Friends of Vellore, Victoria
NEWSLETTER
JUNE 2010

The Friends of Vellore – Victorian Branch **Newsletter, 2, 2010**

Friends of Vellore Victoria & The Australian Vellore Board

You and your friends are invited to the

VELLORE DINNER

6:30 PM Saturday 14 August 2010 *cost **$50** per person*

Junior Common Room, Queens College, the University of Melbourne

Guest Speaker: ***Dr. Isaac Jebaraj***
Deputy Director Christian Medical College Vellore, Tamil Nadu, South India

After the dessert there will be a Panel Discussion and guest contributions, compered by

Dr. Ian Weeks
President Friends of Vellore Victoria:

"What does it mean to have a STROKE in rural or urban areas of India, China and Australia? Is it simply a question of lack of resources?"

Panellists:

Dr. Gillian Webb
Assoc Professor Physiotherapy the Faculty of Medicine, Dentistry and Health Sciences

Dr. Jacques Joubert
Neurologist Royal Melbourne Hospital

Dr. Zhen Zheng
Senior Lecturer in Chinese Medicine RMIT University

Dr. Lynette Joubert
Assoc Professor Social Work the Faculty of Medicine, Dentistry and Health Sciences

R.S.V.P. asap - no later than 30/7/10
Dress: Black Tie / Traditional Evening Wear

Enquiries: Secretary Louise Joy
fovvsecretary@gmail.com

*(Please advise of any **specific dietary** requirements or if a **vegetarian** option is required)*

Ph 54333631 or Mob 0433 326 816

*Please advise details of **all** dinner guests & dietary req'ts by **post or email** & in return a receipt will be given*
*Cheques to be made out to "**Friends of Vellore Victoria**"*

email: fovvtreasurer@gmail.com

Payment can be made to:

Post Evelyn Lehmann and John Gault
co Treasurers Friends of Vellore Victoria
203 View St.
Bendigo 3550 Victoria

or *Direct Debit*

Friends of Vellore Victoria BBL
BSB 633000
Account 139185151
reference - your name/dinner

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From Ian Weeks – President

The meeting of the Australian Board and the dinner at Queens College promise to be great events. I hope to see many of you there. I must say that Louise Joy, our Secretary, has done a remarkable job planning these events.

In the last Newsletter I said that I would like to write about women medical missionaries. Little did I know what a treasure chest I was opening! I had planned to write about Ida Scudder, Sophie Stronach at Azamgarh, and Gladys Aylward who was in China. As I cast about looking for information I was overwhelmed by the number of such missionaries, both in the past and still active in various parts of the world. So many books have been published and many others are waiting to be written about the contributions and activities made by these people over the last two hundred years or so that I have begun looking for a post-graduate student who might like to write a doctoral thesis on this topic.

Instead of doing that myself I turned to a somewhat different topic. For sometime I have been interested in the nature of missionary activities and what they accomplished in the places and nations where they were active. I had supervised a thesis for Deakin University and written by Phillip Brotchie. Dr Brotchie wrote his thesis on the Australians who participated in the China Inland Mission between 1825 and 1950. As well as accumulating an astonishing body of information he addressed the difficult question of the success of these missionaries. In addressing the question of success I had suggested to him that he needed to discuss both *the intended and the unintended results of missionary activity.*

I was reminded of these discussions when I was in China last year, visiting my wife's family in Nanjing. One day my nephew took me out on a carefully planned walk through parts of the city I hadn't previously explored. The long walk ended at the home of a man by the name of Hong Huoxiu (later known as Hong Xiuquan). Hong's family were Hakkas originally from Northern China who had migrated and settled in various parts of southern China. Hong's village of Hua had many other Hakkas living there, about 30 to 40 miles north of Canton. Hong was born in the early nineteenth century. He studied Confucius and while waiting to sit for civil service exams he came into possession of a Christian tract. He was unsuccessful in the exams and when he tried them again the following year he was again unsuccessful. During this time he had been studying the Christian tract very carefully and with astonishing consequences. After his second failure he became ill and during his illness he had a succession of very strange and powerful dreams. In his dreams he met God the father, Mary and Jesus. He came to believe that Jesus was his older brother and that he was God's younger, Chinese, son.

The Christian tract that Hong had was filled with stories of God's growing anger at the sins and faithlessness of his people, and of the terrible punishments that followed from that. The tract was millenarian in character, warning of the dangers of faithlessness and the imminent punishments that could be expected at God's soon to come heavenly kingdom. When Hong recovered from his illness he began to plan for ways to bring this message to China, to clean up the terrible exploitations of the people at the hands of the many warlords, and to drive the Manchu invaders out of China. He saw this as the wish of his elder brother and his father in Heaven, and he understood these wishes had to become the centre of his life. The consequences of this understanding are astonishing. Hong attracted at least two Muslim armies as well as thousands of his own followers, to begin this task of cleansing and punishment. He organised these people into armies under his command and set about cleaning up the country.

