

WORCESTER medicine

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World, But I can cast a
stone Across the Waters to
create Many Ripples.*

Mother Teresa

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contents

Vol. 78, No. 3

MAY/JUNE 2014

- | | | | |
|-----------|---|-----------|--|
| 6 | Editorial
Jane Lochrie, MD | 20 | Volunteer Eye Mission to El Salvador: February, 2014
James Umlas, M.D. |
| 9 | From the Roadside to the Bedside: Following the Saint of the Gutters
George M. Abraham, MD, MPH, FACP | 22 | Legal Consult
Peter Martin, Esquire |
| 13 | Local Volunteerism 101
Harvey G. Clermont, M.D. | 27 | Society Snippets
WDMS 2014
Call for Nominations |
| 16 | Promises to Keep
Carol Jaffarian, MS, ANP-BC | 29 | Society Snippets
2014 Annual Business Meeting |
| 18 | Making a difference internationally
Stephanie Conway, Pharm.D., R.Ph. | | |



On the Cover:
Caring for the Underserved:
Worcester Medical Community Volunteers

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Editorial

Jane Lochrie, MD



Jane Lochrie, MD

Winston Churchill said, “We make a living by what we get. We make a life by what we give.” I think this issue of *Worcester Medicine* is confirmation of this quotation. Our Worcester medical community is reaching out to the medically underserved, both in Worcester and in several developing countries.

As always at this time of the year, our issue opens with the Annual Oration that was expertly and passionately delivered by Dr. George Abraham on Feb. 19, 2014. He turns back the hand of time and describes the life of Mother Teresa, the “Saint of the Gutters.” In 1949, Mother Teresa’s first year as a missionary, she had only the clothes that she wore and she had to beg for food and supplies. The following year, she started the Missionaries of Charity, caring for the “poorest of the poor.” By 1960, she had opened several hospices, orphanages and leprosy homes all over India, and eventually, the Missionaries of Charity came to the United States. Dr. Abraham himself was influenced by Mother Teresa’s work and while a medical student, volunteered every Sunday at a leprosy community and eventually became a consultant to the Missionaries of Charity.

Since it was first said by Martin Chuzzlewit in a Dickens novel, the slogan “Charity begins at home” has been used many times. Dr. Harvey Clermont is the personification of this statement. In his article, Dr. Clermont tells us how to start a free medical program, and he should know; he has started several in the Worcester area and has advised several other physicians on how to start their own free clinics. Dr. Clermont closes by saying, “I can say without reservation that the clinics have been extremely rewarding and have acted as a beacon of hope for the least affluent of our society.” Having worked with Dr. Clermont

at St. Anne Free Medical Program, I consider him right up there with Mother Teresa!

In the third article, Carol Jaffarian, MS, ANP-BC, describes her involvement with the Armenian Relief Society (ARS) with self-deprecating humor. She describes how one phone call from a nurse, Penny Giragosian, changed her life. The next thing she knew, she was speaking at the United Nations and traveling to Armenia to start an HIV program. Together with Carol Bova (a former member of our Editorial Board), she started the HIV Education and Prevention Program, a collaborative effort between UMass Worcester and the ARS.

Stephanie Conway, Pharm D., R Ph., tells us how she is making a difference in Honduras. She portrays patients as walking miles for six-plus hours overnight to be seen in the dental or medical clinic. The pharmacy where she volunteers dispenses enough medication for four months, until the next missionary group arrives. In closing, she advises that sometime we must leave our comfort zone to help those in need.

In the final article, Dr. James Umlas reminds us that cataract blindness and the need for eyeglasses are still the main causes of preventable visual impairment in developing countries. He has been volunteering at ASAPROSAR (Salvadoran Association for Rural Health) for the past 25 years, and he comments that this is one of the most rewarding parts of his professional and personal life. Each campaign provides exams and eyeglasses for 2,000 patients. In addition, 150 sophisticated surgeries are performed.

The most extraordinary feature of these articles is that each author comments how rewarding they found their experiences.

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~ John F. Kennedy

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From the Roadside to the Bedside: Following the Saint of the Gutters

George M. Abraham, MD, MPH, FACP



**George M. Abraham,
MD, MPH, FACP**

Let me turn back the hands of time. Nikolle Bojaxhiu was born in 1874 and became a pharmacist and a successful businessman. He married Dranfile Bernai and had three children, the youngest being Agnes (b. 1910). Bojaxhiu died prematurely and unexpectedly. After their father's death, the three children were raised Catholic by their mother. Agnes Gonxha, meaning "rosebud" or "little flower," was

only 8 when she was fascinated by stories of missionaries' service in Bengal. By age 12, she became convinced that she should commit herself to a religious life.

She left home at 18 to join the Sisters of Loreto as a missionary. She never again saw her mother or sisters. She arrived in India in 1929 and taught at the St. Teresa's School. She took her first religious vows as a nun on May 24, 1931. At that time, she chose to be named after Thérèse de Lisieux, the patron saint of missionaries. Because one nun in the convent had already chosen that name, Agnes opted for the Spanish spelling, Teresa. Teresa served at the school for almost 20 years and was appointed headmistress in 1944. Although Teresa enjoyed teaching at the school, she was increasingly disturbed by the poverty surrounding her in Calcutta.

On Sept. 10, 1946, Teresa experienced what she later described as "the call within the call." She said, "I was to leave the convent and help the poor while living among them. It was an order. To fail would have been to break the faith."

She began her missionary work with the poor in 1948, replacing her traditional Loreto habit with a simple white cotton sari decorated with a blue border (blue is the color of the Virgin

Mary), with white habits to be worn under the sari. Later, she adopted the sari design with three blue stripes but chose to wear it in the rural Bengali women's style, which is different from how a contemporary sari is worn.

