


NEWSLETTER

 **APTA**
American Physical Therapy Association
New Hampshire Chapter
April 2003

The President's Column

Susan C. Abis, PT

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I once asked Florence Kendall, a famous physical therapist, what she felt her most important life accomplishments were. To this she replied, "My children, of course...". I have carried those words with me for

some time. For all the patients I've seen and professional accomplishments I've had, she's right. My children will be my lasting legacy to this world. That's a tough one in today's day and age- what with holding down a job, after school activities, church, community involvement, or even getting a decent meal on the table at the end of the day. It's hard to find time for them too- to mentor, to talk, or to just be there when they have a problem.

I remember many years ago, when my daughter was in first grade. She was a thoughtful, caring child at the time (she's now a teenager- but that's another column...). Anyway, she stepped off the school bus one afternoon gleefully waving a five dollar bill. She explained to me that a little girl, who had recently moved here from China, had given her the money for playing with her today at recess. Horrified that my child would accept money for extending her hand in friendship, I firmly explained that she should give it back. We don't accept money for being nice to other children. She was confused and a bit angry, feeling she had earned this money. I then phoned the little girl's mother, to explain that this wasn't how we did things in this country. Although her English was poor, I was made to understand that the mother felt there was nothing wrong with it either and that she didn't want me to give it back! We brought the money back the next day.

Does this sound familiar? Have any of you been placed in a similar circumstance- where your values and sense of right and wrong (especially relating to money) are completely foreign to another person? Professionally, as you can guess, I speak of the situation of physician ownership of physical therapy services- referral for profit. While most of us abhor this

situation- it continues to grow before our eyes. How, you ask, has this happened?

Stark laws govern us on a federal level and deal with federal and state anti-kickback laws. The two main issues under this law with respect to physician ownership are 1) whether the venture provides some kickback or incentive for referrals, and 2) whether the participants in the venture specifically intended to provide improper incentives for physician referrals. Stark I law prohibited physicians from making referrals for clinical laboratory services to entities in which the physician had any financial interest. In 1993, Congress passed an expansion of this act- commonly referred to as "Stark II"- whereby the physician is prohibited from making any Medicare or Medicaid referral for "designated health services" to any entity with which the physician has "financial relationships". This law applies to ownership or investment interest, compensation arrangements, consulting agreements, or any other arrangement involving remuneration between the physician and referral entity. Unfortunately, this law applies only to patients under the Medicare and Medicaid programs, and can be avoided simply by not accepting these patients. In the "in office exception" rule under Stark II (meant to apply to situations where therapy is provided within the physician's office)- some facilities have successfully skirted this issue when they establish themselves in the same building as their referral source.

In New Hampshire, a law was enacted in 1993 whereby disclosure to the patient of ownership interests in a physical therapy facility is mandated, in writing, at the time of the referral. In addition, the facility as well as the referring practitioner must disclose the data of the numbers of referrals made to facilities they have ownership interest in to the state. Although many facilities do in fact disclose to the patient, few have complied with the full letter of the law in disclosing numbers of referrals to the state. Further, the law mandates that facilities which do not comply will be reported to the Commissioner of Health and Human Services, who is responsible for enforcement of the law. U.S. Attorney Thomas Colantuono, who sponsored the 1993 measure when he was



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NEWSLETTER

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SCHEDULE

February	Legislative Bulletin / Calendar of Events
April	Nominations Call / Caucus Reminder / Academic Update Benefits of Membership (Circulation: All PT/PTAs in NH)
August	Reports: Caucus / National / HOD / Legislative
December	Election Results / Annual Meeting Report



Chief Delegate Article

Marc M. Lacroix, PT, MBA, NHA

Having returned from CMS, I am happy to report there is a move underway to make the House of Delegates more efficient and effective. Most of the proposed changes are to use additional tools so we are not reinventing the wheel in each chapter and also utilizing technology to its fullest. The House of Delegates also realizes that too much time is spent on minutia and larger policy and future setting visions need to be discussed in the house to fully maximize the profession.

