well and a generator, then they could generate water from their well. And so, we would go to those people's houses and fill up every bucket we had. In Swannanoa we were kind of blessed and that a

lot of what people were bringing were like big water bottles. And so, we…we were giving out water to people. The World Kitchen was also showed up right in our block in Swannanoa. And so, it and so they were providing beautiful food for the community for, you know, for many weeks, like many weeks after the storm, like, you know, kudos to World Kitchen. We even had the mayor of New Orleans show up one day and…and cooked food all day for people. So, we had lots of gifts from…from people from all over the place to and especially World Kitchen. And, you know, Walmart was donating water and Ingles was donating water. Ingles their central facility site, it was literally just right down the road, and they were completely underwater, like the entire Ingles distribution center was completely underwater. And they…they lost lives there and semi-trucks and you know, it was like devastating for them. So, but people stepped up when they could, you know, and we were fortunate to have some of those resources there.

JFB: Yeah. You've mentioned some of these I think, but what do you, looking back, consider some of your biggest triumphs during that period?

BG: Well, the first triumph was just coming together as a team in the community and getting to know the community. And it was sort of ironic because, MAHEC had a clinic in that community before, and we had to close it down years before the storm. So it was, you know, a community already in need. Unfortunately, we were not able to make that clinic successful because North Carolina had not expanded Medicaid at that point. That was really important for the success of our rural clinic. Like, it's actually very hard to…to make a successful rural clinic without if-

JFB: Reimbursement. Yeah.

BG: Without reimbursement. Yeah. If you're not a federally qualified health center, which we weren't at the time, it's like very challenging to make it work. And, you know, Senator Budd came and visited us. But speaker of the House Mike Johnson came, and when he asked why we were here, I my…my answer to him was that we were here because there's no medical care in this community. And as a result of not being able to access Medicaid expansion dollars, the clinic closed. And so, we're here because there's no one else here. I mean, there are other regional doctors, like in Black Mountain there we're down the road, but everybody had their own challenges. So I think the most memorable thing was, like all of us coming together in the spirit of what, you know, medicine is for most people and that that's like a spirit of giving something to others and that's, you know, and when you're working in the developing world, settings like, you know, medicine is considered to be public, you know, which it's not in America. And so, we were it being public servants, which was very nice.

JFB: So how long did you maintain your pop-up clinic in Swannanoa?

BG: So, we were there for about a month and we were able to see somewhere between 800 and 1000 patients, both in the clinic and outside of the clinic. And, and, you know, probably our best work maybe towards the end was…was just trying to help people identify like primary care homes. Those people who didn't have a primary care home trying to help them find one. And then ultimately, we had to close down because people had to get back to work, like we all had our lives to return to. And it was painful, I

think, for a lot of the people who had participated, the volunteers in the clinic, because it had become a labor of love. And, you know, people really appreciated just getting to know this community in need. But we all had to get back to our own clinics, you know, we had to share our own patients and that had access to us. Ironically, I saw a lot of my own patients in the Swannanoa clinic, which was really fun to see them in a different setting, you know.

JFB: Now, was that because they lived in the area or? How does that happen?

BG: Well, because they were in the area and because all the clinics in Asheville were closed, like somewhere closed for weeks. And so, they would seek care wherever they could. You know, there was the emergency department of Mission Hospital, and some clinics were trying to open their doors quickly. But I think for most people, you know, it took like a solid a week just to figure things out, to figure out how to flush toilets, turn lights on, run generators, run Starlink. All those barriers were very real. Like if you were just like an independent practice, it took a lot like just to get back on-line. So, I think we sort of, you know, fill the void for a lot of those patients who just didn't have an open practice.

JFB: Yeah.

BG: And then, you know, probably the greatest realization of our like, collaborative work there was that there really needed to be a clinic there. And so, some of the volunteers, actually one of the nurses, Katie Neligan, one of the local doctors, and in Black Mountain and some of the other volunteers have started a free clinic that's going to be based in Swannanoa and Black Mountain. And that's sort of like the closing part of the story. I think that before the tragedy, our clinic was closed. During the tragedy, the community really came together and then post tragedy, a new clinic is born. And that's been a beautiful thing to watch that happen. And I've got-

JFB: That’s fantastic, yeah.

BG: Volunteer there once a month. Yeah. So it was that was sort of a full circle moment. It's like to have that.

JFB: Yeah. Is it currently open or it's in process?

BG: It's currently open and it's called Neighbor Care.

JFB: Okay.

BG: It's part of the SVCM Neighbor Care Clinic that's part of this Swannanoa Valley Christian Ministry.

JFB: Any final thoughts you wanted to share?

BG: Well, firstly, thank you for being interested in recalling like the events of healing because the health care needs are still tremendous, like the social determinant needs for people are still tremendous. We

still have people living in tents. A lot of people in our community feel like, you know, those who are still suffering, like you've been forgotten. And so, I think it's really beautiful to kind of recall that people are still really challenged and struggling in our communities. And then, you know, that's like our communities is vast. You know-

JFB: Absolutely.

BG: Like they probably well, 12 counties that have been like is really seriously affected. And they really feel like they've been forgotten, like FEMA dollars have stopped flowing in. You know, independent practices are still trying to…to negotiate reaching patients who may not have transportation. And so…so thank you for bringing that back into our memories. It's also like a great moment to pause and think about how rural communities are especially affected by climate change and by just the general porosity of providers throughout, you know, rural North Carolina. We're still challenged by trying to create and train and…and retain providers that will stay and nurture these communities. So, thank you.

JFB: If there are people listening to this podcast who want to help, in your opinion, you know, what are the best ways that they can support people in Western North Carolina?

BG: Well, that's a great question. There are lots of different organizations like MAHEC continue to do work. The Office of Rural Health, so that, you know, even not for profits, they're number of not for profits that have done great work throughout Western North Carolina. Dogwood Health Trust has been an amazing partner for supporting up practices and providing different types of, you know, support to projects that are really vital right now. So special thanks to Dogwood Health and all of the many people that have contributed. If you want to give directly to somewhere that you know, if you go to a Neighbor Care, neighborcare.com-

JFB: Yeah.

BG: You can Google that. That'll be a very specific thing. You know, we had a lot of people that were giving money to the independent pharmacies that maintain open doors, you know, like CVS closed during the storm, but the independent pharmacies, like, opened up immediately. And were…were out there helping people get, you know, supporting folks with their medications, running off of a generator. You know, they were there. Again, we had a beautiful collaborative relationship with the independent pharmacies, Blue Ridge and Health Ridge and PSA in Swannanoa. So, shout out to all the independent pharmacies out there that stayed open.

JFB: Well, thank you so much. Again. This has been fascinating. And, we could probably talk forever. I'm sure you have many more great stories, but thank you for sharing this one.

BG: My pleasure.

Episode closing: 28:18

That brings us to the end of this episode of MedBoard Matters. I hope you enjoyed Dr. Gilmer's story. If you would like to learn more about any of the organizations or resources he mentioned, visit our show page at www.ncmedboard.org/podcast. If you have any comments or other feedback to share, email them to podcast@ncmedboard.org. We have just one more licensee story to share and it centers on PA Joshua Newton. PA Newton was a little over a year into owning his own solo practice clinic in Mitchell County when Hurricane Helene came calling. His story gives a whole new meaning to the term "house call". You won't want to miss this one.