A nun's possessions include: three saris (one to wear, one to wash, one to mend), a pair of sandals, a crucifix and rosary. Nuns also have a plate and metal spoon, a canvas bag and a prayer book. In cold countries, possessions also include a cardigan. Nuns never wear anything but sandals on their feet.

Mother Teresa adopted Indian citizenship, spent a few months receiving basic medical training and then ventured out into the slums. In the beginning of 1949, she was joined in her effort by a group of young women and laid the foundations to create a new religious community, helping the "poorest among the poor."

Teresa wrote in her diary that her first year was fraught with difficulties. She had no income and had to resort to begging for food and supplies. Teresa experienced doubt, loneliness and the temptation to return to the comfort of convent life during these early months. She wrote in her diary: "... While looking for a home, I walked and walked till my arms and legs ached. ... Of free choice, my God, and out of love for you, I desire to remain and do whatever be your will in my regard. I did not let a single tear come."

On Oct. 7, 1950, Teresa received Vatican permission to start the congregation that would become the Missionaries of Charity. Its mission was to care for, in her own words, "the hungry, the naked, the homeless, the crippled, the blind, the lepers ~ all those people who feel unwanted, unloved, uncared for throughout society; people that have become a burden to the society and are shunned by everyone."

In 1952, Mother Teresa opened the first Home for the Dying in

space converted from an abandoned Hindu temple. She named it Kalighat Nirmal Hriday, (The Home of the Pure Heart). She soon opened a home for those suffering from leprosy and called it Shanti Nagar (City of Peace). As the Missionaries of Charity took in increasing numbers of lost children, she opened the Nirmala Shishu Bhavan (The Children's Home of the Immaculate Heart) as a haven for orphans and homeless youth.

The congregation soon began to attract both recruits and charitable donations, and by the 1960s, had opened hospices, orphanages and leprosy homes all over India. Mother Teresa then expanded the order across the globe. The first Missionaries of Charity home in the United States was established in the South Bronx, N.Y. By 1984, the order operated 19 establishments throughout the country.

In 1983, while visiting Pope John Paul II, Mother Teresa suffered a heart attack in Rome. After a second attack in 1989, she received a pacemaker. She offered to resign her position as head of the Missionaries of Charity, but the nuns of the order, in a secret ballot, voted for her to stay, and she agreed to continue her work as head of the order. However, on March 13, 1997, she stepped down as the head of the Missionaries of Charity.

Mother Teresa was recognized by the Indian government with every major award, including India's highest civilian award, the Bharat Ratna (Jewel of India), in 1980. Indian views on Mother Teresa were not uniformly favorable. Her critics blamed her for promoting a negative image of Calcutta, exaggerating the work done by her mission and misusing the funds and privileges at her disposal. The Catholic world honored Mother Teresa with several awards. She was also honored by governments and civilian organizations all over the world. The United States granted her honorary citizenship, one of only five people to be so honored. Universities in both the west and in India granted her honorary degrees.

In 1979, Mother Teresa was awarded the Nobel Peace Prize "for work undertaken

in the struggle to overcome poverty and distress, which also constitutes a threat to peace." She refused the conventional ceremonial banquet given to laureates and asked that the \$192,000 be given to the poor in India, stating that earthly rewards were important only if they helped her help the world's needy. When Mother Teresa received the prize, she was asked, "What can we do to promote world peace?" She answered, "Go home and love your family."

However, not everyone was equally laudatory, and Mother Teresa had her share of critics. The German magazine *Stern* published a critical article on the first anniversary of Mother Teresa's death concerning allegations regarding financial matters and the spending of donations.

The quality of care offered to terminally ill patients in the Homes for the Dying was criticized by the *Lancet*, and the *British Medical Journal* reported the reuse of hypodermic needles and poor living conditions, including the use of cold baths for all patients, etc.

On Sept. 5, 1997, after evening prayers at the Mother House, Mother Teresa went to her room complaining of chest pain and passed away soon after. She was granted a state funeral by the Indian government. Her body was carried to her funeral on the same gun carriage that carried Mahatma Gandhi when he died.

After Mother Teresa's death in 1997, the Holy See began the process of beatification, the third step toward possible canonization. In 2002, the Vatican recognized as a miracle the healing of a tumor in the abdomen of an Indian woman, Monica Besra, after the application of a locket containing Mother Teresa's picture. Besra said that a beam of light emanated from the picture, curing the cancerous tumor. Critics ~ including some of Besra's medical staff ~ stated that they had treated her for abdominal tuberculosis for nine months and that is why she got better. Mother Teresa's beatification took place on October 19, 2003, thereby bestowing on her the title "Blessed." A second miracle is required for her to pro-

ceed to canonization.

As a young medical student, I was influenced by Mother Teresa's work and started volunteering in a "leprosy community" close to my medical school. Every Sunday afternoon, a group of medical students (a couple of junior and a couple of the senior students and a couple of residents) would go to the gated community that served as the compound that housed several families with leprosy, where we would dispense simple medications as remedies for common ailments and dress open wounds, including auto-amputated fingers and toes due to the lack of sensation. Later, as a resident in internal medicine and then as a faculty member at the same school, I became the medical consultant to the Missionaries of Charity home, taking on their patients in hospital and making house calls for those who could not be brought in for one reason or the other. These experiences, and many more, shaped a lot of my thinking. Given the constraints of time, I choose to focus on two observations: "the dignity of death" and "the intersect between spirituality and health."

When I moved on from India to Singapore, I worked in the Communicable Diseases Center, where we dealt with advanced HIV disease. Like the U.S., perspectives of dying with dignity had partially taken hold there, although the strong stigma of dying with HIV was entrenched in the culture. People with AIDS-defining illnesses were admitted to the center in isolation rooms, with no family or friends to visit them ~ basically wasting away in loneliness.