One of the immediate changes is the amount of material available to membership on the APTA web site. The minutes of the board of directors can be accessed. These will tell you the direction APTA is moving in and where the resources of APTA are being spent. Another is the availability of power point presentations available to membership to help in their goals with marketing and other issues. The house will be focusing this year on vision 2020. The 6 key point of vision 2020 are: autonomous practice, direct access, practitioner of choice, DPT, Evidence Based Practice and Professionalism. For those interested in all of the RC's they will be posted on the APTA web site on April 11, 2003 with draft packets posted on Feb 28.

At this stage there are only drafts of RC's but here are some of the more interesting concepts to be debated on the floor of the house of delegates.

Should a DPT be called "doctor"? Initial debate is yes as PharmD's, Optometrist, Chiropractors and so on call themselves "doctor" with the same education level. Those who believe no say it will not be well received by MD's and will be confusing to the public.

Again the issue of whether non PT's/PTA's should have membership. This was clearly defeated last year. This year it comes back as a professional partner vs. a member. The difference is as a member someone could hang their APTA membership for someone who we do not want to be associated with at some point in time. A partner is different as they are not part of the organization.

Oregon is interested in having APTA work toward standardization of licensure in all states. It takes away state individuality such as in New Hampshire, it is easier for a foreign trained therapist to obtain licensure then in many other states. It does make it easier for state reciprocity without having to take further..

Ohio believe having the ability to have installment dues such as they do in a health club membership would help with APTA membership.

Do you have an opinion on any of these? If you do, please attend a caucus near you and have your voice heard.

Newsletter Contest

We are looking for a name/title for the NH APTA Newsletter. Please submit your newsletter name to gwoodsum@attbi.com. The lucky winner will receive free admission to the remainder of this year's evening courses or for next year if the winner has paid up for this year's courses. Submission deadline: May 31st.

Registration Form

(duplicate as needed)

Designation :
PT, PTA, etc

Name _____

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APTA No. _____

- April 24—Aquatics*
- May 15—Total Shoulder*
- September 11—Animal PT*
- October 16—Gait Training*

Cost:

APTA member	non-APTA
\$25.00 per lecture	\$40.00 per lecture
	Student (with ID) \$12.00

It being understood that a student has not attained an entry level physical therapy degree.

Cost is \$5.00 more at the door.

Refund Policy:

No refunds, however a substitute will be welcome if NH APTA is notified 36 hours in advance—which is the deadline for telephone reservations.

Make checks payable to NH Chapter APTA

Send registrations to:
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PO Box 978
Manchester NH 03105
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President's Column

(Continued from page 1)

comment on the bill because of his current position. But in a 1993 Senate hearing on the bill, he said disclosure was needed to "get some kind of handle" on how much of this is going on... We believe that this will give us the information that we need (in several years) in which to decide whether to keep this approach of simple disclosure or if we have to go the next step to an outright ban. Democratic Senator Beverly Hollingsworth, who co-sponsored the legislation in 1993, was quoted recently as saying "It's not easy to pass legislation. I'm disappointed when you do it isn't carried out."

Interestingly enough, a house bill was enacted in 1993 here in New Hampshire (HB 457) making fee splitting or accepting fees for referral by pharmacists or pharmacies, or ownership of a pharmacy by a licensed practitioner, grounds for suspension or revocation of a pharmacy license. Our own practice act- revised last year, mandates disclosure by any physical therapist (owner or employee) to the patient of physician ownership in the facility. Failure to do so for ANY PHYSICAL THERAPIST may result in sanctions to their license to practice.

The American Medical Association has clear ethical guidelines which oppose physician ownership arrangements unless there is a true demonstrated need in the community for the facility, also the "self referral based on demonstrated need cannot be justified simply if the facility would offer some marginal improvement over the quality of services in the community". They also state quite clearly "physicians should not refer patients to a health care facility which is outside their office practice and at which they do not directly provide care or services when they have an investment interest in that facility."

Their guidelines for situations of physician ownership clearly delineate that the return on the physician's investment should be tied to the physician's equity in the facility rather than to the volume of referrals, also that internal utilization review programs should be established to insure that investing physicians do not exploit their patients in any way, as by inappropriate or unnecessary utilization.

A study in the Journal of the American Medical Association clearly reported some years ago that physician ownership situations increased costs to patients and insurers. The American Physical Therapy Association has adopted a position that reads as follows: "Consistent with the APTA Vision Statement for Physical Therapy 2020, APTA supports exclusive physical therapist ownership and operation of physical therapy services (HOD 06-02-24-48).

