Outreach in Focus • Psychoanalysis and Society *Volume One. Nº2 Spring 1998*

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We are very pleased in this edition of the newsletter to bring you news of our outreach efforts to deal with social issues. The participants in this endeavor are currently working in two areas: public sector psychiatry, in settings in which the tools of the psychoanalytic trade may be applied, and in consultative work with the pre-school population. In each area, the consulting analyst may have direct patient contact and also make use of psychoanalytic concepts to help direct providers of services to understand and make use of their experiences in the clinical setting. The following reports, by Alan Felix and Nat Donson, are dramatic examples of the rich opportunities available to analysts interested in public psychiatry and preventive services.

Working with the Homeless Mentally Ill

Alan Felix, M.D.

As many of you know, my "day job" consists of directing a program for homeless mentally ill men living in the Ft. Washington Men's Shelter, just a stone's throw from the Columbia Psychoanalytic Center. I am also affiliated with a wonderful agency called the Project for Psychiatric Outreach to the Homeless (PPOH), founded by Kathy Falk and directed by Gail Albert (eds. note: you know this agency; they send us those striking postcards that say "SHRINK the Homeless Population"). This agency recruits psychiatrists who volunteer their time treating the homeless mentally ill. In addition, they sponsor residents in psychiatry and fellows in public psychiatry who treat this population. Some of our members already serve as volunteers.

My outreach efforts consist of monthly case conferences at agencies served by PPOH. My first consultation was with a transitional shelter in Manhattan Everyone from kitchen staff to social workers attended the conference which focused on the program's difficulties dealing with a woman with borderline personality disorder. I began by explaining some of the core principles of psychoanalysis in non-technical terms and how they can be applied to their patient population. A lively discussion of transference and counter-transference followed, focused on this "difficult" patient. Ultimately

even those on the kitchen staff recognized how this woman used splitting and projective mechanisms to make some of the staff feel special while others felt unbearably abused.

We also discussed the difficulties patients have making the transition from the street or one institutional setting to another. This has been a research area of interest to me, and I have found Mahler's phases of separation-individuation especially helpful in illustrating the intrapsychic and interpersonal problems patients have when they move from one setting to another.(i.e. rapprochement crises)

One very basic aim of the consultation is to demonstrate how a careful history can be used to resolve many crises and begin the process of understanding impasses of transference and countertransference. All too often, the staff of the community-based program is unaware of much of the patient's history. Through the case conference format, the source of the patient's acting out is usually illuminated. Suddenly. a "problem patient" is transformed into a person, frequently one with a long history of neglect and/or abuse. Homeless adults often come from a background of family disorganization, characterized by shifting caretakers, parental substance abuse or mental illness, poverty, and domestic violence. It comes as no surprise then that patients act out with the staff of a residential program (their new family).

In the case presented, the patient was noted to become increasingly hostile towards staff after the death of one of the residents, an older male army veteran. Prior to the conference, no one on the staff was aware that the patient's alcoholic father was a veteran. When the history was presented, the door was opened to understanding the patient's anger and grief as presented in the transference to the agency's staff.

The feedback from the case conference was very positive. I think everyone, from the non-professional staff to the professional staff in attendance, developed an appreciation of what analysts can bring to a community setting. Our most basic functions—obtaining a thorough history, linking current behavior to past events, discovering unconscious motives, understanding the roles of resistance and defense, appreciating internalized self and object representations and the affects connected to them, and recognizing transference and counter-transference in the treatment setting—these can be demonstrated to service providers in any setting. I think this is what Freud might have had in mind when he wrote of the potential contribution of psychoanalysis toward the resolution of societal problems.

My next stop will be with the Neighborhood Coalition for Shelter, a drop-in center on the East Side. Future visits are being planned with Street Works, a program serving many gay, lesbian, and transgender homeless youths, and other agencies that serve the homeless.

I would like to find other analysts who are interested in doing similar outreach work, and would welcome anyone contacting me at 927-4536, or 595-1617. If you prefer, my E-mail address is adfl@columbia.edu.

Childhood Mental Health in the Community

Nathaniel Donson, M.D.

The work I describe here is an extension of a twenty year interest in using psychoanalytically informed principles for early child-hood mental health intervention using available routes within my local community. Working onsite (usually voluntarily) at community day-care centers, Headstart programs and nursery schools, I have offered weekly services to center directors and caregivers regarding children and families about whom they are concerned.