A lot has been done here in the U.S. in terms of end-of-life care. The Worcester District Medical Society has been a leader in the same through the good work of so many, led by Dr. H. Brownell Wheeler, former President of WDMS. However, there are other dimensions that are worth exploring and thinking about, especially in the context of the example of Mother Teresa.

Many of us have heard of Dr. Siddhartha Mukherjee, Pulitzer Prize-winning oncologist for his bestseller, *The Emperor of*



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All Maladies. On the Moth Radio Hour, which broadcasts on National Public Radio (NPR), he speaks of the concept of actively dying, of what it feels like to watch someone die, of holding up a dead body that weighs down on you. Additionally, the concept of using added strength to hold up the body with its dead weight bearing down could metaphorically represent the added strength of mind that is required when dealing with those who may be dying out of poor lifestyle choices they made or misfortunes in life ~ that our judgment and compassion is not fatigued by our impressions of patients' value systems.

The second aspect that got me thinking was the intersection between spirituality and health. In clinical practice, we encounter occasions when patients have gone on pilgrimages to offer prayers for their health or carry a picture or some other memorabilia of a spiritual soul or saint that they feel heals them of disease or prevents illness. We have also encountered patients who speak of praying often and more fervently when they or a loved one is seriously ill or on their deathbed. Many of us are familiar with the biblical and Torah reference to Numbers 21: 4-9, where Moses made a bronze serpent coiled upon a staff during the plague when the Israelites were bitten by snakes, so that people could look at it and be healed.

Data seems to suggest that in the U.S., 95 percent believe in God and 57 percent pray at least once a day. A few years ago, a *USA Today* poll of 1,000 adults revealed that 79 percent believed that spiritual faith can help recovery from disease and 63 percent believed that physicians should talk to patients about spirituality. A study of 10,000 people in Washington County, Md., by the late George Comstock, of Johns Hopkins Bloomberg School of Public Health, evaluated the relationship between church attendance and illness. Of those attending church, there were 50 percent fewer deaths from coronary events, emphysema and suicide and 75 percent fewer deaths from cirrhosis. However, Comstock himself later reported

ed that he failed to control for functional capacity, thus leading to a bias in the results.

In one of the few randomized double-blind studies published in this area, patients in a CCU were randomly assigned to standard care or to daily intercessory prayer ministered by three to seven "born-again" Christians. Of the 29 outcome variables measured, the prayer group had fewer problems in six of the variables, including new CHF, new prescriptions of diuretics, new pneumonia, etc. In a more comprehensive analysis of results, however, the authors could not control for the problem of confounding, and multivariate analysis did not substantiate the results as presented.

A recent review has revealed more than 1,200 studies on the effects of prayer on health. Systematic reviews have demonstrated statistically significant positive associations between religion and a lower incidence of heart disease, hypertension, stroke, cancer, etc. Findings are so robust that the science is now called the "epidemiology of religion."

Irrespective of our religious persuasion, I'd like to pose some questions for us to ponder. What prevents a conversation regarding spirituality between patients and providers?

Do we consider it too private?

Do we consider it irrelevant?

Is it only to be discussed in terminal situations?

Is it because we don't have answers for the questions asked, especially why there is suffering?

Is suffering because of wrongdoing?

Is sickness a punishment from God?

Does God exist at the bedside?

Does spirituality connote a physician's inability to give a scientific explanation

for phenomena?

Does the use of modern medical interventions preclude the need for religion?

Do I risk invoking a patient's ire by "God talk?"

I don't have the answers to any of these questions, and I leave it to each of you to form your own opinions in the light of your personal beliefs and values. Suffice it to say, sometimes we are caught flat-footed when we are at the bedside at the time of an impending death, an adverse event or an unexpected complication or outcome, and we often become what T.S. Eliot wrote about in "The Love Song of J. Alfred Prufrock":

"Deferential, glad to be of use
Politic, cautious and meticulous
Full of high sentence, but a bit obtuse
At times, indeed, almost ridiculous
Almost, at times, the Fool."

The words of Sir William Osler are apropos: "Cultivate, then, such a judicious measure of obtuseness as will enable you to meet the exigencies of practice with firmness and courage, without, at the same time, hardening the human heart by which we live."

Mother Teresa said, "It is not how much we do but how much love we put in the doing; it is not how much we give but how much love we put in the giving. I alone cannot change the world, but I can cast a stone across the waters to create many ripples. We ourselves feel that what we are doing is just a drop in the ocean, but the ocean would be less because of that missing drop."

George M. Abraham, MD, MPH, FACP, is a clinical professor of medicine at the University of Massachusetts Medical School and associate chief of medicine at Saint Vincent Hospital. Governor, MA Chapter American College of Physicians (ACP)

Local Volunteerism 101

Harvey G. Clermont, M.D.



Harvey G. Clermont, M.D.

One would think that there should be no controversy regarding the existence of free medical programs. On the contrary, a number of issues immediately surface, as many aspiring free medical programs discover, several of which have prevented either the opening or continued sustainability of these clinics. Figure 1 lists the issues as I have seen them through the years,

and Figure 2 lists all of the free medical programs known to me in the Central Massachusetts area at this time. This short essay will deal with several of these issues as they are rarely dealt with in the medical media.

Should you get involved with the educational part of free medical programs, I would refer you to the Volunteers in Health Care, an organization based in Pawtucket, R.I., where written information on many of these issues is available.

The very first thing that any one person or group needs to deal with before anything else is the definition of the mission. To best define this, one needs to know the target population and do a needs assessment, not based on hearsay but using solid data that can be obtained through the Department of Public Health. Once this data is procured, a venue and a recruitment of both a medical and nursing director are key. The venue must be central to the area served, available on the same day and at the same time every week, and have some dedicated space for the clinic to function. I have found that churches are the ideal venues, and I would not even consider public venues because of their legal counsel. The medical director should be not only available but should be current in his or her practice, which

should be of a primary care nature. Occasionally, a busy volunteer medical program will decide to go full-time and apply for status as a regional health care facility in order to obtain federal funds and backing. It is important for every free medical program to establish a board of directors and to obtain a 501(c)(3) tax exempt status in order to fundraise and collect donations for the clinic usage.