How can we continue to grow as a profession under this situation? Many have fought long and hard to assure our professional status in this country. Over 40 states (including our own- thank you) have passed legislation assuring direct access to patients (New Jersey and Wyoming being the most recent). Why does a profession with autonomy and stature which has been recognized across this country still make the choice of operating under a physician or choosing to share its livelihood with a referring physician? I'm completely stumped!

While some choose to play ostrich and "place their heads in the sand", I say to you now that the snowball of professional autonomy

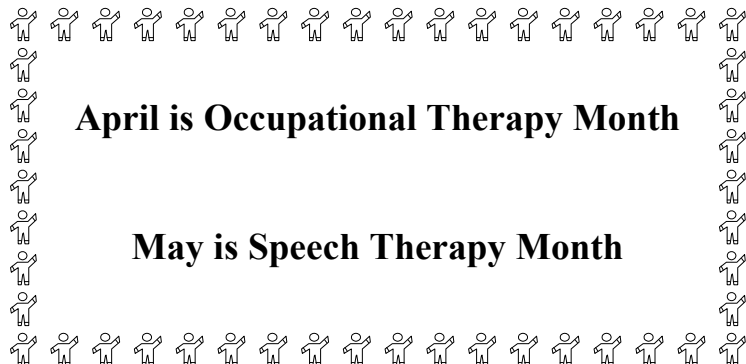
has begun to roll downhill. Our Vision 2020 statement clearly outlines us as "autonomous practitioners" who will be "doctors of physical therapy". While I hope to be sitting on a beach somewhere in 2020 playing with my grandchildren, I applaud this effort to continue to elevate us. Recently, legislation was re-introduced in Congress entitled the Medicare Patient access to physical therapy Act of 2003 (HR 792). Sponsors include Rep. Crane (R-IL), and Rep. Pomeroy (D-MD). A companion bill was brought forth in the Senate as well (S493), with sponsors being Senator Lincoln (D-AR), Senator Specter (R-PA), Senator Landrieu (D-LA), and Senator Ensign (R-NV). Think of the possibilities! If patients can access us directly under the Medicare program- what other insurers will follow suit? No more certifications/ re-certifications, 30 day visits. We would be recognized as independent under the Medicare program!

In addition, there will be a rally and march on Capitol Hill this year to force this issue to our own representatives. We hope to be at least 2000 strong for this march (from across the country). If you are going to be present at annual convention, please consider joining us that Thursday for a march for independence of physical therapy! More details will be forthcoming.

As you know, the \$1500 cap will be re-applied prospectively as of July 1 of this year. Congress is still looking at this issue. A study performed by Dyncorp which evaluated cost savings across disciplines of speech, occupational, and physical therapy found that savings realized were not a function of the \$1500 cap, but of the Medicare fee schedule. Hopefully, we can make congress understand that as well.

Recent legislation enacted provides for a slight increase in payments to physical therapists (3.6%) in 2003. If you have not contacted your congressman/senator regarding these issues- DO IT NOW! You can call directly to any of their local offices, or email them through the Advocacy section of the APTA national Web page. Follow the cues to the legislative action center, and you're on your way! If you use the pre-written letters, it takes about 1 minute. Can you afford to take that much time out of your day to insure your professional future?

In closing, let me offer you these thoughts... although I may be speaking "Chinese" to some of you (in that you see nothing wrong in offering your referral sources money or incentives for business), the rest of you must realize that if we are to succeed as an autonomous profession provided by "doctors of physical therapy", these business practices must stop. Please consider supporting the APTA in this endeavor to assure that physical therapists are the only professionals who profit from their work!



April is Occupational Therapy Month

May is Speech Therapy Month

ARE YOU FRUSTRATED...

Jen Corbeil, PT, MHA

Are you frustrated with the healthcare system? Are you tired of payors dictating what is appropriate for the clients you serve? Would you like to become more active at a state level?

Well, you can! Don't have time?? You have kids to feed, hours to work, housework, paperwork, etc., etc. Well, if every physical therapist in the state thought they didn't have time, where would the Physical Therapy Profession be in the State of New Hampshire?

