# Louis J. Morledge, MD

Louis J. Morledge, MD (known as "LJ" by his friends) has seen many different worlds as a young physician. Originally from Billings, Montana, Dr. Morledge spent most of his childhood in New York City. His residency in internal medicine led him back to New York, and eventually to Nairobi, Kenya, where he spent six weeks in 1993 fulfilling a tropical medicine elective.

If Dr. Morledge found practicing in East Africa to be a "crash course" in medicine at its most basic, he found some of the same conditions upon returning to New York for his fellowship in Community Medicine. For the past two years, he has practiced at a large shelter for homeless men on Ward's Island. The latest antibiotics and diagnostic equipment are not available here, he explains. Without most of the trappings of modern medicine, Dr. Morledge has learned that the doctor-patient relationship becomes all-important.

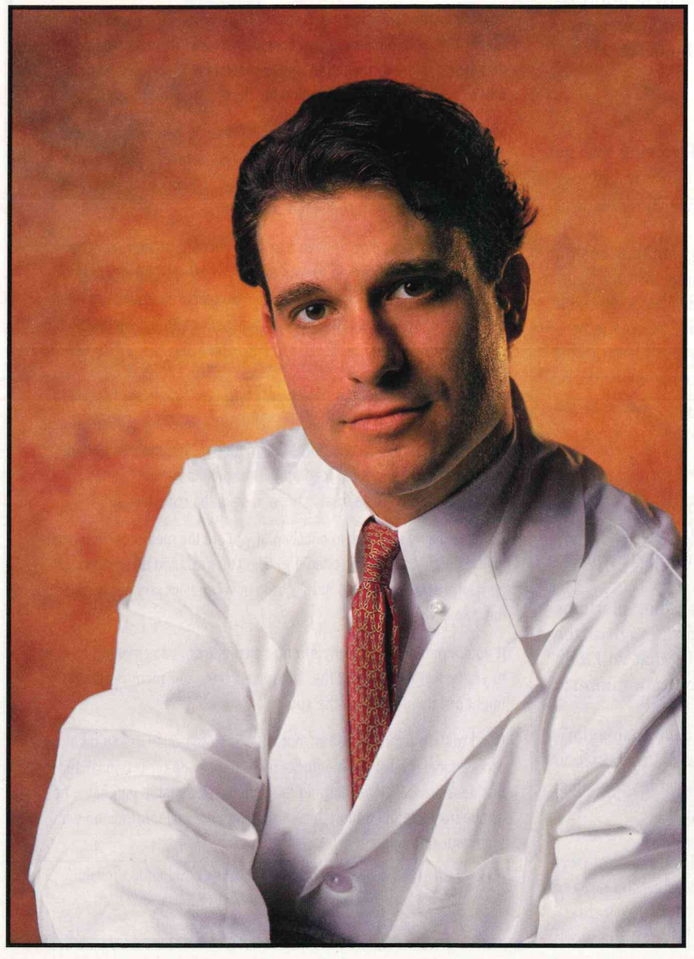


PHOTO BY HERMAN ESTEVEZ, NYC

## CV

**AGE: 30**

**SPECIALTY: Internal Medicine**

**GRADUATED FROM MEDICAL SCHOOL:**
**New York Medical College**
**Valhalla, New York, 1990**

**RESIDENCY COMPLETED:**
**Lenox Hill Hospital**
**New York, New York**
**June 1993**

**FELLOWSHIP COMPLETED:**
**Fellowship in Community Medicine/Primary Care**
**St. Vincent's Hospital**
**New York, New York, 1994**

**CURRENT PRACTICE:**
**Attending Physician in Community Medicine**
**St. Vincent's Hospital**

**TYPE OF PRACTICE:**
**Charles H. Gay Shelter, Ward's Island**
**Satellite clinic providing medical care and social services for homeless men**



**What made you decide to pursue a career in medicine?**
My family's connection to medicine dates back to the turn of the century. My paternal grandfather graduated from medical school at Ohio State and practiced EENT surgery in Billings, Montana. Two of my uncles continue to practice ophthalmology in Billings, and a third uncle practices otolaryngology in California.

**Describe your experience at Kenyatta National Hospital in Nairobi.**
This was a very influential rotation for me. It gave me a chance to reflect on the direction I want to take as a physician and to discover what motivates me. Kenyatta National Hospital is the largest public hospital in East Africa. Although it's a very modern building on the outside, it lacks much of the technology and expensive equipment that American hospitals take for granted.

I did have an opportunity to learn about tropical diseases that you rarely see here in the United States, such as cerebral malaria, and leishmaniasis—diseases you learned about in medical school but assumed you would rarely encounter in a patient. But the greatest contrast I noticed was in talking to the patients. I did my residency at a private hospital where most of the patients are comfortable in their lifestyles, and sometimes would complain to me that they were served tea instead of coffee that morning. In Africa, what the patient wants to know is, am I going to get my medications today? Is it helping, or am I going to die? It really forced me to recognize how fortunate we are in this country.

**How did your residency lead you to your current position in Community Medicine?**
After returning from Africa I accepted a fellowship in the Department of Community Medicine at St. Vincent's Hospital in New York. This position allowed me to be a member of the National Health Service Corps (NHSC), which provides loan repayment in exchange for working in physician shortage areas. These positions are available primarily in rural areas, but I was fortunate to find a position in New York City.

**What experiences prepared you for working with the homeless?**
My fellowship training at St. Vincent's provided opportunities to work with several groups of medically underserved patients. I was part of a team that made house calls to the homebound elderly in New York, acting in many ways like "old-fashioned" country doctors. We visited some people who have not left their apartments for literally five or ten years. I also worked at satellite clinics such as homeless shelters for men and women, and worked with indigent patients at the hospital's clinic.

