WASHINGTON OSTEOPATHIC MEDICAL ASSOCIATION
WOMA

Washington D.O.

Spring 2014

4700 42nd SW, Suite 530 / P.O. Box 16486 Seattle, WA 98116-0486
(206) 937-5358 FAX (206) 933-6529 / www.woma.org

101st Annual Convention Adds Specialty Credits

The Skamania Great Room Overlooks the Columbia River

Skamania Lodge is nestled in the forest above the Columbia River Gorge near Stevenson, Washington.

The 2014 Northwest Osteopathic Convention, hosted by the Washington Osteopathic Medical Association, will take place June 19-22 at Skamania Lodge in Stevenson, about 40 miles east of Vancouver and Portland.

The program has been approved by the AOA for 25 Category 1-A credits. In addition, the following AOA specialty credits have been approved: Family Practice-25, Endocrinology-2, Infectious Diseases-2, Internal Medicine-6, Neuromusculoskeletal Medicine-3, Special Proficiency in OMM-3, OBGYN-1, Pediatrics-1, Physical Medicine and Rehab-6, Sports Medicine-9. A maximum number of 25 specialty credits may be earned from an AOA-affiliated state osteopathic society in the 2013-2015 CME cycle. To qualify for specialty credits, the topic must be presented by an AOA or ABMS certified physician in that specialty.

The CME committee has assembled a high-quality educational program with great networking opportunities. All AOA members are required to have at least 30 Category 1-A credits in each CME cycle, but specialty credits are not limited to AOA Category 1-A. Regardless of your specialty, you are encouraged to attend. With OMED scheduled for Seattle in October, WOMA really needs your support of the meeting to be able to continue providing such programs in Washington. Please join your colleagues, new and old friends, in the convenience of a beautiful and relaxed local venue. The education is serious and the social programs are fun. Go to www.woma.org to print out a brochure or register online. Call the WOMA office at 206-937-5358 if you need assistance or have questions. Don't wait too long or our room block will be gone along with our early registration discount.

Providers Sought for Anonymous Survey

The State of Washington Attorney General's office has granted researchers from the University of Washington an opportunity to develop and deliver a comprehensive CME program for health care providers regarding the scientific basis, clinical applications, and legal ramifications for using medicinal marijuana to treat intractable pain.

To inform the development of the training and to collect information about current beliefs and practices around medical marijuana, the researchers are inviting healthcare providers in Washington State to complete a one-time 10 minute anonymous survey. Consider sharing your perspective.

For more information and to respond to the survey, click here: http://adai.uw.edu/mcacp/

WOMA
5220 California Ave SW, Suite B
PO Box 16486
Seattle, WA 98116
(206) 937-5358
Fax (206) 933-6529
www.woma.org

The "Washington DO" is the official publication of the Washington Osteopathic Medical Association, published in February, May, August and November. Members are encouraged to submit articles for potential publication. Signed columns are, in all cases, the opinion of the author. For advertising information, please contact the WOMA executive offices at (206) 937-5358. Deadlines for ads and articles are the 10th of the month preceding the publication.

Meetings Notice

Washington Osteopathic Foundation Board
Thursday,June 19, 8:30 a.m.

WOMA Board of Governors Breakfast
Thursday, June 19, 9:00 a.m.

WOMA Annual Membership Meeting
Friday, June 20, 12:30 p.m. Lunch

All meetings take place at Skamania Lodge, Stevenson, WA

WOMA Welcomes New Members

At its quarterly meeting on March 22, 2014, the WOMA Board of Governors approved the following applications for membership:

Active
William Forsythe, DO ATSU'94
Svetlana Helms, DO AZCOM'03
Keiko Howard, DO KCUMB'09
Ryan Leonard, DO KCOM'04
Sara Sheaffer, DO NYCOM'03
Damon Sheneman, DO AZCOM'05

Post Graduate
Dongchui Paek, DO TouroNY'13
Natasha Pyzocha, DO UNECOM'12

Student
Shayne Kelly TCOM'17
Philip Lam AZCOM'16
Rachel Wheeler DeBusk COM'18

Getting to Know You

WOMA is pleased to welcome the following Active members:

William Forsythe, DO is a 1994 graduate of KCOM. His Internal Medicine Tracking Internship was completed at Sun Coastal Hospital, Largo, FL in 1995. In 1999 he completed an IM/ED dual residency at Midwestern University, Chicago. He is presently practicing emergency medicine through Northwest Emergency Physician in Tri-Cities.

Svetlana Helms, DO graduated from AZCOM in 2003.She did a transitional internship at Northside Hospital and Heart Institute in Petersburg, FL. She completed an anesthesiology residency at University of Maryland Medical Systems, Baltimore in 2007 and a pediatric anesthesiology residency at Seattle Children's Hospital. Dr. Helms works at Swedish Medical Group in Northwest Seattle, Seattle Special Care Dentistry and Penn Cover Anesthesia at Whidbey General Hospital.

Keiko Howard, DO is a 2009 KCUMB graduate and completed her Neurology residency at St. John Hospital Oakland, Warren Michigan. She practices neurology at Franciscan Neurology Associates in Tacoma.

Ryan Leonard, DO graduated from KCOM in 2004. He completed his internship and residency in otolaryngology and facial plastic surgery at Genesis Regional Medical Center MI. He is in the practice of otolaryngology/facial plastic surgery in Richland.

Sara Sheaffer, DO is a 2003 graduate of NYCOM. She completed a family practice residency at St. Barnabas Hospital in Bronx, NY in 2006. She is in family practice at the Nooksack Community Tribal Clinic in Deming.

Join your colleagues at the 101st Annual Northwest Osteopathic Convention

25 AOA-Approved Category 1-A Credits

June 19-22, 2014
Skamania Lodge\
Stevenson, WA

Reserve your hotel room by calling
1-800-221-7117
Group Code 1XN87O

Call before May 12, 2014

2015 Board Nominees

The following is the proposed slate of WOMA officers and Trustees for 2015. Elections will take place on Friday, June 20th at the WOMA annual meeting luncheon at 12:30 p.m. at Skamania Lodge in Stevenson. The presidency will be assumed by Harold Agner, DO, Scott Fannin, DO will serve as immediate past president.

