association of american medical colleges

January 27, 1987

MEMORANDUM

TO: Robert G. Petersdorf, M.D.

FROM: Elizabeth M. Short, M.D.

SUBJ: CAS Services Program

A group of senior staff reviewed the CAS Services Program and recommends that it be closed. The rationale for and analysis of this recommendation are contained in the attached memo and supporting documents. Should you support this recommendation we would then turn towards a careful analysis of how to disengage the societies currently served before taking any public actions.

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Suite 200/One Dupont Circle, N.W./Washington, D.C. 20036/(202) 828-0400

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DATE: January 27, 1987

TO: Robert G. Petersdorf, M.D.

FROM: CAS Services Review Group
Sherman, Short, Swanson, Turner, Knapp

RE: CAS Services Program

Background The CAS Services Program was begun in 1977, following a proposal from the APM to establish Washington representation, promote closer ties with AAMC and create a secretariat to handle meeting arrangements and coordinate publications. The program was approved by Executive Council and the CAS Council after extended debate and was originally intended to provide office management and/or legislative tracking services for CAS chairmen's groups. Appendix I details the history of the program establishment.

Subscribing Societies have included:

1. Association of Professors of Medicine (APM) 1977 - 1984
2. American Federation for Clinical Research (AFCR) 1978 - present
3. Neurology Intersociety Liaison (NIL) 1978 - present

NIL and AFCR have subscribed to the Legislative Tracking Program; The Professors of Medicine also subscribed to the Office Management Program.

This program has never blossomed or expanded as was initially envisioned. In addition it has been beset by internal management problems which have compromised its functioning.

Demand for the Program

The Council of Academic Societies and the Division of Biomedical Research envisioned a great need for this program in the late 1970s. Many academic societies were just beginning to take an interest in legislative affairs and the AAMC was interested in kindling their involvement to increase the lobbying power of the academic community, and in educating and interacting with societies, especially the Chairmen's groups, to enhance their alignment with Association positions on a wide range of issues.

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In the ensuring decade most chairmen's groups have interacted with AAMC policy formulation through the CAS and have made good use of our pink legislative alerts and WAR in developing their own positions, which are often in concert with ours. However, they have also increased their interest and involvement in public policy issues through increasingly productive interactions with other societies in their discipline including the academies or colleges representing the discipline's practicing physicians. A recent survey of 81 CAS Societies revealed that all major disciplines now have formal or informal arrangements by which they participate in legislative affairs; chairmen's groups are linked with their academies in coordinated policy formulation and many disciplines are organized with Washington-based staff, public policy committees and grass roots lobbying efforts.

It is not clear that in 1987 there is a significant segment of the academic community in need of the services of the CAS Program. Their Office Management needs are met by staff from larger societies in their disciplines and they are active in legislative tracking through multiple resources. It may be to the benefit of the Association to have our Office on Government Relations group work closely with societies and separate staff in coalition fashion to develop positions. These positions could then be lobbied by an entire community of groups that are, from the congressional viewpoint, independent. The societies in the Services Program have at times had their positions dismissed or been labeled as puppets of the AAMC.

Management Problems

A. The Services Program has never been able to take advantage of economies of scale which might accrue if more societies subscribed. The service was envisioned as most helpful to Chairmen's groups which have small budgets and few activities. The interests of the AAMC were believed to be served by the close liaison and while the service was not seen as a moneymaker it was expected to break even by pooling support staff for a number of societies. The few societies participating rapidly wanted more service then was reflectd in the fees and the APM was soon a loss leader. AFCR & NIL fees were raised to reflect costs in 1984.

B. The Office Management services were provided by AAMC only to APM. Staff who were capable of legislative analysis and lobbying and who dealt with issues in biomedical research did not relish secretarial, bookkeeping and meeting management duties.