The house I visited in Nanjing became Hong's headquarters. In the house, now a museum, are laid out details of the various astonishing battles and conquests that saw him coming to control most of China south of the Yangtze-kiang River – almost half of all China. The house in Nanjing became the headquarters of the ***Taiping Heavenly Kingdom***, from where Hong began to plan for the conquest of the rest of China. Nanjing also became the farthest extent of his conquests and his revolution came to an end here.

Among the many fascinating objects at the museum are two letters, one from Dr Sun-yat Sen and the other from Mao, praising Hong as the great pioneering role in the creation of modern China. Of course many different developments led to the Chinese Revolution, but it is important to know that Christianity was one of the ways in which traditional values were changed and new forms of life and learning were created that led to that revolution.

The story of Hong and the Taiping is told in considerable detail by Jonathan D. Spence in a fascinating book ***God's Chinese Son: the Taiping Heavenly Kingdom of Hong Xiuquan*** (W.W. Norton & Co., 1996). Christian missionaries brought much more than the gospel to the countries in which they worked. Inevitably the missionaries brought Western ideas and assumptions about most aspects of life with them. This was as true about medical missionaries as it was for any other missionaries and as it was for the many other representatives of the West who came to Asia, Africa and South America. One of the unintended consequences of medical missionary work was the weakening of traditional forms of health care and medicine and their replacement by Western medicine. While the new medicine achieved many great things, and Vellore is a wonderful testament to that, the weakening and loss of traditional forms of health care was expensive. Western medicine requires huge amounts of money to support the technology, engineering, and pharmaceutical manufacturing and research that hospitals of our kind need. Traditional forms of medicine and health care were much less expensive and tended to be created out of resources that were locally available. Undoubtedly some aspects of traditional medicine were not always the best for health but its destruction in many places created virtual deserts surrounding the "oases" of Western hospitals. So too, the great expense of Western medicine drew out the resources of local communities and moved health and medical practice into cities and regional centres. Today one of the important challenges facing these kinds of situations has been the need to create new forms of health care for areas which might not be able to sustain the expensive forms of medicine that cities might provide. Vellore has been a pioneer in this area of health, beginning with Ida Scudder's who went out into rural areas after founding the hospital, and also set up a roadside dispensary.

Here is a description of an organisation, active in the Corio area of Geelong as well as in other places in Australia and beyond, which reflects this problem:

Home - Hands on Health

Hands on Health Australia (HOHA)

Aims to assist communities to improve the delivery of health and other services to marginalized people, utilizing the resource of community volunteers.

The work of HOH occurs both in Australia and around the world. Volunteers work in communities providing various therapies and services to those who would be otherwise unable to access them. These services include; chiropractic, dentistry, dermatology, general medicine, hairdressing, massage, naturopathy, nursing, physiotherapy, podiatry, psychology and legal advice, just to name a few.

Hands on Health assists communities to establish clinics in which volunteers work in particular healing and service professions. Volunteers also work as "welcomers" who are there not only to assist the practitioners but also to provide a network of people to be there for those who are lonely or isolated and may have no one else to be there for them.

Hands on Health also provides training for health workers in basic myotherapy (massage) in communities where there is no access to this type of care. In this way communities are empowered to care for their own people in a sustainable and affordable way.
(Hands on Health have begun a partnership in 2010 in Rajasthan with a local non-government organisation.)
In India between two-thirds and three-quarters of the population live in rural areas. The provision of health care to these areas is an enormous challenge. In some ways the extraordinary success, but also the extraordinary expense, of Western medicine and modern hospital care makes the need for discovering sustainable forms of rural health care a matter of great urgency. It must also be said that this situation holds in many Western countries where rural health is often in considerable difficulty.

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At the Dinner for the Annual Meeting of the Australian Board of the Friends of Vellore a panel will discuss some of these issues.

Coming Event:

The Victorian Branch of the Friends of Vellore **Annual General Meeting**

Saturday 13th November 2010 at Queens College, The University of Melbourne including ***complimentary*** Queens College "Classic Afternoon Tea" with scones

Guest Speaker: **Dr Dayalan Devanesen AM**, MBBS, MPH, FRACMA, FAFPHM, FCHSE

In recognition of his 30 years of service in the Northern Territory, much of it with Aboriginal communities, Dr Dayalan Devanesen was appointed a Member of the Order Of Australia in 1997, the first person of Indian origin to be so appointed.