Becoming active in the State Chapter isn't as time consuming as one may think. The Board meets monthly throughout the year and as needed during the summer months. You do not need any special experience, come join a relaxed, yet professional State Board and make a difference in your profession. It's easy! Still not sure, then contact someone on the Nominating Committee.

In the past, the leadership of our Chapter has been instrumental in facilitating the passage of legislation to better the profession and protect the interests of clinicians and clients. Come help promote high standards of care and become a voice. As Physical Therapists we are challenged daily with many issues: reimbursement, growth of the profession, direct access, use and supervision of the paraprofessional, and so on. These issues can mean different things to each of you depending on your area of practice, but the bottom line is that these issues affect all of us as Physical Therapists. Make a difference in your profession! Nominate yourself or someone you know for a position. If you are interested in learning more, feel free to contact Jen Corbeil at (207) 332-3009 or email at corbeil@attbi.

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HIPAA Privacy Rule

Carla Bickford, PT

On April 14, 2003 the HIPAA (Health Insurance Portability and Accountability Act) Privacy Rule goes into effect. HIPAA Privacy and Security Guidelines require that patient confidentiality be protected. The Privacy Rule covers all who could potentially come in contact with patient information. Health care providers, health plans, health care clearinghouses and business associates will be responsible for safeguarding Protected Health Information (PHI), whether transmitted by electronic medium or in any form. The Department of Health and Human Services issued a guidance on July 6, 2001 clarifying the new standards. The Guidance can be found at <http://www.hhs.gov/ocr/hipaa>. The APTA has offered a summary of the guidelines at http://apta.org/HIPAA_Part_3_Summary_DEL. The January/February Physical Therapy Reimbursement News also published general guidelines. Some information found in those articles follows.

Therapists must:

- Notify their patients about their privacy rights and how their information will be used.
- Implement privacy policies for their practice.
- Train employees in privacy procedures.
- Designate an individual responsible for adherence to privacy procedures.
- Secure patient records containing individually identifiable health information.

The Regulations in a Minimum Necessary standard requires that health care providers take reasonable steps to limit PHI disclosure to the minimum necessary to accomplish the intended purpose. According to the HIPAA Summary Part 3 these standards do not apply to:

- Disclosures to or requests by a health care provider for treatment purposes.
- Disclosures to the individual who is the subject of the information.
- Uses or disclosures made pursuant to an authorization requested by the individual.
- Uses or disclosures required for compliance with the standardized HIPAA transactions
- Disclosures to DHHS when disclosure of information is required for enforcement purposes
- Uses or disclosures that are required by law.

The above merely touches on the Privacy Rule. Keep an eye on the APTA web site for further information as DHHS issues further guidance on the privacy regulations.



What's new at the NHAPTA for Physical Therapist Assistants?

Stacy L. Thrall, PTA

ACTION PLAN: The New Hampshire Chapter is looking to form an Affiliate Special Interest Group (ASIG)

What is an Affiliate Special Interest Group?

An ASIG is designed to provide opportunities for members who share a special professional interest that cannot be served through existing means to meet and participate in activities related to its members within a component's structure.

When was the Affiliate Special Interest Group Created?

The first ASIG was developed in 1983 as a result of a motion brought forth by the Florida Chapter of the APTA. It was the first formal meeting space for the Assistant within our Association, and it has grown and separated into two current structures, the Affiliate Special Interest Group (ASIG) and the National Assembly.

Who is eligible to become a member?

All active and student physical therapist assistants who are in good standing within the American Physical Therapy Association are eligible to become members of an ASIG.

Why create a New Hampshire Special Interest Group?

A New Hampshire ASIG would create a forum and meeting place (in conjunction with Chapter meetings) for the PTA to develop and promote grass root efforts on issues that affect the Assistant at a State and National Level. Specifically, the formation of an ASIG would address specific 3-5 year goals and objectives of the Chapter as published in the Policy and Procedures Manual (Revised) Adopted 1999

What are the current issues affecting PTAs?

- Advanced Recognition/specialization at the state and national level
- Bachelor level education vs. Associate Level
- A full vote in the House of Delegates
- Bringing the Assistant forward within the APTA Vision 2020 by developing a Vision Statement for the National Assembly with specific goals and strategies

How do I get more information?

