CONJOINT CAS/COD ADMINISTRATIVE BOARDS MEETING

Wednesday, January 19, 1983
5:30 pm - 7:00 pm
Hemisphere Room
Washington Hilton Hotel

AGENDA

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I. A Proposed Sliding Scale of Grant Awards for Biomedical Research

- H. George Mandel, Ph.D., Chairman,
  Department of Pharmacology
  George Washington University
  School of Medicine and Health Sciences

- William F. Raub, Ph.D.,
  Associate Director for Extramurual Research and Training
  National Institutes for Health 1

Thursday, January 20, 1983
9:00 am - 1:00 pm
Dupont Room

I. Call to Order

II. Report of the Chairman

III. Approval of Minutes..... 6

IV. Action Items

A. Report of the AAMC Officers' Retreat
(Executive Council Agenda.....p.25)

B. Undergraduate Medical Education Preparation for Improved Geriatric Care-- A Guideline for Curriculum Assessment
(Executive Council Agenda.....p.35)

C. AAMC Role in Providing Constituent Service Programs
(Executive Council Agenda.....p.67)

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D. Prospective Payment Proposals for Hospital Services Provided to Medicare Beneficiaries (Executive Council Agenda.....p.68)

E. A Proposed Sliding Scale of Grant Awards for Biomedical Research (Executive Council Agenda.....p.87)

F. The Future of the AAMC's Management Education Programs (Executive Council Agenda.....p.91)

G. ACCME Essentials and Guidelines (Executive Council Agenda.....p.93)

H. ACCME Protocol for Recognizing State Medical Societies as Accreditors of Local CME (Executive Council Agenda.....p.110)

V. Old Business

VI. OSR Report

VII. New Business

VIII. Adjourn

CONJOINT CAS/COD ADMINISTRATIVE BOARDS MEETING

January 19, 1983

5:30 p.m.

Hemisphere Room

A PROPOSED SLIDING SCALE OF GRANT AWARDS FOR BIOMEDICAL RESEARCH

H. George Mandel, Ph.D.
Chairman, Department of Pharmacology
George Washington University
School of Medicine and Health Sciences

and

William F. Raub, Ph.D.
Associate Director for Extramural Research and Training
National Institutes for Health

Reception and Dinner

7:00 p.m.

Thoroughbred Room

A PROPOSED SLIDING SCALE OF GRANT AWARDS FOR BIOMEDICAL RESEARCH

In a letter to Science published in February 1982, Elliot S. Vesell and H. George Mandel proposed that National Institutes of Health research grants be awarded on what is termed a "sliding scale" (p.). The purpose is to fund a larger number of research proposals by providing partial funding based on a formula related to the priority scores assigned by study-sections.

Mandel and Vesell aver that the competition for NIH grants is so intense that investigators spend an inordinate amount of time writing and rewriting proposals and reviewing proposals which, although they are considered meritorious, are not funded. The sliding scale would provide 100 percent funding to proposals with "top priority scores;" other proposals with "respectable priority scores" would receive partial funding. The authors envision that about half of study-section-approved applications would be eligible for this formula-based partial funding.

Vesell and Mandell argue that study-sections discriminate insufficiently to identify research proposals that may have an unexpectedly fruitful outcome, even though the ideas upon which they are based are not currently popular. They infer that by partially supporting a greater number and variety of investigators, the opportunity to bring to fruition new ideas will be enhanced and that this will help to maintain the preeminence of the United States in biomedical research.

This proposal must be considered in depth and from every possible angle. While funding more grant requests is attractive, the administrative and political consequences of spreading limited resources more widely through partial funding on a formula basis are formidable both at the national and institutional levels.

