Factors Influencing Resident Participation in the AAOS Political Action Committee

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abstract

Resident participation in the Political Action Committee (PAC) is important for professional advocacy and for ensuring access to quality musculoskeletal care. The following questions were asked: Would faculty contribution-matching increase donation rates and amounts among orthopedic surgery residents at a single institution? What barriers do residents self-identify that prevent or delay PAC participation? How do residents perceive a faculty contribution-matching program? Residents at 1 institution were encouraged to participate in the PAC before and after the introduction of a faculty contribution-matching program. In addition, telephone follow-up was performed and resident perceptions were assessed regarding the program and barriers to participation. Rates of participation, amounts donated, and perceptions are reported. Resident participation in the PAC increased from 10% to 95% following the introduction of a faculty contribution-matching program. The second group of residents contributed 67 cents for every dollar given by the first group. Significant barriers identified included time constraints and an inability to access the PAC Web portal. Ninety-four percent of the initial nonresponders said that they made joining the PAC a priority after learning about the faculty contribution-matching program. They specifically cite giving greater attention to an issue that the faculty value. Four months after the initial e-mail, 100% of residents had contributed. Residents believe that professional activism is important but ascribe it a lower priority than other professional duties. Residency programs might facilitate resident involvement in the PAC by instituting faculty contribution-matching and by assisting junior residents with their American Association of Orthopaedic Surgeons login information.

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Physician advocacy is increasingly recognized as a professional responsibility for the modern orthopedic surgeon. Its strongest foundations lie on a Hippocratic commitment to ‘advocate for patients in need and strive for justice in the care of sick.’ Contemporary advocacy is mired in issues that appear far removed from patient care (eg, the frequent fights to prevent practice-devastating cuts due to the Sustainable Growth Rate formula, liability reform, and scope of practice). However, these issues are informed by the nature of physicians’ commitment to patients and are intimately tied to ensuring access to and quality of musculoskeletal care. Physicians’ insight into the delivery of care is unmatched and elevates physician involvement in health care reform to a privileged status.

The American Academy of Orthopaedic Surgeons (AAOS) advocates on behalf of orthopedic surgeons and disseminates information about relevant contemporary political issues. By engaging politicians and key advisors, the AAOS promotes musculoskeletal medicine and influences health policy in favor of orthopedic surgeons’ ability to care for patients. Effective advocacy first requires access to policy makers. This then affords the opportunity to present a persuasive argument about 1 or more relevant issues. The Orthopaedic Political Action Committee (PAC) provides such access by opening political doors for AAOS advocates in Washington, DC, and other similar venues throughout the country. This access provides the AAOS with an opportunity to deliver well-reasoned points of view developed by the AAOS leadership; it is issue driven and not tied to any particular political party. The mission of the AAOS PAC is to achieve the legislative agenda for the AAOS and the subspecialty societies that have advocacy as a part of their mission.

Political Action Committees such as this one are legal entities administered by an organization that can solicit contributions from members, allowing the organization to represent and advocate on behalf of a large constituency with similar interests. This mechanism allows the AAOS to advocate on behalf of patients and for musculoskeletal medicine. Formed in 1999 as a way to support candidates who would help further the AAOS’s legislative agenda, the orthopedic PAC has grown in influence and relevance. Currently, it is the largest medical specialty PAC in dollars raised. However, the participation rate among orthopedic surgeons is low compared with other professional PACs. The PAC of the trial lawyers boasts more than 90% participation, whereas the AAOS PAC functions with only 28% of member support.

Membership in the PAC begins with a monetary donation of any amount. For surgeons out of training, the PAC relies on substantive contributions to support its mission. For residents in training, significant value exists in converting them into contributing members, even with a nominal contribution. It increases the participation rate, which is an important metric by which PACs are measured. Even a nominal donation introduces the generation of orthopedic surgeons to the role and relevance of the PAC, potentially leading to later substantive contributions.

Residents in orthopedic surgery join their PAC at significantly lower rates than other specialty residents. AAOS PAC internal research has revealed a 0.3% participation rate among orthopedic residents, compared with 27% for anesthesia residents. Thus, the current authors are motivated to develop and study methods of increasing orthopedic surgery resident participation in the PAC. Anecdotally, the authors have found that many residents intend to join but fail to follow through. The goal of this study is to increase resident participation in the PAC by introducing a faculty contribution-matching program. The authors asked the following questions: Would faculty contribution-matching increase donation rates and amounts among orthopedic surgery residents at a single institution? What barriers do residents self-identify that prevent or delay PAC participation? How do residents perceive a faculty contribution-matching program?

**MATERIALS AND METHODS**

Institutional review board approval was obtained for the study. Forty residents at a single urban academic orthopedic training program were encouraged in 3 phases to join the orthopedic PAC. The initial contact comprised an e-mail message sent to each post-graduate year’s listserve by 1 of the authors (R.P.S.), who is also a resident. It contained a brief description of policy issues and an entreaty to become involved by joining the PAC. It included a hyperlink to a Web page where the reader could learn more and join the AAOS PAC. Residents were asked to notify the author if and when they joined, as well as the contribution amount.

