UNIVERSITY OF MINNESOTA
TWIN CITIES

All University
Senate Consultative Committee
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MINUTES OF THE SENATE CONSULTATIVE COMMITTEE

Meeting of June 1, 1978

The All University Senate Consultative Committee convened its twenty-first meeting of the 1977-78 academic year on Thursday, June 1, 1978 in the Regents' Room of Morrill Hall.

Members present included Laird Barber, George Blake, Steven Carlson, Wendell Glick, Harriet Lewis, Kenneth Keller, Richard Kottke, Terry Marchiniak, Fred Morrison, Thomas Potter, Richard Purple, Betty Robinett (chairman), Richard Rydberg, Elizabeth Sands, L.E. Scriven, W. Donald Spring, Barbara Stuhler, and Mahmood Zaidi.

Professor Robinett called the meeting to order at 10:30 a.m.

1. Election of SCC Chair and Associate Chair for '78-'79

Professor Robinett reviewed the election procedure for these offices for the benefit of those new to the committee. Outgoing SCC faculty representatives constituted the nominating committee which developed the slate for these positions. All new and continuing faculty representatives voted in the election. Professor Mahmood Zaidi was elected chairman and Professor Wendell Glick was elected Associate Chairman; their terms begin on July 1, 1978 and continue through June 30, 1979. MOTION PASSED A motion to destroy the ballots was unanimously approved.

2. Election of Student Consultative Committee Chairman for '78-'79

The student representatives on SCC, both new and old, caucused briefly to discuss among themselves the selection of their chairman. Mr. Terry Marchiniak was elected chairman pro tem until the student representative from UMM could be contacted.

3. Additional Meeting of SCC - Thursday, June 8

Professor Robinett announced that it would be necessary to meet soon to decide on the procedures to be used in forming the Select Committee to review the governance structure and consultative processes at the University. It was decided that Thursday, * June 8, at 1:30 p.m. would be the time for that meeting. An announcement of the * location of the meeting will be mailed to SCC members.

4. Planning Council Membership

There was a general discussion of how the Planning Council will be constituted next year. The proposal that the Senate Committee on Resources & Planning (SCRAP) has made for faculty representation was discussed and background on the proposal given to the committee by Professor Robinett. There was some concern that there seems to be an inordinate number of administrative personnel on the Planning Council and that there is no representative from the Graduate School on it at this time. Also, the Consultative Committee generally agreed that there needs to be greater representation of academic interests on the Planning Council than is now the case. The committee approved the addition of Professor Carl Adams to the membership of

* the Planning Council; Professor Robinett will communicate this to Vice President Stein. Professor Keller said he would like to see the research area of the Graduate School represented and Professor Morrison added that there should be a representative from among the academic deans in addition to Dr. Warren Ibele. Ms. Lewis felt that there did not need to be great concern over collegiate representation because under the suggested procedures for the All-University Planning Council each unit will have its own "planning council."

5. Nomination for UCBRBR Chairman for '78-'79

Professor Robinett announced that SCC needed to designate a representative to the University Committee on Biennial Request and Budget Review (UCBRBR). She said that whoever is named is de facto chairman of that committee (Professor Zaidi was chairman for '77-'78). Professor Robinett proposed that Professor Morrison be so designated. He said he could not make a commitment at this time but would consider it and reply to the committee as soon as possible.

6. Vote of Thanks to Committee Chairman

MOTION PASSED

Professor Keller proposed a motion which was enthusiastically and unanimously passed that Professor Robinett be given a vote of appreciation for her excellent work as chairman of SCC this year. She thanked the group and said that everyone has worked very hard all year. She felt that progress had been made in the consultation process and expressed the hope that next year would provide an opportunity for even further improvement. (Professor Robinett will be completing her three-year term on the committee as a regular member during '78-'79.)

7. Copyright Law and Indemnification of Faculty

Professor Purple asked that an item be added to today's agenda: the indemnification of faculty as it relates to the new copyright law. He said that the Senate Committee on Educational Policy (SCEP) has recently reviewed the indemnification policy draft and found it wanting in the area of the copyright law. Professor Morrison, the principal author of the draft, confirmed that it had not been written
* with that law specifically in mind. Professor Purple asked Professor Morrison to contact the chairman of SCEP, Professor Robert Brasted, to go over the questions raised by SCEP.

8. A Conversation with Vice President French and Dean Gault

Vice President for Health Sciences Lyle French and Dean of the Medical School Neal Gault met with SCC at the committee's request to discuss the Health Sciences in general and the consulting policy for the Medical School in particular. Informational materials had been distributed to SCC members previously, and Associate Vice President for Health Sciences David Preston, also present at this meeting, had met with Professors Robinett and Zaidi in advance of this meeting to go over general and specific interests which the committee members had in the Health Sciences. The advance preparation was done because of the complexity of the subjects that would be under discussion and with the hope that the committee could make the best use of the relatively short time available for this meeting.

The Consultative Committee hopes to be able to have more meetings of this type with other units in the University during the coming year.

(Ms. Maureen Smith of University Relations, a student observer, a Minnesota Daily reporter, and a Minnesota Daily photographer joined the meeting at this point.)

Professor Robinett introduced Vice President French, Dean Gault, and Associate Vice President David Preston to the committee and turned over this portion of the meeting to Vice President French. He in turn introduced Ms. Cherie Perlmutter, Assistant to the Vice President.

Vice President French said that the Office of the Vice President for Health Sciences does not try to duplicate what other vice presidential offices do at the University. He works with a small number of staff members and carries out his duties in consultation with the deans and chief administrators of the various units in the Health Sciences division of the University. He then turned the discussion to the subject of the consulting policy for physicians and asked Dean Gault to go into detail on this for the benefit of the Consultative Committee.

Dean Gault cleared up a common misconception concerning what consulting policy or policies members of the Medical School staff are subject to: they are subject to the consulting policy which applies to all University of Minnesota faculty and, in addition, are subject to the Regents' policy relating to medical practice. The latter pertains to each Medical School faculty member who wishes to engage in clinical practice and charge fees for these services. He explained very carefully the rules governing this type of consulting and described in great detail the process for requesting authorization for this type of work. There are different types of staff appointments in the Medical School which also have a bearing on what type of consulting a physician may engage in and how authorization for such practice must be requested. Because the University of Minnesota is legislatively mandated to be the general hospital for the state, there are special regulations that apply to the charging of fees to patients who receive treatment at the University Hospitals. All of these different factors have to be taken into consideration in order to understand the physicians' consulting policy, its history, and its scope.

Dean Gault then explained how the salary ceiling is computed for physician faculty members, describing in detail the formula for determining the equitable base salary and the manner in which a physician's income is carefully monitored through a monitor appointed by the President. There was a discussion of the range of salaries and equitable base figures in the Medical School, how salaries for support staff are funded in part or whole through the income generated by some physicians, and how some outstanding physician faculty members actually contribute more to the Medical School than they receive in salary because their income far exceeds double the amount of their equitable base limit, which is the limit imposed by the consulting policy of the Medical School (funds in excess of this are returned to the Medical School under the Regents' policy). Physician faculty members who are part of a "strict full-time" group (the preceding comments were on the "geographical faculty" group) are subject to the same regulations, but with total income paid through University accounts.

Professor Zaidi said there is an impression that there is a ceiling on income in the Medical School. Dean Gault said that is not entirely accurate since physician faculty members subject to the monitoring agreement do not have to report fees received for consultation in a non-patient setting or for honararia, but function under the same University consultation policy as other University faculty.

The group asked about the composition of the Medical School faculty and whether the apparent division of labor among members of the faculty causes any problems. Vice President French replied that, in fact, some of the more active physicians generate income which helps support the research efforts of those who spend more time in the laboratories or in teaching. Dean Gault confirmed that this arrangement does cause some problems but he and Vice President French agreed that this service component

of the Medical School is needed. Dean Gault said the Medical School here at the University has the largest FTE (full-time equivalent) student teaching load of any medical school in the United States and that its students receive clinical education at nearly four hundred teaching sites throughout the state of Minnesota.

The group then discussed the ramifications of a physicians' consulting policy at other schools in the United States that have recently implemented such a procedure for monitoring physician income. It was Vice President French's opinion that the University has a better medical faculty than it might have had because of the nature of its consulting policy (it is apparently less strict than at some other large medical schools in the nation, and more strict than some others).

The Medical School has a large number of departments in which both Ph.D. and M.D. faculty work but whose salaries are determined on different bases. Also, there seems to be a discrepancy between the salaries paid to basic sciences faculty and faculty at comparable levels in the College of Liberal Arts, for example, which causes some concern among administrators and faculty of the Medical School. (There are seventy-two tenured faculty in the basic sciences division of the Medical School and two hundred and twenty-eight in the medical/clinical division.)

Vice President French then went into the history of the governance structure of the Health Sciences and the reasoning behind the current structure. The Health Sciences does not duplicate functions already being performed by other units at the University; for example, the Graduate School is consulted on tenure and promotion, and Vice President Brown's office is contacted on matters concerning finances and the budget.

Vice President French outlined the role of the University Hospitals as one of support for the teaching of health professionals and those in the allied health fields. He said the core of clinical instruction is done at the University Hospital in the Twin Cities and that most of the basic sciences courses are taught on campus as well. Enrollment is stabilizing at approximately 5,400 FTE students, with a possible increase in the nursing and public health masters' programs because of the demand for graduates in these fields. He went into some detail on the funding for public health programs and the impact on this and other programs of the cut-back in federal funding recently.

Vice President French concluded the meeting with an explanation of pertinent sections of the document, "Health Sciences - Mission Statement and Proposed Structure and Governance," dated July 1970, and the attached graphs and tables (which he distributed to SCC members), showing more recent data on the Health Sciences.

Professor Robinett and the other committee members thanked Vice President French, Dean Gault, and the other members of the Vice President's staff for their informative presentation to the Consultative Committee. The Vice President in turn thanked SCC for the opportunity to meet with the committee and clarify some issues of concern to all.

The meeting was adjourned at 3:15 p.m. The next meeting of the Senate Consultative Committee will be held on June 8, at 1:30 p.m. in the Campus Club.

Respectfully submitted,
Linda L. Compton
Administrative Fellow
Senate Consultative Committee

from 6/1/78
SCC MTG

HEALTH SCIENCES

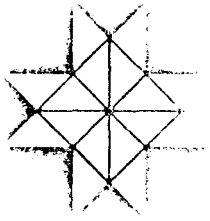
MISSION STATEMENT

AND

PROPOSED STRUCTURE

AND

GOVERNANCE



FOREWORD

The Regents of the University of Minnesota are strongly committed to building improvements in both the quality and availability of health care. In pursuing these goals, the University commissioned several studies that prompted a Regents' decision to expand the scale and scope of the University's programs in the Health Sciences.

To accomplish the objectives of this comprehensive program most effectively it became clear that major administrative reorganization of the Health Sciences was necessary. In seeking guidance on restructuring the Health Sciences the Regents were fortunate in obtaining the advice and counsel of a distinguished panel of experts, and with the benefit of their advice a final proposal—the Mission for the Health Sciences—was formulated and adopted by the Board of Regents on July 10, 1970. This proposal, along with a proposal for the Structure and Governance of the Health Sciences, which was also approved by the Regents, laid down the guidelines under which the University of Minnesota looks ahead with confidence to meeting health care needs of the people of the State.

MALCOLM MOOS
President

STATEMENT ON THE MISSION OF THE HEALTH SCIENCES

The Board of Regents of the University of Minnesota strongly reaffirms its intention of developing programs and training professionals to deliver health care to all Minnesotans whatever their means or wherever they live. The Regents will undertake a careful and continuing scrutiny of philosophies, priorities and techniques which should be employed to assist in achieving an appropriate and equitable distribution of health care personnel throughout the State.

In order to speed these innovations in education, research, and health care delivery systems, the Regents have authorized a unified organization of the health sciences that will bring together in a single administrative structure programs in medicine, nursing, public health, dentistry, pharmacy, and the University hospitals. Veterinary medicine which has related interests will be joined closely to this administrative unit.

The Regents believe the primary mission of the disciplines organized within the Health Sciences will be to educate health care professionals for the needs of the State. Fundamental to this objective will be educational emphasis on patient care, the prevention of disease, and the maintenance of conditions of health. The units within the Health Sciences have had a long tradition of distinguished research aimed at understanding the causes, prevention, and treatment of disease. Clearly such research—so basic to the advancement of health care—should continue as one major mission of the Health Sciences. But the Regents believe it imperative that special and increased emphasis should be given to research and development of innovative systems for delivering optimum health care. These systems should serve all areas and all people in the State. Also, a way must be found to place more family doctors at the service of our people. A nation which can place men on the moon can develop the competence and necessary compassion to care for its sick.

In fulfilling these missions the Regents expect to sponsor cooperative efforts in Minnesota with professional groups, hospitals, educational institutions and community organizations and all agencies concerned with health care. The Regents will also continue to explore their regional and national responsibilities. The Regents recognize the University's responsibility to maintain and develop effective channels of communication with the public so that needs expressed in the community can generate effective response in the University. The Regents will continue to seek better understanding by taxpayers of the financial resources needed by the University if such effective response is to be realized.

The Regents also recognize the University's responsibility for maintaining and developing the competence of health professionals now in practice. They encourage expansion of present University programs and additionally the development of inventive and imaginative programs in continuing education for this purpose. They are also aware that new types of health care personnel may be needed to serve emerging systems of health care delivery, and to extend the effectiveness of present personnel. The Regents encourage efforts to educate, and put into practice such new classes of personnel as may be needed to optimize health care delivery.

For ninety years the University of Minnesota health sciences have been providing leadership in professional education and research. State-wide, nationally and world-wide Minnesota has won acclaim for outstanding achievements in health science education, and for outstanding quality in the delivery of health care. In undertaking major administrative reorganization of the health science units, the Regents proceed with confidence that Minnesota can continue to be a pace setter for the nation as we strengthen our commitment to better serve the health needs of our Minnesota citizens. We are justly proud of our accomplishments in the health sciences in the State, but the question is not how far we have come but how far we have to go.

GOVERNANCE AND STRUCTURE OF THE HEALTH SCIENCES UNIVERSITY OF MINNESOTA

The University of Minnesota has served as the primary source of health professionals for the State of Minnesota for nearly ninety years in response to the needs and expectations of the people of the State. The Regents of the University have been mindful of these expectations and with the resources available to them have sought to encourage the development of faculties and facilities to train men and women in the several professions needed to maintain and deliver the best possible health care.

The expansion in the knowledge of the health sciences, the growth of the population of the State and changing patterns in the distribution of that population have posed new problems in the delivery of health care and the prevention of disease and the maintenance of health. The Regents of the University continue to recognize that ready access to health care is an expectation of all the citizens of the State and that the University has a primary responsibility not only for the training of the necessary manpower but also for the development of innovative efforts to meet changing circumstances. As the knowledge of the health sciences has broadened and expectations for adequate health care has widened, the demands on health professionals has intensified. Health care has always involved the cooperative efforts of the doctor, the nurse and the pharmacist. In their efforts to extend their capabilities to serve greater numbers, health professionals have found it necessary to integrate their efforts ever more closely. This trend has been reflected in more closely integrated, interdependent programs for students in the health profession.

In recognition of these trends the health sciences expansion at the University of Minnesota was planned on an integrated basis. During the planning phase coordination of these efforts was facilitated by a semiformal organization, the Council of Health Science Deans and Directors. As these planning efforts approach realization, it seems necessary and desirable to formalize this arrangement and accordingly it is now proposed that a health sciences administrative structure be established which will serve as an overarching organizational unit for the several health sciences.

MISSION

The Health Sciences of the University of Minnesota should assume leadership in developing programs to meet the needs for health care throughout the state. A continuing mandate is to remain in the closest contact with the people of the State to perceive their health needs in their own terms. There should be a continuing dialogue with the community, in order that the Health Sciences may outline possibilities, methods and practicability of meeting the health needs expressed by the public sector. These programs should be comprehensive and must maintain the high quality of scholarship on which the reputation of this University is based. They must include:

1. *Education of the trained professionals required to fulfill the health care needs.* The educational facilities and programs must provide the interdisciplinary training and experience essential for the provision of comprehensive health services throughout the State. It is emphasized that there should be a comprehensive approach to the patient, recognizing the potentialities of the health team concept. The programs must be organized so the student acquires the necessary skills, attitudes and principles of knowledge to enable him to give the best possible care.

2. *Research to advance the health sciences.* This in the broadest sense should include basic biomedical research, investigation of the normal functions of the human body and mechanisms of disease processes, factors contributing to prevention of disease and maintenance of health, studies of methods of organization and delivery of health care and health services in relation to community needs throughout the State, and studies of the process of communication and education through which the effectiveness of all of the health sciences may be increased.

3. *Providing health care and health services to the people of the State.* This function should be closely correlated with educational and research functions since each is supportive of the other. The University Hospitals and other health science clinic programs should provide the facilities and resources through which exemplary models of health care programs can be tested and the delivery of comprehensive health care services can be used as a teaching laboratory and demonstration model for all the health professions. To obtain the most effective delivery of health care requires that opportunity be widely available for the maintenance of the competence of the practicing health science professionals. Direct patient care is an essential method for maintaining the edu-

cational proficiency of the faculty and for establishment of appropriate educational relationships with community health professionals throughout the state.

In achieving the various segments of the foregoing mission the Regents will undertake to develop the resources commensurate to the commitment of the University Health Sciences to the people of the State of Minnesota.

HEALTH SCIENCES ADMINISTRATIVE STRUCTURE

Throughout its history the University of Minnesota has operated as a single institution with all academic units responsible to the President of the University and through him to the Board of Regents. The close working relationships which this unity has fostered, has strengthened the University and has been a major factor in its development as an institution of great stature among the universities of the world. The close interaction among the many disciplines has been a source of strength and has permitted this University to develop scholastic cohesiveness. Several units of the Health Sciences have strong ties to disciplines in other parts of the University, e.g., psychology, engineering, biology, etc. In a team approach to the delivery of health care such disciplines as education, anthropology, sociology, nutrition and economics will need to be involved. These relationships will be most durable and the Health Sciences will thrive best if they remain integral to the University rather than standing apart. For these reasons the Regents believe that the organization and governance of the Health Sciences should be sought within a framework which maintains the strength of the Health Sciences as an integral part of the University. As in the case of all major universities, it has become necessary for operational purposes that the President delegate responsibilities to Vice-Presidents in order to develop a proper functional framework for various operational and academic units. The Regents of the University of Minnesota have been charged with unusual responsibility for the development of the University by the people of the State. It is the Regents' responsibility to present the general needs of the University to the Legislature and to determine the distribution of the means provided to meet the objectives of the University. The effective exercise of the responsibility given to the Regents has been a major factor in bringing the University to its present eminence.

The unity of the University should not be given up lightly to achieve short term special advantages for any particular unit of the University. Indeed circumstances which at one point in time appear advantageous in this respect can, at another, be disadvantageous. Some arguments have been presented that status for the Health Sciences essentially independent of the University as a whole will provide optimal circumstances under which the Health Sciences can fulfill their mission. The Regents believe, however, that both in the short and long term the Health Sciences will thrive best and most effectively accomplish their mission as units within the University.

For these reasons the Regents propose that the Health Sciences be headed for administrative purposes by a Vice President for Health Sciences. This Vice President shall have the responsibility for developing goals and operational plans in conformity with the missions of the Health Sciences and for developing inter-unit collaboration in fulfilling the missions of the Health Sciences. He will be the principal line officer for the Health Sciences to whom all Deans and Directors in these fields will be responsible. He will represent the Health Sciences and be the advisor to the President, Board of Regents and within the councils of the Central University Administration in matters pertaining to the missions and operations of all health sciences programs of the University wherever they are situated in the State. The Vice President for Health Sciences will report to the President who will, where appropriate, delegate operational aspects of the programs to other officers of the Central Administration.

The Vice President for Health Sciences in cooperation with the Deans and Directors of the Health Sciences units (Medicine, Dentistry, Nursing, Public Health, Pharmacy and the University Hospitals) shall have the responsibility for developing a coordinated resource request for all health sciences. The Regents and President, acting through University policies and procedures, will allocate resources of funds and space to this Vice President in response to his request. The Vice President, after consultation with appropriate University officers and with such advisory bodies to the Vice President as may be established, shall have the responsibility for allocation of these resources to the individual health science units. The Vice President for Health Sciences will delegate to the Deans and Directors in this area the responsibility for deployment of resources assigned to the respective units to meet the objectives of the units consistent with University standards and policies.