The first step has always been to approach and converse with a center director in order to sound out his or her interest in having a psychoanalytic mental health consultant pay regular visits to the program. This is an immensely complex and challenging part of the process and fails as often as it succeeds. Its success depends primarily on the comfort and motivation of the director, as well as his or her willingness to encourage exploration of the developmental needs of children and families at the center. At times, an interested director may be in need of help to deal with difficulties with staff, or will agree after several conversations to a trial period with me or another mental health professional as a potential consultant. Sometimes I have been sent to a director by a board member or friend. After clearing my presence at a given center with the director and governing board, I then begin spending several hours per week at the site.

Once a format for my ongoing presence there has been worked out (even provisionally), by the director, we look for ways of meeting with, and/or announcing my presence there to the staff and parents. At the beginning of each school year a letter is sent out, and I am usually asked to be at the new parents' orientation meetings. At a regular weekly time, I meet first with the director, occasionally interview worried caregivers or parents, and usually am asked to observe children within the classroom who are of concern to the director and staff. Follow-up meetings then take place on an informal or as-needed basis.

There are also regular monthly consultation meetings with the entire staff at which certain children may be discussed and followed, sometimes through the school year. Confidentiality, especially about private matters regarding a child or his/her family, is always well established by agreement with the center. All members of the staff as well as a particular child's caregivers from previous or subsequent years benefit from these discussions. In addition, there are regularly scheduled monthly parents' meetings at which a previously announced topic is discussed ("Sibling Rivalry," "Aggression—Whose?" etc.)

I do not accept private referrals from a center where I am consulting, but may cross-refer to other colleagues who are interested in and skilled in therapeutic work with very young children. (Currently, Larry Shaderowfsky is doing

similar work at a nearby New Jersey nursery school.) So far, I have done such on-site consulting work in three different settings for periods of four or more years: a single parent federally supported day care center, a large (500+ children) private nursery school, and currently a co-op preschool and kindergarten.

Aside from spending on-site time in community childcare facilities, ten years ago I started a monthly interdisciplinary discussion group which we called “Intervention with Under-Fives.” Membership, which peaked at twenty four community professionals interested in disturbances of development in young children, included teachers, therapeutic and day nursery directors, learning and language specialists, and mental health professionals from various analytic and non-analytic disciplines. We met regularly for seven years and considered papers, case presentations, classroom experiences with young children, and instructional videotapes; we also invited guests who presented in their own specialized areas of early childhood research or intervention.

Using a similar model, I have organized three additional discussion groups, or “Pre-School Consultation Workshops” composed of directors of early childcare centers and the mental health professionals who spend time in these settings. These were organized as open-ended monthly discussion groups in which both the director and consultant could learn together and present and discuss evolving consultation programs which were taking place at their centers. Over the years, at least twenty director/consultant pairs have taken part in these workshops. The original workshop lasted four years; the second, started under the auspices of a community mental health center, lasted two years until funding ran out. The third group is still going strong after four years.

For the past two years, I have met with the home visiting counselors in a program called “Healthy Families.” This is a hospital based state and federally funded intensive mother/infant intervention program with dozens of similar units operating in this state (New Jersey) and nationally. It is marketed for purposes of funding as a “child abuse intervention program.” Our discussions touch on intervention strategies with very high risk mothers and infants which have been developed by Fraiberg, Stern, Greenspan, Emde and others, and they incorporate developmental and psychodynamic psychoanalytic principles and clinical theories. My own supervision is weighted heavily on countertransference issues and is clearly appreciated. Our discussions have turned out to be a considerable hedge against staff burnout in this immensely difficult work. I am on the program’s advisory board, and periodically participate in statewide conferences about this work.

Such time is well spent. My consultation work is easily the most enjoyable part of my week, gets me out of the office into settings bursting with energy and activity, has helped me to become well known in my community as a professional interested in early intervention, and has added immeasurably to my clinical skills in thinking through some very challenging problems with young children and their families. I am certain that referrals to my practice have remained at acceptable levels because of these efforts, despite the fact that managed care has siphoned off considerable numbers of young children in need of therapeutic help. I currently have three children in three times weekly analytic therapy, and am hopeful that sustaining levels of referral will continue to be derived from this community outreach work.

The President’s Column

Burton Lerner, M.D.

