

Notes From Abroad

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Vellore, India: “ Providing patient care to those without means”

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The subcontinent should need no introduction. This is the home of the Buddha and the Bhagavad-Gita. Sanskrit and the concept of zero. Gandhi and Mother Teresa. The Taj Majal and The Himalaya. Tigers and elephants and cobras. A center of the exploding global economy but the most parochial of places. In many ways a model of development, in many ways the most violent and fractured nation on earth. India is epic and incomprehensible and larger-than-life.

Vellore is in the state of Tamil Nadu, in deep southern India. What puts this town on the map is Christian Medical College, a prestigious medical school and hospital founded by American missionary Ida Scudder in 1900. CMC is a quaternary care center where some of the world's finest specialists, diagnostic equipment, and therapeutic modalities can be found. But in the shadows of the gamma knife and the MRI huddle the hundreds of thousands of dreadfully ill, hopelessly uneducated, violently impoverished masses with poor access to care. Unfortunately they exemplify life for the overwhelming majority in this country of a billion people.



Eamonn Vitt, M.D., providing medical care in India

The Low Cost Effective Care Unit is an annex of the main hospital. It is run by Dr. Sara Battacharji, a family and community physician with ideals rooted in India's great social movements of the 50's and 60's. The mission of the LCECU is to provide outpatient and inpatient care to those with no means. Hundreds of outpatients are seen daily. Comprehensive primary care is provided. Specialists from CMC consult in the afternoons. Uncomplicated deliveries are done. Minor surgeries and procedures (tubal ligations, herniorraphies, hydrocoele repairs) are performed in an operating theatre. Attached is an 80 bed inpatient ward. The physicians and staff are excellently

trained (India maintains a highly developed educational infrastructure).



The spectrum of disease is typical for such a setting: HIV/AIDS and TB, malnutrition and failure to thrive, domestic violence and depression. I've had lots of experience with third world medicine, and at the time my training back home at Columbia was nearing completion. I approached the clinical challenges with confidence. These were often interesting and difficult. Quite a few Zebras walked through the door.

The true obstacles at the LCECU were confronting the entire biopsychosocial model of illness. For example, every third year resident is familiar with the appropriate antibiotic for a given infection. The true challenge is to somehow ensure that the illiterate patient with no resources will actually get her hands on the drug, take it properly, and follow up in a safe manner. Or how the young boy with marasmus will get his next meal. Why won't these high-risk men consent to HIV tests? How can I

maintain a therapeutic alliance, yet convince my patient that her beloved traditional healer can't cure syphilis with garlic? What do you mean, only prostitutes smoke cigarettes? Are these visions of Vishnu culturally consistent, or is this schizophrenia? Throw in a dozen local languages, religious and caste barriers a thousand feet high, myriad other cultural idiosyncrasies that would require decades to comprehend -- and you begin to get the picture. In this context it was often difficult to feel independent and effective.

Understandably so. Frustrating and overwhelming? Absolutely. But at the end of the day -- beautiful and rewarding more than anything else.

I'm now back home, finished residency, and working at a public clinic on Manhattan's Lower East Side. I have yet to see a young Dominican boy with Kwashiorkor. The Leprosy Ward is empty. And there hasn't been a cobra bite all summer. But the challenges of outpatient medicine and the biopsychosocial model of health and illness remain. Underserved medicine isn't easy -- regardless of locale. The trip to Vellore made me a tougher, wiser, and kinder physician. Go if you have the chance.

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