The fundamental tenet of the NIH review and granting procedures has been to identify and support the best scientific proposals that will advance its mission to improve human health. Peer review by study-sections composed of individuals who can judge both the ideas and concepts and the technical feasibility of accomplishing proposed projects is the foundation of the review system. Study-sections already are carefully reviewing budgets and recommending reductions when it is believed that a project can be accomplished with fewer resources. If, after this review, the project were to be funded at an even lower level, would not the study-section have to once again review the project because it was now altered by modifications required by reduced funding? If the answer is no, then it could be inferred that many projects are over-funded and that arbitrary cuts can be made in NIH funding without reducing the quality or quantity of biomedical research. With both the Congress and the Administration looking for every opportunity to cut budgets, this proposal may invite even greater reductions in funding for the Institutes. Furthermore, serious doubts could be raised as to the widely touted essentiality of the study-section role.

At the institutional level the investigator who receives only partial funding would be likely to seek local support to make up the difference. It is doubtful that in most institutions sufficient resources are available to achieve this. However, were such institutional support made available, the message to the federal government would be that the institutions are capable of even more cost sharing than supposed--again, an impetus to reduce federal research support.

Vesell and Mandel have brought forth this proposal as a means of weathering what is termed a crisis in NIH funding and imply that the reduction in research funding as a result of inflation is dismantling the nation's biomedical research enterprise. They insist that even projects only partially funded would be of high quality and fully approved by study-sections. The extent to which there is a crisis and the degree to which the biomedical research enterprise is being impacted must be measured against the potential long range consequences of this significant alteration in grant awarding concepts, policies, and operations of the NIH.

Dr. Mandel will present the proposed sliding scale in detail and Dr. Raub will comment from the perspective of the NIH.

Crisis in NIH Funding

One of America's great strengths, developed over the last three decades, is its research capability in the basic biomedical sciences. We present below several proposals designed to conserve this strength, which is being eroded as a consequence of inflation, reduction in moneys available for direct costs of research, and by present policies for funding research grants. We wish to emphasize the great need for long-term stability of research programs, even at more modest levels of support, to preserve U.S. research capacity.

Few would doubt that remarkable recent achievements in treatment of disease derive from biomedical research supported by the National Institutes of Health (NIH). This biomedical research continues to offer the most cost-effective means to relieve suffering and to permit delivery of improved health care services. Moneys spent on biomedical research have usually been returned to the economy through increased productivity of individuals who have benefited from improved health or the prevention of disease, development of new drugs, or stimulation of other economically effective programs.

The scientific community manifests a potential for meritorious but unpursued research as evidenced by the large number of grant applications endorsed with high priority by NIH peer review that remain unfunded. The talent of many excellent scientists, with records of past innovative research accomplishment, is now being wasted.

Failure over the past decade of biomedical budgets to keep up with inflation has now, quite suddenly, grown to crisis proportions. Severe competition for NIH grant money, resulting from greatly accelerating cost of research, growth of the scientific community, designation of newly targeted research areas, and the sharp rise of administrative costs, has so strained governmental research budgets that only projects with truly exceptional priority scores are now being funded. Obviously, appropriation by the U.S. government of additional funds for research could solve this problem. We intend to continue to keep our government officials informed of the urgent need for an increased allocation of dollars for biomedical research. However, we also recognize the nation's present economic difficulties and the resulting belt tightening that we must accept on a temporary basis. In any case, action is required immediately before ongoing research groups and programs are irrevocably dismantled and before essential new projects become postponed indefinitely. Current policies for funding research grants should be reevaluated immediately to prevent further erosion of our national scientific research potential.

Scientists are now spending an inordinate part of their time writing and rewriting grant proposals in order to receive a priority sufficient for funding. Simultaneously, due to inflation and an increasing number of quality applications, the relative availability of funds compared to current needs has declined, inexorably raising the priority score required for funding. The increased number of initial and new applications has put additional strain on the review process so that more researchers are needed to evaluate these proposals, most of which will remain unfunded. Thus, scientists must spend an even larger part of their time writing proposals and reviewing others, time better spent on research.