In this column, I would like to fill you in on work that the Association is doing in several areas that are of concern to our members.

Practice issues: We are probably witnessing the beginning of the end of the managed care decade. The deterioration of care and caring—that has been fostered by corporate invasion of the health care system—has become a stimulus for alternatives, both nationally and locally.

Under the leadership of President-elect Eric Marcus, the Council of the APM has been studying ways to develop a practice enterprise capable of establishing links directly with business, agencies and other organizations, as well as with unaffiliated individuals who are seeking care.

The Coalition for Patients’ Rights (CPR) has been active in protecting against the threat to private practice posed by the Clinton Health Plan. The APM is maintaining a close contact with CPR in order to support its efforts and make use of its expertise.

Web sites are an increasingly important communications link in outreach efforts. George Sagi is working on the establishment of an APM web site, which will give our members easy access to information about the activities of the APM and provide a resource for our practice enterprise.

The Bulletin: After years of intermittent publication at best, the Bulletin, the scientific journal of the APM, is back on track. Editor H. David Stein, working closely with Stuart Taylor and George Sagi, says that the next issue will soon be out, and there is the promise very soon of semiannual publication. Content will be expanded to include not only reports of papers, but also original articles, discussion and commentary on the scientific meetings. Bulletin is a superb outreach vehicle, and we are making efforts to obtain funding to expand our circulation in order to promote interest in psychoanalysis in the academic community and reach a broader population, In addition to the issue for this Spring, a special edition honoring Helen and Don Meyers is in its planning stages. Guest editors Betsy Auchincloss and Steve Roose expect it to be ready for Fall/Winter 1998, roughly coinciding with a celebration for the Meyers that will be held in November.

Scientific Meetings: John Ross has put together a series for 1997-98 that has been highly successful academi-

cally, and attendance has been excellent. Of special note was Arthur Zitrin's paper on a peculiar piece of our psychoanalytic history (an evening that also made history as the first of our scientific meetings ever to be co-sponsored with the New York Psychoanalytic Society). In March, French psychoanalyst Daniel Widlocher spoke on "Interaction Between Object Love and Infantile Sexuality." The paper was discussed by Helen Meyers and Marion Oliner, and was jointly sponsored by the five New York City IPA member societies. We also heard, in April, Jonathan Lear's paper "Knowingness and Abandonment:

An Oedipus for Our Time," discussed by Bob Michels and reported by Chris Allegra.

In May, Larry Inderbitzen gave the Rado Lecture "Regression in Psychoanalytic Technique: The Concretization of a Concept."

In June, the final scientific meeting of the year will deal with "Mass Violence and the Psychoanalyst as Government Consultant." Otto Kernberg will chair a panel that will include James Herzog (Germany and Xenophobia) and Sudhir Kakar (India and the Sikh crisis). Vamik Volkan will be the discussant.

The first Alternate Scientific Meeting of 1998 was held in March at the home of Paul Spector, who chairs the program. Elizabeth Tillinghast, lawyer and a first year candidate at the Psychoanalytic Center, presented her paper on "Sexual Misconduct and the Clinician." [Ed. note: This paper will be reported upon in a future issue

of SHRINK]

Outreach The APM's committee on Careers, Identity and Practice would like to identify practice issues which are of concern to our members, and solicit ideas for programs which would address these needs. In the near future, the committee will send out a questionnaire seeking information on this subject. I hope that all of our members will participate.

APM-Center Collaboration I am pleased to report that collaborative efforts between the APM and the Psychoanalytic Center supportive of the careers, identity and practice of our membership have been part of the very positive ongoing dialogue between Center Director Bob Glick and myself. We look forward to building on this process.

The Case for a Joint External Credentialling Body

Donald Meyers, M. D.