Contact Stacy L. Thrall, PTA NH PTA Liaison at Stacy_Thrall@hotmail.com or (603) 893-2900 x720. You can also attend our next Chapter meeting or a local spring caucus to increase your awareness of the issues affecting the Physical Therapist Assistant. Visit the New Chapter website for additional information at www.nhapta.org.



Reimbursement Article

Marc M. Lacroix, PT, MBA, NHA


As I have received updates on reimbursement, I have shared the information via the NH list serve. I would encourage all members to sign up as we will continue to provide you pertinent information as soon as we can.

While at CMS I attended a session on ERISA. ERISA does not affect my practice area and I am not an expert on the subject but I thought many of you would be interested in my notes as this helps providers in dealing with insurance companies.

It covers 50% of the commercial insurance market. Does not include government insurances but does include BX-BS. There were new standards as of Jan 1, 2003. These include determination of coverage for reasonable procedures. It covers the recourse of the provider for unpaid amounts and the assignments of benefits.

It provides time frames for decision to pay (not for how long it takes to pay). The decision needs to be made in 30 days with one 15 day extension, if needed, for the insurance company to respond to an appeal. A claimant (provider) has up to 180 days to appeal (remember this is not Medicare). It tells the insurer the rejection of payment may not be general such as "not medically necessary". It also stipulates the insurer "shall consult a health provider who has the appropriate training in the field of medicine". This hopefully will lead to peer review. It is believed the concept of peer review will be fought in the courts as to who has the appropriate training. More info can be gathered at www.gov/pwba.

What You Hear.



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Patrick Borromeo
PT

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Functional Capacity Evaluation: Considerations for the Physical Therapist

Ernest Roy, PT

Therapists who deal with workmen's comp/disability clients are often asked to provide recommendations regarding the work/functional abilities of those patients. Functional Capacity Evaluation (FCE) is one tool that therapists have used to help answer such questions. Though at least a dozen formats of FCE are commercially available, gaps in our knowledge persist as to what constitutes the "best" format. Protocols range from 1-2 hour, 1 day tests, all the way up to 5-6 day test procedures. (4,6) Additionally, new research is clarifying the extent to which client belief and cognition can influence outcome of FCE. While previously, inconsistent performances were viewed as evidence of "malingering", therapists must realize that this term grossly understates the problem of poor /contradictory performance on testing. Using the APTA's *Guide to Physical Therapist Practice*, as well as other peer-reviewed resources, let's examine some relevant factors that therapists should consider in the FCE process.

With the APTA's emphasis on evidence-based practice, therapists should carefully consider the research support for the tests and measurements they select. Indeed, the 2001 edition of the *Guide* states, "Whenever possible, physical therapists should use measures whose reliability and validity have been documented in the peer-reviewed literature." (1) To illustrate this point, some FCE formats have made use of various criteria measures to assess the consistency of patient effort. One such measure is the co-efficient of variation calculation (CV). The premise is that high CV scores demonstrate unacceptably high levels of variance in client effort on a given test. If the test is tightly controlled by the examiner, the reasoning is that the high CV will be due to an attempt on the client's part to skewer the results for a secondary purpose. However, numerous studies have disputed that contention. (5,7) Peer-reviewed evidence for use of CV in FCE is murky at best. While future research may validate using certain CV calculations, presently the use of CV to make and support contentions about sincerity of effort would be on shaky ground. On the other hand, there is published evidence supporting the ability of experienced, trained examiners to judge safe maximum effort thru the use of observation of key physical criteria. (2) These observations encompass physical displays of appropriate effort such as alterations in stance, reduced speed of raising a load, or use of Valsalva maneuver, to name a few.

As important as choice of individual test criteria, is the manner in which tests are administered and interpreted. The *Guide* goes on to state, "A measurement is reliable only under certain conditions and for certain types of patients/clients." For an FCE related example, consider the application of shoulder/neck non-organic signs. In 1996, Dr. Bertram Kummel reported the results of a 3 year study involving shoulder/neck motion as indicators of non-organic low back pain. (3) This measurement involves asking a client to raise the arms as high as possible, or move the neck as far as possible in each direction. The test is positive if significant reduction in neck/shoulder motion is noted and the client indicates the motion is limited due to low back pain. The examiner must not cue or bias the client with statements such as, "did that hurt

your back?, does that increase your pain?" One can begin to appreciate the degree to which FCE examiners must pay attention to the fine points of technique and detail when using measures such as these.

