Academic
Health Center

Minutes*

Faculty Assembly Steering Committee
Thursday, January 14, 1999
11:00 – 1:30
Room 626 Campus Club

Present:	Sara Evans (chair), Kent Bales, Linda Brady, Stephen Gudeman, David Hamilton, M. Janice Hogan, Leonard Kuhi, Fred Morrison, Matthew Tirrell
Absent:	Mary Dempsey, Roberta Humphreys, Marvin Marshak, Judith Martin, V. Rama Murthy
Guests:	AHC Senators and members of the AHC Faculty Consultative Committee (about 20); AHC department heads (about half a dozen)
Other:	Vickie Courtney (University Senate); Maureen Smith (University Relations)

[In these minutes: discussion with Academic Health Center senators, members of the AHC FCC, and later with AHC department heads, about issues in the Academic Health Center]

1. Discussion with Academic Health Center Senators and members of the Academic Health Center Faculty Consultative Committee

Professor Evans convened the meeting at 1:00, welcomed everyone, and called for a round of introductions. She said that the minutes from this meeting would be only general and that there would be no attribution or identification of speakers.

Professor Evans then explained that this meeting was a follow-up to the meeting held with representatives of the AHC in November. She reported that following that November meeting, Senior Vice President Cerra had called her and requested a meeting. She agreed to meet him, and told him that in her view, as a complete outsider with little knowledge of the AHC, it had been made clear that there were deep and real concerns among AHC faculty about issues of professional culture and decision-making. Dr. Cerra listened carefully and seemed genuinely concerned.

This meeting was scheduled partly in response to email messages after the November meeting inquiring what FCC was going to do. The purpose is to put problems on the table and identify how to address them. In consultation with Professor Hamilton, Professor Evans said, she had identified two major issues. First was consultation at the collegiate level ("What might we do to establish regular procedures for consultation by deans in the AHC with their respective

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faculties BEFORE making major administrative and/or organizational decisions. At least some of the unhappiness clearly has to do with organizational changes that appear to come from nowhere too late for any faculty response to make a difference. Perhaps members of FCC can join with AHC Senators and AHC-FCC members to meet with deans in colleges where this is considered a serious problem"). It was evident at the November meeting that faculty were angry not only about the decisions but also about how they were made.

The second issue clearly of concern was centralization of resources and authority in the AHC central offices.

One of those present at this meeting expressed concern that there was no indication in the minutes of the November meeting who was present, so that there was no way to know if those who spoke were representative of views in the AHC. Professor Evans responded that the minutes had provoked either an "I don't agree with that" or an "it's about time somebody said that" reaction. Perhaps most important, the discussion got the attention of those in the AHC.

It was noted that the AHC FCC has concluded it needed to communicate more effectively next year, and that it and Dr. Cerra must report to the AHC faculty what subjects it had consulted on, what its advice had been, if the advice had been followed (and if not, why not), and that issues must be brought earlier to FCC in order that there can be timely consultation.

What follows is a summary and condensation of the points made in the hour-long discussion.

-- Decision-making has been removed to higher levels, and decisions are now made by people with whom the faculty do not interact. Many believe that the system is not cordial and does not invite comment.

-- The extent of consultation within colleges varies from legitimate decanal responses to issues raised by an FCC-like body to a dean whose view of consultation is to share information about a decision made or to ask for consultation on a decision needed immediately.

-- If FCC and the AHC FCC were to work with deans on shared governance, can the concepts of governance be communicated and behavior changed, or must there be a personnel change? In the case of FCC, it may have been both a change in personnel as well as a change in behavior, in response to a recognition that there was a crisis in institutional governance that had to be addressed.

One difficulty is that there is no agreement on what shared governance means (and effective strategic planning can bring people together, leading to shared governance). There are different conceptualizations of what it means; in the case of this (central) administration, it tries out ideas on the faculty--which IS consultation, a way to help make a decision. That also begets better decisions that are more likely to be accepted by the faculty.

-- To what extent is the problem (1) a lack of consultation about hard decisions, or (2) about hard decisions? The AHC has large financial problems that require hard and harsh

decisions; is the AHC faculty reacting to outcomes or the way they were reached? a) The faculty can accept harsh decisions if they understand them. b) the market in health care has changed drastically, and faculty must look at what those changes are doing to the AHC, which is separate from internal governance and communication; how the AHC is organized to deal with those changes MUST be addressed.