Both the Executive Council and the Board on Professional Standards of the American Psychoanalytic Association have voted to support the American's membership in the Psychoanalytic Consortium* and its participation in the consortium's effort to establish a national accrediting body for psychoanalytic educational institutes and also the ultimate goal of establishing a certifying board for psychoanalytic practitioners. For the past year, the Committee on Accreditation of the Psychoanalytic Consortium has been hard at work organizing a provisional draft of *Standards of Psychoanalytic Education* with the active involvement, indeed leadership, of our committee representatives: Marvin Margolis, President of the American, and Don Rosenblitt, Chairman of the Board on Professional Standards of the American. Cal Narcisi, Leon Hoffman, and myself are participant observers representing the Joint External Credentialling Committee and the Executive Council of the American. On completion of the provisional draft, it will be submitted for review and discussion locally at societies and institutes and at the central governing bodies of the member organizations of the consortium. What follows is an updated statement of reasons for support of this effort originally put forth by Allan Rosenblatt, the chairman of the Joint Committee on External Credentialling which preceded the current one, a longtime member of the Executive Council of the American, a founder and first president of the San Diego Psychoanalytic Society and Institute, and an early graduate of the Columbia University Center for Psychoanalytic Training and Research:

An external credentialling agency is vitally needed because our field must have a generally accepted set of minimal standards by which to judge the adequacy of psychoanalytic training. So-called psychoanalytic institutes are proliferating at a rapid rate. In New York State alone, there are currently more than fifty-eight self-designated psychoanalytic institutes. The public has no way to determine which training programs are adequate and which are bogus. The field is in a position analogous to that of medicine 70 years ago, before the Flexner Report, when medical diplomas could be bought from diploma mills, and untrained or poorly trained persons could claim the title of "Medical Doctor."

Moreover, we have been given to understand by informed observers in Washington that continuing our current stance of opposing the application of the American Board for Accreditation in Psychoanalysis of the National Association for the Advancement of Psychoanalysis (ABAP/NAAP) to be the national accrediting body in psychoanalysis while offering no positive proposal for an alternative organization damages our credibility. In the absence of any generally acceptable alternative, the Council on Higher Education Accreditation (CHEA) and the U.S. Department of Education (DOE), the two national accrediting bodies, will eventually accede to repeated applications by NAAP and award it recognition. If NAAP gains recognition as the national accrediting body, psychoanalysis will be redefined in terms of NAAP's totally inadequate standards as a therapy that can be conducted once a week by individuals with no graduate degree, no mental health background and little, if any, clinical training.

To purvey falsely another modality of psychotherapy as though it were psychoanalysis and represent those trainees as psychoanalysts who practice psychoanalysis, would put the unsuspecting public at considerable risk of danger-

ously incompetent evaluation and treatment. Regardless of whatever organizations may later be also recognized, this lowest common denominator will be perceived by the public, lay and professional, as representing psychoanalysis. Analogous to Gresham's Law of bad money driving out good, when the profession is so devalued, bad therapists will drive out good ones.

Were the American to go it alone and set up an independent accrediting body with the training standards of the American, the other members of the Psychoanalytic Consortium would not only oppose it as representing only a minority of the psychoanalytic community, resulting in a serious disruption of the Consortium and alienation of the other member organizations of the Consortium which are allied with us in representing psychoanalytic interests to the federal government and the public, but they would, no doubt, set up a competing accrediting body with their own standards. The stage would then be set for NAAP or a similar organization to also seek recognition with the credible claim that, since there are no standards generally accepted by the national psychoanalytic community, their standards also deserve recognition. Thus, going it alone would increase the likelihood that NAAP would obtain recognition, with the disastrous consequences described above.

Only a joint Consortium-sponsored effort will provide a generally accepted national "floor" of minimum standards that would preclude the recognition of NAAP-like organizations. Such a jointly sponsored accrediting organization which is now being considered by the Consortium would have recommended standards equivalent to those of the American Psychoanalytic Association: four to five times a week training analyses but with a minimum of three times a week and three supervised cases with a minimum of two. The IPA requires two supervised cases and we belong to that organization although its standard is lower than ours. Our own internal standards would be guaranteed against any erosion by a requirement that any institute seeking accreditation that is affiliated with a national psychoanalytic organization (such as the American) must first meet the standards of that organization to be eligible to apply.

An added bonus accruing from an accrediting organization that is recognized by the Department of Education is the availability to students of such accredited institutes of low-cost leans up to $25,000 per student. In these days of diminished income in our field that increases the hardship of expensive psychoanalytic training, such loans would greatly benefit students, especially those who would otherwise be unable to finance their training.