After graduating from CMC Vellore and working for a time at the CSI Hospital in Nagari Village, in 1974 Dr Devanesen began to work with Aboriginal communities in the Alice Springs area eventually becoming the Director for Aboriginal Health in the NT. By developing a cadre of health assistants (Aboriginal Health Workers) he helped to bring down the infant mortality rate from 200 to 30 per 1000 live births.

While serving desert Aboriginal communities he became aware of the artistic depth of the now burgeoning Dot and Circle art and was quick to adapt those ideas and practises into health education stories for people many of whom were illiterate. As they learnt from him while he was dealing with their health problems he was able to learn from them. As an initiated member of the Warlpiri people, he was given an intimate understanding of their art and stories told in the paintings.

We look forward to Dayalan sharing with us some of this rich experience and its links with his *alma mater*, CMC Vellore. He is currently Chairman of the CMC Alumni Association of Australia

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The Health Report Interview continued:

In the previous Newsletter we reproduced half of a programme played in The Health Report on Radio National. Here is the second part of that programme. The issues raised in this fit remarkably with the concerns I raised in my editorial essay in this Newsletter.

Norman Swan: Ann Tharyan is Professor of Psychiatry at the Christian Medical College in Vellore, Southern India. And you're listening to the Health Report here on ABC Radio National with me Norman Swan.
One of the most difficult and controversial areas in the care of the seriously mentally ill is when a person is violent. They can harm themselves and others. And while the idea of talking them down gently might give you the warm and fuzzies, especially if you've been primed by institutional horror stories like One Flew Over the Cuckoo's Nest the practical reality is that drugs are often needed.
The question is which drugs are safest and best? Remarkably there's been almost no evidence on this, at least until a trial performed at the Christian Medical College in Vellore by Prathap Tharyan, who like his wife Anna, is also Professor of Psychiatry. Prathap is internationally recognised for his work in evidence-based medicine.
Prathap Tharyan: Violence in psychiatric patients is fairly common and in a centre like ours which is the only psychiatric hospital for the entire district which has inpatient facilities we get lots of people brought to us, their families have brought very disturbed patients after four or five days of travel, sometimes they're in chains.
Norman Swan: In chains?
Prathap Tharyan: That's right, they are tied up and they have a whole host of relatives because we don't have a social security system, we don't have social workers, we don't have a police force which understands how to deal with psychiatric patients. So they are brought in by buses, or by bullock carts, or sometimes in trucks and they really need help. And by the time the patient comes here everybody is exhausted, the patient is very, very angry and when we're trying to talk them down he just starts fighting and trashing the place. So we really have to quieten him down to prevent him hurting himself or other people, that's our responsibility. And often this happens either in the middle of the night or during a very busy outpatient days when we have 500 outpatients and 16 doctors to see them and nurses are stretched. We just don't have time to spend four hours with one patient.
Doctors want 15 minutes, I want this person settled, I will go see my patients, I will come back and also it's a question if you ask relatives who come what can we do to help you? And they say my relative has not slept for four or five days, I just think that if he sleeps he's going to be well so I need something that will sedate him, that they will be safe and then I can come back to them and take care of them.
Norman Swan: Prathap Tharyan who heads the South Asian Cochrane Centre which is part of the Cochrane Collaboration - a worldwide network of researchers devoted to bringing together, analysing and disseminating the best available evidence on health care.
One of Prathap's colleagues is Clive Adams, Professor of Mental Health Services Research at the University of Nottingham in the UK who runs the Cochrane Schizophrenia Group. Clive also has an interest in the treatment of violence and was visiting Vellore when I was there.
Clive Adams: People can hear things that just aren't there and begin to believe and know things are happening around them that just aren't happening. So it's not that the person believes that they are being persecuted by the CIA, they absolutely know it and it is remarkable how peaceful most people with schizophrenia are considering what's going on in their head. But sometimes those thoughts get to the point where they react against them and despite efforts of talking down, or trying to pacify the situation some sort of medication has to be used in order to tranquilise the whole situation for the safety of everybody concerned.
Very senior groups across the USA, the UK, Australia have sat down and looked at the best available evidence and there is very little. It's all the same evidence that they've looked at and they've all come to different conclusions.
Norman Swan: You were involved in a trial which the Brazilians conducted.