C. Legislative Liaison staffing has been performed for NIL and AFCR. Staff in this role provide information and analysis of bills and regulation, track issues of interest to the society, prepare testimony and letters to Congress and write newsletters for the society's members. Difficulties have included:

1) Congressional staff dismissing the society's positions when it is in their interest as "puppets of AAMC";

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2) As each society has become more active it has increased its demands that its staffer lobby Congress directly;

3) The BMR Division has had to duplicate the activities of the DPPD legislative Liaison Staff because that Department has not directly supported the Services Program with written analyses or investigation tailored to their issues;

4) Societies have occasionally taken positions at variance with that of AAMC which their staffer must support. Societies have at times been suspicious that they were not receiving fully objective information from AAMC. This possible conflict of interest and loyalties has led all the participating societies, despite assurances from us, to repeatedly consider the use of other lobbying services;

5) Chairmen's group are interested in tracking a wide range of issues especially in clinical practice. These issues are not central to the missions of the Division, but despite support from DOTH, fulfilling the service obligation has required DBMR staff to become fluent on issues of PROs, physician payment, etc., often from a viewpoint divergent from that of teaching hospitals.

6) Services Program staff have been stressed by conflicting loyalties. They have staffed these societies without sufficient recognition or credit within the AAMC and have been tempted to transfer their entire loyalty to the client society. Despite recent improvement in this situation, the divided loyalty issue remains.

7)Societies participating in the Services Program ironically have been less active in the formal AAMC Governance structure through the council. They have had spotty attendance at Council and their CAS representatives have not been integrated into their Services Program activities.

Summary and Recommendations

Some of the management problems outlined (B and C 3,5 above) would be amenable to correction by an internal Association realignment so that the specific tasks needed by the clients were performed by the Association staff usually dealing with those issues. Others are inherent in the nature of this program and should be seriously evaluated by the Association in terms of its desired relations with academic societies, its view of our appropriate roles in lobbying, and a realistic estimation of the demands which are placed on Association resources by this program.

I. The Review Group recommends that the CAS Services Program Legislative Tracking Service be discontinued at the time that the yearly contracts of the participating societies are up for renewal. The contract year runs from July 1.

The conflicts of interest and interdivisional complications already experienced are inherent in this service and its continuance does not benefit the Association. The political ramifications of disengagement from the currently subscribing societies should be carefully reviewed and every effort made to achieve a smooth closure, avoiding the strains which surrounded the APM decisions to leave the program.

A) Relations with CAS as a whole would probably not be affected by closing the program since most current CAS reps do not know it exists. A quiet closure would not be seen as a blow from AAMC, especially if we increased coalition building and issue-oriented meetings with Chairmen's Groups in lieu.

B) The NIL would probably withstand Program closure without a rupture with AAMC. It would turn for legislative tracking to its academy which has this service and wants to provide it to other NIL members. The secretarial service of keeping minutes for their intersociety conference calls could be performed by any number of persons.

C) The AFCR has actively sought an alternative service in 2 of the last 4 years. They have interviewed other lobby groups and been wooed by us to remain with AAMC. If we closed the program, they would probably go with ACP-APM although they were not entranced by a bid from ACP last year. It seems they want to preserve their autonomy within the senior power structure of their profession (active AFCR members must be under 41 years of age), and they are not concerned with the clinical or practice activities of ACP. They were courted by FASEB, but were not impressed with the quality of that staff and were concerned that physician-oriented research interests would be submerged to those of basic scientists. The company which staffs their office and meeting management service has other clients who use John Gruppenhoff's company and might put him forward as an alternative.

II. The review group recommends that the AAMC close the CAS Office Management Program which currently has no subscribers. The only way to offer this service properly would be to organize an efficient service function and aggressively market it to all Chairmen's Groups. Presumably, the goal would be to increase Association hegemony since these groups are not seeking our help and seem to have adequate support elsewhere. Offering client services to only a few disciplines might prejudice our abilities to work multidisciplinary coalitions where these would best serve AAMC interests.

1) We should consider whether coalitions are not the more effective way to achieve AAMC political goals and whether our staff energies would be better directed towards efforts at coalition-building (e.g.the Ad Hoc Research Funding group and coalitions assembled by DOTH around specific issues) than secretarial services.

2) Are not the present close relationships of Chairmen's Groups with their academies of benefit to AAMC in fostering support of academic interests within the medical community?

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