By taking an active leadership role in working with the other psychoanalytic organizations of the Consortium toward such an accrediting organization, the American is now greatly increasing its influence on psychoanalytic education. Certainly the participation of high-quality medical schools, such as Harvard, Johns Hopkins, and Tulane, in accrediting organizations along with schools that have lower standards, has not eroded their standards. Instead, they have acted as role models to lesser training centers, stimulating emulation of their excellent programs. Similarly, the American is now in a position to educate the psychoanalytic community on the advantages of our higher standards and through such education to encourage upgrading minimal standards to optimal ones. If fact, this is now happening.

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*The Consortium consists of representatives of the American Academy of Psychoanalysis, the American Psychoanalytic Association, the Division of Psychoanalysis (#39) of the American Psychological Association, and the National Membership Committee in Clinical Social Work (affiliated with the National Federation of Societies for Clinical Social Work).

The Consortium Agreement and the Future of Psychoanalysis

Eric R. Marcus, M.D.

Throughout the professions in America today, economic and political forces are heading in the direction of deprofessionalization, decreasing economic incentive, increasing patient volume, and shift to less costly treatment modalities. What began as physicians spending less and less time with more and more patients, and with physicians crossing specialty boundary lines in order to prevent depletion of their income, has accelerated to include the credentialling of less well trained healthcare providers.

In all specialties, the fight is on to preserve certification boundaries in order to preserve levels of craftsmanship and quality of care. Several of the more recent examples are the fight by psychiatrists against the move by psychologists to acquire prescribing authority. A similar fight is going on by anesthesia physicians against the move by nurse anesthetists to function independently. Still another fight is between primary care physicians against primary care nurses who are opening independent practices.

However, nowhere except in psychoanalysis are physician organizations attempting to give away their certification to less highly trained groups. All other physician groups are fighting.

Why is it that now psychoanalysis is ready to give away its long fought for and heretofore zealously guarded certification? The arguments fall usually into three general groups. All of them are mistaken. The following discussion will highlight these arguments and show how they are misguided.

The first general argument in favor is often, interestingly enough, not an argument about the virtue of these efforts, but the necessity. "It's going to happen anyway, so it's better for us if we join it now, and thereby, help shape it." In fact, it won't happen unless we actively facilitate it.

"It's going to happen anyway," in the initial discussion with the proponents of the consortium, usually refers to the politics of the issue. Proponents claim that the social workers will go around us to certifying organizations in the

federal government and gain national certification power and monopoly over the term psychoanalyst. It will then be their definition, their standards, their certification, and physician analysts will be left out in the cold.

Aside from social worker intentions, there is little factual basis to support this claim. There is much factual basis to refute the claim. The facts are that when the delegation from the American Psychoanalytic Association met with potential federal certifying agencies like COPRA (Committee on Recognition of Post-secondary Accreditation) and the Department of Education, the delegates were told that if the federal government certified anyone it would be the American Psychoanalytic Association because alone among the psychoanalytic groups, we had actual experience setting standards for institutes, inspecting them, certifying them and likewise setting standards for, inspecting and certifying our individual members. The social workers were way behind in developing any standards at all. Ironically, they now know what those standards are because the American Psychoanalytic Association wrote them up and handed them to the social work organizations! This very mistaken action is now used to justify joining with the social workers!

If the politics really wasn't the reason that the American Psychoanalytic Association leadership joined with the social workers, what did they really mean when they said "It's going to happen anyway"? As far as I can tell, they meant two things. One is that they felt it was going to happen anyway economically. The other is that they felt it should happen as a social good.

That it's going to happen anyway economically is only partly true. There is a growing disparity within the middle-class between the upper third who has joined with the wealthy, and the lower two thirds who are being pushed down. It has meant that all goods and services are relatively more costly and relatively more unaffordable. It has meant that some can only afford the fees of non-physician analysts. They must therefore accept the wider variation in quality.

Our leadership has decided to help society by accepting this and by inculcating and promulgating our standards for them and certifying them under the same umbrella and with reportedly the same standards with which we certify ourselves. Our leadership wants to raise social work analytic standards as a social good. The goal is high quality low cost psychoanalysis for all in need of it.

This benevolent gesture is doomed to failure on two grounds. The first is the educational and the second is economic.