Following this, the faculty e-mail listserve was used to solicit supportive faculty members to match resident contributions. Two months after the initial e-mail, residents were again invited to join the PAC via e-mail, and they were informed of the faculty contribution-matching program. They were not told which specific faculty had committed to matching contributions. In addition to the e-mail, individual telephone calls were made to each resident to gather the following information: PAC membership status, intent to join, impression of the PAC, perceived or real barriers preventing their membership, and reaction to the faculty contribution-matching program. All communication with the residents regarding the PAC was made by a single author (R.P.S.), who is a resident. No communication requesting resident participation was made by any faculty members. One month following the second contact, additional e-mail, telephone, and personal requests were made to the resident nonresponders.
Percent of participation was calculated before and after the introduction of the contribution-matching program. The participation rate before contribution-matching is given as number responding over total number of residents (less the author). The participation rate following contribution-matching is given as the number responding over the initial nonresponsive number of residents. The amount contributed was averaged for each group.

A 2-tailed t test was used to determine statistical significance, with an accepted level of .05 as the threshold.

RESULTS

All forty residents were successfully contacted by e-mail and telephone. The initial e-mail resulted in 10 (25%) residents joining the PAC (the early cohort). The introduction of faculty contribution-matching had a positive effect on resident participation in the PAC, leading to 93% participation by the remaining residents (the late cohort). The early cohort gave an average contribution of $30.00 (range, $10-$120). The late cohort donated an average of $20.00 (range, $10-100), or 67 cents for every dollar given by the early cohort. The difference was not statistically significant (P=.38). Fifty percent of the early cohort comprised post-graduate year 4 residents; this class was also the first to achieve 100% participation, followed by the post-graduate year 5 class.

All but 1 (98%) resident agreed with the importance of engaging in policy issues. The remaining resident cultivated a general aversion to all political issues, regardless of their relevance to orthopedic surgery. At the time of telephone interview, all residents indicated that they had intended to join the PAC after receiving the initial e-mail. Of those who did not join by the time of the interview, all explained that they were either too busy either to fully read the initial e-mail (n=6; 20%) or too busy to follow through with the process of joining (n=24; 80%). Among interns, 6 (75%) stated they did not know their AAOS login information, which is necessary to access the PAC Web page.

Of those residents in the late cohort, 27 (97%) considered the PAC a higher priority after learning of the faculty contribution-matching program. The majority of residents attributed this influence to the example set by the faculty. Namely, faculty were equally or more busy than residents but were able to prioritize joining the PAC and valued resident participation enough to match their contributions. Residents also frequently noted the parallelism of faculty matching with public radio fundraising and associated an increased motivation due to the higher dollar impact of their involvement.

At the time of the interview, all of the residents in the late cohort stated that they would join the PAC shortly. Nonetheless, 11 (37%) residents had not donated 1 month later, again stating that they were busy, but that doing so was still planned. Three residents on a single rotation known to have the heaviest clinical load were among the group who still had not joined the PAC. In collaboration with the faculty member on that service, they were offered a protected block of 15 minutes after the conference to join the PAC. None joined during this time or within 1 month of this time.

DISCUSSION

Including the residents in this report, only 55 (1.1%) of the 4,738 orthopedic residents in the United States have contributed to the PAC by April 1, 2012, of the 2011 to 2012 election cycle. Thus, a substantial void exists in the orthopedic surgeons’ advocacy constituency, and efforts should be made to increase resident participation in the PAC. The authors found that resident participation increased following the introduction of a contribution-matching program. Ultimately, 100% of residents in this study joined the PAC.

This study aimed to isolate the effect of faculty contribution-matching on the political participation of residents. It is impossible to entirely eliminate confounding influences on the result. First, multiple requests and reminders by the author (R.P.S.) likely contributed to the high participation rates that were found. Indeed, residents in the late cohort may have joined the PAC not only because of the introduction of faculty contribution-matching, but also because of the author’s persistence in following up on their stated intent to join. To control for this effect, the authors conducted telephone interviews to gauge resident reaction to the faculty contribution-matching program. The majority of residents (97%) responded positively to the program. Ultimately, the authors hope to increase resident participation throughout orthopedic programs, and any implementation of a contribution-matching program should also include a mechanism to provide periodic reminders to residents because this must have played a role in achieving a high participation rate in the current study.