Clive Adams: One of the things that I do is I undertake workshops on evidence- based care. I undertook one on a rainy hillside in Rio de Janeiro and the one person who was a psychiatrist out of 50 came up to me at the end and said I'm worried about how we're treating people in our emergency rooms and I'm not sure there's good evidence for it. And we worked together in order first to line up the best available evidence.
The treatments of choice in Brazil were haloperidol promethazine versus a treatment that's used in Australia, midazolam.
Norman Swan: Just explain what those drugs are.
Clive Adams: Haloperidol is an old anti psychotic drug, promethazine is one that's paired with it to decrease the adverse effects but also to increase the sedation.
Norman Swan: It's an old fashioned anti-histamine.
Clive Adams: An old fashioned anti-histamine and midazolam -
Norman Swan: That's what you get for your colonoscopy, it's like an anaesthetic.
Clive Adams: Exactly and it's a benzodiazepine that works very quickly and is heat stable. In Brazil, in the emergency rooms, they don't have fridges. And we did find one trial of haloperidol versus placebo, versus midazolam, but it was 15 people with no clear findings. We said well maybe at least these people were interested, we identified them on the internet and found that they were very famous and that was because they were put in prison for embezzling company funds and possibly mucking up data. So that was the best evidence on 15 people -
Norman Swan: For the criminals.
Clive Adams: - with an unsure study so it seemed reasonable to undertake the trial ourselves.
Norman Swan: And at the same time you were doing a similar trial here?
Prathap Tharyan: Except that the drug we chose to trial was lorazepam which is also a benzodiazepine sedative.
Norman Swan: So a valium-like drug?
Prathap Tharyan: Like valium the only thing is that it can be given as an inter-muscular injection which valium is not very good at and it's very cheap. It's as cheap as the combination of haloperidol and promethazine but the question was which is better because haloperidol is a toxic drug and we've been using haloperidol promethazine for many years. And what we thought was fascinating about this trial was it was being done during routine clinical practice.
Norman Swan: This was not some artificial situation, this is real life?
Prathap Tharyan: This was a real world trial and we didn't exclude large numbers of people because most trials tend to exclude somebody with this condition or that condition. But a clinician doesn't have that luxury, you've got to treat everybody who comes so a lot of that evidence isn't applicable to us. So we decided to create our own evidence using our own patients using our usual clinical practice.
Norman Swan: And what did you find here?
Prathap Tharyan: We found that if you give haloperidol promethazine or you give lorazepam, at the end of four hours they were equally effective, people are tranquil, nobody gets harmed but if you use haloperidol promethazine this happens much sooner and our patients are looked after by the nurses and their family members. We don't advocate giving a person an injection and walking away.
Norman Swan: So it's not just a chemical solution?
Prathap Tharyan: No, it's not. Sometimes when you give an injection you have to make sure that until the injection acts the patient is quietened. In our part of the world restraint is very commonly used, where people are restrained to their beds but the family member sits by their side and talks to them and tells them listen we'll release you just calm down. And usually every 15 minutes they are assessed to see can we release that person. So we found that if you use this you tend to get people out of restraints a little sooner so the first trial seemed to suggest that haloperidol promethazine is good. But the other problem we had to deal with was what about the new drugs like olanzapine.
Norman Swan: This is one of the newer drugs against schizophrenia which has also been a bit controversial.