From the practical side, there a number of other items which are most helpful to keep in mind. The purpose of the FCE must be identified prior to the exam. Often, this will dictate the choice of measurements or the format. I find case managers are a good resource, along with the referring physician, when it comes to defining the purpose of the exam. If determining the possibility of return to a job or potential jobs is the aim, obtain a copy of the job description to identify critical physical demands the client will need to meet. Safety is a foremost concern and I make a point to let clients know that their safety is the first consideration in testing. This often helps relieve pre-test anxiety a bit. In drafting your report, avoid conclusions based on statements such as "in my opinion etc." As much as possible, let the data tell the story. This minimizes the chance of inserting bias into your findings.

Finally, FCE is in keeping with some of the core elements of the Physical Therapy Scope of Practice. Again quoting the *Guide*, PT's "Provide services to patients who have impairments, functional limitations, or disabilities..." By addressing those impairments and functional limitations directly, FCE is consistent with the foundation functions of the PT profession. I encourage any therapist wishing to pursue this skill to educate themselves as much as they can, scan the relevant journals frequently, and work with a mentor. FCE is a specialized aspect of PT, but one well suited to the skill mix Physical Therapy has to offer.

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Referral for Profit Expanding in NH

Michele McLellan, PT, OCS

Unfortunately as our state and professional association, the American Physical Therapy Association seeks to increase physical therapists autonomy, in our state of New Hampshire more physician owned practices have opened in the past three years. These practices can only survive if physical therapists chose to work in these employment situations where their boss also receives financial compensation for the referrals made.

This past summer our state American Physical Therapy Association was successful in passing legislation changing our practice act so that all physical therapists in New Hampshire could treat a patient without a physician referral. On a national level, the American Physical Therapy Association is expanding our educational requirements to reach a doctor level to increase our independence.

Both the American Physical Therapy Association and the American Medical Association are against Referral for Profit arrangements. The APTA HOD 06-99-13-17 states: *It is the policy of the American Physical Therapy Association that: The American Physical Therapy Association opposes participation in underutilization or over utilization of services for person or institutional gain, or participation in services that is in any way linked to the financial gain of the referral source.* The American Medical Association E-8.032 titled Conflicts of Interest: Health Facility Ownership by a Physician. States, “When physicians refer patients to facilities in which they have ownership interest, a potential conflict of interest exists. In general, physicians should not refer patients to a health care facility which is outside their office practice and at which they do not directly provide care or services when they have an investment interest in that facility.”

The potential conflict of interest was well documented as real in two articles published in the Journal of the American Medical Association. A study done in Florida under legislative mandate had an 82% response rate. The study concluded that when physicians are involved in referral for profit situations known as joint ventures, over utilization of services was present to an alarming degree. When focusing on physician ownership of physical therapy facilities, visits were 39% to 45% higher in joint venture facilities. Both gross and net revenue per patient were 30% to 40% higher in facilities with referring physician ownership. Time spent with patients at each visit by licensed physical therapists and assistants was 60% higher in non-joint venture ownership facilities than in joint venture ownership clinics.

Twelve states have some form of legislation that prohibits self-referral with penalties imposed for violations. Sixteen states have disclosure laws. In the state of New Hampshire, we only have a disclosure law TitleX, Chapter 125 “Disclosure of Ownership Interest by Health Care Practitioners whereby a physician is required to disclose both to the patient and to the state that he/she has an ownership interest on the facility to which the patient is being referred and the amount of referrals made are to be reported to the Health and Human Services Department.

In an article published in the Feb.21 – Mar. 6, 2003 New Hampshire Business Review written by Bob Sanders, Mr. Sanders has found very little reporting of this self referral activity is being reported to our state offices.

Most of the physicians owned physical therapy clinics in New Hampshire ride a fine line trying to avoid violating federal laws. As part of Stark I and Stark II as well as the anti-kick back provision of the Fraud and Abuse portion of the Balanced Budget Act, federal law prohibits any kick back given to a referring physician. Thus most physician owned clinics do not become Medicare providers. Interestingly the Florida study previously quoted, also mentions that many physician owned clinics kept the better paying insurance patients for themselves and referred the lower paying insurance patients elsewhere.