The proposed organization of the Health Sciences will require dissolution of the now existing College of Medical Sciences. The present Schools of Public Health, Nursing, the Medical School and the University Hospitals will become constituent units of the new organizational structure and will be headed by Deans with the exception of the University Hospitals whose administrative officer will bear the title of Director. The College of Pharmacy and the Dental School will be joined in the Health Sciences organi-

zational structure as units with those named above. It would be appropriate to designate these units in uniform style either as schools or colleges. The principal administrative officers of each of these units will be directly responsible to the Vice President.

The Regents recognize the multi-lateral relationships in which the College of Veterinary Medicine is involved. The affairs and activities of the College of Veterinary Medicine will be important to the Health Sciences and vice versa. It is proposed that the Dean of the College of Veterinary Medicine carry adjunct status in the Health Sciences to facilitate coordination and cooperation but that the status of the College otherwise remain as it is at present.

The location of the Departments of Mortuary Science and the History of Medicine, presently reporting directly to the Dean of the College of Medical Sciences, will need to be determined by the Vice President for Health Sciences.

It is assumed that the Vice President for the Health Sciences will establish a number of advisory groups for purposes of planning and coordination of the various areas of activity within the Health Sciences. Specifically, for administrative purposes, it is assumed that there will be created a Council of Deans and Directors who will serve the Vice President in a cabinet capacity. The Council will advise the Vice President on programmatic matters and serve in a coordinative and review capacity with respect to the development of budgets to insure that educational, service and research needs are met in a manner which optimally serves the needs of the Health Sciences and the public. It is also assumed that the office of the Vice President will require the appointment of a number of assistant and associate officers responsible for major functions which involve more than one health sciences unit.

The External Visiting Committee in its report made the following statement about the responsibility of the Health Sciences:

> "The Center has a continuing mandate to remain in the closest contact with the people of the State to perceive their health needs in their own terms – not necessarily as perceived by the professional. Indeed, the Center can make a major contribution by engaging in a continuing dialogue with community, Regents and legislators. A new pattern of professional-public interchange can be generated. The professional becomes the expert witness who outlines possibilities, methods, and practicability of meeting the health needs expressed by the public sector. The professional provides the data so that rational public policies can be adopted from among recognized alternatives. The choice of goals – the distribution of resources between health and other social purposes–remains with the Regents and the public. This having been done, University administrators, faculty, and students will be able to interpret and implement the mission of the Health Sciences and will be able to work together toward a common goal."

The Regents, therefore, recommend the establishment of a committee advisory to the Vice President broadly representative of the professions related to the Health Sciences and including representation for the public. They propose that this committee be appointed by the President of the University from nominations submitted by the Vice President with the advice and counsel of the Health Sciences Deans and Directors. It would be appropriate for the Advisory Committee to concern itself in the role described by the External Visiting Committee.

BASIC HEALTH SCIENCES

The Regents are mindful of the concerns expressed by the health science units outside the Medical School that their needs have not been fully met by the basic health sciences, presently constituted of the departments of Anatomy, Biochemistry, Microbiology, Pathology, Pharmacology and Physiology. They are also aware of the long and important relationship between the basic sciences and the Medical School which has strongly influenced the developments in clinical medicine. It is not the wish of the Regents to disturb this close relationship but to seek arrangements which will provide for closer liaison with the other health science units which will insure that their needs are more fully realized and met.

The Regents propose that the basic health sciences remain integral to the Medical School. A coordinator for the basic sciences with an academic appointment appropriate to his discipline should be designated to serve as a staff officer to the Vice President to define over-all basic science needs for all units of the Health Sciences. The coordinator shall have the specific responsibility for seeing to it that the basic science programs effectively serve the programs of all health science units. He and appropriate members of the basic science faculty might properly hold faculty status in units other than the Medical School.

The Regents are particularly concerned that the needs of the health science units outside the Medical School be well served and accordingly propose that a review of the effectiveness of the arrangements proposed be carried out after a suitable trial period.

ALLIED HEALTH PROFESSIONS

There is need to encourage development of new programs in the allied health sciences in order to meet the requirements for the delivery of health care throughout Minnesota. Each health science unit

which now trains allied health personnel will continue presently established programs in their existing locations. As programs for new types of allied health personnel are developed, each curriculum should be organized within the collegiate unit and department which relates most closely to the role which such allied health personnel will serve in delivery of health care.

In each of the units in the Health Sciences which trains allied health personnel an administrative officer, drawn from the faculty, shall be assigned the responsibility for coordinating allied health training programs, providing a central source of leadership, promoting the development of new training programs as needed and acting as staff advisor to the Dean on policy related to allied health personnel within the unit. This administrative officer shall act as Chairman of a Council of Allied Health Sciences Professions which shall be composed of a representative from each of the allied health training programs located in that unit (Dentistry, Medicine, Public Health, etc.). These Councils are assigned the responsibility for development of appropriate coordination between programs within the respective units and among the several health sciences units.

A coordinator of all these programs shall be located in the office of the Vice President of Health Sciences.

The Regents recognize that patterns of delivery of health care and health services may well change markedly in the future requiring the development of new professionals who do not fit the present structure of the health science disciplines. These new professionals may well bridge the existing disciplines and may, in fact, involve disciplines outside those in the proposed Health Sciences organizational structure. The Regents propose, therefore, that the structure proposed above be subject to review and possible modification after a suitable interval.

PUBLIC HEALTH

The School of Public Health has had a long standing tradition of concern for the prevention of disease and maintenance of conditions desirable for the promotion of community health. Given the stipulated mission for the Health Sciences the Regents believe that the public health unit can play an important role in developing broad innovative patterns for delivery of health care and health services involving professionals from within and without the Health Sciences. This unit can provide educational programs which will develop public understanding of the resources available to meet community needs and facilitate communication of public expectations to the Health Sciences.

UNIVERSITY HOSPITALS

The University Hospitals play a key role in offering service to the people of Minnesota while serving as the principal clinical laboratory for the Health Sciences. The Regents believe that the University Hospitals can serve all the health science units most effectively as a distinct unit in the Health Sciences organizational structure. The Director of the Hospitals should be a member of the Health Sciences Council with status equivalent to that of the Deans of the other health science units. The Regents recognize that policy for and administration of such a complex as the University Hospitals involves participation by many groups having interests varying both in degree and emphasis. Such special groups will wish to be able to influence the administration and operations of University Hospitals. In particular the relationships of the clinical departments of the Medical School and their counterparts in the other health science units (e.g., Nursing, Pharmacy, Dentistry, ambulatory care programs, Public Health) will have special concerns. It is recommended, therefore, that the heads of the clinical departments of the Medical School and their counterparts in other health science units should be appointed chiefs of the clinical services and related services of the Hospital. This group could form a Clinical Council advisory to the Director of the University Hospitals. Representation on the Council might also include representatives from the staff at large and an ex-officio representative of the Vice President for the Health Sciences. Such a Clinical Council would be large and it would be appropriate, therefore, for the Council to elect from its numbers an appropriately representative executive committee including an ex-officio representative of the Vice President. The Council and its Executive Committee should be chaired by the elected Chief of Staff of the University Hospitals. The Clinical Council should have as its concern the quality and adequacy of the professional programs within the University Hospitals and the responsibility for participating in policy making. The Deans and Directors of all the health science units will have a major concern for the activities of the University Hospitals as they relate to the instructional and research activities of their collegiate units.

AFFILIATION—HOSPITALS, COMMUNITY AGENCIES AND SERVICES

The Medical School has developed undergraduate and graduate teaching programs in affiliated hospitals over a period of many years. These programs are a major source of strength in medical education and will become increasingly important in education in the other health sciences. A large number of full-time as well as part-time faculty are located in these hospitals. Initially the program involved Hennepin

County General Hospital, St. Paul Ramsey County Hospital and Veterans Administration Hospital. More recently a number of private hospitals have been included in the teaching program. The educational programs may involve multiple departments or may relate to a single department. Formal affiliation agreements have been developed to guide the relationship between the hospital and medical school.

Other health science units have begun to develop relationships with the affiliated hospitals but as yet these programs do not involve large numbers of students. In the future these relationships may be expected to expand.

The actual training of health science professionals is carried out by the individual departments at the University and coordinated by the Deans of the Schools and Colleges directly responsible for curricular content and implementation. With the expansion of the number of professionals to be trained and the need to incorporate the affiliated hospitals into such a training effort, it is important that some uniformity of departmental effort and goals be maintained in order to develop properly those teaching efforts necessary to accomplish this goal. The involvement of individual departments in other relevant academic units in coordinated educational efforts will be essential if uniformity of quality is to be maintained.

A coordinator in the office of the Vice President for Health Sciences should be appointed and serve to coordinate programs involving more than one health science unit and to develop new programs. He would also be responsible for development of relations with non-hospital health delivery systems and with community groups. The Regents foresee that such affiliate relationships may provide opportunities for health science education programs which may vary in kind and emphasis.

As the complexity and size of the Health Sciences develops it may become desirable to establish separate clinical campuses. This would require an administrative structure in the office of the Vice President which would facilitate programmatic relationships. Such developments would be preceded by adequate consultation with the faculties and administrators of the various units within the Health Sciences.

GRADUATE SCHOOL RELATIONSHIPS

The External Committee recommended that the present requirements with respect to the graduate status of "Residents" should be modified. The Regents support the recommendation that "Residents" should not automatically be required to register as graduate students but rather that the option should be determined according to individual choice and subject to departmental or collegiate policy. Alternate methods for registration of residents as students in the appropriate Health Sciences school should be developed. The Regents believe that the basic direction and control of the clinical program of residents associated with programs in the individual health sciences units should be a shared responsibility of the Vice President for Health Sciences, the particular unit and the appropriate department.

These conditions to which the External Committee referred apparently have been a problem primarily for the Medical School but it is the Regents' intent that the modifications to be effected should be applicable in other health science units where appropriate.

Residency and graduate programs in the health sciences will impose major demands on the resources of the University and the health sciences. It seems appropriate therefore that the Vice President for Health Sciences should have some administrative responsibility in cooperation with the Deans of the health sciences units for determining the relative effort devoted to such programs. However, the admission of candidates to residency programs and the number of such residents should continue to be the responsibility of the departments and specialties according to their individual programmatic needs relative to their education and research objectives. The Vice President for Health Sciences will have the responsibility for reviewing the recommendations of the departments with the objective of insuring balance and will be responsible for the distribution of available state resources according to over-all program needs and balance. The Vice President, the Deans and the Health Sciences Departmental Heads should share with the Dean of the Graduate School the responsibility for the quality of graduate programs and the standards of admissions.

CONTINUING EDUCATION

The Regents recognize the responsibility of the University for assisting practicing health care professionals to maintain their capability through continuing education. The trend toward periodic recertification of health care professionals gives this University activity special importance. The Vice President for Health Sciences and his staff will be expected to assist and coordinate the activities of each of the health science units. The direct responsibility for the continuing educational programs will rest with the individual health sciences units. The Vice President's office will provide appropriate liaison with the General Extension Division.

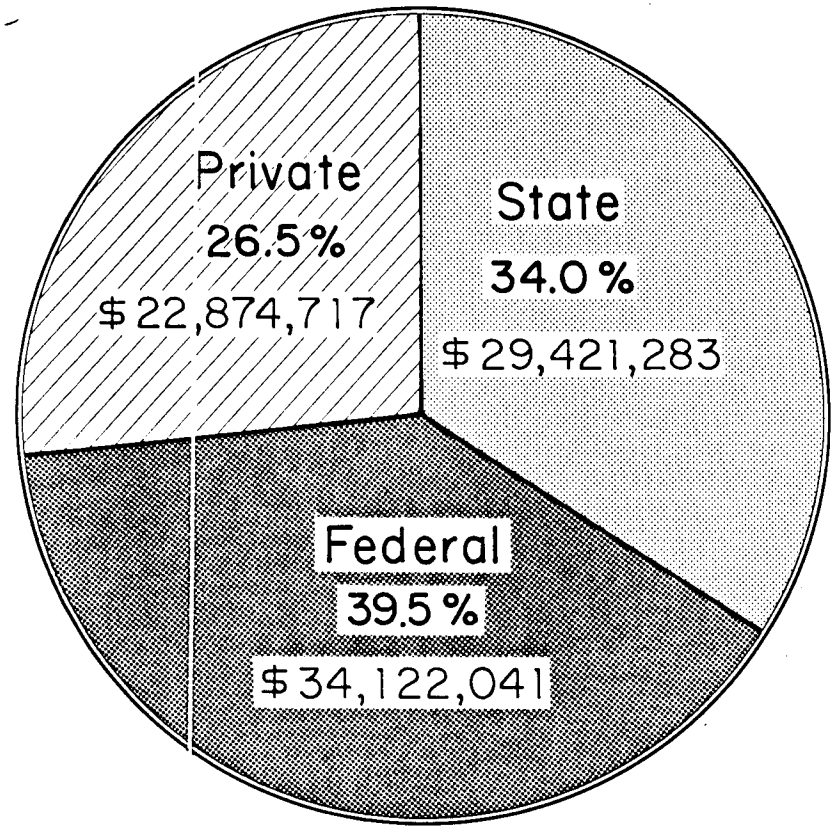
ENROLLMENT DATA

	1969-70	1977-78
Nursing		
Baccalaureate	245	452
MS - on campus	37	92
MS - off campus	0	33
	282	577
Pharmacy		
Baccalaureate	282	364
Pharm. D.	0	37
MS/Ph.D.	29	71
	311	472
Public Health		
MPH/MHHCA	168	331
MS/Ph.D.	126	145
	294	476
Dentistry		
DDS	420	589
Dental Hygiene	124	357
Dental Assisting	29	50
MS/Ph.D.	42	52
	615	1048
Medical School		
MD (Does not incl. N.D.)	707	1048
Graduate Basic Sciences	252	224
Graduate Clinical Sciences	650	276
Medical Fellow Specialist	0	796
OT/PT	147	133
Medical Technology	128	126
Nurse Anesthetist	0	35
Psych. Fellow Specialist	0	8
Biomedical Graphic Design	0	0
Radiation Therapy Tech.	0	0
Health Care Psychology	0	0
Other Graduate	0	27
	1884	2673
Mortuary Science		
Baccalaureate	71	82
MEd	0	0
	71	82
Totals	3457	5328

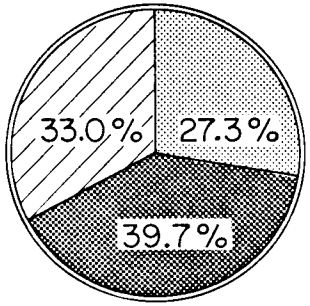
HEALTH SCIENCES MAJOR ACADEMIC UNITS

1976-77

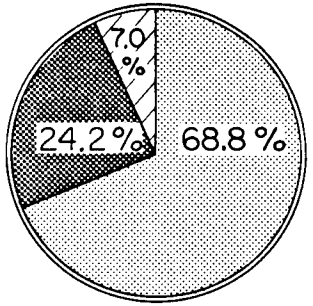
$86,418,041



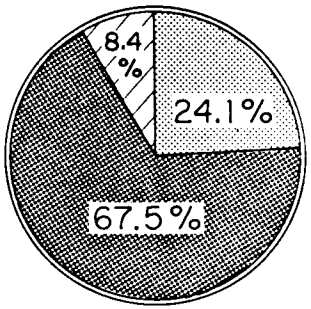
Medical School
Twin Cities Campus
$63,225,775



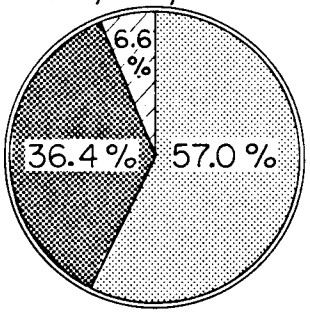
School of
Dentistry
$8,859,583



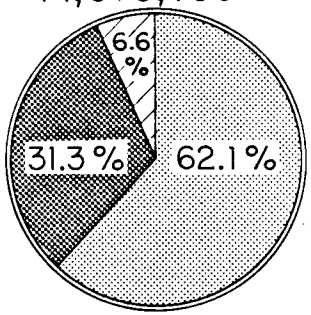
School of
Public Health
$7,204,673



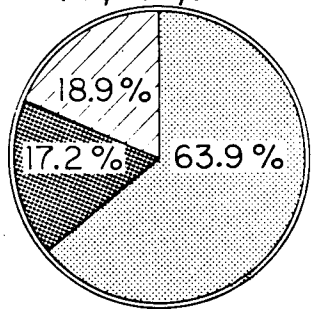
College of
Pharmacy
$2,788,797



School of
Nursing
$1,870,136

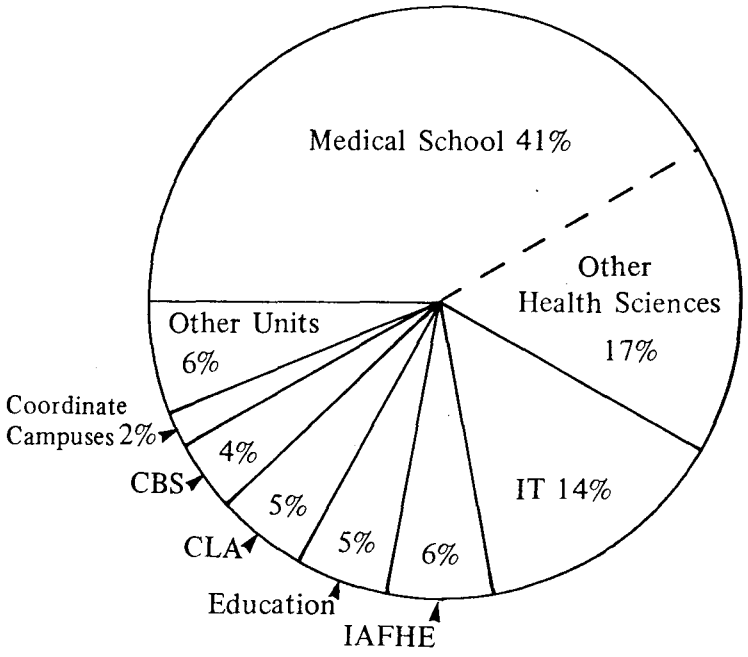


Medical School
Duluth Campus
$2,439,077



Levels and Trends in Sponsored Programs at the University of Minnesota

FIGURE 2
Expenditures for Sponsored Programs
by College
Fiscal Year 1977



Office of Research Administration
University of Minnesota

May 1978

HEALTH SCIENCES REQUEST
Capitation Contingent Fund
October 15, 1977

Unit	Grants Received (1974-75) Effective Dates	Grant Amounts	Grants Received (1975-76) Effective Dates	Grant Amounts	Grants Received (1976-77) Effective Dates	Grant Amounts	Grants Received (1977-78) Effective Dates	Grant Amounts	Amount Allocable to 1977-78	Drawdown Needs for 1977-78
Nursing	7/74-6/75	$ 79,873	7/75-6/76	$ 75,733	7/76-6/77	$ 100,800	7/77-6/78	$ 93,645	$ 93,645	$ - 17,912
Pharmacy	7/74-6/75	$ 332,406	7/75-6/76	$ 237,846	7/76-6/77	$ 139,118	10/77-9/78	$ 112,702	$ 84,526	$ 153,320
Public Health	7/74-6/75	$ 387,600	7/75-6/76	$ 378,842	7/76-6/77	$ 367,042	7/77-6/78	$ 382,842	$ 382,842	$ - 4,000
Dentistry	7/74-6/75	$1,206,152	7/75-6/76	$1,042,172	7/76-6/77	$ 636,619	10/77-9/78	$ 784,086	$ 588,064	$ 454,108
Medical School	7/74-6/75	$1,950,095	7/75-6/76	$1,383,455	7/76-6/77	$ 887,659	10/77-9/78	$1,057,725	$ 793,294	$ 590,161
Veterinary Medicine	7/74-6/75	$ 403,966	7/75-6/76	$ 315,633	7/76-6/77	$ 236,936	10/77-9/78	$ 228,668	$ 171,501	$ 144,132
TOTALS		$4,360,092		$3,433,681		$2,368,174		$2,659,668	$2,113,872	$1,319,809

Revised 12/6/77

PRIVATE CONSULTATION PRACTICE
IN THE COLLEGE OF MEDICAL SCIENCES

Statement of Policy and
Implementing Resolution

Originally adopted by the Board of Regents of the University of Minnesota on June 15, 1963. Clarifying language approved by the Board on September 20, 1963. Further modifications approved by the Board on March 11, 1966.