Prathap Tharyan: Well the problem for us was the cost, it was four times more expensive than haloperidol promethazine but the drug companies sold it and we looked at the studies this is based on entirely by the drug companies and what we found was the patients who were selected were people who all gave informed consent to be randomised.
Norman Swan: So they couldn't have been let off.
Prathap Tharyan: I thought to myself I don't know a single patient who comes to my emergency room I'm going to give injections to who'll give me informed consent to be randomised. So we did the same design the only thing was we had 300 patients this time.
Norman Swan: And the finding?
Prathap Tharyan: Haloperidol promethazine and olanzapine are both good drugs but if you give haloperidol promethazine the patient stays tranquil for four hours. Olanzapine needs to be repeated, the doctor has to be called back and it just defeats the purpose of trying to keep people down. After these studies we talked to our patients, how did they feel about being restrained, and they said thank you for doing this to me, I don't know what I was doing at that time. And our patients relatives they say this is exactly what we want, we want people to be safe.
We also asked them would you prefer to be kept in seclusion like in many other countries in the west?
Norman Swan: A locked ward.
Prathap Tharyan: And we don't have a single locked ward here and they say no, no, no we want to be sitting with them but I want to be in a position where I'm not harming anybody. So we think in our kind of situation haloperidol promethazine is affordable, cheap and safe combined with the nursing care and the family's attention. It's only a short term remedy until we can actually start working on their illness.
Norman Swan: What did you find in Brazil?
Clive Adams: In Brazil there were two trials as well. The first trial finds that again haloperidol promethazine is an excellent drug but that midazolam was clearly faster in producing the tranquilisation but it decreased the respiration.
Norman Swan: Because basically it's an anaesthetic.
Clive Adams: It's an anaesthetic.
Norman Swan: And it's also more expensive.
Clive Adams: It's more expensive, we have to keep a very close eye on people.
Norman Swan: So here are trials done independently from the pharmaceutical industry where you could actually trust the results?
Prathap Tharyan: And it cost 5000 rupees each trial.
Norman Swan: 5000 rupees per patient?
Prathap Tharyan: For the entire trial.
Norman Swan: For the entire trial?
Prathap Tharyan: Absolutely, 5000 rupees that's all it cost to do a good quality trial independent of drug co. funding relevant to our needs, involving real life patients and the kind of working conditions we work in.
Norman Swan: And for the Australian audience we are talking about 40 rupees to the dollar so this is cheap stuff. Whereas some of these drug trials can cost $190 million so the drug companies say.
Prathap Tharyan: And one of the tricks that they do is they try and get the outcomes rigged in such a way that you can get a positive result and one of the ways you can do it is use a rating scale. The ones that the drug companies use is called an overt aggression rating scale, it's a number of questions which nobody in real life actually asks.
Norman Swan: What you're talking about here is you've got to observe some kind of behaviour, you've got to be able to measure it objectively to be able to say in your published paper you went from 100 points on the scale to 50 points or what have you as a measure of violent or disturbed behaviour.
Prathap Tharyan: I don't know a single clinician in the emergency room who will sit and ask patients or rate them on any scale. What do they do? They think, is this guy seriously ill, how violent is he and what do we do with him? These are the kind of clinical questions that we need to ask.
Norman Swan: And this is a recurrence not just in psychiatry but is a recurrent question in trials. There's a huge debate about anti-Alzheimer's drugs and the rating scales the drug companies use and did it actually make any difference to patients or carers and nobody could observe a difference.

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Clive Adams: On a day when clinicians are asked multiple questions on the overt aggression rating scale and then are also asked did you think that the situation got better or not rather unsurprisingly good clinicians can tell. So perhaps we should learn to trust them more also in the trials.
Prathap Tharyan: And when we actually compare the way clinicians think and patients' relatives think, it's exactly the same.
Norman Swan: Tell me about the tsunami story?
Prathap Tharyan: The South Asian Cochrane network met in Goa in December 2004 and decided we were going to start working towards providing real life evidence from the Cochrane Collaboration and on the 26th December 2004 a tsunami hit India. So as part of the government effort a team from CMC went to the tsunami affected areas.
Norman Swan: The CMC being the Christian Medical College here in Vellore?
Prathap Tharyan: That's right.
Norman Swan: And of course the east coast here of Tamil Nadu would have been affected by the tsunami?
Prathap Tharyan: It was the largest area in India, we lost about 4000, 5000 people. Everybody thought that because of the trauma there's going to be a lot of post traumatic stress disorder and everybody needs counselling. And we found that everybody was providing counselling.
Norman Swan: And there've been Australian studies which have shown it does harm.
Prathap Tharyan: That's right. So I asked the people who were doing the counselling what are you doing? So they said we go to the first village out of 63 or whatever and we get everyone together and do mass debriefing because we can do a lot of people at one time. And I said do you think it works? They said we are sure it works, what are you doing? We said we are going to a village, finding out who needs help, sitting with them, sometimes it just means rebuilding their houses because this is a natural disaster. There's going to be a period of grief and loss and they have to go through it and six, seven months down the line is when you see have they recovered. And all you can do is sit with them and do practical stuff and find the ones who are vulnerable.
So I happened to have a laptop and the laptop had a CD version of the Cochrane Library, I fired up and asked the question - single session mass debriefing and post traumatic stress disorder and it came up with this review which showed that single session mass debriefing does not prevent post traumatic stress disorder or depression in the short term and in the long term there is a suggestion that it might increase the odds of getting it. Why? Because you sensitise a person and you walk away and there was other evidence from the Cochrane library that said repeated psychological support in many forms, to people who are vulnerable and who need it could be effective. And that's what ultimately we got the government to get everybody to do.
And nine months later we went down and did a survey and the people said what really helped them was the community support, their belief in God and they told us that mental health services they don't think that is an important thing. Strengthening communities using their own belief systems and their own strengths is what really works there and practical help in the immediate aftermath.
Norman Swan: Prathap Tharyan is Professor of Psychiatry at the Christian Medical College in Vellore, Tamil Nadu and before him Professor Clive Adams of the University of Nottingham. I'm Norman Swan and you've been listening to the Health Report, to hear us again download a podcast from the website.

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