Executive Committee
Term 1/1/-12/31/2015
President-elect
Mischa Coleman, DO
Vice-President
Michael Scott, III, DO
Secretary
David Farrell, DO
Treasurer
Mark Hunt, DO
Trustees
Terms 1/1/2015 – 12/31/2016
District 1
Jeanne Rupert, DO
District 2
Richard Koss, DO
District 3
W Allen Fink, DO
District 4
Paul Emmans, Jr, DO
District 5
David Hofheins, DO
Institutional Member
Anita Showalter, DO for PNWU
Postgraduate Member
David Escobar, DO
Student Member
TBA
AOA Delegates
Harold Agner, DO
Paul Emmans, Jr, DO
Paul Emmans, III, DO
Scott Fannin, DO
Lindy Griffin, DO
David Lukens, DO
AOA Alternate Delegates
Amber Figueroa, DO
Michael Scott ,III, DO

Nominations for all positions will be open from the floor. The Board of Governors meets quarterly in March, June, September and December. The Executive Committee meets with the Public Affairs Committee in the interim months to conduct association business.

Proposed Bylaws Amendments

At its meeting on March 22, 2014, the Board of Governors voted to recommend adoption of the following bylaws amendments to the membership at the annual meeting:(*old language crossed out, new language underlined)*

Article II

Section 3: Post-Graduate Trainee Membership. A post-graduate trainee membership shall be open to all graduates of schools approved by the American Osteopathic Association at the time of their graduation, and who are serving an internship, residency or fellowship. The Post-Graduate Trainee membership shall be concurrent with the training years. Post-Graduate members shall not have the privilege of voting or holding office, except for the one postgraduate member of the Board of Governors. (There are no dues for Postgraduate members).

Section 16: Dues. a) The annual dues for active membership in this Association except as hereinafter provided shall be determined by the membership. Installment payments may be arranged with the Secretary/ Executive Director on an individual basis. ~~Payments shall be equal to at least one- twelfth the total amount of dues every month to remain in good standing.~~

Article V11

Section 3: Board of Governors Duties. a) The Board of Governors ~~shall meet immediately after the annual meeting; the Board~~ shall meet quarterly ~~thereafter~~ in June, September, December and March;

Section 7: Student Representative. The Student Representative to the Board of Governors shall be a student member of WOMA who is a member of the student government of the Pacific Northwest University of Health Sciences College of Osteopathic Medicine. The student body shall select a nominee deemed appropriate by the Dean to be placed on the ballot at the WOMA annual meeting. The term of office is one year beginning January 1st after the election.

Section 8: Postgraduate Member: The Postgraduate representative shall be a postgraduate member of WOMA currently in a residency program or fellowship physically located in Washington State. The Postgraduate representative nominee(s) will be selected by the Nominating Committee. The term of office is one year beginning January 1st after the election.

Section 11: Committees of the Department of Public Affairs. Committees of the Department of Public Affairs shall be structured as follows: 1. Legal-Legislative and ~~;~~ 2. ~~Peer Review-Ethics; 3. Medical Advisory Committee, Department of Labor and Industries; 4. Medicare and Health Planning bodies; 5. Medical Advisory Committee Division of Public Assistance, and 6.~~ Public and Interprofessional Relations.

Section 13: Department of Professional Affairs. Committees of the Department of Professional Affairs shall be structures as follows: 1. Professional Education; 2. ~~Convention; 3. Seminars;~~ Continuing Medical Education; 3 ~~4~~. Student and Physician Recruitment, Reception and Assistance; 4~~5~~. Insurance Member Coverage; 5~~6~~. Constitution and ~~,~~ By-Laws ~~and Directory~~; and 6~~7~~. Parliamentarian and Historian.

Article IX

Fees for Non-Members to ~~Annual Meeting~~ WOMA CME Programs

There must be a charge equal to the registration fee plus one year's WOMA first-year dues ~~of the Divisional society of the state in which they practice~~ to all osteopathic physicians and/or surgeons attending ~~the technical program of the annual meeting~~ WOMA CME and practice management seminars who are not members of the AOA Divisional Society of the State in which they practice ~~Division Society of the American Osteopathic Association~~.

The Unintended Consequences of the ACGME Merger

Norman Gevitz, PhD (Reprinted with permission)

A presentation delivered before the Association of Osteopathic Directors of Medical Education, April 23, 2014 in Santa Fe, New Mexico.

I speak to you today as Norman Gevitz, PhD—a medical sociologist and historian who has researched and written about the osteopathic medical profession over a span of 40 years. I do not speak to you as a spokesman for my University. The opinions I will express here and In February of this year, the AOA Board and AACOM Board of Deans voted to embark on a unified graduate medical education accreditation system under the auspices of the ACGME. They did so without comprehensively considering the impact of this merged accreditation system on all the pillars of the osteopathic medical profession. These pillars include AOA board certification, AOA specialty colleges, AOA membership, and osteopathic medical colleges.

My conversations with several of the leading people negotiating this merger agreement reveal that they did not commission any independent written analysis of the consequences of the ACGME merger. This lack of a written analysis is puzzling since this proposed ACGME accreditation merger will have far reaching effects not only in the residency arena-but on the entire structural underpinnings of the osteopathic medical profession.

Briefly, I want to look at some of the likely consequences of this proposed merger on some other osteopathic pillars before turning to my main subject: the unintended impact of this merger on osteopathic medical schools.

First let me say right from the beginning that the ACGME should be congratulated in trying to develop a competency-based GME accreditation system. But let me also point out that what they are trying to accomplish is not the most pressing matter before us today in Graduate Medical Education.

The two most pressing issues facing GME today are first, developing sufficient numbers of new residency programs for all our graduates, and second, developing ambulatory-based primary care residency programs which mirror the real-life practices of family physicians, general pediatricians, general internists and others. These two pressing issues are the ones on which the osteopathic medical profession should be primarily focused.

The ACGME Next Accreditation System fails to address these most pressing issues. Proponents of the Next Accreditation System admit that this new merger will not create a single new residency program. Not one! In addition, the Next Accreditation System does not transform the current and out-dated hospital-based residency training system for primary care practitioners. This is most disappointing.

In fact, if we go forward with the ACGME merger, our doing so will most likely reduce the number of existing OGME slots and make it more difficult for DO graduates to find PGY-1 positions.

Experienced OPTI and program directors, including those who support the merger, tell me that approximately 20% of all OGME positions do not have the requisite resources or are not otherwise structured to be able to achieve ACGME accreditation. So, if we now have 9000 slots—funded or unfunded—a 20% cut would bring the total number of OGME slots down to 7,200.

Under our current system, unfilled OGME slots provide an excellent safety net for osteopathic students who do not secure slots in either the osteopathic or allopathic match. Last year, 500 US MD graduates did not find residency positions after their scramble. By contrast, all DO graduates who wanted a residency position found a residency position because we have a safety net.