STATEMENT OF POLICY

1. THE PURPOSES OF THE UNIVERSITY OF MINNESOTA MEDICAL SCHOOL AND ITS HOSPITALS ARE TO TEACH MEDICAL STUDENTS AND PHYSICIANS THROUGH COURSES IN THE BASIC SCIENCES AND FROM THE EXAMPLE SET BY HIGH-QUALITY CARE OF THE SICK, TO CONDUCT INVESTIGATIONS INTO UNKNOWN AREAS OF SICKNESS AND HEALTH, AND TO SERVE THE CITIZENS OF MINNESOTA BY PROVIDING, UPON REFERRAL BY PHYSICIANS, THE HIGHEST QUALITY OF MEDICAL CARE. THE ADMISSION AND TREATMENT OF PRIVATE PATIENTS IN THE UNIVERSITY HOSPITALS, UNDER PROPER CONDITIONS, CAN CONTRIBUTE TO THESE PURPOSES.

2. IN THE ESTABLISHMENT OF THE UNIVERSITY HOSPITALS IT WAS THE INITIAL INTENT OF BOTH LEGISLATURE AND THE UNIVERSITY THAT THE MEDICAL SCHOOL FACULTY SHOULD NOT ENGAGE IN ANY PRIVATE PRACTICE AND THAT THE PATIENT POPULATION SHOULD BE WHOLLY INDIGENT. WITH THE OPENING OF THE GEORGE CHASE CHRISTIAN CANCER UNIT, THIS POLICY WAS CHANGED TO PERMIT PRIVATE CONSULTATIONS AND FEES ONLY TO AN EXTENT WHICH WOULD NOT INTERFERE WITH TEACHING AND RESEARCH.

3. AS MORE AND MORE OF THE STATE'S POPULATION HAS COME UNDER THE PROTECTION OF SOME SORT OF HEALTH INSURANCE, THE PERCENTAGE OF INDIGENT PATIENTS REFERRED TO THE UNIVERSITY HOSPITALS HAS DECREASED. IN ORDER TO MAINTAIN A HOSPITAL POPULATION ADEQUATE TO THE TEACHING AND RESEARCH NEEDS DESCRIBED ABOVE, PROPERLY REFERRED PRIVATE PATIENTS HAVE BEEN ACCEPTED. IN THE LAST DECADE THIS PRIVATE-PATIENT POPULATION HAS ASSUMED SIGNIFICANT PROPORTIONS AS A VITAL PART OF THE OPERATION OF THE MEDICAL SCHOOL. IT IS IMPORTANT THEREFORE TO INSURE

THAT THESE PATIENTS ARE INCORPORATED FULLY INTO THE MEDICAL SCHOOL PROGRAM.

4. IT IS CLEAR THAT ACCEPTANCE OF PRIVATE PATIENTS, ON REFERRAL, CAN FURTHER THE ACADEMIC GOALS OF THE MEDICAL SCHOOL IN THE FOLLOWING WAYS:

A. PROVIDE TEACHING OPPORTUNITIES OF A KIND LESS FREQUENTLY ENCOUNTERED IN THE REMAINING HOSPITAL POPULATION;

B. PROVIDE RESEARCH OPPORTUNITIES FOR THE FACULTY MEMBER INTERESTED IN STUDYING A PARTICULAR CONDITION;

C. ENHANCE THE QUALITY OF TEACHING OF THE FULL-TIME CLINICAL FACULTY MEMBER BY A CONTINUING CONTACT WITH PRIVATE PATIENTS.

5. SUCH REFERRAL CONSULTATION PRACTICE CAN THEN HELP TO CREATE AN ACADEMIC ENVIRONMENT ATTRACTIVE TO CLINICAL SCHOLARS WHO WISH TO DEVOTE THEIR CAREERS TO TEACHING, RESEARCH, AND SERVICE. IT MUST, HOWEVER, BE INTEGRATED CAREFULLY WITH TEACHING AND RESEARCH, IN ORDER TO PROMOTE SCHOLARLY ACTIVITY AND THE DEVLEOPMENT OF THE HIGHEST STANDARDS OF ETHICS IN THE MINDS OF STUDENTS. THE REGENTS' POLICIES ARE DESIGNED TO PROMOTE FULL PARTICIPATION OF ALL PATIENTS (PRIVATE, PER DIEM, AND COUNTY) IN THE TEACHING AND RESEARCH PROGRAMS, PROVIDED ONLY THAT SUCH PARTICIPATION IS COMPATIBLE WITH EXEMPLARY MEDICAL CARE.

6. THE REGENTS REAFFIRM THE PRINCIPLE THAT PATIENTS, BOTH PRIVATE A INDIGENT, MAY BE ADMITTED AT THE UNIVERSITY OF MINNESOTA MEDICAL CENTER UP REFERRAL BY A PHYSICIAN IN ACCORDANCE WITH THE DEFINITIONS OF THE BOARD OF REGENTS AND WITH THE REGULATIONS OF THE UNIVERSITY OF MINNESOTA HOSPITALS. (THE RELEVANT SECTION OF THE HOSPITAL REGULATION READS AS FOLLOWS: "PATIENTS ADMITTED TO THE HOSPITAL MUST BE REFERRED BY THEIR FAMILY PHY-

SICIAN OR A PHYSICIAN IN THE LOCAL COMMUNITY. OBSTETRICAL PATIENTS WITHOUT A REFERRING PHYSICIAN AND EMERGENCY PATIENTS ARE AN EXCEPTION TO THIS RULE." RULES COVERING THE REFERRAL OF PSYCHIATRIC PATIENTS BY COURTS AND OTHER LEGAL AND JUDICIAL AGENCIES ARE COVERED IN THE MINNESOTA STATUTE, 1923, SECTION 4596, ESTABLISHING THE PSYCHOPATHIC HOSPITAL.)

7. THE REGENTS AFFIRM THE POLICY THAT PATIENTS OF ALL CATEGORIES ARE TO BE INCORPORATED FULLY INTO THE TEACHING AND RESEARCH PROGRAMS UNLESS, IN THE OPINION OF THE RESPONSIBLE PHYSICIAN, SUCH INCORPORATION WOULD JEOPARDIZE THE WELFARE OF THE PATIENT. THE DEAN OF THE COLLEGE OF MEDICAL SCIENCES IS REQUIRED TO MAKE AN ANNUAL REPORT TO THE REGENTS ON THE EXTENT TO WHICH PRIVATE PATIENTS HAVE BEEN INCORPORATED INTO THE TEACHING PROGRAMS OF THE VARIOUS DEPARTMENTS AND DIVISIONS.

8. IN THE BELIEF THAT FACULTY MEMBERS HAVE A PRIMARY DEDICATION TO THE ACADEMIC PURPOSES OF THE MEDICAL CENTER AND THAT PRIVATE PRACTICE IS COMPLEMENTARY TO THESE PURPOSES, THE REGENTS URGE THAT EVERY EFFORT BE MADE TO ENCOURAGE THE ACADEMIC CAREERS OF PROMISING YOUNG STAFF MEMBERS BY PERMITTING AND ENCOURAGING REASONABLE PARTICIPATION IN THE STUDY AND CARE OF PRIVATE PATIENTS. SUCH PARTICIPATION, DONE IN PROPER MEASURE, SHOULD CONTRIBUTE TO THE DEVELOPMENT OF THE STAFF MEMBER'S MATURITY AND INDEPENDENT STATURE, AND TO THE STIMULATION OF HIS RESEARCH PROGRAM. THE DISTRIBUTION OF PRIVATE PATIENTS, AS OF INDIGENT PATIENTS, AMONG THE FACULTY MEMBERS OF ANY DIVISION OR DEPARTMENT SHOULD BE SUCH AS BEST TO SERVE THE NEEDS OF THE PATIENTS AND TO PROMOTE THE TEACHING AND RESEARCH PROGRAM OF THAT DIVISION OR DEPARTMENT. DUE RECOGNITION MUST, OF COURSE, BE GIVEN BOTH TO THE DOCTOR-PATIENT RELATIONSHIP AND TO THE RELATIONSHIP

OF THE REFERRING PHYSICIAN AND THE INDIVIDUAL FACULTY MEMBER.

9. THE MEDICAL CENTER HAS AS ONE PURPOSE TO SERVE THE CITIZENS OF MINNESOTA AND THE MEDICAL PROFESSION IN THIS COMMUNITY. IN ORDER TO KEEP FAITH WITH THE MEDICAL PROFESSION IN OUR COMMUNITY, IT IS ESSENTIAL THAT PATIENTS BE ADMITTED STRICTLY ON A REFERRAL BASIS, AS SPECIFIED IN THE RULES AND REGULATIONS OF THE UNIVERSITY HOSPITALS. IT IS ESSENTIAL THAT APPROPRIATE, COMPLETE, AND PROMPT REPORTS BE SUPPLIED TO THE REFERRING PHYSICIAN. EVERY EFFORT SHOULD BE MADE TO ACQUAINT THE MEDICAL PROFESSION WITH PLANS AND PROCEDURES OF THE UNIVERSITY HOSPITALS REGARDING THE CARE OF PATIENTS, BOTH PRIVATE AND INDIGENT, SO THAT THE MEDICAL PROFESSION IN OUR COMMUNITY MAY HAVE A CONFIDENT UNDERSTANDING THAT THE MEDICAL FACULTY IS ENGAGED IN HELPFUL SERVICE TO THEM.

10. FULL-TIME FACULTY MEMBERS MAY, IN UNUSUAL CIRCUMSTANCES, SEE PATIENTS IN CONSULTATION IN OTHER HOSPITALS IN RESPONSE TO A REQUEST FROM THE PATIENT'S PHYSICIAN. FULL-TIME FACULTY MEMBERS SHALL NOT HAVE STAFF MEMBERSHIP IN PRIVATE HOSPITALS NOR SHALL THEY MAINTAIN PRIVATE OFFICES FOR PROFESSIONAL PRACTICE.

11. THE TOTAL INCOME OF THE FULL-TIME STAFF MEMBER, FROM ALL OF HIS UNIVERSITY WORK, OUGHT TO BE DETERMINED ULTIMATELY, ON THE BASIS OF AN ASSESSMENT OF THE RELATIVE VALUE OF HIS CONTRIBUTIONS TO TEACHING AND RESEARCH AND SERVICE, INCLUDING,OF COURSE, ALL FORMS OF TEACHING, FORMAL AND TUTORIAL, AND BASIC AS WELL AS PURELY CLINICAL RESEARCH. THE REMUNERATIONS AND PRIVILEGES OF A FACULTY MEMBER SHOULD BE SUCH AS TO ATTRACT AND RETAIN A SUPERIOR FACULTY.

12. THE REGENTS AND PRESIDENT, AS RESPONSIBLE OFFICERS OF A PUBLIC SUPPORTED INSTITUTION, SHALL HAVE AVAILABLE, UPON REQUEST, FULL INFORMATION REGARDING THE TOTAL COMPENSATION TO INDIVIDUAL STAFF MEMBERS FOR THEIR UNIVERSITY ACTIVITIES.

13. PRIVATE CONSULTATION PRACTICE WITHIN A MEDICAL SCHOOL SETTING SHOULD FURTHER THE PURPOSES OF THE MEDICAL SCHOOL. FUNDS GENERATED BY SUCH PRACTICE SHOULD BE USED TO BOLSTER THE ATTRACTIVENESS OF THE ACADEMIC CAREER AND THUS TO FACILITATE THE BUILDING OF A FACULTY BEST QUALIFIED TO FURTHER THE TEACHING, RESEARCH, AND SERVICE GOALS OF THE MEDICAL SCHOOL. IN PARTICULAR, SUCH FUNDS SHOULD BE USED TO ASSURE THAT THE INCOME AVAILABLE TO A CLINICAL FACULTY MEMBER, COMBINED WITH THE OPPORTUNITIES FOR RESEARCH AND THE INTANGIBLE ATTRACTIONS OF A STIMULATING UNIVERSITY ENVIRONMENT, WILL BE SUFFICIENT TO ATTRACT AND RETAIN THE ABLEST CLINICAL SCHOLARS WHO DESIRE TO DEVOTE THEIR CAREERS TO ACADEMIC MEDICINE. A PORTION OF SUCH FUNDS MIGHT BE USED TO IMPROVE THE SALARIES OF YOUNGER MEMBERS OF THE STAFF, TO PROVIDE NEEDED SPECIAL RESOURCES FOR HOUSE OFFICERS, AND TO PROVIDE APPROPRIATE FUNDS FOR ASSISTANCE IN THE HANDLING OF PROBLEMS RELATING TO PRIVATE PATIENTS.

14. A MEDICAL SCHOOL FACULTY IS A COMPANY OF SCHOLARS COOPERATING IN MEDICAL TEACHING AND RESEARCH, AND IN THE CARE OF PATIENTS WHICH IS ESSENTIAL TO THESE OBJECTIVES. IN SUCH A COMMUNITY, THE CONTRIBUTION OF THE BASIC-SCIENCE FACULTY IS OF COMPARABLE SIGNIFICANCE TO THAT OF THE CLINICAL STAFF MEMBERS. THE LATTER ARE PRIVILEGED TO HAVE CONTINUING CONTACT WITH BASIC SCIENCES, IN ADDITION TO ALL OF THEIR OWN ACTIVITIES, WHETHER PURELY CLINICAL, TEACHING, OR RESEARCH. WITHOUT THIS

CONTACT THE OUTLOOK OF THE CLINICAL TEACHER WOULD BE NARROWED AND HIS CONTRIBUTION WOULD TEND TO DIMINISH. BUT DESPITE THIS VERY REAL CONTRIBUTION OF THE BASIC-SCIENCE DEPARTMENTS, ANY PLAN WHICH WOULD MANDATE THE USE OF FUNDS GENERATED BY PRIVATE-PRACTICE ACTIVITY IN SUPPORT OF THESE DEPARTMENTS MAY WELL CREATE SERIOUS PROBLEMS. IT WOULD APPEAR THAT THE MOST DESIRABLE USE OF SUCH FUNDS IS FIRST TO STRENGTHEN THE SALARY STRUCTURE OF THE FACULTY IN THE CLINICAL DEPARTMENTS, WITH SOME PORTION THEN GOING TO SUPPORT OTHER ACADEMIC ACTIVITIES; THIS LATTER USE SHOULD BE GUIDED BY THE FACULTY MEMBERS PROVIDING THE CLINICAL SERVICE AND MIGHT WELL BE IN PART IN SUPPORT OF BASIC-SCIENCE ACTIVITIES.

15. IN VIEW OF THE WIDE VARIETY OF OPPORTUNITIES AND PRACTICES AMONG CLINICAL DEPARTMENTS, AMONG SPECIALTIES WITHIN DEPARTMENTS, AND AMONG INDIVIDUAL FACULTY MEMBERS WITHIN SPECIALTIES THE APPROPRIATE USE OF PRIVATE-PATIENT FEES IN TERMS OF A "SCALE" OR "FORMULA" WOULD LEAD TO INEQUITIES, AND WOULD THUS UNDERMINE THE SENSE OF MUTUAL PURPOSE AND CONFIDENCE AMONG THE MEDICAL FACULTY WHICH MUST ALWAYS REMAIN THE PRIMARY STRENGTH OF A MEDICAL SCHOOL. THE REGENTS' POLICY ON ADOPTION AND IMPLEMENTATION WILL PROVIDE TO THE ADMINISTRATION APPROPRIATE INFORMATION REGARDING THE PRIVATE-PATIENT PROFESSIONAL ACTIVITIES OF THE MEDICAL FACULTY, AND SHOULD INSURE A GENERAL UNDERSTANDING AMONG THE MEDICAL FACULTY CONCERNING THE WAYS IN WHICH PRIVATE-PATIENT FUNDS ARE TO BE USED. THE ESSENTIAL OBJECTIVE IS TO SECURE THAT PRIVATE-PATIENT PRACTICE SHALL BE PART OF AN OVERALL PROGRAM WHICH WILL ATTRACT AND RETAIN SUPERIOR FACULTY MEMBERS; TO THIS END PRIVATE-PATIENT FUNDS SHOULD BE USED IN AN APPROPRIATELY FLEXIBLE MANNER, IN THE SPIRIT OF A GENTLEMEN'S AGREEMENT BASED ON MUTUAL TRUST.

16. Clinical services provided in the Medical Center are not only for patients' benefit, but are also an integral part of the educational program of the College of Medical Sciences. To charge the physician providing care or service to a private patient a facilities fee is inconsistent with this principle; such a facilities fee would suggest that private-patient service is incorporated in the Medical Center activities for the benefit of the individual physicians, rather than for the benefit of the patients and of the educational program. For this reason no University facilities charge is made against any faculty member serving private patients in the Medical Center.

17. The income augmentation which a given medical faculty member may derive from private practice activity is not a fixed amount. It may, however, be predicted in a general manner for any given year, and each member of the clinical faculty needs some understanding of the income he may reasonably hope to derive from such sources. This amount may vary from one specialty to another, and from one individual faculty member to another within a given specialty. It will also depend upon the general departmental program and the faculty member's allocated responsibilities resulting from the departmental program. Each faculty member will discuss with his department or division head his own program of research and teaching and the existing requirements for private practice. From such conversations he should arrive at an understanding of his departmental responsibilities, and may thus determine the income augmentation he should reasonably hope to derive from private-practice activity. For general understanding, it is well for an outer limit to be agreed upon; and one might expect that the

UNIVERSITY SUPPORT SALARY MIGHT BE USED AS A BASIS, WITH AGREEMENT THAT THE INCOME AUGMENTATION, AT AN OUTER LIMIT, SHOULD NOT EXCEED THIS SUPPORT SALARY. IT IS, HOWEVER, A FACT OF LIFE, ARISING FROM UNIVERSITY BUDGET PROBLEMS, THAT CERTAIN FACULTY MEMBERS IN CLINICAL DEPARTMENTS WHO HAVE UNUSUAL OPPORTUNITIES FOR PRIVATE PRACTICE HAVE NOT BEEN ALLOTTED SALARIES COMMENSURATE WITH THEIR RANK AND STATURE, AS MAY BE SEEN BY COMPARING THEIR SUPPORT BUDGET SALARIES WITH THOSE OF THEIR ACADEMIC COLLEAGUES. THE OUTER LIMIT, THEREFORE, IS TO BE BASED ON THE UNIVERSITY SUPPORT SALARY, ACTUAL OR, IN THE LIGHT OF THE ABOVE, ONE ADJUDGED TO BE EQUITABLE, WITH A MAXIMUM INCOME AUGMENTATION LIMIT SUCH THAT THE TOTAL INCOME FOR UNIVERSITY ACTIVITY, I.E., SALARY PLUS AUGMENTATION, SHOULD NOT EXCEED TWICE THIS SALARY.

18. IN ORDER THAT THESE AGREEMENTS MAY BE RECORDED, SO THAT APPROPRIATE INFORMATION REGARDING THE OPERATION OF THE MEDICAL SCHOOL MAY BE AVAILABLE WHEN NEEDED, THE REGENTS REQUIRE EACH MEMBER OF THE MEDICAL FACULTY TO FILE WITH HIS DEPARTMENT AND DIVISION HEAD, WITH A COPY TO THE DEAN, OR OR BEFORE APRIL 15 OF EACH YEAR, A STATEMENT OF THE INCOME AUGMENTATION LIMIT HE ANTICIPATES FOR THE CURRENT CALENDAR YEAR, WITH AN OUTER LIMIT IN THE SPIRIT OF THIS POLICY. A FACULTY MEMBER MAY SUBSEQUENTLY, FOR CAUSE, FILE A REVISED STATEMENT OF EXPECTED INCOME AUGMENTATION LIMIT. GROUPS OF FACULTY MEMBERS MAY JOINTLY FILE THEIR RESPECTIVE STATEMENTS OF INCOME AUGMENTATION LIMITS, AND GROUP AGREEMENTS; HOWEVER, NO FACULTY MEMBER IS REQUIRED TO JOIN SUCH A GROUP ARRANGEMENT. IN THE EVENT OF DEATH, RESIGNATION, OR RETIREMENT OF A DEPARTMENT OR DIVISION HEAD WHO IS A PARTICIPANT IN SUCH A GROUP, HIS SUCCESSOR IS UNDER NO OBLIGATION TO CONTINUE THE GROUP ARRANGEMENT.