We agree that the best scientific investigators and targeted programs must continue to be funded. We also believe, however, that in a situation where funding is clearly inadequate, the present system of priority scoring permits some groups to attract a disproportionate percentage of the available funds. America's strong leadership in biomedical science is related, in large part, to our past generous support of a variety of research ideas whose outcomes were most unpredictable at the time of funding. Quite a few of these ideas, which formed the foundation of many subsequent advances, were unpopular at their inception. Scientific excellence can best be perpetuated when there is a breadth of research accomplishment that serves as the basis for future outstanding achievement. Although we favor peer review, this process cannot be expected to discriminate with accuracy between projects receiving close numerical scores. Forcing out large numbers of talented and productive independent researchers leads inevitably to an undesirable centralization of basic research in fewer laboratories. The unwillingness of many talented newer faculty members and younger scientists to continue their research career because of the extreme competition for funding of research constitutes a severe economic and intellectual loss to our country for which it will ultimately pay dearly.

We strongly endorse the funding of only high-quality research, as judged by peer review, but we also believe that more grants approved by peer review

should be funded. When the NIH granting system began in the 1950's some 90 percent of all approved applications were funded. Now most NIH institutes can pay only about 15 percent. These temporal fluctuations and declining support for quality applications suggest an obvious need to reevaluate policies to support a higher number of worthy investigators. We have considered various alternatives, and none are easy or ideal. However, because of the present crisis we feel a decision must now be made on a revised procedure for funding.

1) We recommend the development of a "sliding scale," depending on the priority score that peer review groups assign to applications: those with top-priority scores would receive 100 percent of *study section approved* budgets; others would receive only a proportion of their approved budgets, depending on priority scores. However, only those applications with very respectable priority scores, that is, encompassing about half of all *study section approved* applications, should be eligible for this formula-based partial funding. This procedure would require considerable belt tightening for many investigators but is still preferable to the absence of any support. Obviously, investigators will not be able to meet all of their original research objectives with only partial funding. Our proposal would permit them to attain at least some of their research goals through the use of their own ingenuity and to continue as productive investigators. Obviously, study sections will have to scrutinize budget requests with great care to maintain standards. Finally, if an ongoing project cannot be continued, a more gradual phase-out system should be instituted that will allay some of the trauma.

Furthermore, this proposal would alleviate for competent scientists the unnecessary hardships and anxieties which the present procedure generates. The Veterans Administration and other scientific institutions already use a sliding scale system for funding research grants. This procedure permits a diversity of research rather than limiting it to few laboratories.

Several additional approaches also merit consideration:

2) The present system for allocating indirect costs should be reconsidered at once. A reduction in nonproductive business practices should reduce administrative costs which now devour an ever-increasing percentage of funds earmarked for research. The nonuniform allocation of expenses to indirect or direct costs and the exceedingly disparate indirect cost rates among institutions create confusion and excessive and unnecessary accounting requirements and thus needlessly raise the costs of conducting research. Consideration should be given to returning to a fixed and reasonable indirect cost rate, such as that in force before 1966 (see K. T. Brown, *Science*, 24 April 1981, p. 411).

3) Large center grants and program projects, valuable for multidisciplinary programs, also support investigators already funded for other research; such funding might be reexamined to determine how much of this type of support we still can afford in a time of crisis. Allocation of shrinking funds to such large proposals and contracts occurs at the expense of individual independent research projects which most scientists feel are of greater value to our national research efforts.

4) A dollar limit could be placed on total support for an individual investigator's laboratory.

The sliding scale now appears to be particularly attractive, but all these ideas should be considered, and a combination of them may be worth trying. In any case, our objective is to initiate a review of current funding procedures and to support a larger fraction of highly meritorious research proposals.

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*The authors are, respectively, president and chairman of the NIH grants committee of the Association for Medical School Pharmacology (AMSP), an organization composed of chairmen of departments of pharmacology in medical schools of North America. Most members of ASMP contributed to this document, which was initially presented on 10 January 1981 and adopted in essentially its present form on 21 May 1981 by ASMP. Since that time, the situation described above has clearly deteriorated even further.