One particularly valuable experience for me was attending the Hazelden Physician Training Program, which is an intensive program designed to teach physicians about substance abuse and addiction. The training involves staying in a halfway house and observing firsthand the problems of alcoholism and drug use.

**For someone who has nothing even the smallest token becomes a thing of value**

**What is your daily routine of your current job at the homeless shelter?**
The Charles H. Gay Shelter is a 900-bed facility for homeless men run by the Volunteers of America of Greater New York. The facility is on an island off Manhattan, so one sometimes feels a sense of isolation working there, but it is also one of the safest and best-run shelters in the city.

In an eight-hour day I see between 12 and 22 patients. The clinic has two to four physicians on duty at a time and treats from 1,100 to 1,400 people in a month. I'm fortunate to be part of a very strong team of providers, including physicians, nurses, social workers, and HIV counselors. Our approach to treatment must include the whole person, taking into account substance abuse, nutrition, education and preventive care. For example, every encounter includes screening and counseling patients about tuberculosis and HIV. Because a large percentage of the patient population is affected by these diseases, infection control is paramount.

**How do you cope with the emotional difficulty of working in such a setting?**
A shelter client of mine once said, "When a man sits with a man on a hollow log and drinks his muddy water when he don't have to, he has really found a friend." In many ways, these words embody what I experience daily. I've found that you have to be satisfied with small gains, such as getting a patient to agree to HIV screening or to complying with their treatment regimen.

Treating the homeless has definitely been my greatest challenge as a physician. Even simple medical problems become a tremendous task when the patient is deprived of adequate food, shelter, and education. For someone who has nothing, the smallest token represents something of value. For example, a single aspirin tablet or antibiotic can be sold or bartered to someone else. Certain drugs, such as bronchodilators, can be used to

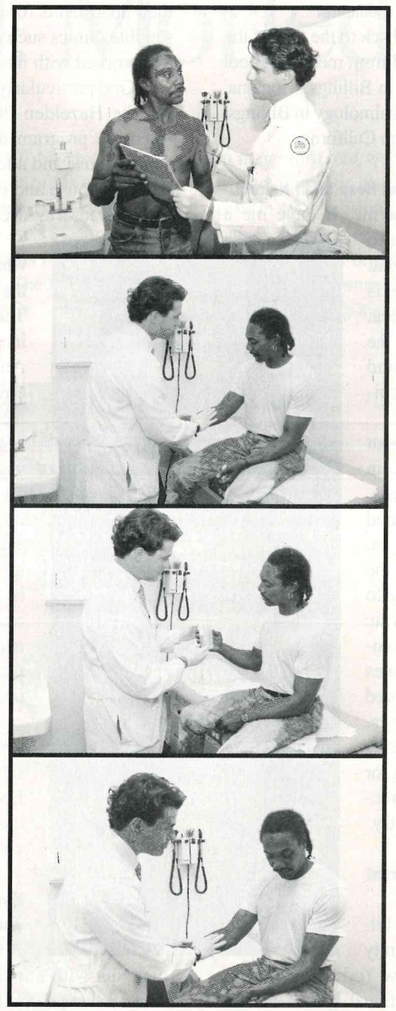
enhance the effects of crack cocaine. Even bed rest is a valuable commodity. So you learn the tricks of the trade, and you let the patient know that you understand his motives but that you are trying to help him recognize and be responsible for his own medical problems.

**How do you cope with the demands that your career places on your personal life?**
Burnout is a very real concern in this type of setting. I try to schedule activities that take me away from the clinic or the hospital. Even a few minutes of solace with my girlfriend or my family is sufficient to help me recharge my batteries. I also play squash three or four times a week and participate on a squash team. I've been working on a collection of short stories based on my experiences of treating the indigent, but with the all-consuming practice of medicine, I don't know when I'll complete it.

I also get great satisfaction from teaching residents and second-year medical students in community medicine at St. Vincent's Hospital. Our clinic setting is popular among the students, and I try to act as a role model for them, setting an example of how to behave with professionalism and sensitivity. This is particularly important when working with the population of HIV-infected patients. Students must learn that it's possible to use appropriate infection control techniques while at the same time delivering sensitive and high-quality patient care.

**Would you recommend an NHSC position to physicians currently in training?**
For certain young physicians who have the energy and the motivation, it's an ideal training ground. Working with underserved patient populations provides a "crash course" in both primary care medicine and managed care. In a shelter population with minimal resources, I can't pick out a newfangled antibiotic or antihypertensive agent—I simply don't have them. Most of my patients do not have insurance, Medicaid, or Medicare. I have to use what is available, which are the basics. You have to rely heavily on patient communication skills and your own instincts, on developing trust, and staying on your toes. How did the patient look? Is the information consistent with what he or she told you on the last visit?

An important benefit of NHSC is loan repayment. Unlike many of my peers, I will be free from loan payments by the end of the year. Therefore I feel that the NHSC is a smart option for other young physicians who are considering residency or fellowship positions.



**Dr. Morledge sees between 12 and 22 patients a day at the Volunteers of America Charles H. Gay Shelter. The clinic's team approach to primary care includes counseling on nutrition, infectious disease protection, and substance abuse problems.**

**What are your plans for the future?**
I've recently signed on for one more year in the Community Medicine department, and will probably continue to be assigned to the Charles H. Gay shelter. However, I'm going to split my time between the shelter and a large multispecialty group practice. I am currently applying to some managed care plans, including the plan that offers health benefits to the Volunteers of America staff at the shelter. Interestingly, some of the successful shelter patients go on to get staff jobs at the shelter. So it is possible that I could have former shelter patients who become my patients under a prepaid health plan! I anticipate caring for the indigent and homeless throughout my medical career, although the degree of involvement may change as my career develops. ■



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