Just as the medical director should be responsible for the recruitment and retention of physician volunteers, the nursing director should have several nurses, including retired nurses, who would be available to perform the duties of triage, intake and discharge. A strong support staff leader who answers to the nurse director should be in charge of all of the ancillary supplies and keep the medical records.

St. Anne's Free Medical Program, operating since September 1996, has a contractual agreement with three of the local schools of nursing, as well as with the College of Pharmacy and the College of Physician Assistants. There are several medical students from the University of Massachusetts who act as liaisons to each of the four main free medical programs on an annual basis. Foreign medical graduates are literally banging on the doors, trying to either shadow a physician volunteer at the free clinics or to perform some kind of task so they can add the experience to their résumé. Unless you are prepared to closely monitor each one of these foreign medical graduates, I would not consider this an immediate necessity to run the clinics. Ideally, a local civic group or business could be encouraged to sponsor the clinic financially, as this would greatly ease the demands on the board of trustees.

If you wish to provide immunizations for the patients, there is a process of application to become a provider with the Massa-

Figure 1

Starting A Volunteer Free Medical Clinic Issue		
Mission	Steering committee Needs assessment Resource assessment	Brief Specific
Venue	Location Parking Dedicated space Availability	Legal
Medical Director	Nursing Director Support Staff Leader	Available Current Responsible
Staff	Recruitment Retention Retired Professionals	Students-Educational Value FMG's-Monitoring Credentialing-Contractual CORI
Structure	Board of Trustees 501C3	Lines of Communication ? Umbrella Organization Responsibility Policies /Procedures
Supplies	Donations Storage Recycling	501C3
Support	Financial Community	Grants Fund Raisers School Nurses Seniors Shelters Churches
Medications	Strict policy No Schedule 1 or 2 Generics Local Pharmacy	If yes – Pill Poppers Storage Security Monitoring
Liability	Professional Structure/Property	Director Volunteer
Referrals	Insurance Free-Care Specialists Dental	Mental Health Eye ENT Orthopedics Dermatology Minor Surgery
Publicity	Target Population	Churches Barber Shops Local Stores
Records	Handwritten Electronic	Storage
Phlebotomy Labs	Local Laboratory	Contractual Student Education
Immunizations	DPH provider # Refrigerator/Freezer Temperature Monitor	Security Access
Education	Patient Student Staff	Common Illnesses Labs Problems
Liaisons	Schools Civic Groups Community	Other Clinics

Massachusetts Department of Health, Vaccine Management Division. I would caution you, however, that you need to have a minimum of a registered nurse as the primary manager of this program. Also, you need to obtain a separate refrigerator and freezer and to use constant secured temperature readings to store your vaccines. If you wish to also provide for tuberculosis screenings, the PPD material must be purchased separately.

Medical records may either be written or electronic, but must be secured.

Two major issues must be discussed. Invariably, I am asked about the liability to become a volunteer at a free medical program. As long as you are simply a volunteer and are a primary care physician who sees patients almost identical to those seen at the clinic, you simply have to contact your liability insurance carrier to inform them of your volunteer activity.

Most likely no additional charge will be placed on your malpractice premium under these circumstances. If, however, you choose to become a medical director of one of these programs and have the same criteria as mentioned for a volunteer, it is possible that you may have additional premium charges to your liability policy.

Very few liability claims arise from these voluntary efforts, however. Forty-three states have charitable immunity laws (notable exceptions are Massachusetts, California, New York, Vermont, Nebraska, Alaska and New Mexico). These are distinct from Good Samaritan laws, which protect all providing care in an emergency situation. Simply raising the negligent standard from simple to gross makes negligence more difficult to prove. Other states indemnify the volunteer physician as if he or she were a government employee, with a legal defense fund to cover any damages. In 1997, Congress passed the Volunteer Protection Act, providing protection from simple negligence and placing caps on both non-economic and punitive damages. In September 2004, a Federal Tort Claims Act for volunteer health care professionals was added. In brief, it provides for the United States Department of Health and Human Services to deem these clinic volunteers to be a federal employee for the purposes of FTCA coverage for medical malpractice claims. The free clinic must properly credential such staff and submit an annual sponsorship application.

The other major issue which should be discussed is the provision of medications. What I may tell you is controversial, except in Massachusetts. The expiration dates placed on medications by the pharmaceutical houses are treated as gospel in Massachusetts. Depots are designed by the Department of Public Health for the regular dropping off of "expired medications" by consumers. It's as if these medications no longer are effective after that designated fatal date. Thirty-seven states