19. It shall be the policy of the Regents that funds generated by the faculty member's private practice activity that exceed the augmentation limit shall be paid into special University accounts designated by the faculty member but established in accordance with regular University procedures. These shall include accounts set up in support of divisional, departmental or college-wide activities or special academic programs in the clinical fields. Expenditures from divisional or departmental funds will be administered with the advice of an appropriate divisional or departmental committee, elected by the members of the department or division. Expenditures from accounts established for the support of college-wide activities will be administered by the dean with the advice of the Committee on Private Practice Activity. In no event shall funds generated by the faculty member's private practice activity and remitted under this paragraph be expended for his personal benefit.

IMPLEMENTING RESOLUTION

The Regents, having approved a statement of policy, covering the Private Consultation Practice in the College of Medical Sciences, direct the appropriate administrative officers to implement the policy in accordance with the following:

1. A faculty member whose University duties anticipate his rendering professional services to or on behalf of private patients will file by April 15 of each year with his department and division head, with a copy to the dean, a statement of his income augmentation limit for the current calendar year. The facilities of the University

OF MINNESOTA MEDICAL CENTER WILL BE AVAILABLE WITHOUT FACILITIES CHARGE TO THE FACULTY MEMBER RENDERING SUCH SERVICES IN ACCORDANCE WITH THE PRINCIPLES ESTABLISHED BY THE BOARD OF REGENTS.

2. BECAUSE OF THE FACT THAT IN THE INITIAL IMPLEMENTATION APRIL 15 IS NOT A CONVENIENT DATE, THE DEAN OF THE COLLEGE OF MEDICAL SCIENCES IS AUTHORIZED TO ESTABLISH AN APPROPRIATE DATE FOR THE FILING OF THE INITIAL EXPECTED INCOME AUGMENTATION LIMIT STATEMENT.

3. ANY QUESTION CONCERNING THE ACCEPTABILITY OF A PROPOSED INCOME AUGMENTATION LIMIT WHICH CANNOT BE RESOLVED BY THE FACULTY MEMBER, THE DEPARTMENT HEAD, AND THE DEAN, WILL BE REFERRED FOR AN ADVISORY OPINION TO THE STANDING COMMITTEE ON PRIVATE PRACTICE ACTIVITY ESTABLISHED IN ACCORDANCE WITH PARAGRAPH 4 FOLLOWING. SHOULD THE MATTER REMAIN UNRESOLVED, THE DEAN WILL FORWARD THE ADVISORY RECOMMENDATION OF THE STANDING COMMITTEE ON PRIVATE PRACTICE ACTIVITY TOGETHER WITH HIS OWN RECOMMENDATION TO THE PRESIDENT FOR ADMINISTRATIVE RESOLUTION.

4. IT IS UNDERSTOOD THAT A COMMITTEE ON PRIVATE PRACTICE ACTIVITY WILL BE FORMED EACH YEAR IN THE FOLLOWING WAY: A SENIOR MEMBER OF THE FACULTY OF A CLINICAL DEPARTMENT SHALL BE APPOINTED AS CHAIRMAN BY THE DEAN. FOUR ADDITIONAL MEMBERS OF THE FACULTY OF CLINICAL DEPARTMENTS SHALL BE ELECTED BY THE VOTE OF THE EXECUTIVE FACULTY OF THE CLINICAL DEPARTMENTS OF THE MEDICAL SCHOOL. THE COMMITTEE ON PRIVATE PRACTICE ACTIVITY WILL ADVISE THE DEAN, ON A CONTINUING BASIS, WITH REGARD TO BETTER INTEGRATION OF THE PRIVATE PATIENT IN THE EDUCATIONAL PROGRAM, IMPROVED UNDERSTANDING BETWEEN THE UNIVERSITY MEDICAL CENTER AND PHYSICIANS IN THE MINNESOTA COMMUNITY, AND ANY OTHER MATTERS WHICH MAY ARISE IN CONNECTION WITH MEDICAL CENTER ACTIVITIES INVOLVING PRIVATE PATIENTS.

19____

UNIVERSITY OF MINNESOTA
Medical School

Private Consultation Practice Agreement

1. I am receiving a **strict fulltime salary** from the University of Minnesota and have read and will adhere to the strict fulltime agreement between _____ ("Unit") and the Board of Regents of the University of Minnesota and the Revised Agreement for Monitoring Private Practice Income, copies of which I have received.

   Unit Address: _____

2. My home and business addresses are as follows:

   Home: _____

   Business: _____

3. For the period _____ through _____

   My Base Salary is estimated to be $ _____

   My Commutation Allowance is estimated to be $ _____.

4. I estimate I will receive the following income from professional practice or consultation related to patient care outside of the University Hospitals (including consultation rounds at the Veterans Administration Hospital or other hospitals). $ _____.

Name _____

Signature _____

Date _____

Concurred in by Head of the Department

_____

Date _____

WHITE—Dean's Office Copy
BLUE—Faculty Member's Copy
PINK—Departmental Copy
GOLDENROD—Monitor's Copy

REVISED AGREEMENT
for MONITORING PRIVATE PRACTICE INCOME

University of Minnesota
Medical School

March 1976

This is a memorandum of an agreement reached by the President ("President") of the University of Minnesota ("University") with the Professional Reimbursement and Insurance Committee of the Faculty of the Medical School of the University of Minnesota ("Committee"), successor to the Committee on Private Practice Activity, and the Council of Chiefs of Clinical Services of the University Hospitals as ex officio members of the Committee, effective for the year beginning 1 January 1976.

On 15 June 1963 the Board of Regents of the University ("Board") adopted a "Statement of Policy and Implementing Resolution" concerning "Private Consultation Practice in the College of Medical Sciences of the University" ("Regents Rules"). Clarifying language was approved by the Board on 20 September 1963 and further modifications on 11 March 1966.

In order to assure compliance with the Regents Rules, THE PRESIDENT AGREES WITH THE COMMITTEE:

1. The Regents Rules are interpreted to mean the following:

   a. That part of the private practice receipts of a clinical medical faculty member ("Member") equal to his maximum income augmentation limit in the case of a geographic full-time Member, and equal to his commutation allowance (and other allowances provided in his strict full-time agreement with the Medical School of the University) in the case of a strict full-time Member, determined in accordance with the Regents Rules, plus all expenses attributable to the private practice activity, is the private practice income of the Member.

   b. All receipts in excess of such private practice income, over and above any income taxes thereon, shall be used for the purposes and objectives of the Medical School as provided in the Regents Rules,all in recognition of the goals of private patient practice at the University, and in consideration of the participation therein by Members and others.

   c. When a Member agrees to the determination of his maximum income augmentation limit or commutation allowance he thereby agrees

      -that the Regents Rules shall be interpreted and carried out in accordance with the provisions of this agreement, and

      -that any partnership, corporation or other entity in respect of private practice in which the Member has an ownership interest or authority to act is also bound by this agreement.

   d. The acceptance by a Member of an appointment to serve a clinical department of the Medical School constitutes an agreement by the Member to abide by the Regents Rules.

2. The President will appoint as a reviewer and referee of compliance of the Regents Rules a person ("Monitor") who shall have been selected jointly by the President and the Committee. The Monitor's compensation and reasonable expenses shall be paid in equal parts by the President and the Committee. Each professional practice unit shall pay

such part of such expense as is proportionate to its part of the income augmentations and commutation allowances for all units. The appointment of the Monitor shall be reviewed annually. Any decision to appoint another Monitor shall be subject to approval by the President and the Committee. The Monitor shall be removed at any time that the President or the Committee has given the other party and the Monitor at least 30 days' written notice. The Monitor may resign his appointment on giving at least 30 days' written notice to both parties hereto. He shall be available to give information for a reasonable time on all matters pending at the time of termination of his appointment. He may use such assistants as he may determine.

3. Not later than 31 March of each year, the Head of each clinical department will furnish the Dean of the Medical School ("Dean") with the income augmentation or commutation allowance information for the department in respect to that current year. At the same time, the Head of the department will submit to the Monitor for each Member in the department or at the time of termination of appointment of any Member of the department, including the department head, the following:

    a. The actual University support salary;

    b. the equitable support salary (if it differs from the actual support salary);

    c. the outer income augmentation limit in the case of geographic full-time Members;

    d. the commutation allowance information in the case of strict full-time Members;

    e. the home and business addresses of the Member;

    f. the names and business addresses of the professional practice unit with which the Member serves, and of the owner or owners of the unit;

    g. any additional information which the department head may wish to give.

    Revised information may be filed subsequently as permitted by the Regents Rules.

"Private practice receipts" include all fees paid by patients or third-party payers for services rendered by a Member on behalf of patients, or as a consultant or teacher within the University of Minnesota affiliated hospitals. Private practice receipts do not include amounts paid by way of honoraria or royalties or other payments for patents.

The Monitor, in his discretion, may request a department head to review the income augmentation or commutation allowance for any Member of the department, including the department head. After such review, the

Monitor may, if he deems it appropriate to do so, refer the matter to the chairman of the Committee on Private Practice Activity (presently the Professional Reimbursement and Insurance Committee) of the faculty of the Medical School.

4. Within 3 months following the close of the year, the head of each professional private practice unit shall furnish the Monitor with a statement of the amount each Member in the unit, including the head of the unit, derived from private practice receipts for the past year, together with such other information as the head of the unit deems appropriate.

   Each solo practitioner shall furnish to the Monitor similar information as to the practitioner's private practice receipts, together with all applicable business deductions relating thereto, and such adjustments and other information as the practitioner deems appropriate. Each Member may also furnish data concerning any applicable business deductions and such adjustments and other information as he deems appropriate. All information shall be signed by the Member furnishing the information and shall be certified as accurate and complete by a certified public accountant or other public accountant, and shall be submitted to the Monitor.

   In the alternative, a Member may at his discretion submit copies of such parts of the relevant United States income tax returns, and accompanying schedules, as report the private practice income and expense of the Member for the period in question, providing the data furnished is identified by a public accountant as being true and complete copies of the information relating to private practice income set forth in the tax returns signed by the accountant.

   In the event of termination of appointment of a Member for whatsoever cause, the Head of the department of the Member shall furnish the Monitor with a full disclosure of the terminating Member's vested interest in the Unit's income at the time of termination.

   The Monitor, to the extent and in the manner he may determine, may verify the correctness of the data furnished to him, including having an audit made, but he shall not be required to do so. Each professional unit shall also account for all its private practice receipts for the year in question.

5. Promptly after receipt of the data, the Monitor will determine, as to each Member, whether there is compliance with the authorized augmentation limit. To each Member in compliance, the Monitor will send confirmation thereof. He will also notify the respective department heads, the President and the Dean, certifying which Members have complied with the Regents Rules in respect to their augmentation limits. For Members in this group the Monitor's statement of compliance ends the matter for that particular year.

6. In the event a Member appears to be in noncompliance, the Monitor will promptly notify the Member and request an early reply. If the Member

has not demonstrated compliance within 60 days thereafter, the Monitor will notify the head of the particular professional unit to which the Member belongs and will again notify the Member in question, after which the Member will have an additional 30 day period in which to demonstrate compliance.

7. If compliance has not been demonstrated at the end of the aforestated periods, the Monitor will so notify the Chairman of the Committee, with copies to the head of the appropriate department, the Dean and the Member in question. The Committee will ask the Member to furnish relevant information to, and appear before, the Committee, which will examine into the surrounding circumstances. The department head shall participate in this procedure upon the invitation of the Committee, or upon the invitation of the Member concerned, and may participate at his own election.

8. In the event the Committee finds that a Member has not demonstrated compliance with the Regents Rules, the Chairman of the Committee will inform the President, the Vice President of Health Sciences, the Dean and the Member to that effect. Seven days after such a finding, the private consultation practice privileges of the Member under the Regents Rules shall be suspended until the Committee finds that the Member is in compliance with the Regents Rules as required under this agreement. For the time that the private consultation practice privileges of a Member are so suspended, he shall not be paid that part of his commutation allowance or income augmentation which is proportionate to the number of days such suspension bears to the total calendar days in the fiscal period involved. Any such suspension shall be taken into account in the administration of the Medical School and in making appointments to serve the clinical departments thereof.

9. Any questions involving the interpretation of this agreement or the applicaton of the Regents Rules shall be referred to the Monitor for resolution within the terms of this agreement. Either party to this agreement may request a reconsideration of the Monitor's decision by giving written notice of such request to the Monitor and the other party. The decision on such reconsideration shall be final. Should the Monitor so determine, he may refer any matter to the Committee for such disposition as it may deem appropriate.

10. The Monitor shall be available to both parties to this agreement, and to any Member, to provide counseling and advice in respect of the performance of this agreement. He shall treat as confidential all information received by him. He shall, nevertheless, have authority to disclose, only to the persons identified in this document, and may also disclose other information, but only if, in his sole discretion, such disclosure will be in furtherance of this agreement. The Monitor, in his discretion, shall, from time to time, return all data and documents to the persons furnishing the same. When the Monitor terminates his services, he shall deliver all data and documents to his appointed and approved successor.

11. The Monitor shall determine what expenses are "attributable to the private practice activity". Generally these will be any deductions allowed under the Internal Revenue Code in computing net income for income tax purposes, including but not limited to, reasonable compensation paid for personal services rendered by employees, indirect payroll costs, fringe benefits to employees and self-employed persons, reasonable allowances for depreciation and obsolescence and reasonable reserves appropriate for valid business purposes. Accelerated deductions shall be allowed only as permitted under the Internal Revenue Code. The Monitor may allow other adjustments which in his opinion are appropriate and equitable in determining net income. Expenses which are personal in nature, and not expenses of doing business, shall not be allowed. A deduction allowed to a professional unit shall not again be allowed to individuals within the unit. Determinations by the Monitor made after the close of a fiscal year, based upon the reports or audits relied upon by him, shall not subsequently be adjusted, whether by reason of actions of any governmental agency, or otherwise, unless it is shown to result in a grossly inequitable result, in which case the Monitor may allow such adjustments as he deems appropriate.

12. It is acknowledged by both parties to this agreement that the Monitor may be asked by either party to this agreement to perform services not directly related to the subject of this agreement, and he may accept such employment.

13. This agreement is binding upon any person appointed and approved to serve as Monitor when he shall have signed an acceptance to be so bound. It is also binding upon the successors of each of the parties hereto. It amends and supersedes the earlier agreement of 3 September 1975.

SIGNED by the parties April 12, 1976, to be effective as set forth at the beginning of this instrument.

PROFESSIONAL REIMBURSEMENT AND INSURANCE COMMITTEE OF THE MEDICAL SCHOOL OF THE UNIVERSITY OF MINNESOTA

UNIVERSITY OF MINNESOTA

President date

Eugene Gedgaudas, M.D., Chairman
Chairman, Council of Clinical Sciences
Head, Department of Radiology

Richard L. Varco, M.D., Vice Chairman
Regents Professor of Surgery

A. B. Baker, M.D.
Regents Professor of Neurology

John E. Harris, M.D.
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Donald W. Hastings, M.D.
Professor of Psychiatry

Harold O. Peterson, M.D.
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Edward W. Ciriacy, M.D.
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Practice and Community Health

Richard V. Ebert, M.D.
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Joseph J. Buckley, M.D.
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Michael M. Paparella, M.D.
Chairman, Council of Chiefs of
Clinical Services
Head, Department of Otolaryngology

John S. Najarian, M.D.
Head, Department of Surgery

A CHAT WITH THE DEAN . . .

Medical Bulletin

UNIVERSITY OF MINNESOTA
Winter 1978

MINNESOTA MEDICAL FOUNDATION

THE UNIVERSITY OF MINNESOTA MEDICAL BULLETIN

TOM PATTERSON, EDITOR
EIVIND O. HOFF, EXECUTIVE EDITOR

WINTER 1978 ISSUE

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A CHAT WITH THE DEAN

In the first three years of its existence, the University of Minnesota Medical School graduated a total of nine physicians. There were 243 graduates at the June 1977 commencement and 38 more at other commencement dates in 1977.

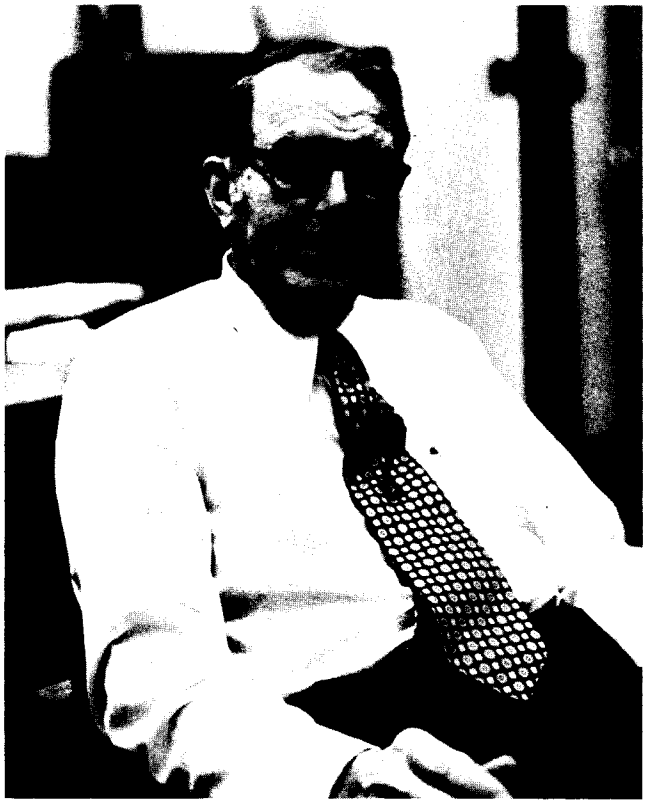
In 1888, Medical School tuition at the University of Minnesota was $40 a year for state residents and $60 a year for out-of-state students. In 1978, tuition is $2,708 a year for residents and $6,936 a year for non-residents.

In 1888, the Medical School had 28 faculty members housed in a rented building and was three years away from an $80,000 legislative appropriation to build its first on-campus medical building. In 1978, it has 857 faculty members and an annual budget of more than $60 million.

To consider these facts and others relating to the size, cost, methods and reputation of the University of Minnesota Medical School, we visited with Dr. N. L. Gault, Jr., Dean since 1972, and a member of the class of 1950.

Dr. Gault speaks with pride of the fact that the University of Minnesota Medical School continues to train record numbers of medical doctors up to and after the M. D. degree, and of the Medical School's national reputation as a quality institution. He mentioned a Columbia University survey by sociologists Jonathan R. Cole and James A. Lipton which measured the perceived quality of U. S. medical schools through a survey of medical school faculty. Replies showed a high degree of consensus. The authors of the study devised methods for minimizing the effect of "self-aggrandizement" (high ranking by faculty of the ranked school or high ranking for an alma mater).

The study ranked 94 medical schools, but only 13 were on every faculty member's survey list of 40 medical schools. Cole and Lipton found that most respondents rated the 13 schools alike. The questionnaire was designed to gain an appraisal of faculty quality and effectiveness of training. The University of Minnesota Medical School was ranked 12th overall. California (San Francisco) and Michigan were the only two state medical schools ranking above Minnesota. The private medical schools ranking higher than Minnesota were, in rank order, Harvard, Johns Hopkins, Stanford, Yale, Columbia, Duke, Cornell, Washington-St. Louis, and the University of Pennsylvania.



Numbers on the graph on page 5 show where the University of Minnesota Medical School (Minneapolis) ranks among 114 U.S. Medical Schools on 16 points. Figures are for 1976–77.

