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A Mission to Heal

Grat Correll '89

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While volunteering in an impoverished Third World region, a physician and his colleagues rediscover the joy of a more personal approach to the practice of medicine.

By Grat Correll

Mornings come early in the Third World.

Whoever said that roosters crow at dawn obviously was an urbanite, and was speaking out of speculation. Practical experience teaches that there is actually a cacophony of sounds throughout the night in rural South America.

On this particular night it was a dog, barking incessantly just outside the window. As our medical relief team gathers for breakfast, the bags under our eyes offer compelling evidence of our lack of sleep, thanks to the dog.

I begin our day with some reflections on culture shock for those new to medical relief work, then mention the importance of developing an appreciation for the experiences that await us on this, our first day of clinics. "Now you understand," I say, "why in some Third World countries, they eat dogs!"

Thus begins a typical day on a medical missions trip. Since 1984, when I was a senior in high school, I have been involved in medical relief work, starting first as a translator and eventually working my way up to project director.

It was on one of these trips that I discovered a love for medicine, which started me down the long road toward an M.D. degree. Now in private practice in Johnson City, Tenn., I take time each year to bring healthcare to thousands who otherwise have no access to doctors or dentists, and to introduce physicians from the United States to the joy of doing this kind of work.

Healthcare in many parts of the Third World ranges from primitive to nonexistent. Impoverished nations with failing economies and unstable governments find it impossible to bring even basic healthcare resources to their citizens in rural communities. It is to such places that physicians associated with Global Health Outreach go.

This spring, I led a group of 30 doctors, dentists and health care professionals to Chimborazo, Ecuador, a remote Indian province in the highlands of South America. The Quechua, descendants of the Incas, seem little affected by the changes of the last several centuries, dressing in the same style and speaking the same language as their ancestors have done for hundreds of years.

Here, most rural homesteads still have no electricity or running water. They are plagued by tuberculosis, and in some areas the infant mortality rate approaches 50 percent. The majority of children who die in their first year of life do so as a result of preventable diseases, such as dysentery, malnutrition and neonatal tetanus — diseases that are virtually unknown in U.S. hospitals because of the success of our public health initiatives. In Ecuador, however, some healthcare problems are ubiquitous. Intestinal parasites, for instance, are found in the bellies of all the children we examine. Imagine the indignity of living with a 30-foot tapeworm in your gut, or the horror of expelling orally an 18-inch roundworm.

Much of their poverty has to do with their country's economy. In 1984, you could purchase 20 Ecuadorian sucres for one American dollar. By 2000, however, the exchange rate had gone from 20:1 to 25,000:1. Think of a house that in 1984 was worth $100,000 but in 2000 was worth less than $100, due simply to the devaluation of the currency.

The average income of a Quechuan family is $300 to $400 a year. Many of the clinic patients have no cash, so they barter for medical services. One day a woman wanted to trade an egg for medical care. Consider the irony of taking an egg, a valuable source of protein, from the mouths of your malnourished children to give it to an American whose cholesterol is too high anyway. And yet,

Opposite page: The Global Health Outreach team saw 3,000 patients in less than five days. This page, left: From the window of the pharmacy, Grat Correll explains a prescription to a patient; for many of the Quechuan children, the relief team's visit marks the first time they have seen a doctor. (Photos courtesy of Grat Correll)

we had to take her offering to help her save face — to maintain her dignity and help her to feel as though she were getting a "hand up" and not a "handout."

Another reason for the area's poverty is its isolation. This year, our team works in a remote part of the Andes, on the side of a mountain that is more than 20,000 feet high. The clinic is located in a village more than two miles high. Each day brings hundreds of patients — 3,000 in just 4 1/2 days. Many of these people have never seen a doctor or dentist before, and many have traveled great distances, often on foot.

It is not unusual for someone to walk two or three days to the clinic, spend the night outside on the ground, wait for up to 10 hours to see the doctor or dentist, and then begin the long journey home in the dark. One woman carried her 12-year-old son on her back because his foot was so badly infected that he couldn't walk. Several years ago a woman in labor walked 12 hours through the mountains, arrived at our doorstep, and delivered the baby minutes later. Her only other option was to deliver at home, where the major cause of mortality for women is childbirth. After delivering, she and her newborn made the 12-hour trek back to her village.