Since physician ownership of physical therapy services can only survive if our fellow physical therapy colleagues chose to work in these situations, perhaps the therapists making these choices would reconsider their employment options. Quality care for our patients independent of physician profit should be our foremost concern. Most employment situations in New Hampshire do not have this conflict of interest arrangement. If a physical therapist has an entrepreneurial spirit and wishes to open a physical therapy clinic, several physical therapists in independent practice welcome the opportunity to help to mentor the therapist in such an endeavor. The autonomy of our profession is at stake. Otherwise the practice of physical therapy may be reduced to that of a highly skilled “technician” with the physician owner making the ultimate decisions or productivity, frequency and quality of treatment.

Volunteering in Physical Therapy

Mary Cullen, PT

After years of talking about it in the Spring of 2001 Tom, my husband a recently retired general surgeon, and I left the snowy NH winter for our first volunteer jobs. It had taken many months of research to come up with positions that were practical and feasible for both of us but now we were headed to the island of St. Lucia, to work at St. Jude's Hospital for a month.

The St. Jude Hospital was built in 1940 by the US army so it comes complete with cannon in the front yard! In the 1960s it was leased by nuns from Iowa who wished to serve the poor of the island. It is an oldfashioned building both inside and out. Wards of 6-8 beds are common along with some rooms or 2-4 patients. The beds would have been common here 50 years ago. Many beds lack even hand controls for raising and lowering. The wards have plenty of windows and the upper part of the walls have holes to let the breeze blow through ..and the dust!

Physiotherapy at St. Jude's is very dependent on volunteers. The department is like stepping back in time, too far back for most of you to remember! The equipment is old but functional: a huge paraffin bath, impractical in size, a bicycle that badly needs to be replaced, an ultrasound machine that is old and I wonder if it has ever been calibrated since it was donated way back when. Volunteers bring splints, theraband, gel packs, pulleys, crutches and other items needed by the department. There is one whirlpool which is used for treating the many severe wounds that come through the department.

Treating inpatients I saw several spinal cord injuries. One, a C2 injury was treated successfully by a Halo splint, only to develop a partial lumbar spine paralysis two weeks later. Another C7 injury, once stabilized, was being discharged home despite there being no home health services. We did all the chest therapy, something I had been trained in in Ireland many years ago. Pediatrics often had severe orthopedic injuries and getting crutches or walkers was always a challenge.

Out patient therapy covered a myriad of conditions, many the usual backs, shoulders, knees etc. Severe tendon injuries are not uncommon. Machetes are used for cutting bananas and coconuts and a slip of the blade can cause a serious injury. Some were the result of a fight when one slashed another in anger. Diabetes is very common and I saw such severely infected sores that much of a foot or leg might be missing. These patients come in for wound care which is part of physiotherapy at St. Jude's. You also see many amputees as a result of this.

The volunteer orthopedic surgeons usually bring their own equipment with them so seeing patients with external fixation contraptions on their arms or legs seems just a little incongruous in the very unmodern setting of the hospital. There is little sense of time on the island and patients have to rely on public transport to get to the hospital. As a result patients arrive when they get there! Sometimes 3 or 4 might arrive at the same time, some an hour early or late, or a day late. However they are such patient people and they sit patiently till their turn comes. On orthopedic

outpatient clinic days there might be 4 or 5 walk-ins to be seen there and then. Flexibility is the keyword in volunteering. Apart from work there were plenty of new experiences. We lived on site, in the old nurses' dorm. Rooms were small, the beds ancient; we shared two showers with 6-8 others. We ate in the hospital café where food was plentiful, high in carbohydrates with meat that could best be described as "brown". The other volunteers were such a varied and interesting group and quickly became family for the stay. Beach trips, tours of the island, organized dinners out made leisure time very enjoyable. Going to church was always an inspiring experience...such joy and participation! We returned to St. Jude's last Spring and are off again this April for another month. I would encourage any one of you who has ever thought of volunteering to do so. One only needs to be adaptable, flexible and open to all that comes your way and you will be sure to gain insight into yourself, into another culture and enriched beyond measure.

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