In fact, under the ACGME accreditation merger, this safety net will disappear. Both MDs and DOs will compete equally for current osteopathic slots. Please note that if, in the event that any osteopathic-oriented programs place significant barriers or hurdles in the way of MD candidates to enter these programs because of osteopathic manipulative medicine requirements, MD candidates will sue in federal court and probably win their constitutional claim that these programs are violating the "equal protection clause" of the 14th Amendment. Most likely what will ultimately happen is that these osteopathic-oriented residency programs will simply pledge allegiance to the four osteopathic tenets and that will be the extent of the osteopathic component.

Let's now consider AOA Board Certification and our Specialty Colleges. The ACGME merger will likely reduce to a trickle the number of individuals who will pursue AOA Board Certification. In recent years, the great majority of DOs who pursued AOA Board certification have been those individuals who have completed AOA residencies. These osteopathic residencies will now end. All of our graduates will now enter ACGME residencies.

Up through the present, DOs who have pursued ACGME residencies have not generally sought certification from AOA Boards. And going forward, there will be no compelling reason for any DO to be certified by an AOA specialty board. The ABMS certifying board is all they will need for hospital affiliation, insurance, or any other requisite for acceptance. Why should we expect our graduates to expend money on a second board certification and membership in a second specialty college? Indeed, the great likelihood is that the principal function of osteopathic specialty boards will be to re-certify existing osteopathic specialists—not to test new candidates. As a consequence, Specialty Colleges will get few new members, and over time all AOA specialty colleges will wither away as aging AOA collegians retire or expire.

ACGME specialists could still join the AOA without being AOA board certified. In fact, the AOA has previously calculated that no more

continued on page 6

Continued from page 5

than 18% of all DOs who are ACGME trained have joined the AOA. If, when all our graduates become ACGME-trained, and if this current percentage remains constant, the AOA would actually gain slightly in membership. This is because of the rapid increase in the number of osteopathic medical graduates—up to 7,000 new DO graduates a year by 2020.

But this predicted membership bump should be of small comfort. With each passing year of only 18% of our graduates joining the AOA—the absolute total AOA membership will represent an increasingly smaller percentage of all DOs in practice. Within 15 years of the merger the AOA would likely represent less than 25% of all active DOs. How then can the AOA say it represents the entire osteopathic profession?

Please keep in mind too that this just mentioned membership scenario is based on an optimistic assumption. The stability of AOA membership requires that the number of graduates from osteopathic medical schools will remain constant or grow. Under what I believe is the most likely scenario the number of osteopathic graduates in the future will fall precipitously. The rest of my paper will answer the question of why would this happen?

Since the announcement of the ACGME agreement, some of my MD friends are talking excitedly to me about the possibility of one single undergraduate medical education accreditation system which will ensure quality training for all physicians-in training and which they say will result in improved health care for the public.

Thus, in addition to the AOA and AACOM partnering with the American Medical Association and the Association of American Medical Colleges in ACGME, the AOA and AACOM would partner with the AMA and the AAMC on the undergraduate side through the Liaison Committee on Medical Education—the LCME.

Indeed, going forward, I have no doubt that before this ACGME merger is completed by 2020, organized medicine will place growing and enormous pressure on the AOA and AACOM to join the LCME and most importantly to require osteopathic medical schools to adhere to the LCME's accreditation standards as a prerequisite for allowing their newly graduated DOs into ACGME programs.

Why would the AMA and AAMC do so?

I already mentioned to you the 500 graduates of US medical schools who could not find residency positions last year. With each passing year, the situation for newly graduated MDs will get worse. New MD schools are being established at an unprecedented pace. Since 2006, 16 new MD-granting medical schools have been established in the US. More are on the way. By 2020, there will be a minimum of 2,000 more US MD graduates per year then there are currently. At the same time, the number of annually created GME slots is widely predicted to increase by only 1% a year.

Adding to the MDs' problems is the explosive growth of DOs who are occupying slots that were originally designed for US trained and internationally trained MDs. Where MD medical school enrollment will grow by a healthy 30% from 2002 to 2016; osteopathic medical school enrollment will jump by an amazing 125%. Although this rapid increase in osteopathic numbers of schools and graduates was initially observed with apprehension by the AMA and AAMC; their attitude towards rapid osteopathic growth is now hardening.

Osteopathic medical graduates are now increasingly being perceived by our ACGME partners as effective competitors to US allopathic school graduates in getting GME positions. There is no question that LCME-accredited medical schools want to ensure that all their graduates get GME slots going forward. Increasingly, they are realizing that the one way they can effectively do that is to have influence upon the number of osteopathic schools and their graduates. And the only way to accomplish this is through a merger of the COCA and LCME accrediting processes into an expanded LCME. This ACGME merger opens the door for them to accomplish just that.

A very polite invitation to the AOA and AACOM to become part of the LCME will come very soon from our ACGME partners—the AMA and the AAMC. Should the AOA and AACOM repeatedly refuse the invitation to join an expanded LCME, our allopathic partners will undoubtedly take their case to the Department of Education, the news media, and to the American public. Our ACGME partners will argue that it is in the public's interest that osteopathic medical schools adopt the same accreditation standards which MD schools need to meet to produce competent graduates. After all, they will argue, both types of US medical schools seek to produce "physicians and surgeons." And how, in fact, can we justify a refusal to join the LCME when we, ourselves say how beneficial it is to the public interest for us to be part of a unified GME Accreditation System in the ACGME with these same allopathic partners?

What I hope all of you will appreciate is that if you embrace the concept of one unified accreditation system and standard on one end of the medical education curriculum, you are logically compelled to accept the appropriateness of one accreditation system and one single standard on the other end of the medical education continuum.

Some osteopathic college deans and other administrators have told me that the assimilation of the entire osteopathic profession is inevitable. They believe that an independent osteopathic profession cannot survive indefinitely. So for them, I'm sure this ACGME union is a natural step in the inevitable process of osteopathic medicine being absorbed into the medical mainstream.

But if these college administrators believe that in this inevitable process of absorption their colleges will seamlessly make the transition from COCA-accredited medical schools to becoming LCME-accredited medical schools they are quite mistaken.

Let me explain why?

The LCME from its' beginning has unambiguously declared, and its members genuinely and fervently believe, that any medical school which is dependent primarily upon tuition is intrinsically incapable of delivering a quality medical education to their students. Indeed, tuition counts for only 3.6% of all LCME-accredited medical school

revenue. By contrast, tuition counts for 67% of all revenue in COCA-accredited medical schools.