In one day, physicians in the medical clinic see more cases of intestinal parasites, head lice, scabies and tinea (a fungal infection) than they have seen in their entire career. And yet some common American medical problems — "diseases of excess" such as high cholesterol or type II diabetes — are not found here. The absence of diabetes attests to the unavailability of healthcare, since most patients die at a young age when they have their first episode of ketoacidosis (lack of insulin).

With no MRI scanners or multiple chemistry panels, the physicians must rely on their most valuable tool — the strength of the doctor-patient relationship and the trust that seals that bond. Physicians who have become dependent upon the cold precision of modern medicine once again learn the joy of the human touch. The absence of HMO mandates, Medicare bureaucracy, and a sea of government acronyms from CLIA to OSHA helps the physicians remember why they entered medicine in the first place — to heal. In many ways, this kind of experience is as therapeutic for the doctors as it is for the patients.

While the medical clinic stays busy during the relief trips, the dental clinic is really where the action is. Unlike in the United States, where much of dentistry is all about aesthetics, dentistry in the Third World can be a life-saving profession. Patients, already suffering from malnutrition, often can't eat what little food they have because of horribly abscessed teeth. The simple act of pulling a tooth can mean the difference between life and death, as in the case of a young woman who presented with two dental abscesses that had drained to her right cheek, leaving her with two holes on the side of her face.

Another patient comes to the dental clinic asking for an extraction. "Which one?" asks the dentist. Typically patients point to all their teeth, since they know that eventually they will all rot and require extraction — and that this may be their only chance ever to see a dentist. This time, the young boy points to only three teeth and asks if we have anesthesia. The few dentists that work in this part of the country don't always have anesthesia available. Luckily for the patient, we are well stocked.

It's not uncommon for a dental team to tackle tough cases that in the States would require pre-operative X-rays and referral to an oral surgeon. Because of the sheer desperation of these patients' circumstances, our dentists learn to stretch their comfort level, because their patients have no other options. And they do it all by flashlight, as the clinics have no electricity or running water.

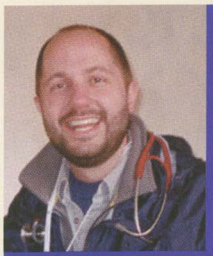
The list of services provided doesn't stop at basic medical exams and dental care. Our team's pharmacy is stocked with over 100,000 pills. More than 6,000 prescriptions are written, and we dispense medicines whose cost eclipses the patients' annual income.

An optometrist fits a pastor with glasses, and for the first time in five years the man suddenly can see well enough to read. A physical therapist works with patients suffering from illnesses ranging from polio to congenital deformities. Specialists, including ENTs, dermatologists and infectious disease experts, are also on hand. The dental triage team teaches children to use a toothbrush, does basic dental education, and provides fluoride treatments. A van powered by a generator enables the dentists to do fillings, and pastors and local church leaders are on hand to provide patients with support and counseling.

Why do I participate in these annual medical missions? For one, I feel that all physicians have a responsibility to those in need. This idea used to be an integral part of the profession. Somewhere along the way, it seems to have been forgotten.

But probably the most important reason is a deeply personal one. There's something special that happens to you when you take a child who is dying from malnutrition, play with him, and realize that next year he won't be there if you don't return to the village. That kind of experience changes your perspective on life. Things that before seemed so significant ("Will there be an empty table at the restaurant?") diminish in importance after you have seen firsthand the poverty of the Third World.

In today's American society, we have become a horribly egocentric people, ignorant for the most part about the daily struggles of the majority of the world's population. Experiences like this help to put things in proper perspective.



Grat Correll '89 lives in Bristol, Tenn., with his wife, Christy Boyd '92, and their two children. A Spanish major at Furman, he earned his medical degree from the University of South Carolina School of Medicine.

He has been named "Best Physician Bristol" and received the 2001 "Most Outstanding Preceptor" award from the Quillen College of Medicine at East Tennessee State University. Through the years, his work with medical relief teams has taken him to Honduras, Mexico, the Dominican Republic and Guatemala, as well as to the Amazon jungle.