Worcester's Free Health Clinics

Figure 2

	St. Anne's Church	India Society Of Worcester	Epworth Methodist Church	Ronald McDonald Care Mobile	Wesley Methodist Church	Akwaaba	Greenwood St (Bethlehem Covenant)
Schedule	5:30-8pm Tuesdays	6-8pm Wednesdays	6-8pm Mondays	9am-3pm Weekdays	6-8pm Mondays	6-8pm Thursdays	6-8pm Wednesdays
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Bus Route	15	None	9		3-21	11	
Appointment	Not needed	No	Not needed	Preferred	Not needed but call for schedule	Not needed	Not needed
ID or insurance required	None required	No	None required	None required	None required	None required	None required
Help to get insurance	Yes	No	Yes	Yes	Referred to other clinics for medical insurance	Yes	Yes
Bilingual/interpreter	Yes, Spanish/Portuguese	Varies	Yes, Spanish Call ahead and they will try to get an interpreter for your language	Yes, Spanish/Portuguese	Yes, Spanish	Yes, Spanish	Yes, Spanish
Medication (No narcotics or benzol or Adderall)	Yes, plus prescriptions	Prescription low cost at area pharmacies	Prescription low cost at area pharmacies	Prescription free at some pharmacies	No	Limited plus prescription	Limited (call ahead) prescription
Preventive care	Call ahead for GYN care, physicals for school or sports or DOT	Physicals Sick visits Pediatrician	Physical exams Immunizations referred to the Dept of Public Health	Yes dental services	Vision & Hearing Tests	Physicals for school/sports GYN by appointment	Physicals for school/sports/DOT
Treatment for illness testing	Yes, rapid tests and Lab Testing	No	Yes	Help to get primary care Doctor	Free or low cost glasses & hearing aids	Yes	Yes, rapid tests
Immunizations	Full & TB testing Flu Clinic	No	None	None	None	None	Full Immunization No PPD
Other Services	Psychiatry-variable Dermatology-1 st Tuesday Minor Surgery by appointment Diabetic Supplies Durable equip EKGs	1 st Wed: Psychiatrist & Dentist 1 st & 3 rd Wed: Dietician 3 rd Wed: Nephrologist				Minor Surgery Diabetic Supplies Labs EKG	

have drug recycling programs, allowing the redistribution of these drugs to the uninsured. On the books, Massachusetts has a program allowing redistribution of recycled medications to Massachusetts residents, excluding only Schedule I or II substances. The United States military, as well as several large medical volunteer programs that work internationally, have analyzed these medications for their potency and effectiveness. They found that many exceeded 10 years of useful life. With notable exceptions, I generally use medications for two years beyond the expiration date.

Should you decide to have the dispensing of medications to your patients as part of your program, it is intensely laborious and filled with regulations.

I generally use the generic programs that are available in the community. I try to keep up to date with all of the specials that are offered in the pharmaceutical field. I try to make use of the patient assistance programs that are available through the pharmaceutical houses.

None of the medications that I receive at St. Anne's come from pharmaceutical house donations. Less than 10 percent come from physicians' sample closets. About 10 percent come from nursing homes. The remainder come from individuals who either no longer need that particular medication, their dosage has been changed or because a relative who had a significant chronic illness has expired.

Education is one of my primary goals at the St. Anne's Free Medical Program. This includes not only patient education, but also education for both the staff and for the students on an ongoing basis. We try our best to provide quality health care in a three-hour segment of time every Tuesday evening and average nearly 70 patients an evening. As I approach retirement, I can say without reservation that the clinics have been extremely rewarding and have acted as a beacon of hope for the least affluent of our society.

Harvey G. Clermont, M.D., is the medical director of three, all-volunteer, free medical programs in the Central Massachusetts area.

Promises to Keep

Carol Jaffarian, MS, ANP-BC



Carol Jaffarian, MS, ANP-BC

Just another day at work, or so I thought. Little did I realize that day in 2001, I would receive a phone call that would change my life. The phone call was from Penny Giragosian ~ a nurse and a person I admired tremendously ~ who spearheaded the Armenian Relief Society's (ARS) efforts at home and abroad: spearheading its efforts to gain Consultative Status on the Economic and Social Council at the United Nations (UN); spearheading its efforts to care for children left disabled by the earthquake in Armenia. In her "spare time," Penny served as the nurse each summer at Camp Haiastan (translated: Camp Armenia) in Franklin, Mass., all of this while working full-time and raising a family. Her request was simple: that I present a "quick update" on HIV infection during a panel discussion at the United Nations. The name of the conference baffled me ("The Preventive Aspects of Maternal-Child Development: the Rights of the Child, Third Session of the Preparatory Committee for the Special Session of the 2001 UN General Assembly Follow-Up to the World Summit for Children"). The location of the conference scared me to death. Penny would not take "no" for an answer.

With the strong encouragement of good friend and co-worker, Carol Bova, I found myself at the UN. (I secretly took comfort in the fact that, if my presentation was not well-received, chances were I would never be at the UN again.) Sitting next to me on the panel was Dr. Sevak Avagyan, former deputy health minister of Armenia. Dr. Avagyan asked me when I could come

to Armenia to start an HIV program. Not thinking that he could possibly be serious, I told him to "name the date." Within 48 hours, I received another phone call from Penny ~ the ARS would soon expand its Mother-Child Clinic in Akhourian, Armenia, to include a birthing center. Cases of HIV infection were beginning to be documented, and it would be important to offer HIV testing to expectant mothers.

"But I've never been to Armenia."

"But I can hardly speak Armenian."

"But little is known about HIV infection in Armenia."

Penny, again, would not take "no" for an answer; the ARS would fund a needs assessment. I was soon back in Carol Bova's office ~ this time, enlisting her to participate in an HIV needs assessment in Armenia.

By 2002, Carol and I completed our needs assessment, and by 2003, the HIV Education and Prevention Project was born ~ a collaborative effort between UMass Worcester and the ARS, funded by a grant from the World AIDS Foundation. Throughout the ups and downs of carrying out a project in an underserved country, Penny was our constant cheerleader. Unfortunately, Penny never saw the completion of our project. She was diagnosed with cancer soon after we received the grant. As ill as Penny was, her diagnosis did not deter her from making one last trip to Armenia, this time as a member of our project team.

Shortly before Penny died, she made a phone call to me. I did not realize at the time that this would be our last con-

versation. Penny made it clear that our conversation would not end until I made a promise to continue to work with the ARS, to continue our work in Armenia and to become active at the UN. Shortly after Penny's death, I was invited back to the UN, this time to participate in a panel discussion celebrating the life of Penny. The panel discussion was appropriately titled, "The Power of One: Bringing Hope and Change through Volunteerism."

Since that time, I've tried my best to keep my promise to Penny ~ serving on the executive committee of the United Nations NGO (non-governmental organization) Committee on HIV/AIDS, serving on the board of directors of the Armenian Relief Society's Eastern Region, serving as the Armenian Relief Society's liaison to the Camp Haiastan Board of Directors and, of course, continuing our work in Armenia.