Another ranking of 98 U.S. medical schools showed Minnesota to be 9th in the number of living graduates, 3rd in the total number of graduates in family or general practice, 17th in the number of graduates in primary care fields, and 12th in the number of M.D. graduates on faculties of U.S. medical schools.

The Journal of the American Medical Association (JAMA) reported in its 1977 Education issue that the University of Minnesota Medical School was 15th in the number of state residents entering medical school, 11th in the number of state residents *per 100,000 population* entering medical school, and 17th in the number of state residents entering medical school per 1,000 bachelor's degrees conferred in the state.

In addition to its reputation for quality medical education, the University of Minnesota Medical School also ranks high in the *number* of students trained. In 1977, the total teaching load for the University of Minnesota Medical School in Minneapolis was 1,969, including 1,012 undergraduate medical students, 657* graduate medical students in specialty training, 61 candidates for a master's degree in basic science, 191 candidates for a doctorate in basic science, and 48 post-doctoral trainees in basic science.

The teaching job is done by 543 M.D.s, 196 Ph.D. scientists, and 118 faculty with other degrees. Of 857 total faculty members in medicine, 624 are at the University itself and 233 work through the several area hospitals affiliated with the Medical School. The faculty ranks of these teachers are as follows: 196 full professors, 182 associate professors, 291 assistant professors and 86 instructors.

And more people are needed, according to Gault. He says that it is particularly difficult to find good leadership. He had just returned from an unsuccessful attempt to recruit a new faculty member. A search committee continues to look for a qualified person to accept a permanent appointment as head of pediatrics, as one example.

An even greater problem he faces is that the Medical School is far short of the needed funds to complete construction of space in the new Health Sciences Building B-C, the clinical facilities unit. If space in B-C can be completed, he can move people in and then utilize the space they vacate to move still others from crowded laboratories and offices to more adequate quarters.

He would also greatly like to see more endowed chairs for the Medical School — at least one in every department. There is at present the American Legion Heart Research Professorship, the George Clark Research Professorship in Medicine, the Paul F. and Faith S. Dwan Chair in Pediatric Cardiology, the Paul F. Dwan Chair in Education in Pediatric Cardiology, the Masonic Professorship in Cancer, the Malcolm B. Hansen Professorship in Radiology, the Nesbitt Chair in Medicine, the Pardee Foundation Professorship in Cancer Biology, and the Royal A. and Olive Stone Professorships in Cancer Research and Cardiovascular Pathology.

Gault sees a special need for space and personnel to develop a program in neurosciences. He sees neuroendocrinology opening as a major new research area and finds the Medical School lacking at this point in the means to take advantage of new knowledge. He hopes to be able to expand Minnesota's research efforts in the area of immunogenetics.

"And while on the subject of need," Gault said, "the need for medical student financial aid is virtually insatiable."

There has been a 77% increase in enrollment in the University of Minnesota Medical School over 19 years. Applications remain high but dipped slightly in 1977 from the peak year of 1974.

APPLICANTS AND ADMISSIONS

YEAR	1958	1962	1966	1970	1974	1977
Applied	282	504	639	974	1898	1758
Enrolled	135	152	163	227	239	239
Increase		13%	7%	39%	5%	

Nationally, there are more students in U.S. medical schools than at any other time in history, according to an Association of American Medical College's (AAMC) study. AAMC says there were 16,136 first-year students admitted to 120 U.S. medical schools in 1977, bringing total medical student enrollment for all classes to an all-time high of 60,039. Women composed 25.6% of the entering class and minority students 9%. The study shows that in the "nation's" first-year class there are 1,085 Black students, 51 American Indian or Eskimo students, 246 Mexican Americans and 68 Puerto Ricans. Enrollment today is double that of 1960 when there were 86 medical schools with a total enrollment of 30,288 and a first-year enrollment of 8,298.

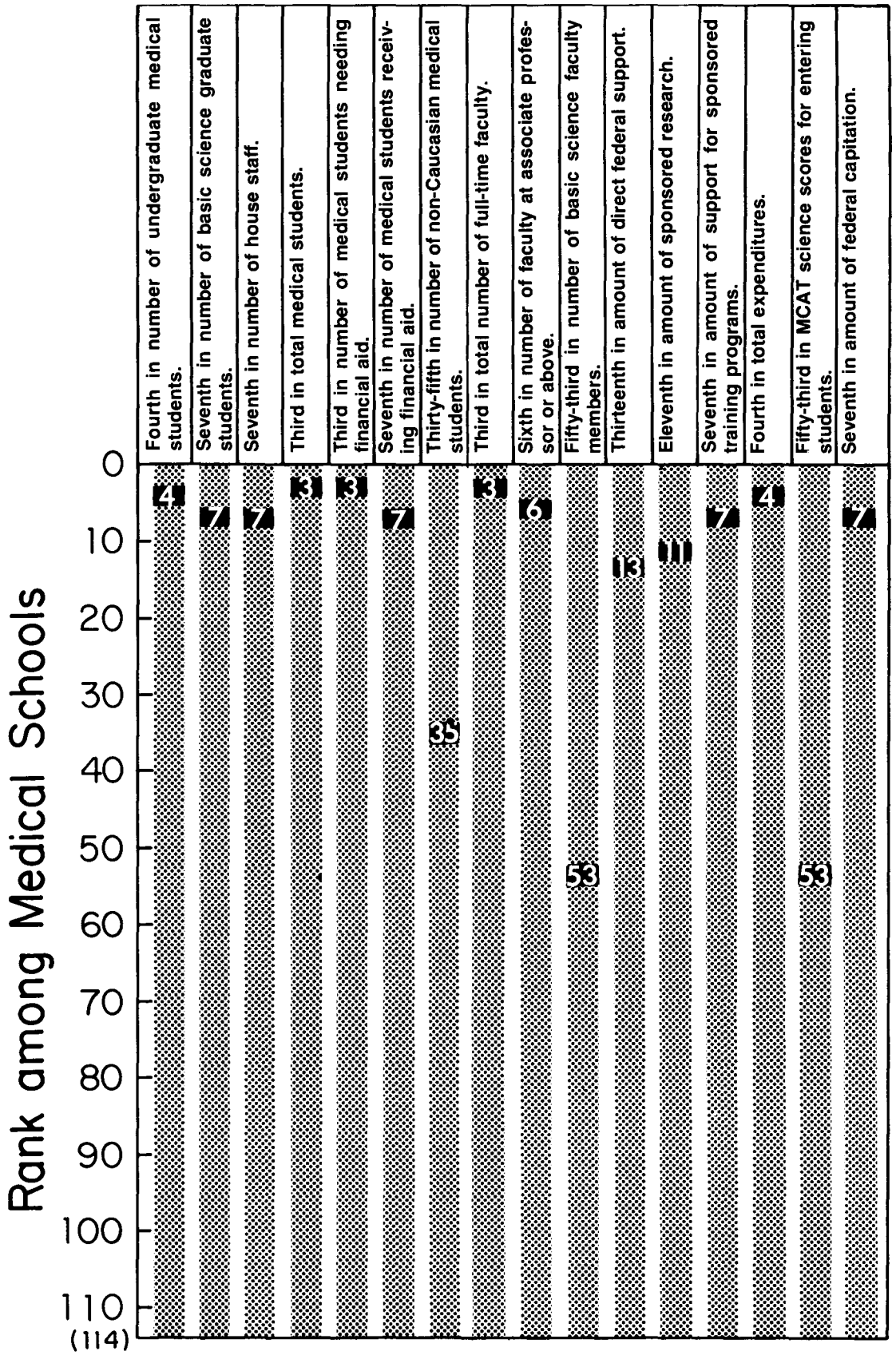
The map on page 6 shows the distribution of state applicants to the University of Minnesota Medical School for 1977–78. The map indicates the number of applicants from each county, the number accepted and the number who actually enrolled.

Applicants to the two-year Scool of Medicine in Duluth are not included in the figures on the map.

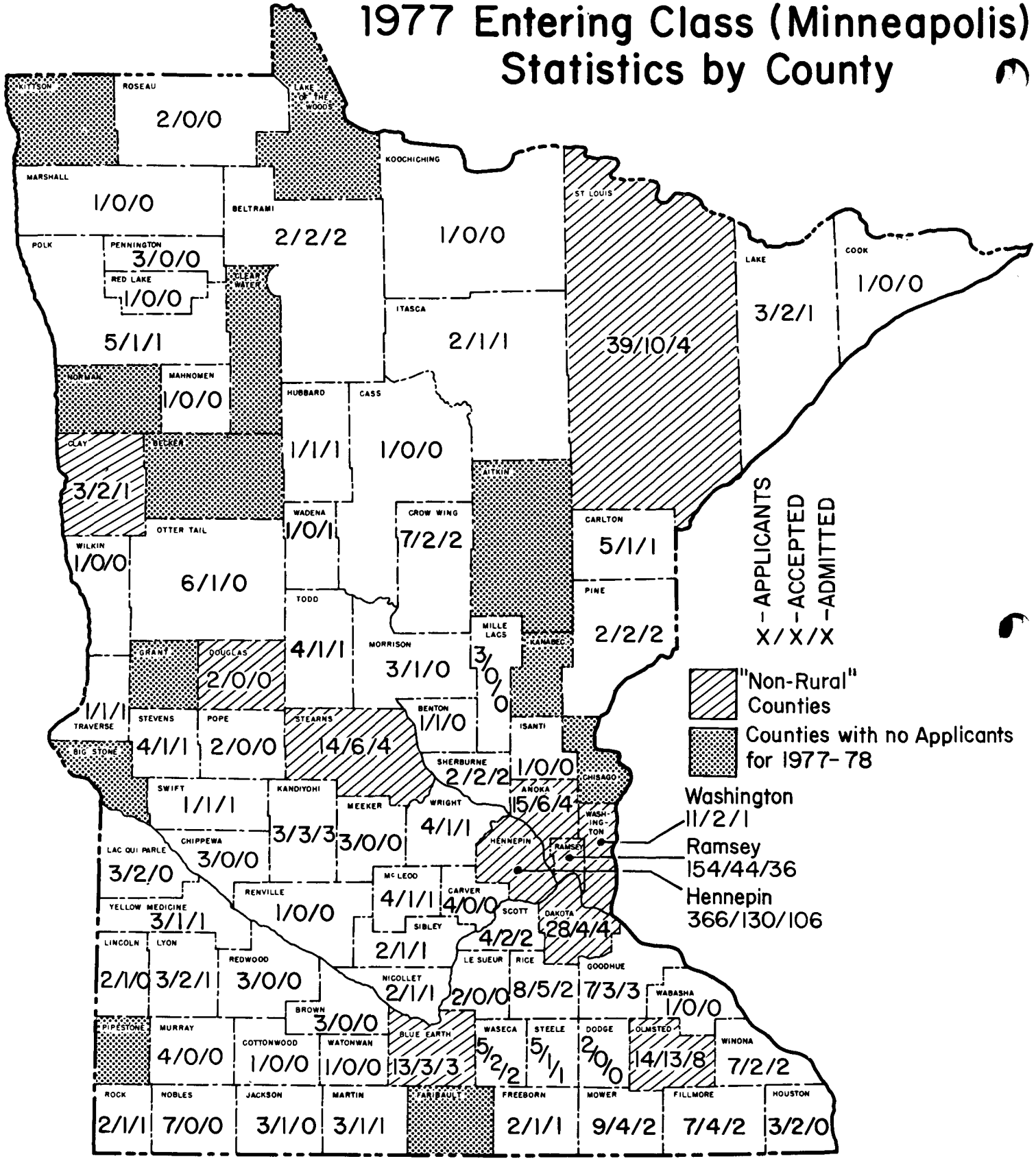
*** This number had increased to 1,058 by the fall of 1977.**

(Continued page 7)

Minnesota Ranked on 16 Points



1977 Entering Class (Minneapolis) Statistics by County



The following indicates for UMD the number of applicants accepted and the number admitted by county: Anoka 2-2, Beltrami 1-1, Blue Earth 2-0, Carlton 1-1, Chippewa 1-1, Cook 1-0, Dakota 1-1, Fillmore 2-0, Goodhue 1-0, Hennepin 8-5, Houston 1-1, Hubbard 1-0, Isanti 1-1, Jackson 1-1, Kandiyohi 2-0, Lake 1-0, Lac Qui Parle 2-1, Lyon 1-1, McLeod 1-1, Morrison 1-0, Mower 1-1, Olmsted 2-0, Ottertail 1-1, Pennington 1-1, Polk 2-2, Ramsey 9-8, Red Lake 1-0, Rice 2-2, Scott 1-0, St. Louis 10-8, Stearns 3-3, Waseca 2-2, Washington 1-1, Watonwan 1-1.

Of 239 students admitted to the entering class in Minneapolis, 93 (39%) did their undergraduate work at the University of Minnesota. Minnesota private colleges prepared 80 (33%); 6 (2.5%) took their undergraduate training at other Minnesota state universities, and 60 (25%) got their undergraduate training out of state (representing 48 different schools).

MEDICAL SCHOOL (MINNEAPOLIS) 1977

Applicants: 1,758

Minn. Residents	889 (51%)	Non-residents	869 (49%)
Males	667 (75%)		653 (75%)
Females	222 (25%)		215 (25%)

First-Year Class

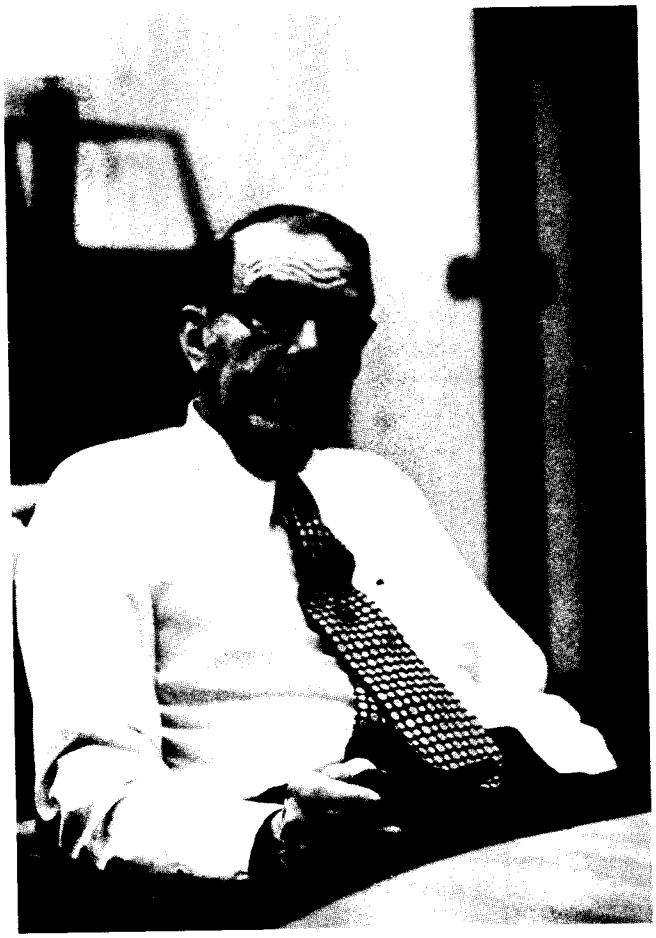
Residents	224	
Non-residents	15	(6%)
Males	184	
Females	55	(23%)
Minorities	22	(9.2%)

Origin of Students

Number from the Twin Cities and Suburbs	152
Number from Duluth	3
Number from Rochester	6
Number from 45 Other State Communities	63

The chart on page 8 shows how available first-year post M.D. positions in Midwest states were filled in 1977, as places offered and places filled per 100,000 population. Comparison scales are shown for Minnesota, the combined Midwest states and the entire U.S.

The top bar (or left on the key) of each double bar segment represents all graduates, including those who did not participate in the National Intern-Resident Matching Program (NIRMP) and those who participated but did not match. The lower bar (right on the key) represents the number of first-year graduate medical positions available. Raw numbers of graduates and positions are included for Minnesota. The chart was devised by John Graettinger, M.D., executive



vice president of NIRMP and dean of faculty affairs at Rush.

Minnesota offered positions (385) for about 9.5 first-year medical graduates per 100,000 state population, and filled about 8.5 per 100,000 population. Minnesota graduated 281 M.D.s — about 8 per 100,000 population — in 1977. This compares with about 6.2 graduate physicians per 100,000 population for the U.S. and about 7 graduates per 100,000 population for the Midwest. About 8 first-year graduate medical positions per 100,000 are available for both U.S. and Midwest. Minnesota filled more graduate medical positions per 100,000 population than any other Midwest state, and attracted more post-M.D. trainees than were graduated from the state. The Midwest as a whole loses about 1,000 medical graduates per year to both Coasts and the South.

JAMA's 1977 Medical Education issue reports that Minnesota is the 4th largest educator of graduate medical students, with 213 interns and 587 residents, when all levels of training are considered. Michigan is first with 205 interns and 689 residents and Illinois and Ohio State are second and third.

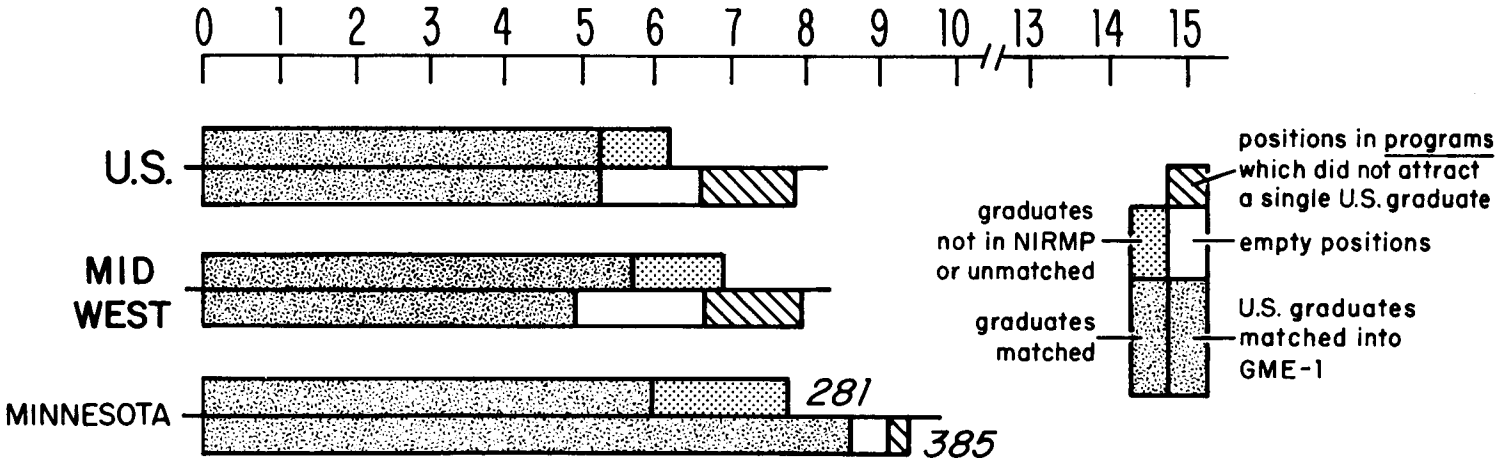
(Continued)

(Explanation of this chart on page 7).