Science, Vol. 215
February 26, 1982

ASSOCIATION OF AMERICAN MEDICAL COLLEGES
ADMINISTRATIVE BOARD OF THE COUNCIL OF DEANS

MINUTES

Thursday, September 9, 1982
9:00 am - 12:30 pm
Farragut Room
Washington Hilton Hotel
Washington, D.C.

PRESENT

(Board Members)

Steven C. Beering, M.D.
Arnold L. Brown, M.D.
John E. Chapman, M.D.
D. Kay Clawson, M.D.
William B. Deal, M.D.
John W. Eckstein, M.D.
Richard Janeway, M.D.
William H. Luginbuhl, M.D.
Richard M. Moy, M.D.
Leonard M. Napolitano, Ph.D.
Edward J. Stemmler, M.D.

(Staff)

James Bentley, Ph.D.
Robert Beran, Ph.D.
Robert Boerner
John A.D. Cooper, M.D.
Debra Day
John Deufel
James Erdmann, Ph.D.
Charles Fentress
Sandra Garrett, Ph.D.
Paul Jolly, Ph.D.
Robert Jones, Ph.D.
Thomas J. Kennedy, Jr., M.D.
Joseph A. Keyes, Jr.
James R. Schofield, M.D.
Emanuel Suter, M.D.
Kathleen Turner

(Guests)

Robert M. Bock, Ph.D.
Robert I. Keimowitz, M.D.
Robert L. Hill, Ph.D.
Grady Hughes
Ed Schwager
Dr. I. Singer

I. Call to Order

The meeting was called to order at 9:05 a.m.

II. Report of the Chairman

Dr. Luginbuhl reported on several items considered by the Executive Committee at its meeting preceding the Board Meeting:

- The Executive Committee reviewed and recommended approval of the audit report.

- It reviewed proposed sites for future Annual Meetings. The Association is returning to its previous practice of alternating Washington and out-of-town meetings. The alternate sites are: Chicago, New Orleans and San Francisco. We have a long term relationship with the Hilton Hotels, but it now appears that the Chicago hotel renovation will not be completed as promised and alternate sites were considered for the 1988 Annual Meeting. The Chicago Marriott appeared to present the most attractive alternative.

- The Executive Committee reviewed the AAMC Work Plan and agreed to set it on the agenda for this year's Officers Retreat. That consideration would be accompanied by staff commentary on progress towards accomplishing the plans, goals and objectives.

- The Executive Committee reviewed the AAMC participation in the Federation of Associations of Schools of the Health Professions. The AAMC had been instrumental in the founding of this organization, as an alternative to some of the more sweeping recommendations of the Coggeshall Committee. It had served a useful purpose in bringing together in the early and mid-1970's, the variety of interests affected by the health manpower legislation, to negotiate differences, and enabled us to present a common front in this arena. Now, however, it appears to serve no useful purpose for the AAMC to belong. Other organizations would appear to welcome our withdrawal since our presence only makes them uncomfortable as they discuss the problems their schools have in relating to medical schools. The Executive Committee voted to withdraw from the Federation.

III. Approval of the Minutes

The minutes of the June 24, 1982 meeting of the Administrative Board were approved with one correction. It was noted that Dr. Clawson was present at the meeting.

IV. Action Items

A. Election of Institutional Members

Mr. Keyes noted that the LCME action giving Mercer Medical College provisional accreditation is the sole criteria for membership in the Association established by the Executive Council. The request for membership from Mercer was received after the printing of this agenda. The matter was brought to the Board with the recommendation that Mercer Medical College be nominated for membership.

On motion, seconded and carried, the Board endorsed the nomination of Mercer Medical College as provisional institutional members of the AAMC.

The Board asked Dr. Schofield to review the status of Meharry Medical College with regard to its program of medical education.