24 osteopathic medical schools are private. Their medical education is funded primarily by tuition and they are heavily dependent upon voluntary faculty members. Despite evidence that our private schools produce a competent annual cohort of individuals well prepared for graduate medical education, the LCME finds this model utterly incompatible with its long-held standards and expectations.

6 osteopathic medical schools are state supported. In a recent AACOM Study, the six state supported osteopathic medical schools generated an average of $117 million per annum. However, the average total annual revenue of LCME medical schools is more than $700 million. In other words, the average revenues for public osteopathic medical schools constitute only one-sixth of the average revenues for all LCME medical schools. Thus, both our public as well as private osteopathic medical school revenue models are not in compliance with LCME standards and expectations.

Given this disparity between the financing of our schools, one of the most obvious differences between LCME- and COCA-accredited medical schools is the average full-time faculty to student ratio. There currently exists a more than 14 to 1 difference in FTE faculty per student ratio between LCME and COCA-accredited medical schools. MD schools rely on full-time clinical faculty, osteopathic schools don't, and our way of educating medical students is totally incompatible with LCME standards and expectations.

If we examine basic science faculty workforce for the first two years of medical education we also see significant differences. LCME-accredited medical schools have an average of 127 full-time basic science faculty members. The great majority of osteopathic medical schools employ between 20 and 30.

This last gap is especially notable given the difference between the numbers of students MD and DO schools accept. MD schools have an average class size of 145. DO schools, despite having far less resources, enroll an average of 229—55% more. The average number of students that osteopathic schools matriculate, given their available resources, is completely inimical to LCME standards.

Let me be absolutely clear and unambiguous on this one point. The LCME will not establish a different standard for osteopathic medical schools from that to which their currently accredited community-based MD medical schools must adhere.

Thus, when the AOA and AACOM are either willingly or reluctantly brought into the LCME, they will be obligated—just like in the ACGME merger—to accept our allopathic partners' standards—with some minor concessions made by the LCME that do not impair its ability to judge osteopathic schools on the same basis that they evaluate existing MD programs.

When homeopathic and eclectic medical schools reluctantly agreed to become accredited by the AMA in the first decade of the 20th century, no special accommodation was made for their schools. Indeed, the mantra—then as is now—was conformance by all medical schools of whatever type to one common standard.

In 1905, there were no less than 24 homeopathic and eclectic medical colleges. In 1935, the number of such schools shrunk to a mere 3. In that latter year, the two surviving homeopathic medical colleges were required to drop all mention of "homeopathy" in their self-descriptions and remove any semblance of homeopathy from the required medical school curriculum. In 1939, the last surviving eclectic medical school closed its doors forever.

What would likely happen when osteopathic medical schools become subject to LCME accreditation? Based on existing LCME standards and my historical knowledge of allopathic medical school accreditation I am comfortable in predicting the following: First, all COCA-accredited osteopathic colleges would be put on probationary status; second, they would likely be required to cut their class size to an average of 100 students per year—and perhaps less; third, they would be required to support a minimum of 75 basic scientists and provide the buildings, labs, human and other resources for them to do research; fourth, each school would be required to develop multiple clinical departments and sufficiently staff them with full time faculty members; fifth, each college would need to forge formal and stronger partnerships with hospitals and other clinical sites; sixth, all schools would have to find new and enormous funding streams to support medical education; seventh, schools either would be required to award the MD degree from the beginning or our colleges will soon voluntarily adopt the MD degree as a means of reaching a wider audience and securing the revenues they need to survive; and eighth, osteopathic schools will have to subsume "osteopathy" under the heading of "physical medicine" in their curricula. Ultimately, the term "osteopathy" or "osteopathic medicine" will eventually be excised from the college curriculum and the catalog.

If in the unlikely, but best, scenario that all formerly DO-granting medical schools survive this process of becoming LCME-accredited colleges, the number of graduates they produce –which is currently expected to approximate 7,000 by 2020, will be dramatically reduced thereafter. Assuming a total of 35 osteopathic medical colleges in 2020, the number of total graduates would be cut by one half to no more than 3,500 per year.

This means that under "the best" of scenarios, there will be 3,500 less of our graduates a year to compete with "congenital" MD graduates for scarce GME positions. Please note that this dramatic drop in our graduates would go a long way in solving the residency slot shortage for future graduates of congenital allopathic medical schools.

The far more likely scenario is worse, however. In this scenario the great majority of private osteopathic medical schools, particularly those without a strong alumni base and endowment, would cease to be free-standing medical colleges. Some private schools, because of their geographical location and rural

Continued on page 8

Continued from page 7

mission may become small, branch campuses under the auspices of existing allopathic medical colleges. Some formerly osteopathic medical schools may use their facilities and faculty members to either create or expand other graduate-level health programs such as for physician assistants or nurse practitioners. Some of their existing school facilities might be retrofitted for non-educational uses such as nursing homes, office buildings, or shopping centers.

Publically-funded osteopathic medical schools would also face continuing challenges to survive. All of our state osteopathic medical schools have faced periodic legislative scrutiny and some, on occasion, have had to mobilize their supporters to combat serious efforts by cost-conscious lawmakers to close them down.

State-supported osteopathic schools on average generate only 16% of the average revenues of LCME-based schools. How these public osteopathic colleges would obtain the needed revenues to make the grade to continue as fully operational medical schools is unclear given the tight fiscal situation many of their respective state governments now face. State governments could simply decide it would be more cost effective for them to just close these osteopathic colleges down and expand enrollment at other state allopathic medical schools.

In this more likely and bleak scenario, the number of annual graduates from what were formerly "osteopathic" medical schools, may drop to 1,000 to 1,500 per year. This decline would be even better news for congenital MD-granting medical schools in guaranteeing their graduates an ACGME residency position.

The AMA and the AAMC –our proposed partners in the ACGME unification—would no doubt proudly trumpet the demise of "osteopathic" medical schools as being in the public's interest. Their argument always has been and will always be—one profession of medicine—one standard of medical education—and one medical degree to signify "physician and surgeon". This has been and always will be their genuine and firmly-held belief.

As for the AOA and AACOM being members of both the ACGME and LCME, that will end after this process of college assimilation is completed as there will be no "osteopathic" medical schools, per se, whose undergraduates or graduates these all but defunct associations can legitimately represent.