Intern—Resident Match Offered and Filled

MIDWEST—1977

Per 100,000 Population



OCCUPATIONAL SURVEY OF PARENTS
1976 ENTERING MEDICAL SCHOOL CLASS
(Minnesota Residents Only)

	FATHER	MOTHER
Physician	21	1
Professional	66	50
Managerial	50	9
Own Business	5	
Homemaker		120
Farmer	14	
Sales	13	2
Clerical and Office	1	21
Skilled Trade	18	3
Service Trade	11	8
Unskilled	15	4
Unemployed	2	
Retired	2	1
Disabled	1	
Deceased	1	1
	220	220

WHAT MINNESOTA GRADUATES DO FIRST POST-MD TRAINING YEAR

Straight	1968	1970	1974	1977
Primary Care	18%	29%	25%	41%
Specialty	3%	5%	10%	23%
Family Practice			22%	28%
Rotating	79%	66%	41%	8%

PERCENTAGE OF MINNESOTA GRADS PRACTICING IN MINNESOTA

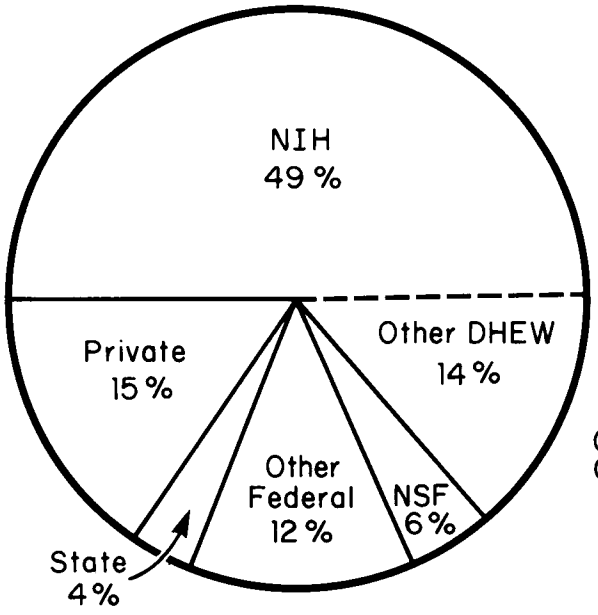
1965–67	1970–73	1974–77
37.4%	58.2%	58%

RURAL PHYSICIAN ASSOCIATE PROGRAM

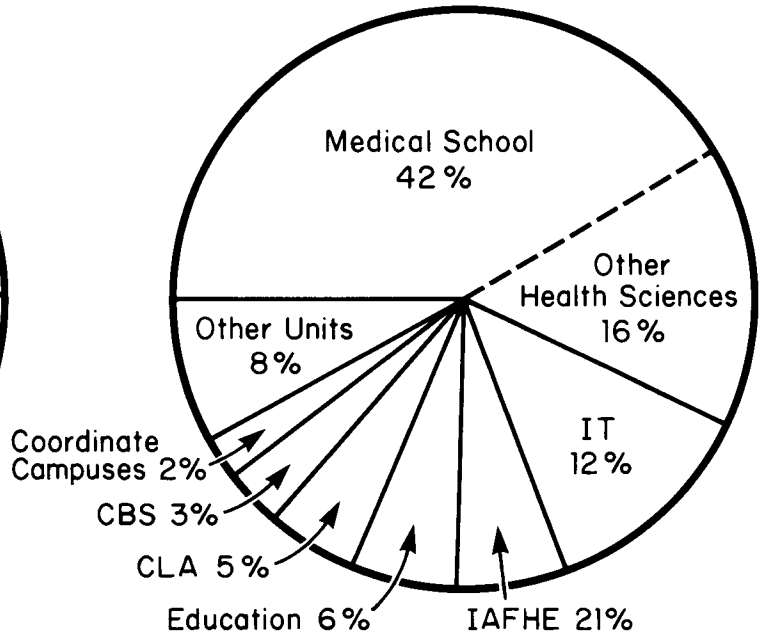
As of 1976, there were 30 graduates who had participated in the program; 20 are in rural practice in Minnesota and 6 are in rural practice in other states. Of 89 RPAP students through 1976, 80% are in primary care residency training. Under RPAP, third-year students practice full-time with rural physicians.

The two pie charts below show, by percentages, the sources of University of Minnesota sponsored program funds and the college units which attract this support. About 58% of all of the University's income for sponsored programs is earned by the health sciences, 42% of it in medicine alone.

Expenditures for Sponsored Programs by Agency



Expenditures for Sponsored Programs by College



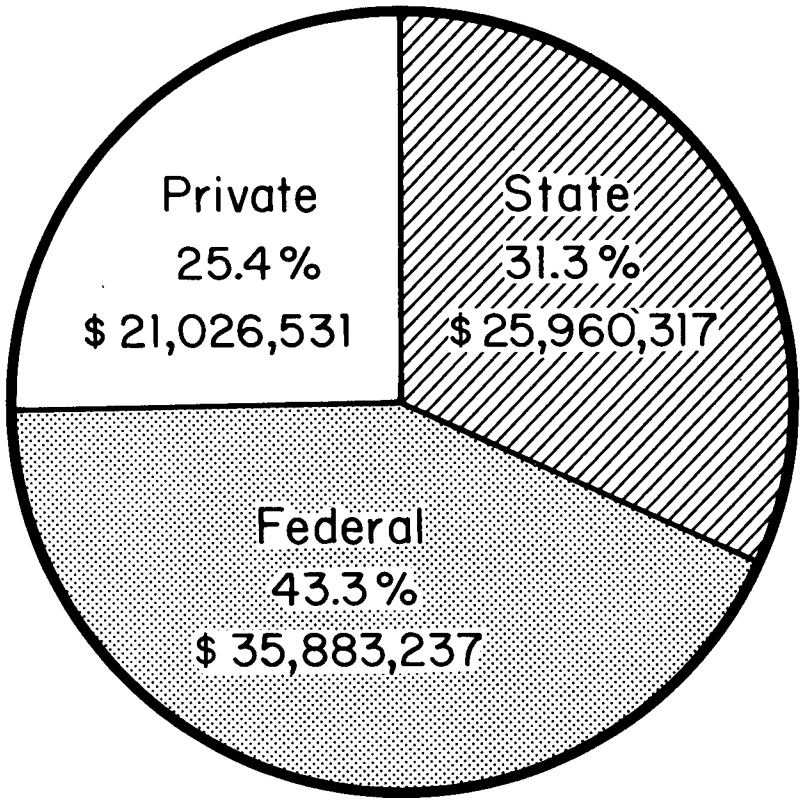
(Figures are for fiscal 1976)

Abbreviation key:

NIH—National Institutes of Health
NSF—National Science Foundation
DHEW—Departments of Health, Education & Welfare
CBS—College of Biological Sciences
CLA—College of Liberal Arts
IT—Institute of Technology
IAFHE—Institute of Agriculture, Forestry and Home Economics.

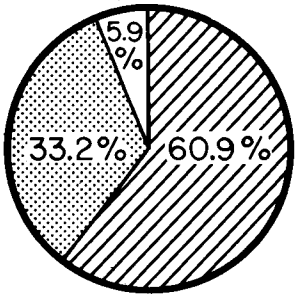
(Continued)

Health Sciences Major Academic Units
$82,870,085

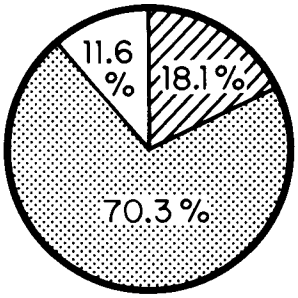


Medical School
Twin Cities Campus
$60,840,280

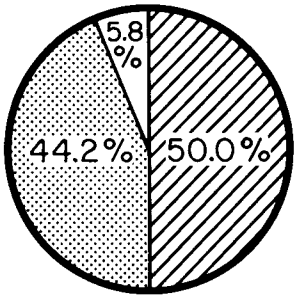
School of
Dentistry
$8,310,759



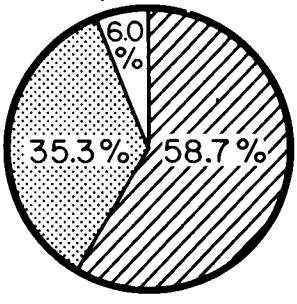
School of
Public Health
$6,837,709



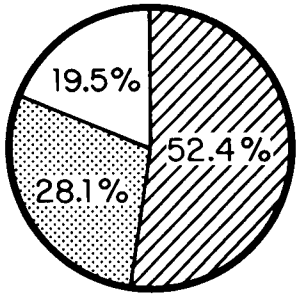
College of
Pharmacy
$2,685,942



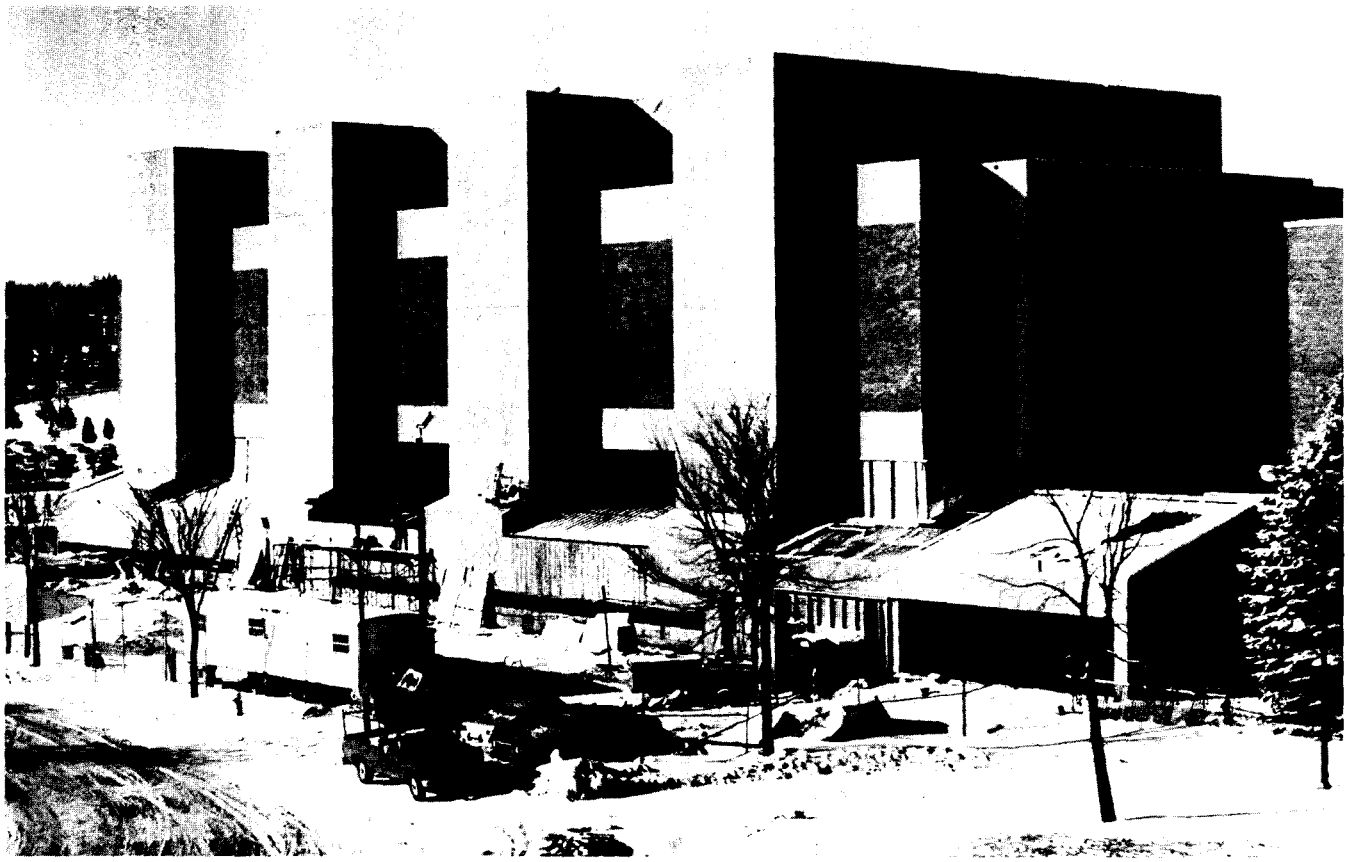
School of
Nursing
$1,726,458



Medical School
Duluth Campus
$2,468,937



(Figures are for fiscal 1976)



The new medical school building on the UMD campus is becoming a reality. Construction is on schedule for completion this summer.

The total budget for University of Minnesota Health Sciences was $82,870,085 for 1976 — $60,840,280 of that was for the Medical School.

The pie charts with shading show the amounts and percentages of federal, state and private support in the overall budget and the same breakdown for the six major academic units.

The primary mission of the Medical School is to provide opportunities and programs in undergraduate and graduate medical education for future physicians and related health professionsals to serve the health care needs of the state and nation, to conduct basic research for the advancement of health care, and to help maintain and develop competence of health professionals in practice.

Gault says that the Medical School has developed a number of features to attain those objectives:

1. Small groups of student learners; tutorials
2. Numerous optional and elective courses
3. Learning Resource Center — self instruction
4. Student involvement in planning, feedback, evaluation
5. Six alternative pathways (tracks) after the second year
6. Optional three-year shortened curriculum
7. Optional 12-month Rural Physician Associate Program
8. Integrated, systemic approach to "core" curriculum in the second year
9. Combined and correlative clinical and basic science instruction
10. Behavioral science knowledge and skills
11. Opportunities for work with practicing physicians.

The same year that Neal Gault became Dean of the Medical School in Minneapolis a brand new UMD School of Medicine opened its doors in Duluth, enrolling 24 students in its first class and, when they became the second-year class, adding 24 more. The two-year medical school has already experienced the dynamics of increasing enrollments. Its class sizes

(Continued)

Dr. John W. LaBree, Dean of UMD School of Medicine.

were first raised to 36 and then to 48. Today UMD has 34 students in its second-year class and 47 in the first-year class. There are two minority students and 17 women. There are 38 full-time salaried faculty members and 8 part-time salaried. There are 130 non-salaried clinical teachers and 65 non-salaried family practice preceptors.

Dr. John W. LaBree, University of Minnesota Medical School class of 1941, is Dean of the UMD School of Medicine. Despite its youth and relatively small size, "his" medical school is also experiencing growing pains. A new medical school building is expected to be ready for occupancy this summer. Some of the warmth and charm of the present location will be sacrificed to occupy the new building. But, also because of the small size, some of the warmth and charm will no doubt make the move.

In Minneapolis, Neal Gault ponders space problems of a different kind — where to get the money to finish the B-C construction which has such a good start on the outside.

Gault has a favorite answer for those who would ask him if the pressure and responsiblity of administering a medical school keeps him awake nights.

"I sleep like a baby," he says. "I sleep for an hour, then I wake up and cry for an hour . . . then I sleep an hour and . . ."

-tp

MEDICAL ALUMNI GROUP SETS 'FALL MEETING' FOR JUNE

In hopes of better weather and a larger turnout, the annual fall meeting of the Minnesota Medical Alumni Society will be held June 17, 1978. This is the first time the group's major annual event will not be held in the fall.

In changing its program to June, the Medical Alumni Society follows the lead of several recent anniversary classes which held successful spring and summer reunions. In another major change, however, the Medical Alumni Society has also done away with its own involvement in organizing and sponsoring reunions for anniversary classes. Instead, the society has planned a one-day Continuing Medical Education (CME) program and will skip the customary evening banquet and dance. Society board members are encouraging quinquennial classes to organize their own reunions, and providing them with the June 17 CME program around which they can plan their own reunion activities.

The society's annual Harold S. Diehl Awards will be presented at a luncheon in conjunction with the CME program, both to be held in Health Sciences Building A at the University.

The three-hour morning session of the CME program will be entitled, "New Imaging Techniques," and will include information on mammography, CAT scans, ultrasonography and nuclear imaging. The two-hour afternoon session will be devoted to the subjects of DNA and chromosome mapping. The fee for the program and luncheon is $25. Alumni who are not members of the Minnesota Medical Alumni Society will be urged to join for an additional $12.50, with the added funds going toward future programs.

Quinquennial classes planning reunions around the June 17 date, or persons interested only in the CME program, are urged to contact Jim Barnum at the Minnesota Alumni Center, 2610 University Avenue, St. Paul, Minn. 55114. Telephone: (612) 373-2466.

BRITISH EXCHANGE PROGRAM GOING JOLLY WELL, THANK YOU

The British are coming. The Minnesotans are going.

For 17 years, a limited number of University of Minnesota medical students and British medical students have been able to change places for three months because of a pet project of Dr. W. Albert Sullivan, associate dean.

Sullivan's interest in a permanent exchange started in 1961, when he worked with a medical fellow at the University of Minnesota, "Mr." J. Alexander Williams of Birmingham, England. ("Call me mister" is the byword of the English surgeon). Sullivan was impressed with Williams and Williams was impressed with medical education at the University of Minnesota. They agreed that some kind of regular exchange of medical students would be a good idea.

Contributions from surgery patients were first used to finance the program. A few years ago, the Minnesota Medical Foundation began annual support of the exchange program. British medical students coming to Minnesota stay at medical fraternities, where room and board is paid by the Foundation. University of Minnesota medical students going to Birmingham, England, Glasgow, Scotland, and Cardiff, Wales, each receive $500 in expense money from the Foundation. An average of four students have gone each direction each year. Participants receive credit for the three-month elective. The medical schools on both sides waive tuition to hold down costs of the program.

A committee of the Medical School selects the Minnesota students who participate. This year there were 18 applicants for three available places. Sullivan tries to have a British influence on the committee by selecting at least one member from faculty or graduate students who had training in Great Britain to serve on the committee.

Sullivan has visited Birmingham and Cardiff for a firsthand look at their medical education programs. He has recently received an inquiry about the program from Manchester.

"Participants have been ecstatic on both sides," Sullivan says. "Students are not only exposed to a different medical school, but to a different country and culture."

At least three Minnesota students who have participated in the program would list another advantage. It's how they met their wives.

—tp

Dear MMF:

As you know, I am presently studying at the University of Glasgow under the British Exchange Program. Thus far it has been an excellent experience. I am working at the Royal Infirmary, a large general hospital on the east side of Glasgow, in Professor McGirr's unit, which is a general medicine ward and a regional endocrinology referral center.

As expected, the consultants are excellent clinicians, a feature that British medicine is particularly known for, as they practice general medicine daily in addition to their subspecialty. I am also seeing a wide range of pathology that I have not previously encountered.

This exchange has also been valuable for the interaction with the medical students here. I find that from one-third to half of them have studied or worked in hospitals in the States or Canada. Also, it is routine that consultants in the University unit receive a part of their postgraduate training in the States or do research there. Funding to do research is very hard to come by under the National Health Service. In all, the practice of medicine at the hospital level is much the same as in Minneapolis-St. Paul.

In addition to medicine, I am finding the Scottish society very interesting. The people have been very warm and friendly toward me. It took a few days to be able to understand English as it is spoken here. There are many different Scottish accents (some Highland communities still speak Gaelic) and some Scots have a difficult time understanding Scots from the other side of town.

I've attended a rugby international, Scotland vs. France, and also had a taste of the pub life, which seems to be a high priority among all of the people here. The lager is excellent and also cheap. The hard thing to become accustomed to is the weather. In January, it rained two out of three days — a damp, penetrating cold rain.

The University of Glasgow has accommodated me well and has given me the option to study what I wish. Thus far it has been an excellent experience and I would recommend it to anyone who has the chance.

I appreciate very much the support of the Minnesota Medical Foundation. Without it, I don't think that I could have afforded to be here.

Thanks again and Cheerio!

Joel Holger
Glasgow Transfer Student

(Left to right) Joel Holger, Mark Johnson and Brad Pazandak, Minnesota's 1978 exports to British medical schools, at a last minute briefing with Dr. Sullivan before their departure.

PARENTS' DAY 2

Mothers and fathers of first-year medical students came from as far away as California, Texas and Massachusetts, and from every corner of the state of Minnesota, to attend the Minnesota Medical Foundation's Second Annual Parents' Day on Nov. 12.