B. Election of Distinguished Service Members

Dr. Deal, Dr. Eckstein and Dr. Schwarz were the members of the Distinguished Member Nominating Committee. The Committee recommended that John A. Gronvall and Julius R. Krevans be nominated for Distinguished Service Membership.

The COD Administrative Board on motion, seconded and carried, approved the two candidates for election to Distinguished Service Membership.

C. AHA's Proposed Medicare Prospective Payment System

Dr. Bentley, Associate Director of the AAMC Department of Teaching Hospitals explained that this item was back before the Boards because of the hospital community's concern with the Reagan Administration's efforts to reduce reimbursement to providers. The primary way in which the Administration is attempting to do this is to identify specific costs that they no longer want to pay for or to limit the cost they would pay to providers.

Dr. Bentley set out the principal features of the AHA proposal noting that these were the features that the COTH Administrative Board had endorsed in principle. The proposal was based on five major principles: the base period for each hospital would be its own costs in the accounting period preceding prospective payment; payment rates would be determined by applying an inflation adjustment to each hospital's base; hospitals would be allowed under defined conditions to charge patients more than standard deductibles and copayments; hospitals would be permitted to retain payments in excess of costs; and the prospective payment system would terminate after four years. It was requested that the Board provide their reaction and if possible, endorsement of this proposal.

On motion, seconded and carried, the Board endorsed the prospective payment proposal as a concept.

D. Statement on Status of Minority Students in Medical Education

The Board endorsed the statement appearing in the Executive Council of its commitment to continuing efforts to assure accessibility to medical education for individuals of underrepresented minority groups

E. Proposed Monitoring Function of the Group on Student Affairs in the Distribution of NRMP Matching Results

Dr. Luginbuhl introduced Robert Keimowitz, National Chairman of the Group on Student Affairs, who presented a proposal developed by the GSA Steering Committee regarding the handling of the NRMP Results Book. The proposal was stimulated by the desire to assure the continued availability of the results 48 hours in advance of the match so that unmatched students could be prepared and

counseled. Occasional violations of the match agreements -- seeking places for unmatched students prior to the specified hour -- created the prospect that the NRMP Board might withhold advance notification. To preclude this, the GSA proposed that the GSA be involved in the distribution process, monitor compliance with the release time, and be authorized to withhold early release of the results book in future years from any institution at which there was substantial evidence of premature disclosure of its contents.

Dr. Cooper, in his role as President of the NRMP, objected to the proposal. He noted that the Board had a series of contractual obligations to institutions and individuals which prevented it from delegating the distribution and withholding decisions. He suggested that the monitoring function proposed be initiated and that violations be reported to the NRMP President for investigation. The President would in appropriate cases, discuss the matter with the dean of the institution concerned and seek assurances that the process be rectified. In cases where he was unsatisfied that remedial action had been taken, he would report to the Council of Deans Administrative Board. He suggested that this "jawboning" was the maximum involvement possible for the AAMC. Any decisions to withhold the early release of the results to a particular institution should remain the prerogative of the NRMP Board.

The Administrative Board was attracted to Dr. Cooper's proposal, and after assurances from Dr. Keimowitz that it appeared to fullfill his Committee's objectives, recommended that this alternative be pursued. The Board also endorsed the suggestion of its members that the medical school dean be the designated recipient of the result book. The rationale was that if the school stood to lose access to the book, the official ultimately accountable, the dean, should be explicitly involved in the process.

V. Discussion Items

A. MCAT Review Program

Dr. Luginbuhl introduced this subject by noting his view that the Administrative Board had a responsibility to periodically review the MCAT Program, to familiarize itself with its operations, to be informed of programmatic issues and how they are being handled, and to assure itself that the program continues to serve the interests of the medical schools. He had had several discussions with Dr. James Erdmann, Director of the AAMC Division of Educational Measurement and Research, and had asked Dr. Erdmann to present some materials to the Board.