I believe, as I think most in this room believe that the loss of osteopathic medical schools would not be in the public interest. First, osteopathic medical schools despite their limited resources produce uniformly qualified candidates for graduate medical education; second, osteopathic medical schools educate a higher percentage of future primary care physicians than do allopathic medical schools; third; graduates of osteopathic medical schools are more likely to serve in rural areas where they are needed; fourth; osteopathic medical graduates are trained in distinctive diagnostic and therapeutic means not taught in MD-granting schools and these means provide DO graduates with an additional set of competencies to provide quality patient care; fifth, osteopathic schools provide a challenge to conventional allopathic wisdom as to how much and what type of resources are actually needed to prepare competent individuals for graduate medical education; and sixth, osteopathic medical schools have the capacity to swiftly develop and institute innovative programs to educate their students and to better serve the underserved.

Let me conclude. The ACGME plan will transform graduate medical education for newly-minted DOs. But it will do far more. It will unintentionally weaken and irreparably damage the other pillars of the osteopathic profession including its specialty boards, its specialty colleges, and the AOA.

If the ACGME merger goes forward, there will be no compelling and rational argument against osteopathic medical colleges NOT being accredited under the auspices of the LCME. And if the LCME makes no allowances for the vastly different financial models of osteopathic medical colleges—which it most assuredly won't—then this profession will lose its schools, and will see every pillar that holds up the edifice of the osteopathic medical profession collapse.

All of you need to closely question your leadership as to the wisdom of the path they are on. And quite frankly, the leadership needs to step back, pause, and comprehensively consider the unintended consequences of the path they are now on—before going forward. They also need to stop saying "We have no Choice." You have a choice!

I am one with the current leadership on one important point. They say "the status quo is unacceptable." I absolutely agree. But I am convinced that following the ACGME route is not the solution to addressing any of the difficult challenges the osteopathic medical profession faces now or in the future.

*Reference sources for this oral presentation include but are not limited to: *AAMC Data Book: Medical Schools and Teaching Hospitals by the Numbers*. Washington DC: Association of American Medical Colleges (April, 2013); *Functions and Structure of a Medical School: Standards for Accreditation of Medical education Programs Leading to the M.D. Degree*. Washington DC: Liaison Committee on Medical Education (March 2014): Stephen C. Shannon, *Osteopathic Physician Supply and Distribution*. (Power Point Presentation) Chevy Chase, MD: American Association of Colleges of Osteopathic Medicine, (February, 2014); Norman Gevitz, "The Fate of Sectarian Medicine" in Barbara Barzansky & Norman Gevitz, (eds.) *Beyond Flexner: Medical Education in the 20th Century* (Westport, CT: Greenwood Press, 1992).

Norman Gevitz received his PhD in Sociology from the University of Chicago. He is currently senior Vice President—Academic Affairs, AT Still University in Kirksville, Mo. And Mesa, AZ. He is the chief academic officer of ATSU overseeing its six colleges including the Kirksville College of Osteopathic Medicine (KCOM) and School of Osteopathic Medicine in Arizona (SOMA). He is the author of more than 50 publications including *The DOs: Osteopathic Medicine in America* Baltimore, MD, 2nd ed.2004). He has obtained grants from the National Institutes of Health (Library of Medicine), the national Endowment for the Humanities, and the US Department of education. He is the recipient of 7 honorary degrees and public service awards for his research and service to the osteopathic medical profession.

Joint Accreditation Counterpoint

Anita Showalter, DO

After reading Norman Gevitz's speech on the joint accreditation pathway, I wish to make some counterpoints. While I recognize Dr. Gevitz's prominent position as an osteopathic historian, I believe we have much more to fear from within than without in regard to the future of our profession.

For many years the AOA has welcomed the training of DO's by the ACGME with mixed feelings. It is admittedly difficult to start new residency programs, and the expansion cap in the late 90's prevented growth of existing ones. Our students are welcomed by many ACGME programs because of their competence and teamwork. The availability of residency opportunities has made us less determined than we should be to assure residency growth meets the demand of our undergraduate expansion. Now we are facing true crisis in dwindling postgraduate training slots for both professions. I anticipate our candidates will continue to be attractive to ACGME programs as they have been in the past.

If one has concern of how DO's will fare in a single accreditation system, we can look at the military as an example. DO's are well represented across all specialties and work side by side with their MD counterparts in a single match system. The spots are competitive with more demand than supply. Our performance in the military match is real evidence that we may not need to fear the Memorandum of Understanding with ACGME.

While we have relied heavily on the allopathic profession to assist in postgraduate training, we have always totally owned undergraduate training. Osteopathic undergraduate training cannot exist without our Colleges of Osteopathic Medicine, unlike postgraduate training. Therefore, we don't need to worry that combining MD and DO undergraduate colleges will automatically occur. We do need to worry, however, whether or not our profession is willing to train our next generation. If we abdicate this role, we can kiss our profession goodbye. This includes not having sufficient preceptors that use osteopathic techniques for our students to get training in the field. It also includes a paucity of texts and training materials that teach the use of osteopathic techniques and differential diagnosis in the specialties.

In addition to undergraduate challenges, we need to make sure that our specialty colleges remain relevant and that services and requirements, such as continuous certification processes and CME are cost effective and value added. When our allopathic medical societies provide more resources with less expensive dues, we do need to worry about maintaining a loyal base.

I agree that we face challenges that could undermine our profession, but the enemy is from within, not from without. As an osteopathic medical educator, I welcome a system that will make strategy for choice of residency easier for our students. I also welcome MD's into osteopathic programs to see the value of our philosophy and practices. I do not fear that this will be our undoing. I fear it will be because we fail to do due diligence to pass on our heritage, to research our principles and teach osteopathic distinctiveness with authority.

Anita Showalter, DO, FACOOG (D)
Assistant Dean of Clinical Education
Associate Professor and Chair, Women's Health
Pacific Northwest University of Health Sciences

Governor Seeks Board Applicants

The Department of Health (DOH) is currently accepting applications to fill **three** vacancies on the Washington State Board of Osteopathic Medicine and Surgery (board). The board ensures that osteopathic physicians and osteopathic physician assistants practicing in Washington State are competent and provide quality medical care.

We are looking for people willing to study the issues and make decisions in the best interest of the public. Our member selection reflects the diversity of the profession and provides representation throughout the state. The board has three openings for osteopathic physicians practicing in Washington. These positions will be open July of 2014.

The board consists of seven members appointed by the governor: six osteopathic physicians who have been in active practice for at least the last five years and one public member. The board meets about six times a year, usually on a Friday every eight weeks. There is an expectation to review disciplinary cases between meetings, and additional conference calls, meetings, or hearings are often necessary.