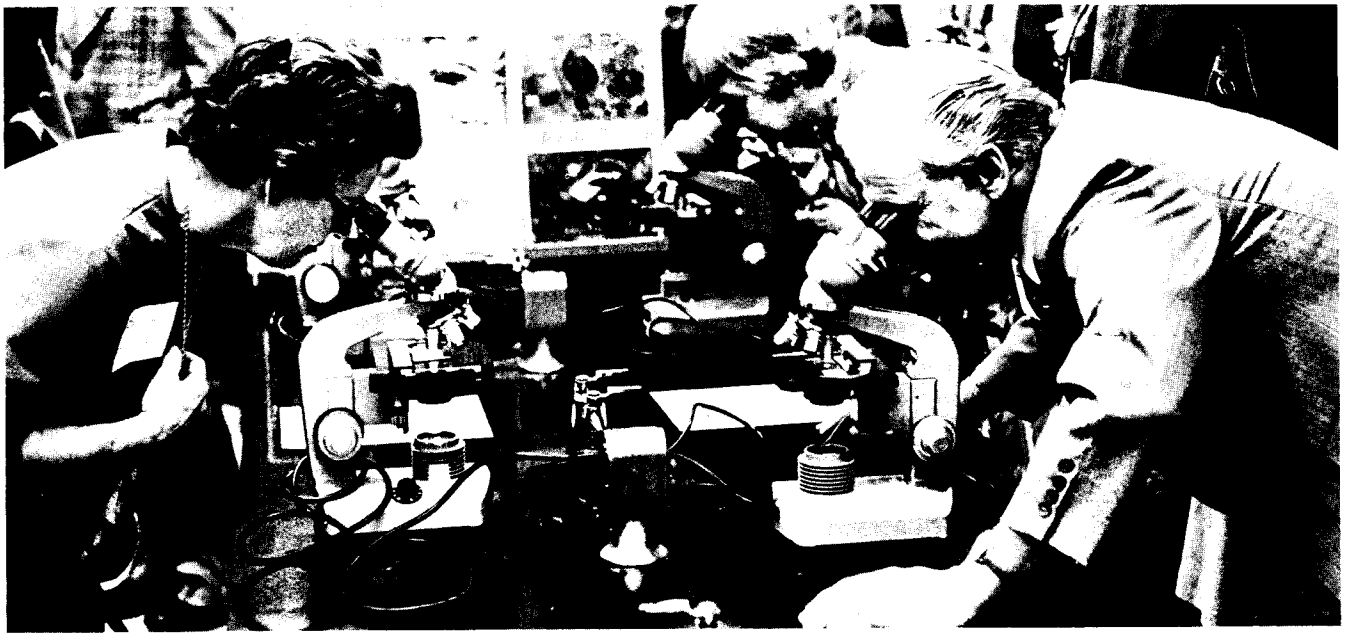
More than 325 parents heard reports from faculty and students and toured the school. Speakers were: Dr. N. L. Gault, Dean; Hildy McCarthy, vice president of the Medical Student Council; Dr. Jack Miller, professor of pharmacology and curriculum coordinator for the first year, and Dr. Galen Hanson, assistant professor of family practice, who talked about typical problems of medical students and how the school deals with them. Dr. Pearl Rosenberg, assistant dean, spoke at lunch on, "The Care and Feeding of the Medical Student." Mrs. Ruth Bean, vice president of the Minnesota Medical Foundation, brought greetings from MMF, the host for the day's events.

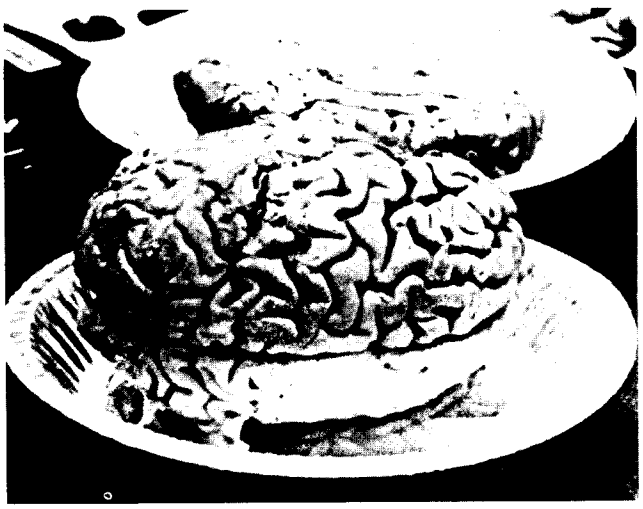
Many first-year medical students were involved in the program, as tour guides and as speakers. President of the class is Catalina Perez-Lacey.

Faculty members who provided mini-anatomy courses and showed off their labs were Gerald Bratt, Anna Mary Carpenter, James Prince and Morris Smithberg.

Dr. Anna Mary Carpenter, left, professor of anatomy, talks with the mother of a medical student.

Hildy McCarthy, vice president of the Medical Student Council.





A closer look at a human brain than they ever hoped for . . .

. . . Or wanted?

MORE PHOTOS ▶

Dr. N. L. Gault, Dean, (right), and Eivind Hoff, executive director of the Minnesota Medical Foundation, (center), answer questions during a break.

Dr. Morris Smithberg gives the parents an abbreviated anatomy lesson.

THIS FACTORY GIVES LIFE

"Bad factories make bad products. If you want to make good products, you need a good factory."

The above would make a pretty sound business maxim, but the subject is health, not business. Dr. John H. Kersey, professor of laboratory medicine/ pathology and pediatrics, likes to use the manufacturing example in describing the University's bone marrow transplant program. The marrow is the "factory" and its product is blood cells.

In the past four years, Kersey and his associates have transplanted new blood cell factories into 35 patients with life-threatening blood diseases. All would have died without the transplants. Thirteen are alive today because their new bone marrow is producing normal, healthy cells. Other doctors participating in this promising new research and patient care program are Peter Coccia, William Krivit, Jeff McCullough, Mark Nesbit and Norma Ramsay.

Kersey says the transplant procedure itself is "beautifully simple." About one and a half pints of marrow is aspirated from the donor's pelvic bone. It is injected in a vein of the recipient and finds its home in his bones. The donor will regenerate the lost marrow within a couple of weeks and should suffer no side effects, except, Kersey says, "feeling for a few days as if he had been kicked by a horse."

In the best of results we see successes like transplant patients Gary Smith and David Stahl. Gary, 13-year-old son of a Minneapolis policeman, was critically ill with aplastic anemia only a few years ago. His sister was donor for the bone marrow transplant he received in February of 1975. Three years later Gary has no sign of disease. He has no infections and no bleeding. He has caught up on all of the school he missed while he was sick and he is an active member of a downhill ski club.

David had Burkett's lymphoma. His brother served as donor for the marrow transplant he received in October, 1975. David is 18 now. He is free of disease and has no complications. He attends vocational-technical school in Willmar, exercises regularly at the local sports center, works in a sporting goods store, and, like Gary, is an enthusiastic skier.

David and Gary represent more than the best of the program's successes. They also represent the two categories of patients who have been transplanted in the University of Minnesota program so far — those with severe aplastic anemia and those with severe forms of leukemia or lymphomas. Of 18 patients with aplastic anemia transplanted, 9 are alive. Of 17 leukemic or lymphoma patients transplanted, 4 are alive. As the results would seem to indicate, the leukemia and lymphoma patients are the more difficult to treat. Kersey explains that all of the leukemic cells must be destroyed with chemotherapy and radiation, which also destroys any healthy blood cells. (Some forms of leukemia are treated very effectively with chemotherapy alone, or combined with radiation. But, even there, the limiting factor for the treatment is toxicity to the bone marrow).

Dr. Kersey (St. Paul Pioneer Press photo).

A major reason for the relatively low number of successes in the leukemic patients is that with only two exceptions the patients were "end-stage" in the course of the disease. The program is now transplanting earlier, Kersey says, with anticipation that the results will be greatly improved, and with preliminary

results bearing that out. (Two of the four survivors were transplanted earlier in the course of the disease.)

Those patients who die after a bone marrow transplant might die of infection, because they are so susceptible during the recovery period. There isn't a problem of immune system rejection of the transplant, as with other types of transplants, since the new marrow effectively gives the recipient a new immune system. But, the opposite can occur, with the new immune system recognizing the host as foreign and attacking it. This graft-versus-host disease doesn't always happen, as in the many successes, and the new immune system seems to know it is outnumbered and tolerates the host.

Because bone marrow transplants give the recipient a new immune system, they can be used to treat some immune deficiency diseases. Kersey sees several other possibilities for the technique. Since chemotherapy must sometimes be stopped short of destroying a tumor because of toxicity to the bone marrow, Kersey suggests that the patient's bone marrow could be removed before chemotherapy, permitting a better attack on the tumor, and then be replaced. It is already known that bone marrow can be safely stored in liquid nitrogen for at least a year.

It is also possible that a person receiving another organ transplant could be given some of the donor's bone marrow as well, thus providing an immune system that will accept the transplanted organ and likely tolerate the rest of the body as its host.

The University of Minnesota's bone marrow transplant center is one of five major ones in the United States. It began only a few years ago with a $17,000 start-up grant from the Minnesota Medical Foundation. Today the program supports itself with federal grants and patient fees, the latter being provided primarily by third party carriers. But the research must continue. Greater financial support is needed for further development and research.

The future of the bone marrow transplant program can only improve on the past. And the past has been impressive. We know a couple of young skiers who will attest to that.

David Stahl.

Gary Smith and his sister.

EVENTS SCHEDULED FOR 40TH & 50TH REUNION CLASSES

The Minnesota Medical Foundation will host luncheons and programs for medical graduates (M.B.) of the classes of 1928 and 1938, in conjunction with all-school 40th and 50th reunions scheduled by the University of Minnesota Alumni Association.

University of Minnesota alumni, from any division's graduating classes of 1928 and 1938, will be honored by the University on Saturday, May 20 ('38 class) and Monday, June 5 ('28 class).

The University's program for '38 graduates will include a lunch, an afternoon program, and a banquet as part of the University of Minnesota Alumni Association Annual Meeting. The University's class of 1928 program includes a lunch, a bus tour, University President's Reception, and a dinner. Program details will be mailed soon, or send for information in care of the University of Minnesota Alumni Association, 2610 University Avenue, St. Paul, Minn. 55114.

The Minnesota Medical Foundation will host special events for '28 and '38 medical graduates the day after the University's class of '28 program and the day before the University's class of '38 program. On Friday, May 19, MMF will host '38 medical alumni at a lunch with a program and conduct a tour of the new Health Sciences Center. On Tuesday, June 6, MMF will host '28 medical alumni at a similar program. There will be no charges for the MMF program. Interested alumni should contact Dave Teslow, Minnesota Medical Foundation, 5412 Powell Hall, University of Minnesota, Minneapolis, Minn. 55455.

PROGRAMS ON AGING

Human Aging III is a conference sponsored by the professional schools of the Health Sciences of the University of Minnesota, April 7–8, 1978. The conference will be held in Mayo Auditorium.

Three major themes to be discussed are: trends and issues in public policy on aging, environment-aging relationships, and biological and physiological factors of aging. Each area will be introduced by a nationally-recognized leader in the subject: Robert H. Binstock of Harvard University on public policy; Robert A. Aldrich of the University of Colorado on environment; Harold C. Slavkin of the University of California and Donald M. Watkin of HEW on biology and physiology. Other topics presented are the effects of public policy on the health professions, the effect of sensory deprivation on human function, reality orientation, sensory deficits and the immunologic system in aging.

The registration fee of $30 is waived for University of Minnesota faculty and students. For registration information contact the Office of Continuing Medical Education, Box 293 Mayo Memorial Building, University of Minnesota, Minneapolis, Minn. 55455.

Frontiers in Aging: Life Extension is a multidisciplinary conference sponsored by the All-University Center on Aging. The conference will be held at the Radisson Hotel in St. Paul which is offering special room rates to conference participants. The conference will be held April 27–28. Sessions focus on such questions as: possibilities for prolonging physical and mental health; social, biological and cultural factors affecting longevity; ethical implications for increased longevity; quality of life considerations in life extension; and how increased lifespan might alter social, political and economic institutions. Conference participants are: Floyd K. Garetz of the University of Minnesota, Robert Butler of the National Institute of Aging, W. Donald Denckla of Harvard, Robert E. Kennedy of the University of Minnesota, Sula Benet of Hunter College, David Hackett Fischer of Brandeis University, Richard G. Cutler of the National Institute on Aging, Robert Veatch of the Institute of Society, Ethics and the Life Sciences, Hastings on Hudson, New York, Herbert Gerjuoy of the Futures Group, Glastonbury, Conn., Jerome Eckstein of the State University of New York Department of Judaic Studies, John L. McKnight of Northwestern University and Tom McDonald, member of the U.S. House of Representatives Select Committee on Aging. Research reports will also be presented by 10 University of Minnesota faculty members: Thomas P. Anderson, Henry W. Blackburn, A. Saari Csallany, Leonard L. Heston, B. J. Kennedy, Robert G. McKinnell, John P. Brantner, Robert Fulton, John E. O'Brien and Henriette E. Saloshin.

For program or registration information, contact David Chittenden, program chairman, 219 Nolte Center, University of Minnesota, Minneapolis 55455 or phone (612) 376-2578.

SPRING & SUMMER CME

In addition to Human Aging III, the following continuing medical education programs have been scheduled for spring and summer:

Cardiopulmonary Diseases, March 30-April 1, Coffman Memorial Union Theatre, University of Minnesota, $120.

Cardiovascular Disease; Conference with Clinical Preceptorship, April 13–15, St. Paul-Ramsey Medical Center, Gillette wing, St. Paul, $300. The program is in two parts. Part 1 is a three-day lecture and demonstration course held April 13–15. Part 2 is a five-day preceptorship on the cardiology service at St. Paul-Ramsey. Part 2 is scheduled on an individual basis with program participants. Both parts must be taken to enroll.

Current Concepts in Retinal Disease, April 17–18, IDS Center Conference Theatre, downtown Minneapolis, $145.

Current Concepts in Perinatal Medicine, April 20–21, St. Paul-Ramsey Medical Center, St. Paul. The first day considers high-risk obstetrics and reviews common obstetrical problems. The second day is devoted to problems of newborn management in the community hospital setting. $95.

Common Colorectal Problems, May 5–6, Sheraton Ritz Hotel, Minneapolis, a practical approach to resolving the most commonly encountered anal, rectal and colonic problems, presented under direction of Dr. Carl E. Christenson, $85.

Practical Dermatology in Primary Care, May 18–20, Mayo Auditorium, University of Minnesota, $140.

Current Concepts in Radiation Therapy, May 24–26, Coffman Union Theatre, University of Minnesota, major emphasis is on cancer of the pelvic region, $200.

Recent Advances in Laboratory Hematology and Hematopathology, May 24–26, Health Sciences Unit A, University of Minnesota, Minneapolis, emphasis on the use of cytochemistry, immunology, cytogenetics and lymphocyte membrane surface marker studies in the diagnosis of hematopoietic disorders, $250.

Gastrointestinal Surgery, June 14–17, West Bank Auditorium, University of Minnesota, Minneapolis, presented as the 42nd annual continuation course of the Department of Surgery, $250.

For further information on any of these CME programs, contact:

Continuing Medical Education
University of Minnesota
Box 293 Mayo Memorial Building
420 Delaware St. S.E.
Minneapolis, Minn. 55455
(612) 373-8012

MEDICLINICS HONORS DON HASTINGS

Donald W. Hastings, who died unexpectedly of a heart attack Sept. 4, 1977, at age 61, was honored with a memorial lecture at the Annual Mediclinics Refresher Course in Florida March 13. The Don Hastings Memorial Lecture was presented by Dr. Howard P. Rome, emeritus professor of psychiatry at the Mayo Clinic. Dr. Hastings was one of the founders of Mediclinics and a long-time participant in its annual meetings.

Dr. Hastings was born in Madison, Wis., in 1910 and received his undergraduate education and his medical degree from the University of Wisconsin. He served as chief psychiatrist for the famed Eighth Air Force during World War II and joined the University of Minnesota as professor and head of the department of psychiatry in 1946. He created an academic psychiatry program at the University of Minnesota and was organizer of a change-of-sex program begun at the University in 1966. The sex change program received wide attention when 29 transsexuals received male-into-female operations at the University in a three-year period.

Among many honors and positions held by Dr. Hastings were: membership in the National Research Council, consultant to the Surgeon General of the United States Air Force, and consultant to the Advisory Council on Medical Sciences of the Department of Defense.

He is survived by his wife, Jane, and their children, Don Jr., Mary, and Jane Hastings Silver.

Dr. Hastings.

ALUMNI DEATHS

David D. Allison — 1950

Died Jan. 8 at age 52. The Litchfield, Minn., physician was on his way to church after making hospital rounds when he suffered a heart attack. He was born in Brainerd, Minn., April 16, 1925, and married Georgia Sanford there in 1946. He began his practice in Litchfield in 1951. His wife Georgia and their six children survive him.

Theodore Q. Benson — 1929

Died Oct. 24, 1977. He practiced in Grand Forks, N.D.

Rolland A. Bock — 1908

Died Nov. 29, 1977, at age 98. After retirement as a general practitioner, he began work with the Red Cross and continued with that organization well into his nineties. He lived in St. Paul.

Albert Boles — 1917

Died Aug. 20, 1977, in Oakland, Calif. He was captain of the 1914 Minnesota Gopher football team and coached football at Minnesota, the U.S. Naval Academy and the University of California at Berkeley. He practiced medicine in Oakland from 1919 to 1973. He was honored as the San Francisco area "Minnesota Alumnus of the Year" in 1960.

Ruth E. Boynton — 1920

Died Dec. 21, 1977, in Miami, where she made her retirement home. She was selected by the Minnesota Medical Alumni Society for a Harold S. Diehl Award in 1977 but did not attend award ceremonies because of ill health. Her Diehl Award certificate has been placed in the Boynton Health Service Building, the student health service at the University of Minnesota. The building was renamed in her honor in May of 1975. Dr. Boynton became director of the University's Health Service in 1936 and retired in 1961. Under her leadership virtually all of the stated purposes of the health service were fully developed and refined. She was born in LaCrosse, Wis., in 1896. She was named assistant director of the student health service not long after graduating from the Medical School. From 1922 to 1927, she was

Dr. Boynton.

first instructor and then assistant professor of preventive medicine and public health at the University of Minnesota. She received a master's degree in public health in 1927 and accepted a position as assistant professor of medicine and chief medical advisor for women at the University of Chicago. Four years later she returned to Minnesota. For three years, during World War II, she served as acting director of the University of Minnesota's School of Public Health. At the student health service she conducted special studies of tuberculosis, including studies of infection rates among student nurses. She found that student nurses whose training was limited to general hospitals without special tuberculosis services had a tuberculosis infection rate 100 times that of students in the College of Education. She was president of the Minnesota State Board of Health in 1945 and served as a member until her retirement from the University. She became a member of the American Student Health Association, later called the American College Health Association, at its beginning and was its secretary from 1935 to 1940 and its president from 1940 to 1941.

John A. Cowan — 1931

Died June 30, 1977. He received a master's degree in public health from the University of Minnesota in 1940. He practiced in East Lansing, Mich.

Solomon D. David — 1916

Died Dec. 1, 1977, at age 89. He practiced and died in Houston, Texas. He was a Fellow of the American Academy of Orthopedic Surgeons and was a founder of his county orthopedic society. He established a David family foundation for charitable giving and also founded the Endowment Foundation for Worthy and Needy Students at Macalester College in St. Paul, his undergraduate alma mater. He was author of four volumes of Arabic Poetry, as well as many articles on orthopedic surgery.

William W. Hall — 1918

Died Jan. 6 in San Diego. He was 85. Dr. Hall was the first pathologist assigned to the Balboa Naval Hospital. His early success with tetanus immunization aboard a hospital ship in 1934 resulted in routine immunizations for tetanus being started at the Naval Academy in 1938. His efforts were reportedly directly responsible for the total elimination of tetanus in Navy and Marine casualties during World War II. He contributed significant research into the effects of black widow spider venom. After retiring from the Navy in 1949, he worked for 15 years as a pathologist at Mercy Hospital in Bakersfield before moving back to San Diego in 1964. He was a Diplomate of the American Board of Pathology and the American Board of Internal Medicine. He was a Fellow of the College of American Pathologists and a member of the American College of Physicians and the American Society of Clinical Pathologists.

Anderson Hilding — 1919

Died Dec. 5, 1977, in Duluth, Minn. He was 85. A specialist in eye, ear, nose and throat disease, he reportedly did much of the basic research establishing the fundamental functions of the nose, sinuses and lungs.

Gerhard E. Knutson — 1939

Died in St. Paul Feb. 9 at age 70. He had been a hemiplegic since suffering

Dr. Gerhard Knutson.

a stroke in 1975. He graduated from Luther College, Decorah, Iowa, and taught high school music and Latin for five years before returning to college at St. Olaf. After graduating from Medical School, he studied pediatrics at McGill University in Montreal. He served as medical officer and head of the pediatrics department at Oak Ridge Tennessee during the war. After his discharge in 1946, he entered practice in St. Paul with Drs. Vernon D. E. Smith, Malcolm Pearson and Herman Wolff, where he remained until his illness. He married Margaret Johnson of Mankato in 1938, and she and their five children survive him. Their son David W. Knutson is a 1967 graduate of the University of Minnesota Medical School and is now instructing and doing research in nephrology at Wordsworth and the University of California, Los Angeles. Their son Gerhard W. is a doctor of mathematics with his own company, Industrial Health Engineering Associates of Hopkins, Minn. Their son James is a dentist in Mora, Minn. Their daughter Mary Brabeck is an instructor in educational psychology in Rhode Island. Their daughter Karin Grosscup is a clinical nurse specialist at Hennepin County Day Treatment Center.