Dr. Erdmann, accompanied by Dr. Beran, Associate Director, and Dr. Jones, Research Associate in the Division, reviewed and elaborated upon the materials presented in the agenda book. He addressed five areas:

1. Efforts underway to assess both the content validity and predictive validity of the New MCAT;

2. Results of a recent study of changes in performances on the examination by repeaters which explored:

   a. changes in scores of those taking it a second time without an intervening formal experience,

b. changes in scores following participation in a commercial review course, and

c. implications of the magnitude and patterns of such changes;

3. Test security;

4. Special projects, specifically a systematic study now underway to detect item bias (which might disadvantage examinee subgroups) and to evaluate the effectiveness of the present review mechanism; and

5. Proposed new services including:

a. Diagnostic Services Program - to permit college students to attain a detailed assessment of strengths and weaknesses in their academic preparation by completing separate test modules in the content areas measured by the MCAT, and

b. A Proposed Essay Section on the Examination.

The Board discussion focused primarily on the implications of the repeaters study. Some members suggested that the improvement by one-half scaled score point, while not impressive, might have significance at the crucial margin. That is, it may be a sufficiently large improvement to bring some individuals above a threshold for consideration in schools which use the examination as a screen. Staff was encouraged to examine this question more thoroughly. A second question of interest was whether it would be possible to establish on a national basis, a threshold score below which it could be confidently asserted a person would be incapable of performing acceptably in medical school. The staff was quite skeptical, asserting that instutitional requirements and expectations were so highly variable that such determinations should be made at the institutional level.

B. Graduate Medical Education Positions

The Executive Council agenda contained briefing material on this matter, very similar in content to that reviewed by the Administrative Board at its previous meeting. Administrative Boards of the Councils of Academic Societies and of Teaching Hospitals, as well as the Organization of Student Representatives, met the previous evening to discuss the topic with Jack Graettinger, Executive Vice President of the NRMP, John Gienapp, Secretary of the ACGME and Richard Reitemeir, Vice Chairman of the ACGME. Dr. Jolly who attended the meeting was asked to highlight any significant developments. He reported that the main concern was that the number of GME positions might be further reduced as a result of financial pressures on the hospitals. Also of interest was the dramatic increase in the number of foreign medical graduates in the match program and the effect that this might have on future matches. It appears that, to date, no foreign medical graduate has displaced a domestic graduate, but this should be watched closely. Dr. Suter was asked to review this matter.

C. AAMC Response to Enactment of Small Business Innovation Development Act

AAMC staff developed a discussion paper to assist institutions exploring the implications of the mandated Small Business Innovation Research (SBIR) program at the NIH. The paper explored whether AAMC members could, consistent with their own missions and objectives and with the law, develop organiztional forms which could participate in the program.

The Board was asked to review the document and to advise as to whether the analysis served its purpose. The Board was of the view that the document was very helpful and recommended that it be distributed to the AAMC membership.

VI. Information Items

A. Impact of TEFRA on Payment for Pathologist Services

This issue was placed on the agenda at the request of Dr. Chapman who had been alerted that the changes in the Medicare reimbursement rules brought about by the Tax Equity and Fiscal Responsibility Act might result in a substantial loss of income to pathologists.

Under the terms of Section 108 of the Act, the DHHS Secretary is to prescribe regulations which will distinguish between:

1. professional medical services which are personally rendered to an individual patient which contribute to the patient's diagnosis and treatment and are reimbursable only under Part B on a charge basis, and

2. Professional services which are of benefit to patients generally and which can be reimbursed only on a reasonable cost basis. Such an action will be directed to a large degree at physician reimbursement in the clinical laboratory.

Dr. Bently received the January 24, 1980 Executive Council Action with respect to Medicare reimbursement for pathology services. (Attachment A to these minutes)

While members of the Board expressed concern over the deleterious impact that a substantial reduction in pathologists' reimbursement would have on medical school financing, there was no sentiment that the AAMC should adopt a different position on the issue. The Board suggested that no action be taken until the Association could review a position statement from the Association of Pathology Chairmen and other organizations who would be affected by this legislation.