Additional information on the board, along with a link to the governor's application is available on the board's website at:

http://www.doh.wa.gov/LicensesPermitsandCertificates/ProfessionsNewReneworUpdate/OsteopathicPhysician/BoardInformation.aspx

Applications, along with a current resume must be submitted by **May 12, 2014**.

If you have any questions about serving on the board, please contact Brett Cain, Program Manager, at the Department of Health, PO Box 47852, Olympia, Washington 98504-7852, by email at brett.cain@doh.wa.gov, or by telephone at (360) 236-4766.

AOA Hosts Single GME Accreditation System Progress Update

By Jeanne Rupert, DO, WOMA District 1 Trustee

All state osteopathic societies were invited to send representatives to a meeting in Chicago on May 4, 2014 for an update on the proposed single GME accreditation system. I was honored to be able to represent WOMA. There were approximately 150 attendees, including both DO and MD leaders. All attendees were able to read a copy of the Memorandum of Understanding, take notes, and ask questions. I have provided WOMA with a copy of the handouts at the event.

There were presentations by speakers from both the AOA and the ACGME, and ample time for questions and concerns expressed by the attendees. The main points included:

1) This agreement is only about GME. While Dr. Gevitz predicts consequences for other aspects of our profession, the agreement does not include any features which would specifically lead in that direction.

2) This agreement supports the idea of osteopathic distinctiveness. The ACGME proposes to create 2 new bodies within their accrediting structure. One is a Review Committee for NMM. That means that the NMM specialty will have equal status with all other specialties which are accredited by ACGME. The NMM Review Committee will consist of 5 DO members and 1 MD member. The second new body will be an Osteopathic Recognition Committee, which will be the organization responsible for reviewing programs which desire to have Osteopathic content. OPP standards will be added en bloc for programs with Osteopathic Recognition. That means that OPP competencies will have equal status to other competencies that are certified by the ACGME. The Osteopathic Recognition Committee will have 13 DO and 2 MD members.

3) This is a broad outline, and a work in progress. Either party may withdraw from the agreement as it unfolds.

4) Residency faculty with DO-only training will be accepted as faculty automatically. DO program directors will be looked at on a case-by-case basis to determine if they meet existing ACGME standards for program directors. This was a controversial point. The ACGME point of view is that they require consistent standards, and that they are not trying to eliminate any program directors per se.

5) Dual accreditation will go away, because there will only be one way of accrediting, through the ACGME. Programs with Osteopathic Recognition will need to have co-directors, so that both pathways to Board Certification are represented. Both MD and DO graduates will be able to apply to every residency in the US. MDs who wish to train in a program with Osteopathic Recognition can be required to do a pre-course of some kind to start them learning OPP.

6) Students in DO schools are overwhelmingly in favor of this agreement. All 23,000 were surveyed, and about 23.5% responded. 85% of those expressed strong support for the agreement. Only 5% were strongly opposed. Students represent a full quarter of our profession now. A student leader there stated that they are fully aware of the complexities of this change, but they believe it provides them with a strong future.

I would like to conclude by referring to remarks by two of the leaders present. One was Dr. Veit from PCOM, who pointed out that more than half of our graduates are already in ACGME residencies. He stated "now there will be an osteopathic voice in their accrediting body."

The other was Dr. Nasca, the head of the ACGME. He stated "We are immortalizing osteopathic principles within the ACGME." He expressed the view that the ACGME will be transformed. "I envision this as a bidirectional process."

Based on the knowledge I gained on Sunday, and as an osteopathic GME leader in the state of Washington, I feel that this is an historic opportunity for Osteopathic medicine to be set on equal ground with Allopathic medicine.

Thank you,

Jeanne L. Rupert, DO PhD
Director of Medical Education
Skagit Valley Hospital

In Memorium Karl Johnson, DO

Dr. Karl Daniel Johnson was born on May 7th 1941 in Urbana, Illinois to Karl Robert and Madeline Johnson. Karl Robert was a Master Sargent in the Air Force while Madeline remained at home to raise their son. As a military family, Karl moved between several bases throughout the country before settling at Selfridge Air Force Base in Mount Clemens, Michigan.

Karl was drawn to sports, playing football, basketball, and running track and field in high school. He was also passionate about music and took up playing the accordion, even appearing on a local Mt. Clemens television show. Karl developed a fondness for sailing from his father who after retiring from the Air Force was a sailing instructor in the Detroit area. His mom helped to plant and nurture a faith in Jesus; one that Karl continued to grow in throughout his life.

Karl attended Kalamazoo College and went onto study medicine at the College of Osteopathic Medicine and Surgery in Des Moines, Iowa. Halfway through his studies, Karl married Marion Clara Siewert on August 28, 1965. Karl graduated in 1967 and he and Marion moved to West Seattle where he began his career at Standring Memorial Hospital.

While serving his patients as a family doctor, he invested in the community by volunteering as a team doctor for local high schools' football and basketball teams. Karl and Marion loved living in the Northwest, taking up sailing and cycling. They celebrated the arrival of their daughter Julie Krista on August 15, 1974. In the fall of 1975, the Johnson family moved to Normandy Park where they have resided for over 38 years. Karl loved being a doctor and caring for his patients. Julie remembers her dad leaving for the office to "stamp out disease".

He was an active member of the Washington Osteopathic Medical Association, serving as a District Trustee and Convention Program Chair.

Sailing, cycling, and traveling with Julie and Marion were the highlights of his life. He also loved sports, especially football. Karl had a passion for life and love for his family, son-in-law Joseph, and grandson Caleb. His patients were like family to him and their care was one of his greatest concerns.

Talking With Your Patients About Screening for Lung Cancer

After conducting a comprehensive review of the medical evidence, including the results of a recent large clinical trial, on December 31, 2013, the U.S. Preventive Services Task Force (Task Force) issued a final recommendation statement on screening for lung cancer. This fact sheet will help you implement a lung cancer screening program and discuss lung cancer screening with your patients.

The Task Force Recommendation on Lung Cancer Screening with Low-Dose Computed Tomography

The U.S. Preventive Services Task Force recommends annual screening for lung cancer with low-dose computed tomography (LDCT) in persons age 55 through 80 years with a 30 pack year history of smoking who are currently smoking or have quit within the past 15 years. Screening should be discontinued once the individual has not smoked for 15 years or develops a health problem significantly limiting either life expectancy or ability or willingness to undergo curative lung surgery.