Kenneth R. Larson — 1943

Died Jan. 4 in Scottsdale, Ariz. He was in the general practice of medicine in the Lowry Medical Arts Building in St. Paul for over 20 years and was on the staffs of St. Luke's, St. Joseph's, St. John's, Riverview and Children's hospitals. He was well known for his accomplishments in the treatment of alcoholism, diseases of the aging, and endocrine disorders. In 1965 he joined the staff of the Moose Lake State Hospital where he worked primarily in geriatrics. He retired in August of 1976 and moved to Scottsdale. He was the recipient of numerous awards and honors, including citations from the President of the United States, the Governor of Minnesota, the Mayor of St. Paul, the American Red Cross, Alcoholics Anonymous groups and the Calix Society, an organization of Catholic recovered alcoholics which made Dr. Larson its first non-Catholic non-alcoholic member. Dr. Larson was founder and president of American Geriatrics Enterprises, Inc., a company established to give employment to men who were unable to obtain employment due to their age. He was a member of the American Academy of Family Practice, the American Association for the Advancement of Science, the American Geriatrics Society, the American Psychiatric Association, the American Society of Clinical Hypnosis, the Endocrine Society of America, a charter member of the Minnesota Academy of Family Practice, a member of the Minnesota Governor's Committee on Aging and the Governor's Citizen Council on Alcoholism, and many other local, state and national medical and community service organizations. He is survived by his wife, Ella Wilcox Larson, their son Leland L. of St. Paul and three grandchildren.

Lawrence M. Larson — 1927

Died Feb. 13 at age 74. He was an active staff member of Northwestern Hospital in Minneapolis for 52 years and was a clinical professor of surgery for the University of Minnesota Medical School. He is survived by his wife Phyllis and sons Dr. Richard E. of Edina, Dr. Stephen L. of Excelsior, Dr. David E. of Alexandria, and Philip P. of Wheaton, Ill.

LeRoy J. Larson — 1920

Died recently at Bagley, Minn. He practiced medicine in Clearwater County, Minnesota for 57 years. Minneapolis Tribune columnist Robert T. Smith recently wrote that Dr. Larson delivered at least 4,000 babies in the county and handled everything from measles to heart attacks. Smith also reported that Dr. Larson died "with more than $100,000 due him in fees. He never was much good at collecting bills."

Stanley W. Lundblad — 1936

Died in February at age 65. He practiced and retired in Minneapolis.

Kenneth P. Malvey — 1933

Died recently at age 73. He was associated with the Boynton Health Service at the University of Minnesota.

Howard Mahorner — 1928 (M.S.)

Died Oct. 27, 1977.

William T. Miller — 1946

Died in Feburary in Minneapolis. He was in general practice in West St. Paul for several years and was recently associated with the VA Hospital in Minneapolis.

Earl Opstad — 1946

Died Dec. 25, 1977, of cancer after an illness of about one year. He was an internist at St. Louis Park (Minn.) Medical Center and former assistant medical director of Northwestern National Life Insurance Company.

Robert B. Radl — 1924

Died Feb. 13, 1977, at Aptas, Calif., where he had been retired for a number of years. He was 75. He was reportedly the first certified specialist in internal medicine to practice in North Dakota. He was a Fellow of the American College of Physicians and of the American College of Allergists. He was the state medical officer for the Selective Service program in North Dakota, and later for Minnesota. He left North Dakota in 1959 for California, where he was medical director for the state department of employment disability insurance in Sacramento. He retired in 1970. His wife Louise survives him.

William R. L. Reinhardt — 1921

Died April 11, 1977.

Walter C. Stillwell — 1922

Died Jan. 14, 1977. He practiced in Mankato, Minn.

Clarence F. Wohlrabe — 1924

Died Feb. 17, 1977. He practiced medicine in Mankato, Minn., beginning in 1939, and in Springfield and Minneapolis prior to that.

TWO ADVICE COLUMNISTS AGREE ON IMPORTANCE OF WILLS

Nationally syndicated advice columnist Ann Landers said in a recent column, "The way to make certain your money and possessions will go where you want them to go is to draw up a will with the assistance of a lawyer. Be aware that changes made at a later date must be witnessed in accordance with the laws of your state. Most states require two witnesses, some three. Without the signatures of the witnesses, the changes will not be considered valid."

In her nationally-syndicated financial column, Sylvia Porter recently told about a widow who divided her husband's estate with a niece of her husband whom he disliked and had not seen in years. The niece got $10,000 because the state's law was that, in the absence of a will, the spouse of a person who dies without descendants shares the estate with any brother, sister, nephew or niece of the deceased.

Ms. Porter listed the following reasons for having a will, as suggested by the Research Institute of America:

- To dispose of your belongings to those whom you wish, in the proportions that you choose and to provide for your loved ones in the best possible way.
- To let all interested relatives and friends know your wishes.
- To make it easier for the recipients to obtain and use what you left and to avoid fights and irritations.
- To reveal aspects of your financial affairs that may be unknown to anyone else.
- To ease the task of whoever is going to take care of minor children and influence the choice of any guardian.
- To avoid the "bottomless pitfalls" of dying intestate, which means your property will be distributed according to the laws of your state, you may forfeit important tax advantages, your close relatives will share in the estate but probably not in the proportions you would have wanted, and you might actually penalize your loved ones.

The Minnesota Medical Foundation adds to this the suggestion that charitable contributions can be handled quite easily through your will — but charity will receive no part of your estate if you die without a will. We hope that you will remember your Medical School through a bequest to the Minnesota Medical Foundation.

Seven out of every ten Americans who die, do so without having drawn a will. Don't let it happen to you.

☐☐☐☐☐☐☐☐ REQUEST FOR FURTHER INFORMATION ☐☐☐☐☐☐☐☐ ON ESTATE PLANNING

MAIL TO: David R. Teslow, Development Officer
Minnesota Medical Foundation
5412 Powell Hall
University of Minnesota Medical School
Minneapolis, Mn. 55455 (612) 373-8023

☐ Please send information on including MMF in my will.
☐ Please send booklet on PLANNING YOUR RETIREMENT
☐ Please send booklet on PLANNING YOUR ESTATE AFTER TAX REFORM.
☐ Please send booklet on UNDERSTANDING TAX REFORM.
☐ Please send booklet on TRUSTS FOR FAMILY AND SOCIETY.
☐ Please send booklet on BEQUESTS.
☐ Without obligation to me, please call to arrange to visit me at my convenience.

Name Dr. Mr. Mrs. Miss _____ Telephone _____

Address _____

_____
(City) (State) (Zip)

Birthdate _____ Gift Amount (optional) $_____

(Please note questions on an attached sheet of paper)

Page 285 — Sarah Davidson Wangensteen, Owen's wife, is a Phi Beta Kappa graduate of Vassar, and is indeed senior medical historian for the University of Minnesota, but she is not a physician.

Page 296 — Add WOLTJEN, M. J., '49, 17 Green Bay Circle, Abilene, TX 79602.

Page 300 — Evertt R. Youngren is deceased.

Page 334 — We can't explain how Rochester came to be listed as a country, with E. J. Faber listed as the only Minnesota graduate in practice.

Page 339 — There were two Hartigs in the class of 1914, Hugo and Hermina, husband and wife. They are both deceased.

Page 356 — Needless to say, perhaps, but the class of "195" does not exist. **Michael M. Chmel,** who is listed with that non-existent class, was omitted from the 1975 class list, his correct class. Dr. Chmel does appear in the alphabetical section on page 46, correctly listed as a 1975 graduate.

Page 366 — The entire class of 1977 is listed on pages xiv and xv.

MEDICAL ALUMNI DIRECTORY

ADDITIONS, CORRECTIONS, UPDATES

The first University of Minnesota Medical Alumni Directory in 10 years was published in 1977 by College & University Press, Falls Church, Virginia, under the auspices of the Minnesota Medical Foundation, the University of Minnesota Medical School and the Minnesota Medical Alumni Society. Well over 2,000 of the directories have been sold directly to medical alumni by College & University Press. None of the Minnesota medical affiliates mentioned derives any income from the sale of directories.

Since the directories were released late in 1977, a number of errors have been discovered by the Minnesota Medical Foundation, medical faculty and alumni. The following is the first of what we expect will be many efforts by the **Medical Bulletin** to occasionally update the Directory and point out errors which have been called to our attention. The Minnesota Medical Foundation invites readers of the Bulletin to write concerning other errors in the Alumni Directory. The 1977 Medical Alumni Directory was published in limited quantity based on advance orders. Although the supply is limited, a few copies are still available to alumni who wish to directly contact College & University Press, 803 West Broad, Falls Church, Virginia 22046.

These corrections and updates of the Medical Alumni Directory can be cut from the **Medical Bulletin** and placed inside your directory. Each notation includes the directory page number on which the addition, deletion or alteration should be made, for those who wish to write notes in the directory itself.

Page xi — Charles G. Sheppard received a Harold S. Diehl Award in 1963.

Page xiii — "Sam Foster" in list of recipients of University of Minnesota Outstanding Achievement Awards is Sam Foster **Seeley.**

Page xx — Identifications under photos of Medical School Dean N. L. Gault, and immediate past Dean Robert B. Howard were reversed. A corrected "overlay" was mailed to owners of the Alumni Directory by the publisher. This overlay can simply be placed over the present photos to correct the error. If you own a directory and did not receive the overlay, write to the Minnesota Medical Foundation, 5412 Powell Hall, University of Minnesota, Minneapolis, Minn. 55455 and a corrective overlay will be mailed to you free of charge.

Page 2 — Madeline S. Adcock is deceased.
Page 4 — David D. Allison is deceased.
Page 5 — Albert E. Amundsen is deceased.
Page 12 — J. Richards Aurelius is deceased.
Page 16 — Add BARNET, E. G., '29, ENT, allergy and headache. 550 W. Thomas Rd., Suite 2230, Phoenix, AR 85013, 602 264-7957
Page 21 — Theodore Q. Benson is deceased.
Page 24 — Alfred N. Bessesen is deceased.
Page 26 — Add BIRKEY, Thomas G., '61, 513 N. 9th St., Montevideo, MN 56265.
Page 30 — Earl N. Bossingham is deceased.
Page 31 — Ruth E. Boynton is deceased.
Add BOYSEN, Alexander M., '48, Ret. Army Col., Rt. 6, Box 191, Bemidji, MN 56601.
Page 41 — Wayne W. Canfield is deceased.
Page 42 — Add CARLSON, Hjalmar E., '29, 525 Penn Park Medical Center, 2929 Baltimore, Kansas City, MO 64108.
Page 49 — Woodard L. Colby is deceased.
Page 52 — Albert D. Corniea is deceased.
Page 53 — John A. Cowan and John Patrick Craven are deceased.
Page 57 — Solomon D. David is deceased.
Page 59 — James E. DeMeules, '64, is an *associate* professor.
Page 68 — S. Paul Ehrlich Jr. is deceased.
Page 77 — D. O. Ferris is deceased.
Page 83 — Add FRENCH, Lyle A., '39, neurosurgery, vice president of health sciences, University of Minnesota, 612 373-7610 and 373-7615, res. 85 Otis Lane, St. Paul, MN 55104, 612 644-7115.
Page 90 — Milton J. Geyman is deceased.
Page 102 — Frederick C. Hadden is deceased.
Page 104 — William A. Hall is deceased.
Add HALD, Chris, '51, general practice, Box 127, Ashland, OR 97520.
Page 108 — Harry P. Harper and William F. Hartfiel are deceased.
Page 111 — Martin C. Havel is deceased.
Page 112 — Philip C. Hedenstrom is deceased.
Page 115 — Erling G. Hestenes is deceased.
Page 116 — A. C. Hilding is deceased.
Page 126 — Edward A. Jackson is deceased.
Page 145 — Gerhard E. Knutson is deceased.
Page 154 — Kenneth R. Larson, Lawrence M. Larson and Leroy J. Larson are deceased.
Page 170 — Howard R. Mahorner is deceased.
Page 178 — Frank F. McKean is deceased.
Page 199 — Carl E. Norberg is deceased.
Page 200 — Add NWOKEUKU, Albert A., '58, 85/87 Okigwe Rd., Owerri, Imo State, Nigeria. Director of Ellison Hospital.
Page 201 — Add NYDAHL, Bruce C., '60, internal medicine, Southdale Internal Medicine, P. A., Minneapolis, MN 55435, 612 920-2696.
Audrey B. Nydahl is not a physician.
Page 202 — Michael David Okada is deceased.
Page 205 — Earl T. Opstad is deceased.
Page 211 — Fritz R. Pearson is deceased.
Page 214 — Add PETERSON, Edward Nohl II, '54, 616 Glengary Dr., Pittsburgh, PA 15215.
Page 223 — Add RASMUSSEN, Ruth Campbell. She is listed on page 41 under Campbell, but does not practice under that name.
NOTE: Most women graduates are listed in the directory under their married names. Those who practice under their maiden name should write or call the Minnesota Medical Foundation, 5412 Powell Hall, University of Minnesota, Minneapolis, MN 55455, 612 373-8023, to alert the Foundation to the incorrect listing.
Page 225 — William R. L. Reinhardt is deceased.
Page 229 — Otto F. Ringle is deceased.
Roger J. Ripple Jr. is not a physician.
Page 231 — Arthur B. Roehlke is deceased.
Page 232 — Lucy Balian Rorke is a nueropathologist.
Page 237 — Add SAINE, Brian, '67, The South Bend clinic, 211 Eddy, South Bend, IN 46617, res. 1842 Southernview Dr., South Bend 46614.
Page 249 — David A. Sher is deceased.
Page 256 — Olaf Ivar Sohlberg is deceased.
Page 260 — Raymond J. Spurzem is deceased.
Add STAVIG, Paul H., '49, obstetrics, 1119 Cottonwood St., Woodland, CA.
Page 270 — Add TANI, George T., '50, ophthalmology, 810 Belmont Lane, St. Paul, MN 55117.
Page 273 — Jon R. Thorshov is deceased.
Page 279 — Robert H. Vadheim is deceased.
Frederick H. Van Bergen is professor and chairman of the University of Minnesota's department of anesthesiology.
Page 281 — A. Verbrugghen, '22, is in neurological surgery, not neurology.
Page 285 — Owen H. Wangensteen, one of Minnesota's best known surgeons, is listed as a general practitioner.

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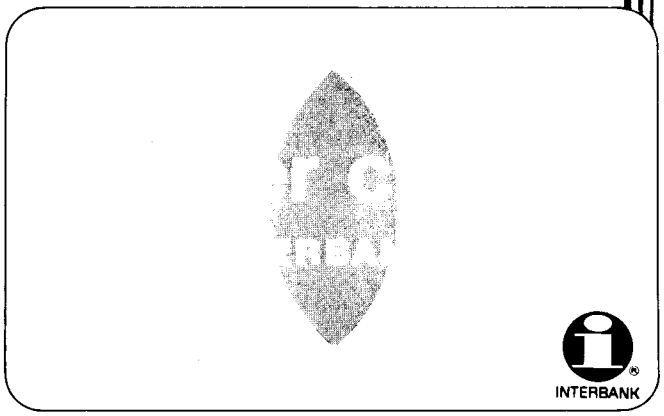

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Minneapolis, Minn. 55455

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PARENTS' DAY 2 . . . MORE PICTURES INSIDE

UNIVERSITY OF MINNESOTA

Office of the President
202 Morrill Hall
100 Church Street S.E.
Minneapolis, Minnesota 55455

May 23, 1978

Professor Betty Robinett, Chairman
University Senate Consultative Committee
154 Klaeber Court

Dear Betty:

You will recall that last fall I felt compelled to address certain salary issues affecting two of the University's coordinate campuses at Duluth and Morris. In part, this was in response to a judgment of mine that, in addition to dealing with a salary equalization rider that the Legislature enacted in the 1977 Session, it was desirable to improve the competitive position of Duluth and Morris. However, I shared the view of the Consultative Committee and others in the University community that legislative intervention in salary matters is a very dangerous and ultimately self-defeating precedent, and I have clearly communicated this view to individuals who chair the money committees in the State Legislature.

In any event, I made some salary decisions with regard to equity funds undistributed from the 1977 appropriation which were subject to some controversy on the Twin Cities Campus. In addition, I clearly signaled to the Consultative Committee and others my judgment that a long-standing problem involving faculty salaries within the College of Agriculture would have to be addressed with a portion of the salary money available to the University for distribution in 1978/79.

To complete this process, and to resolve this long-standing equity problem involving the College of Agriculture, I have directed, as I previously indicated that I would, that $180,000 from the equity and special merit money for 1978/79 be made available to the College of Agriculture. This equity money will be supplemented by funds that have been internally reallocated within the College of Agriculture, the Agricultural Experiment Station, and the Agricultural Extension Service.

One piece of unfinished business remains. The Technical Colleges at Crookston and Waseca are part of the equalization rider enacted by the 1977 Legislature, and I must present a report to the Legislature by January, 1979 with regard to all four of the coordinate campuses. On the basis of the data we have generated, it does not appear as if there

is a case for salary equalization involving Crookston and Waseca. For the record, I want to state emphatically that while I believe in the concept of equity, which is admittedly hard to define, I do not and have never believed that equalization of salaries among diverse faculty groups is a desirable objective. However, those two campuses undoubtedly have individuals who would qualify for special merit salary increases, and we should take this into account as we turn to the next subject.

I would hope that we could put behind us some of the controversy generated, especially by the coordinate campus equalization rider issue, and work constructively on distributing a considerable sum of special merit faculty salary money that is available to us. About a year or so ago, the University Senate Consultative Committee suggested that a portion of money should be reserved for especially meritorious units. This idea seemed very good to me and my associates in the Central Administration, and we endorsed it in principle. We do have left over $125,000 from the 1977/78 salary distribution money for this purpose. In addition, we have available $325,000 from the 1978/79 salary distribution money. In other words, we have approximately $450,000 available for special merit.

I now seek the advice of the University Senate Consultative Committee on the distribution of this special merit money, and I am also seeking advice from the Council of Academic Officers (CAO). I have no plan for the use of this money, and genuinely invite your assistance in developing criteria for its distribution.

Specifically, I would value your advice on these points:

1. What criteria should be used by the Central Administration in distributing this special merit money?

2. Can you assist us in developing a workable definition of "merit" in the context of distributing money to units and individuals who are deemed to be especially meritorious?

These questions should be looked at in the context of the total University of Minnesota system, of course. Also, I would suggest one principle for your consideration: The money should not be distributed too broadly, creating a situation where a relatively large number of faculty receive a tiny amount of money. Instead, it seems to me that some principle should be established such as, for example, that every faculty member who receives a special merit award should receive a sum of no less than $1,000. As you know, this is the sum of money we use in giving the Morse-Amoco teaching award winners a financial recognition; naturally, this salary increase money would be permanently added to the faculty member's salary.

I will also, as indicated, be seeking the advice of the Council of Academic Officers and appointing a committee of deans to be chaired by Dean Frank Sorauf of the College of Liberal Arts to advise me on these questions. After receiving your recommendation and that of the CAO committee, the Administration will develop a specific plan distributing the special merit money. I would propose to review the specific plan that we develop on the basis of advice from the Consultative Committee and CAO with the two groups.

In order that the special merit money can be distributed during the current calendar year, it would be particularly helpful if I could have your Committee's recommendations by no later than October 1, 1978. The Administration will be more than willing to assist the Committee in presenting any information or data you might wish to have. Finally, I am ready to meet with you and the Committee to discuss this matter at any time. I sincerely hope we can work together constructively on this sensitive but significant matter in a truly consultative fashion.

Cordially,

Peter

C. Peter Magrath
President

CPM:nw

cc: Professor Mahmood Zaidi, Vice Chairman, University Senate Consultative Committee
University Vice Presidents