B. Annual Meeting Program

Mr. Keyes reviewed with the Board the Annual Meeting program and highlighted specific topics of interest to the deans. A short presentation in follow-up to the management of academic information will be presented at the COD Business meeting. A special program offering on the Wednesday will feature a panel discussion titled, "Academic Medical Centers Confront the Information Age."

Mr. Keyes also brought to the Board a proposed invitation of a special tour of the Georgetown University Medical Center's emerging "electronic library". The

Board agreed that this would be of interest to several deans but recommended the deans be invited to send a delegate if they themselves could not attend. He was asked to proceed with the necessary arrangements.

VII. OSR Report

Grady Hughes, OSR Chairman, reported that the Board had discussed its Annual Meeting plans for the coming year and was in the process of restructuring the program to emphasize OSR projects rather than resolutions. Other issues discussed included the students desire to disseminate information on career counseling programs to students and to develop and discuss case studies in dealing with ethical issues in the clinical years.

The OSR Board also discussed the HEAL program, and student participation in and response to the GPEP project.

VIII. Adjournment

The meeting was adjourned at 12:40 p.m.

EXECUTIVE COUNCIL ACTION
January 24, 1980

Medicare Reimbursement for Pathology Services

In promulgating reimbursement policies for Medicare, HEW and Congressional policy-makers have proposed various methods to separate Part A and Part B services provided by physicians. These proposals have been of serious concern to a number of medical disciplines, particularly pathology. The Association's Executive Council policy approved in March 1977 supported reimbursement policies which recognized crucial professional services in pathology and furthered the development of the discipline and opposed payment limitations which inhibited development of the discipline. A copy of a recent draft revision of HCFA regulations was objectionable to pathologists because it required the pathologist to be personally involved in the performance of each clinical pathology service in order to receive fee-for-service payment. The Association's ad hoc Committee on Section 227 considered this issue at its October 17 meeting, and recommended a revision in the Association's current policy to make it consistent with Senate Finance Committee language supporting percentage arrangements based on a relative value scale for compensation of pathologits. It was reported that such a policy was supported by pathologists. The proposed new policy statement:

> While the AAMC does not have a compensation alternative which would recognize the concerns of pathologists and of the government, it is concerned about payment mechanisms which could possibly discourage the contributions pathologists make to patient diagnosis and treatment and inhibit the development of the discipline. The Association, notes, however, that Senate Report 96-471 would permit physicians to be compensated on a percentage arrangement if the amount of reimbursement is based on an approved relative value scale "...which takes into consideration such physicians' time and effort consistent with the inherent complexity of procedures and services." The Association supports such a proposal.

The Council of Deans reported some discomfort with supporting percentage contract arrangements, but recognizing the difficulty in changing funding for any department within a short period of time, by a split vote agreed that the statement should be supported as a temporary device. CAS approved the statement, citing its concern that the development of the discipline might otherwise be inhibited. COTH recommended that the statement be

amended to clarify that the percentage contract arrangement was being supported as only one option of compensation, and on that basis had approved the statement.

ACTION: On motion, seconded, and carried, the Executive Council agreed to amend the proposed policy statement to add the phrase "as one option of compensation for pathology."

ACTION: On motion, seconded, and carried, with one dissenting vote, the Executive Council approved the following policy statement on payments for pathologists services:

While the AAMC does not have a compensation alternative which would recognize the concerns of pathologists and of the government, it is concerned about payment mechanisms which could possibly discourage the contributions pathologists make to patient diagnosis and treatment and inhibit the development of the discipline. The Association noted, however, that Senate Report 96-471 would permit physicians to be compensated on a percentage arrangement if the amount of reimbursement is based on approved relative value scale "...which takes into consideration such physician's time and effort consistent with the inherent complexity of procedures and services." The Association supports such a proposal as one option of compensation for pathology.