The educational issue is that you can never guarantee the uniform quality of the allied professions no matter what your standards nor no matter how rigorously you try to adhere to them. This is partly because their education is very different. A master's level social work degree is two years past college. An M.D.'s training involves four years of medical school plus four years of psychiatric residency for a total of eight years. Of greater concern is the destruction of clinical training that has occurred in the allied professions, even more devastatingly than it has occurred within the medical profession. Social workers are being used for rapid placement and less and less clinical assessment and treatment within hospital and clinical settings. It has gotten so bad, that my social work friends who teach in the social work institutes complain that even the "caseness" of patient care and of clinical thinking has been destroyed. Their students no longer can get clinical proficiency as prerequisite to analytic training. (Please realize that I am not arguing against gifted individual social workers being given waivers to join the American).

But even if this were not the case to the extent that it is, the economic argument would be sufficient for great caution on our part. The economic issue that the proponents of the Consortium overlooked is the principles of distribution that are well known to all health policy analysts in public health. The principle is that you can choose any two out of three among the variables quality, cost, and distributive access. You can never have all three. In other words, if you lower the price, and you increase the access, you will also lower quality. If you keep the quality high, and you lower the cost, you will limit the access. If you keep the quality high, and you increase the access, you will increase the cost. Policy experts who propose widened access for all of healthcare are willing to see the quality drop for the sake of trying to improve the quality of care of the disenfranchised and the very poor. When quality falls, all professional organizations, particularly physician organizations, respond to this public health threat (and falling quality is a public health threat) and economic dilemma by reinforcing their professional standards and boundaries. This is not in an effort to fight better medical care for more numbers of people, but an effort to protect the quality and craft levels of the profession without which all people with all incomes or lack of incomes will suffer.

The distributive justice argument, naive in its economic and public health aspects, also naively tinkers with a psychoanalytic delivery structure that has held up well in the eyes of those of us who have committed parts of our careers to treating the poor. That structure involves a private practice structure and a supervised clinic structure. In New York City, where some of the highest fees in the world for private practice analysis are maintained, there is also a most outstanding clinic structure, where patients can get psychoanalytic treatment with graduate M.D.s who have finished their psychiatric residencies and are in analytic training, supervised by the most experienced members of our profession. Are we flooded with such patients? On the contrary. We're looking for more. There is therefore no economic or intellectual justification, and no public policy justification, for altering and diluting our standards. The result of such efforts will be severely detrimental to the stated quality goals of the proponents of the Consortium.

Space does not permit an elaboration of this brief. However, in summary it could be said that in answer to the assertion it's going to happen anyway, no, actually it's probably not going to happen anyway. In response to the assertion that it's better for us and our craft if we join it, well, it's better if we don't. In response to the assertion that it's better

for patients if we join it, probably it's disastrous for patients if we join it.

Remember that once the fences are down, the foxes mingle among the chickens. The only reason we haven't been destroyed by managed care and single party payers is that so far they've refused to pay for us. The moment they do is the moment of our destruction. But fortunately, there is no collective medical plan of any arrangement anywhere in the world that, for more than 10 or 15 years, has paid for psychotherapeutic treatment let alone psychoanalytic treatment, without either going broke or stopping the payment. This includes the communist and noncommunist countries, it includes the social welfare countries of Western Europe, it includes not only the onerous managed care plans of today but also the benevolent point-of-service insurance plans of yesterday.

At the end of the last century, midwives delivered babies in America. By the turn of the last century, physician obstetricians did. How did this happen? The physicians convinced the American people that they had the training, they had the education, they had the standards, and they had the certification. There is no physician group that has ever voluntarily given these factors up. Will we be the first? Before we do so, we had better think hard and long about why the others have not, what we hope to gain by doing so, and whether or not we have really had a chance to think about, discuss and vote our individual consciences on this matter.

In your thinking about this please think about the above and also the following: the educational standards proposed by the Consortium do not come close to meeting minimal acceptable standards for training in the American. Acceptance of the Consortium's educational standards would therefore increase the confusion of the public and decrease the likelihood of the stated goal of the proponents which is to have a freestanding quality psychoanalytic profession composed of many different professional groups.

Our membership should realize that far from a *fait accompli*, this proposal is gathering growing dissent. Representatives from other societies of the American have specifically voted against continuing negotiations for the Consortium. New England, and New Orleans have voted against. NYU has abstained.

We need to think about these issues, discuss them among ourselves and make our opinions known vigorously and vociferously to our leadership because they are deciding crucial issues of our future without a vote of the membership.

All the goals of the Consortium can be achieved by close political and public relations liaison with the other association organizations. This would not mean the necessity of sharing credentialization. Each group can credential its own.