Another concern of this study is the potential for undue influence of faculty over residents due to the inherent power differential of a hierarchical system. The risk for coercion, intimidation, and pressure is high with this type of proposition; therefore, the authors took precautions to minimize or eliminate this risk. First, no communication was made between faculty members and residents to endorse or encourage participation in the PAC. All e-mails and telephone calls were made by the resident author without reference to any faculty members. Protected time was given by 1 faculty member without endorsing or encouraging the PAC. As strong evidence for the lack of faculty intimidation or pressure, none of the 3 residents joined the PAC during this protected time or within 1 month of that time. If direct faculty coercion contributed to resident involvement in the PAC, a temporal correlation would have been observed between their PAC participation and the protected time, but this did not occur.
Second, residents were not told which faculty members were participating in the match. Third, only a nominal enlistment of faculty members was sought rather than the entire faculty body. From a resident’s perspective, this would help isolate the effect of faculty matching as a concept and limit the confounding effect of knowing that all or a large number of faculty are participating. Ultimately, only 7 (33%) of 21 operative faculty members underwrote the matching program. Fourth, the authors’ gauged resident intent to join the PAC after receiving the initial e-mail (prior to learning of the contribution-matching program), and all residents expressed intent to join. Furthermore, the survey results demonstrated that 97% of residents in the late cohort appreciated the faculty matching program and believed it helpful in getting over the inertia of inaction.

This study shows that residents are interested in joining the PAC after learning about its role, but that time constraints and resident obligations interfere with the act of joining. The challenge facing orthopedic advocacy efforts lies in capturing that interest with completed donations. Faculty contribution-matching may provide the impetus for residents to complete the process of joining the PAC because the current data shows that 90% of non-participating residents were enrolled soon after beginning the program and 100% of residents had joined by 4 months. The residents were not made aware of which faculty had committed to matching contributions. However, one may speculate that individual residents would find increased motivation when personal role models participated in the faculty contribution-matching program.

No statistical difference was found between the amounts donated by the early cohort and the late cohort, but the number of participants in the early cohort was too small to power a conclusion that the donations were statistically not different. The average amount contributed by the early cohort was more than that of the late cohort. One might have expected the converse to be found (ie, the late cohort would have higher average donations due to the effect of contribution-matching on the relative value of each dollar donated). However, this was not found. One explanation for this may be the heightened motivation of the early cohort and attendant heightened enthusiasm for the AAOS PAC.

The data show that post-graduate year 4 and 5 residents are most likely to respond to a request to donate to the PAC. Undoubtedly, these residents are most attuned to the landscape of practicing orthopedic surgery after residency and fellowship training. This group is closer to entering practice and recognize that several of the issues managed by the PAC will directly influence their lives in the near term.

Two main barriers were found that inhibited an interested resident from completing the process of joining the PAC: being busy and not having their AAOS identification number to access the PAC Web site. The authors attempted to intervene on the first issue by granting 3 residents on a clinically busy rotation protected time to join the PAC during morning conference. However, none joined during that time. The reasons for this are unclear but were related in part to significant patient care and preoperative tasks that required their attention. However, it is not entirely convincing given that the process takes less than 10 minutes when using the Internet portal. Nonetheless, many of the late cohort residents inquired whether they could bypass the online portal by giving money directly to 1 author, who could then convey the donation on their behalf. No donations were accepted in this manner. The apparent disconnect between the perceived and actual time and effort required to make a donation suggests that the psychological hurdle of making a donation is a significant barrier. Further work should identify additional factors and incentives beyond faculty contribution-matching that may help overcome this psychological barrier.

The finding that the AAOS identification number and login process are barriers may be helpful to other residency programs trying to increase their PAC participation rates. The program could determine these numbers in advance for their interns and junior residents. Alternatively, the AAOS PAC might investigate ways to allow participation without knowing one’s AAOS identification number.

Political disenchantment befuddles contemporary political scientists and plagues many professions and vocations in modern America. It is debatable whether orthopedic surgeons—and modern medicine altogether—were ever enchanted by political winds. Fortunately, politics and government relations more frequently acquire the interest of senior orthopedic surgeons, who have more experience and fewer preoccupations with the demands of practice building, professional development, and family expansion of junior surgeons. However, failing to capture the resources, energy, and ideas of residents and junior orthopedic surgeons handicaps the profession. For example, law students engage politics and government from the earliest stages as an integral part of their education. Political action committees are among the ways that the orthopedic profession might begin to engage residents early to instill a professional duty to remain aware and involved in political issues.

Because external pressures continue to weigh on the contemporary practice of medicine and because policy remains focused on the implications of our spiraling system, physicians have a duty to advocate for access to high-quality musculoskeletal care. Political action committees have a significant effect on political discourse and are the primary means by which organizations voice their collective positions. It is imperative that the orthopedic residents understand the role of the PAC and its effect on their future profes-
Resident education should include a primer on contemporary health policy issues and the importance of the PAC. Much of this can come from faculty members setting an example of civic involvement and PAC support. By garnering resident contributions to the PAC and creating future donations, the orthopedic community can continue to sustain itself in a variable political environment. As the adage goes, if you don’t have a seat at the table, you’re probably on the menu.

REFERENCES
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