During a recent trip to Armenia to complete a women's health needs assessment, Carol Bova and I found ourselves without an interpreter, hours before we were scheduled to interview one of the country's health ministers. I frantically searched the "Emergency List for Armenia" Penny had provided for us shortly before she died. Sure enough, nestled between the name of a lawyer and the name of a driver, was the name of an interpreter. Less than an hour later, an interpreter appeared, happy to interpret for friends of Penny. Penny was "watching over us."

Thank you, Penny, for being a role model and a friend. Thank you for being the person who would never take "no" for an answer. Your passion for helping others lives on in those you mentored.

Carol Jaffarian is an instructor at the University of Massachusetts Worcester Graduate School of Nursing.

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this exciting. I was about to embark upon a week with more than 20 dedicated, selfless, just plain amazing people to help those in significant need.

Hours later, we arrived in Los Encinitos. We were hours into the mountains, where the roads weren't exactly roads but rocks lining the side of the mountain. Several incredible drivers were hired (with very durable trucks) to take us on the journey. With truck beds full of suitcases and boxes full of supplies (all volunteers only bring small carry-ons and backpacks), military personnel ride along at the front and back of the procession to ensure our smooth arrival. As we pass small homes, with makeshift walls, roofs and panels, set amidst barbed wire-lined farms with grazing cattle and horses, we are greeted with huge smiles and cheers from the locals who have known about our arrival through word-of-mouth and a local radio announcement. We already know the next six days will be well worth the long hours, underdeveloped living conditions and inordinate amounts of DEET-containing insect repellent.

Over the next several hours, the transformation of the compound maintained by a nun, Sister Hermana, is astonishing.

The plane inhabitants braced themselves for the sharp U-turn at low altitude as we quickly approached the runway of the international airport of Tegucigalpa, Honduras. This wasn't abnormal or alarming, however, as anyone who had flown into this Central American airport previously was familiar with the necessary landing in this mountainous region. This was my third time flying in, and it was always

An empty room of concrete becomes a dental office with chairs, a compressor and sterilization equipment; three small rooms with medical tables become examination rooms; a moderately sized rectangular closet becomes a pharmacy. We are ready to see patients of all ages, with numerous conditions or concerns, and we're ready to do so with a smile.

When the patients arrive, they must first wait outside the gate of the compound. They are respectful and don't get pushy most of the time. They separate into three lines: men, women and families with small children. They then begin to register with their two first names, two last names, village and chart number. Most of the patients have pieces of this information, but the two individuals helping with registration will have their work cut out for them. Small groups are then let into the compound, where patients sit outside either medical or dental (whichever they requested) and wait to be called in. Some patients walked for many miles overnight with nothing but their families and only the moon and knowledge of the land guiding them to the compound ~ six-plus hours for some families. Primarily, care is based on a first-come, first-served basis, with typical exceptions being the extreme young, elderly or ill. We know we need to do all we can, however, to try to treat everyone so no one has to make the trek again.

Each day begins with a 6 a.m. walk around the compound to see some beautiful mountainside, followed by breakfast and an 8 a.m. clinic start. We work until noon, have a quick lunch, then head back to work until at least 6 p.m. Then, we have dinner and possibly showers before bed. The shower water is rain water collected in cisterns; the faucet water must come from bottled water sent by our Knights of Malta liaison prior to our arrival; and we must check our shoes each morning for scorpions and tarantulas. Needless to say, each day is quite different than life here in Worcester ~ something none of us can take for granted through this experience!



Counseling a 92-year-old woman, Sabrina, on her medications.

In the pharmacy, we dispense medications for blood pressure, cholesterol, diabetes, asthma, heartburn, mild pain, allergies, sleep, prostate issues, seizures, lice and other parasites ~ and vitamins galore! We counsel them on proper administration and check disease state markers such as blood pressure, iron levels, thyroid function and blood glucose. For chronic disease states, we dispense a supply sufficient to last until the next group travels (four months later). Teams go to Los Encinitos in February, May and November. We can't go in the summer months, as this is the rainy season, and the "roads" leading through the mountains are washed out. This further illustrates how in need the farmers and villagers are, as medical help is extremely difficult to obtain so far away from the country's capital. This also demonstrates how necessary our trips are to maintain the general health of these patients.

After the six days, the dental clinic has provided hundreds of cleanings, fillings, extractions and general dental repair. They've given countless toothbrushes, tubes of toothpaste and educational seminars on proper dental hygiene. Many children have incredibly poor teeth, so this part of their experience is crucial. The medical clinic, including two adult physicians and one pediatrician, has seen hundreds of patients, some of which the clinic has been serving for 20 years! The Honduran people we serve are unbelievably appreciative. They take pictures with

us. They shake our hands. They hug us. They promise to work hard on staying healthy and smile incessantly when they know we have done all we can to improve their health.

Did I mention they only speak Spanish? Some volunteers' sole purpose is to act as interpreters or translators (although they do so much more), while the rest of us work on our medical and dental Spanish so as to be as effective as possible. We just want them to be well.

The Cape CARES organization (CapeCARES.com) has been sending teams of healthcare providers to Honduras for many years. We must always give to our local community, but sometimes, we must leave our comfort zone and help those in far greater need. I was fortunate enough to have been afforded the opportunity to work with many incredible humanitarian volunteers in Los Encinitos, Honduras, and am so grateful. *Hacer una diferencia* ~ make a difference.

Stephanie Conway, Pharm.D., R.Ph. is an assistant professor of pharmacy practice, MCPHS University School of Pharmacy-Worcester/Manchester.