Population

This recommendation applies to people age 55 through 80 with no signs or symptoms of lung cancer who are current smokers or have quit within the past 15 years. Within this population, the magnitude of the benefit for each individual depends on that person's risk for lung cancer; people who are at the highest risk for lung cancer are most likely to benefit from screening.

Evidence Base for Screening

This recommendation is based largely on the National Lung Screening Trial (NLST), the largest randomized controlled trial to date with more than 50,000 patients. The Task Force used modeling based on the NLST data to assess the benefits and harms of screening programs for varying populations. Based on the trial data and the model, the Task Force concluded that a reasonable balance of benefits and harms is achieved by screening people from age 55 through 80 years old who are current smokers or have quit within the past 15 years.

Expected Benefits of Screening

Evidence suggests that this screening program would detect approximately half of lung cancer cases at an early stage, which makes it more likely that patients will be cured. Right now, 160,000 people die from lung cancer each year. If the Task Force's recommendation were to be fully implemented, it may save about 20,000 lives each year.

Potential Harms of Screening

Lung cancer screening has significant harms, most notably the risks of false positive tests and incidental findings that lead to a cascade of testing and treatment that may result in significant harms that include having unnecessary invasive procedures. Evidence shows that if ten million people were screened for lung cancer with a low-dose CT scan, approximately 250,000 people would experience a false-positive test result and some of those will lead to invasive procedures. Overdiagnosis and the radiation exposure are also potential harms.

Maximizing the Benefits of a Lung Cancer Screening Program

We recognize that the body of evidence on the effectiveness of screening for lung cancer will continue to evolve, which may help the Task Force further clarify its recommendation in the future. What we know now, is that lung cancer screening can save lives and prevent deaths from lung cancer, and that the benefits of screening can be maximized if health care professionals consider the following:

Limiting screening to people who are at high risk. Based on current evidence, the Task Force recommends that screening be limited to people between 50 and 80 years old, who have a 30pack-year history of smoking, and who are current smokers or quit less than 15 years ago. While future research will likely help us refine the criteria for screening, possibly removing some people now considered at increased risk and including others who are not currently included, at this time health care professionals should limit screening to those currently defined as being at high risk. Additionally, most trials, including the NLST, only enrolled people who were generally healthy. The benefit of screening may be significantly less in people with serious medical problems and there is no benefit in screening someone for whom treatment is not an option.

1 Accurately interpreting the images produced from the LDCT. The evidence on the benefits of lung cancer screening comes from research conducted in large academic medical centers with expertise in diagnosing and managing lung cancer. Those benefits are most likely to be duplicated in clinical settings that have high rates of diagnostic accuracy using LDCT.

2 Resolving most false-positive results without invasive procedures. False-positive results occur in a substantial proportion of people screened; 95 percent of all positive screens do not lead to a diagnosis of cancer. To help reduce the harms associated with false-positive test results, health care professionals could consider resolving false-positives with further imaging and watching lesions overtime rather than invasive procedures.

Most importantly, the Task Force recommends that everyone enrolled in a lung cancer screening program receive interventions to help them stop smoking. Most lung cancer deaths cannot be prevented by screening, and smoking cessation remains a critical way to help reduce lung cancer diagnoses and deaths.

[chart/call out box with screening inclusion criteria]

- Age: age 55 through 80
- Pack-Year: 30 pack year history of smoking
- Current smoker, or quit within past 15 years

Talking With Your Patients About Lung Cancer Screening

Explain the facts about lung cancer and who the evidence shows will receive most benefit from screening. Use this fact sheet or the information sources below. Discuss the benefits and harms of not only LDCT screening itself, but of potential subsequent diagnostic testing and treatment. Help your patient understand if he or she is at high risk for lung cancer and should consider getting screened.

Lung cancer screening is most beneficial for those at high risk. Use the scenarios below to help explain to a given patient why he or she may or may not benefit from screening.

Scenario 1: Current smokers between age 55 and 80 who have smoked 30-pack years who request lung cancer screening .

Discuss the importance of smoking cessation, and hat quitting smoking is the most effective way to reduce the risk for lung cancer and recommend that they quit. Explain that the screening test can prevent some, but

not all lung cancer deaths, and screening is not a substitute for quitting smoking. The CT scan will find things that require further testing, and 95 percent of what is found is not lung cancer; the screening is likely to result in additional testing and possible overdiagnosis. Emphasize that there's a significant risk for these patients to develop lung cancer and that most people who are diagnosed with lung cancer die from the disease. This screening program can provide some hope for preventing death from lung cancer by detecting some of these lesions at a point when they are most treatable.

Scenario 2: Patients who are just outside the the screening criteria (too old, too young, doesn't have enough pack-years, or quit smoking more than 15 years ago) and ask about screening.

Emnphsize that they don't currently fit the screening criteria and not all people who may be at risk for lung cancer will benefit from screening because there are so many harms, including false-positives and exposure to radiation. **If the patient is still a smoker:** State that the most important thing they can do to prevent lung cancer is to quit smoking, which is more effective than screening. For every year they don't smoke, their risk for lung cancer goes down. **If the patient has already quit:** Let them know that quitting is the most important thing they can do to prevent lung cancer and their risk for developing lung cancer has been going down every year since they quit smoking. Explain that ordering the screening test will likely do more harm than good because they are not considered high risk. Explain that there is not enough evidence to recommend screening people at lower risk for lung cancer and explain the potential harms of screening.

Scenario 3: Patients who fit all screening criteria age, current or recent former smoker, pack-years) however they have a significant co-morbidity.

Explain that while lung cancer screening hs been demonstrated to be effective in some people, there are certainly risks associated with false positive tests and the following treatment including, invasive procedures and surgeries. And, because of their co-morbidity, they may be at greater risk of harms for any invasive procedures resulting from the screening tests. If they are current smokers, discuss the importance of smoking cessation, and that quitting smoking is the most effective way to reduce the risk for lung cancer and recommend that they quit.

The Bottom Line Screening high-risk patients for lung cancer will save lives. In order for screening to be beneficial, it must be limited to those at high risk and implemented carefully.

The most important way to prevent lung cancer is to help smokers stop smoking and protect nonsmokers from being exposed to tobacco smoke.

Editors Note:This guideline has the potential to increase malpractice exposure for physicians should the patient develop lung cancer and the physician failed to document that they have advised their smoking patients of the new screening recommendation.

101st Annual Northwest Osteopathic Convention
June 19-22, 2014
Skamania Lodge
Stevenson
Save $50 if you register before May 19, 2014
www.woma.org

Exhibit Space Available

There is still space available to exhibit at the 101st Annual Northwest Osteopathic Convention to be held June 19-22 at Skamania Lodge in Stevenson. If you know of a firm that has a product or service of interest to physicians, please extend an invitation to participate and direct them to www.woma.org for a prospectus and exhibit hall map.

As of May 8th, Exhibitors include AbbVie, ATSU-SOMA, Astra Zeneca, Medical Protective, Reckitt Benckiser, RYSE Medical Solutions, USAF Health Professions and Western U – COMP NW.

A WOMA Membership can Pay Dividends…

On March 25, 2014, the Pierce County Council voted to pass Ordinance 2014-12s. The title of the new law was "An Ordinance of the Pierce County Council Amending Chapter 2.07 of the Pierce County Code, "Department Director Qualifications – Pierce County Appointed Officials".

Under Chapter 2.07.080 Medical Examiner, Osteopathic trained physicians would have been prohibited from applying and serving as the Pierce County Medical Examiner. During testimony, legal counsel for the County Executive, Al Rose, JD objected to having any reference to osteopathic medicine or osteopathic physicians being inserted into the law noting that he doubted seriously that D.O.s would qualify as a physician to hold such an appointment nor did he believe the American Osteopathic Association existed as a professional organization. In his final remarks, he strongly urged the council to reject an amendment offered by Stan Flemming, D.O., who likewise is a member of the County Council and Chair of the Tacoma – Pierce County Health Department Board of Health. Flemming countered arguing that osteopathic physicians are one of two groups of physicians (the other being M.D.s) recognized by the federal government and every state in the union. "As an osteopathic trained and board certified physician, I can assure this council that D.O.s are qualified to serve in this capacity and…the American Osteopathic Association is a nationally recognized and legitimate organization. You may agree with me since most of you know that I am a physician, but I also happen to be an osteopathic trained and board certified physician and a member of the American Osteopathic Association."

On a 7-0 vote, the council voted to amend the law to read, "Education. Doctor of Medicine **or Doctor of Osteopathic Medicine** from an approved American Medical **Association or American Osteopathic Association** school of medicine required…Certification by the National Association of Medical or **Osteopathic Medical** Examiners is preferred."

Bear Droppings.....

by Loren H. Rex, D.O.

According to Kathie, I have a column due so here goes my attempt for the WOMA newsletter. Nearly twenty five years ago, Kathie called with the information she was going to start a Newsletter and would I be willing to contribute a column to said endeavor? Since I have always considered myself to be barely literate, I was hesitant to become involved at any level. After many assurances from Kathie that all she wanted was a report on the goings on of the various committees such as L&I that I attended on behalf of WOMA, I finally agreed to become involved. Due to my inability to ever be completely serious about anything, I tried to inject some levity where possible. That wasn't real easy when dealing with the State of Washington and especially L&I.

According to Kathie she was receiving two types of feedback. The first was from a couple of old docs who objected to the name of the column. They were no doubt unfamiliar with the name Bear Droppings as a colloquial name for Alaskan fry bread. So much for scatological linkages. They were easy to deal with: ignorable. The second group was a bit more difficult. They liked the humor and wanted the column to go in that direction; just forget about the dry boring statistics. Unfortunately that was the easy stuff to write about. So here we are almost twenty five years later. Are the columns funny or boring? Your call.

Some of you may have heard, since my retirement, I have had to develop some job skills as a patient, unfortunately I had absolutely none. WOMA has come through for me and I would like to do a couple of call-outs at this point. One Sunday afternoon awhile back I got a call from some of our members asking if they could drop by. The next thing I knew, Doctors Dan Wolf, Lindy Griffin and Harold Agner were at my door step and cheering me up greatly. Even though he has had an increase in pressures in his life, Harold has continued to visit me weekly and treat me with an old fashioned Osteopathic treatment. What a great thing to look forward to each week. I suspect this was what WOMA was like in the day. Having been on the receiving end, I wish we were still like that. Maybe we need a committee to see to it that people who are ill get the message they are still a part of the group and not forgotten. On my birthday, Kathie, who always seems to find time for everything, along with her husband Steve, showed up at the Re-Hab center and shared a Birthday cake with some other friends who were visiting. I have been very blessed and I truly appreciate the many blessings that are raining down up on me. My Father's favorite song was an old song that learned as a Bluegrassized ballad. The name is so apt now: "T'is sweet to be remembered".

I guess I have stalled long enough, it is time to try and inject a little bit of humor. I like to think that no matter how ludicrous the situation, I can always see a bit of humor somewhere in the situation even though it may take quite a while for me to become enlightened. I had unwittingly introduced what in today's vernacular is "a teachable moment". And so it was with what I will call the great power chair learning incident.

It was late at night and I was preparing to go to sleep in my wondrous two-motor chair and had begun to adjust the chair into the perfect position utilizing my hand held controller with its coiled power cord for my convenience. A few short minutes later, I had it nailed. My lumbars were flattened perfectly and my cervical curve beautifully flexed for comfort . My thoracics were fairly locked and stable, the perfect sleeping position had been achieved. Confident of a good night's sleep, I laid the controller on my abdomen and released my grip on same object. I failed to take into account that the coils of the cord were at a stretched position and I was greeted with an immediate KERZING! coming from the controller as it sailed across the room to hide itself under the bed and definitely beyond my reach. Not to worry, I will just push the call button and summons a care giver to save me. I, of course had forgotten to move the button to my side of the bed and thus my fate was sealed. I immediately could feel my transformation from a Bear to a Turtle. A Turtle on its back. I rocked in every direction trying to find a way to free myself from my technological incarceration but alas, I was a victim of my own undoing. Since it was on the far side of midnight, the fact that I was close to the elevator was of only slight benefit. I considered screaming at the top of my lungs but decided I already looked foolish enough so I settled in to wait for some form of help.

After a wait that seemed forever, a lady appeared at the elevator door I swung into action. Actually, I have never tried to convince a strange lady that she should crawl under my bed and retrieve my chair controller but this was not the time for timidity. After some amount of discussion, mainly pleading on my part, I did finally convince her she had a chance to save a life with only a small amount of danger to her and a large amount of embarrassment to me. She finally climbed under the bed and reappeared with the chair controller held like a black Lab anticipating a bone. After a suitable period of thanking her effusively I began the task of moving the chair into various positions on my pathway to freedom. I finally escaped and lived to tell the tale.

Bear