Volunteer Eye Mission to El Salvador: February, 2014

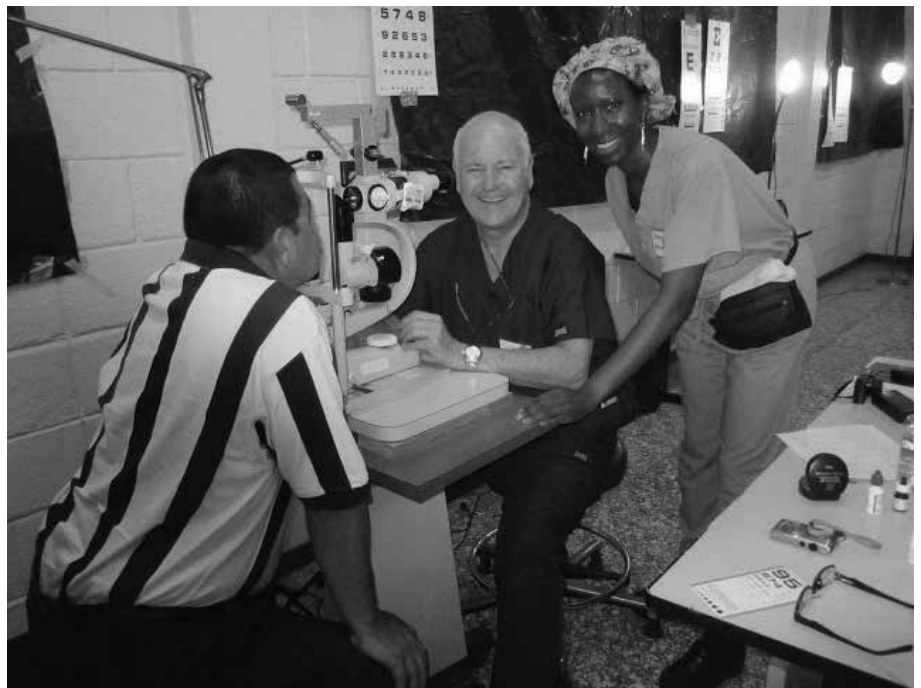
By James Umlas, M.D.

After a long day of travel from Boston, the caravan of minibuses pulled through the heavy iron gate, past the staid security guard with a sawed-off shotgun. Almost 60 weary, but excited, volunteers filed out into the lush tropical courtyard of ASAPROSAR (Salvadoran Association for Rural Health) in Santa Ana, El Salvador. Thus began another winter eye mission trip, continuing an uninterrupted string of campaigns over the past 25 years in our home away from home.

My involvement with ASAPROSAR began as a Tufts ophthalmology resident in 1995 and has continued over the past two decades. This experience has been one of the most rewarding parts of my professional and personal life, and I look forward to the annual 10-day excursion all year long. I have formed many great friendships and learned the universal value of medical training across borders and cultures.

ASAPROSAR is a multifaceted clinic founded by Dr. Vicky Guzman, a remarkable physician who continues to be the visionary behind its efforts to bring health care and social service programs to the underserved in El Salvador. With great sacrifice, she has guided her clinic through civil war, gang violence and other hardships. Through good fortune, Dr. Guzman made connections with the United Church of Christ in Norwell, Mass., in the 1980s. This led to the recruitment of a small group of Boston-based volunteers, who started the first eye campaign in 1987 and formed Friends of ASAPROSAR, a 501(c)(3) “sister” organization.

Joseph Bowlds, M.D., formerly Chief of Ophthalmology at La-



David Greenseid, M.D., and Zinaria Williams, M.D., examining a patient.

hey Clinic, spearheaded the early eye trips, starting with eye exams and dispensing glasses. The earliest mission trips were conducted in Salvadoran churches and community buildings and sometimes involved house calls and difficult travel by Jeep or on foot. Eventually, surgical eye services were added, which now include cataract surgery, corneal transplants, eye muscle surgery, pterygium excisions, basic eyelid procedures and laser treatment for glaucoma and retinal diseases.

Each campaign provides exams and donated eyeglasses for almost 2,000 patients, who come from all over El Salvador. High-quality, modern surgeries are performed on another 150 people. The patients often have limited access to sophisticated eye care, due to economic hardships and an overburdened national health care system. ASAPROSAR uses local health promoters



Douglas Scott, M.D., performing cataract surgery.

to screen patients and inform them of our arrival. Grateful patients travel hours by bus, car and on foot and then wait, without complaining, in long lines to be evaluated. Although volunteers provide their time and service for free, patients do pay ASAPROSAR a nominal, graded fee for their exams, glasses and surgeries, based on what they can afford. In this way, the poorest patients are subsidized by others who have some means. This allows for sustainability of the programs.

After many years of practice, the team of American nurses, doctors, technicians and other volunteers unpack supplies and set up equipment within a few hours and are ready to start work by the second day. Great *esprit de corps* keeps everybody focused during intense 12- to 14-hour workdays. The surgical and medical cases are complex and marked by extreme pathology, infrequently seen in the United States. Although fixing mature cataracts in blind patients provides great satisfaction, simple dispensing of glasses also offers much needed services to people who otherwise could not afford them.

The trips require intensive planning and fundraising, which proceeds throughout the year. Many of the pharmaceutical and surgical supplies are donated, but volunteers often raise most, if not all, of the costs of their travel and lodging. Fundraising has also allowed ASAPROSAR to build its own operating

rooms and clinical space, as well as buy ophthalmic and optical dispensing equipment, which is used by Salvadoran doctors throughout the year. The group is non-denominational and has no political or religious agenda. Translators are provided for nonSpanish-speaking volunteers. Our hosts provide us with safe accommodations and excellent food and support.

Throughout the past 25 years, Friends of ASAPROSAR has managed to accomplish significant inroads to eye care in El Salvador. It has been crucial to partner with a local organization that is familiar with, and entrenched in, El Salvador. Ophthalmology lends itself to helping many people in a very short time. However, there is much that is yet to be done. Cataract blindness and the need for eyeglasses are still the main causes of preventable visual impairment in the developing world. The group is always interested in recruiting committed volunteers, especially those with nursing, anesthesia or operating room skills, but also laypeople who want to lend a hand in raising funds, gathering and packing supplies in Boston, or travel to work in the eyeglasses dispensary. Fortunately, Friends of ASAPROSAR will continue to organize eye missions for the foreseeable future.

James Umlas, M.D., is a glaucoma specialist at Lexington Eye Associates.

Exempt Organizations and the IRS's New Paradigm: From Application to Audit

Peter Martin, Esq.



Peter Martin, Esq.

Many well-intentioned people who wish to pursue good works in the health care world do so by creating tax-exempt organizations. Volunteers can thus coordinate their activities through an entity that can raise funds from individuals seeking a charitable contribution deduction and foundations wishing to support the organization's charitable mission. Such organizations can

take many forms, such as unincorporated associations, corporations or charitable trusts. Recently, the Internal Revenue Service issued a proposal that would simplify the process for obtaining tax-exempt status for such organizations.

Tax-exempt status is a matter of federal law. The IRS "recognizes" the tax-exempt status of organizations through an application process, using Form 1023 for many such organizations. (Certain nonprofit organizations, such as churches, are not required to apply for tax-exempt status.) To obtain and maintain tax-exempt status, organizations must meet both an organizational and an operational test. The tax-exemption application, Form 1023, poses many questions pertaining to these tests and requires the applicant to provide extensive back-up documentation about its organization and proposed operation. Completing these applications and pulling together the documents to make a compelling case to the IRS that the organization ought to be exempt from taxes is a major and costly undertaking for the applicant. The current Form 1023, with its optional supplemental schedules, is 26 pages long; the instructions for filling it out take up 38 pages.

Analyzing such applications is also a major undertaking for the IRS. Distinguishing the applicant from profit-making enterprises, sniffing out schemes to use the organization to unfairly benefit its "insiders," and sorting the organization into one of the Internal Revenue Code's various exemption categories is a time-consuming process. One recent estimate is that there is a 65,000-case backlog of IRS-exempt organization determinations.

The reasons for this backlog are many. One is that the IRS ruled that existing tax-exempt organizations that fail to file their annual information returns with the IRS will have their exempt status automatically revoked, and in order to reinstate that status, a new exemption application must be filed (this ruling has recently been relaxed). Another is that a large number of applications for so-called "social welfare" organizations under section 501(c)(4) of the Internal Revenue Code, many having missions of a political nature, have recently been filed. Controversy has swirled around the IRS's handling of these social welfare organization applications, in part due to the IRS's stated objective of carefully evaluating whether these applicants are seeking to evade federal campaign finance and disclosure laws. The increased volume of tax exemption applications stemming from the reinstatement and political social welfare organization applications, added to the already significant number of "normal" applications, has created a situation in which applicants have to wait for a potentially lengthy, and in any case indeterminate, amount of time for IRS action on the application.

One index of this uncertainty and delay has to do with that portion of exemption applications that require analysis by an IRS agent. The IRS website currently states that such applications submitted in July of 2013 are only now being assigned to an agent. This potentially lengthy delay in obtaining exempt

status can compromise volunteers' ability to raise funds to support the charitable mission of a proposed new organization. It may also discourage volunteers in the health care field, as in other areas of charitable endeavor, from creating a nonprofit organization in the first place.

In response to this untenable situation, the IRS recently proposed use of a new, streamlined application process using a new Form 1023-EZ. (The IRS estimates the Form 1023-EZ will come into effect sometime this summer.) This new application, only two pages long, relies upon the applicant's "self-attestation" that the proposed nonprofit meets both the organizational and operational tests. Unlike Form 1023, the applicant need not supply copies of its organizational documents, estimate anticipated expenses and revenues, nor even describe in detail its specific charitable mission. Certain organizations will be unable to use the Form 1023-EZ, such as entities with more than \$500,000 in assets or anticipated annual gross receipts exceeding \$200,000, or hospitals, medical research organizations, schools, colleges and universities.

For many other organizations, use of Form 1023-EZ will make obtaining tax-exempt status much easier. This proposal represents a fundamental shift by the IRS from administering the organizational and operational tests for tax-exempt status at the beginning of the entity's life through an application process to evaluating the actual operations of the entity through a retrospective compliance and audit process. This will be accomplished presumably through analysis of the annual information return filed by tax-exempt organizations, one of several versions of Form 990. It appears that the IRS plans to shift employees and resources toward compliance reviews and away from applications, as the backlog of ap-

plications decreases over time.

This change in approach by the IRS raises some interesting questions. How long will it take for use of the new form to result in reduction in the existing backlog? It is not clear whether the older forms still require evaluation under the old rules or whether existing applicants will get the benefit of the "self-attestation" presumption. Will the lingering political/social welfare organization controversy make it difficult for the IRS to quickly shift resources away from careful examination of those applications? Will the smallest exempt organizations, those with gross annual receipts less than \$25,000 and which merely file the "postcard" Form 990-N annually, essentially avoid any significant scrutiny by the IRS?

The IRS's proposal lowers the barrier to entry into the tax-exempt organization field represented by the cost, in money and time, of the existing application system. Use of the new Form 1023-EZ may result in the creation of many new nonprofit organizations, pursuing health care, as well as other charitable missions.

The availability of the new application form, and the consequent increased emphasis on compliance review by the IRS, does not mean that such organizations can ignore their ongoing obligations to operate consistently with federal exempt organization law. Health care volunteers wishing to create such organizations should not do so without understanding the compliance obligations that attach to tax-exempt status.

Peter J. Martin, Esquire, and Terrence J. Briggs, Esquire, are partners in the Worcester office of Bowditch & Dewey, LLP, their practice concentrating on health care and nonprofit law.

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