-- Would it help were there a University REQUIREMENT that each college have an elected faculty consultative body of 4-6 members with which the dean MUST consult weekly about his or her agenda? If such a requirement existed, would the faculty who participated in such a group be seen by other faculty as representative?

In the case of the Medical School, which is huge, and which is engaged in a vast array of activities, to have only four or six individuals representing faculty views would be hard to accept. Less centralization would be more acceptable to faculty. It is not always clear who has been consulted, whether professional faculty politicians or those doing science. Another difficulty is that there is no means for representatives to canvas opinion.

-- Most people in the AHC are of good will; the idea of a workshop with deans is a good one. One must look at both the theory and the mechanisms of consultation; in the AHC, it is the MECHANISMS that are missing, as is effective communication with constituents. It may also be that there is SO much change occurring, so many initiatives, that people cannot get a handle on them and there is too much for a governance system to deal with.

-- The AHC FCC may not have done a good enough job of communicating with the faculty about what it had consulted on, and it may be that Dr. Cerra is not being treated completely fairly. The AHC FCC did consult with him but did not communicate well with the faculty.

-- Is the concern about consultation in the AHC greater now than it was 20 years ago? Or has there long been deep resentment about exclusion from decision-making? a) One can date the resentment to 3-4 years ago, when re-engineering and then the tenure debate occurred. b) The AHC used to be much more decentralized, without this enormous structure at the center. c) Many of the problems can be attributed to the changes in health care. d) Department heads/units were more self-governing. e) The problems vary by college in the AHC; in one, the faculty took strong action and made the dean reverse a decision to eliminate departments, and communication has been much better since. (This was costly for the faculty, who refused to participate in meetings and made it difficult for the dean to run the college; productivity and morale dropped considerably.) f) The dean of one AHC college has gone out of the way to consult with faculty, but then also makes big decisions without consultation. There is need to heighten understanding about the necessity for joint effort involving a lot of faculty, or consultation will not work.

-- Professor Evans recalled that she had spoken with Dr. Cerra about the shift in funding that might occur if the biennial request funding is approved; this could mean more state (education) funding for clinical faculty, which in turn would mean that clinical education would be paid for with educational funds rather than clinical or other income. (In the case of some

departments, at present O&M funding--state and tuition dollars--amounts to less than 10% of the budget.) It is her impression that clinical faculty have no time for and are not rewarded for participation in decision-making; in her department, by contrast, it is PRESUMED such participation will take place. If the shift in funding were to occur, she has suggested to Dr. Cerra that the responsibilities of being an educator could include participation in some form of institutional governance, at the department, college, or institutional level. It will be important to create a culture where some level of participation is expected. This may require a huge cultural change, or a huge amount of money--or in the future the University may not deliver medical education.

a) Such a change may already be occurring in the Medical School. Whether or not it will occur depends on the evaluation criteria for faculty; if participation is not recognized and required, it will not occur. b) There is faculty concern about the legislative initiative, and the lack of faculty consultation on it.

-- It is necessary to think about how to organize units; departmental boundaries are almost non-existent in some cases.

-- A factor contributing to the problems is the increased use of non-tenured/tenure-track faculty (NTT faculty); new clinical faculty are all NTT. a) It should be emphasized to them that they need to develop an academic career--or they should be in private practice. b) The requirements for clinical-track faculty are quite rigorous, but there is no requirement for mentoring, as there is (in some units) for tenure-track faculty. Few clinical faculty were involved in setting the requirements. (There is no clinical ladder outside the Medical School.) c) Should clinical faculty be involved in such things as setting the curriculum? If they do scholarly work, yes; if 90% of their time is in practice, no. If they have educational responsibilities, they should be in governance.

All want a good governance system, but it is not clear who should be in it; this has been a problem for the Academic Appointments Subcommittee, chaired by Professor Bales. There is a dilemma in the Medical School: to change medical education, there must be more community-based clinical training, which is costly, requiring funding; at the same time, the faculty would like to be largely a research faculty that does faculty work, but will be unable to do so unless there are state funds to release them from the pressure of clinical practice. People are leaving because they are unable to do faculty work. The picture is bleak, and unlikely to be resolved by reconfiguring the situation.

Professor Evans summarized by commenting that she had identified three issues in the conversation:

1) the possibility of FCC and the AHC FCC working with the deans on consultation;
2) the need for clear mechanisms of consultation at both the collegiate and department levels; this is perhaps something the AHC FCC could take up, with involvement of FCC; and

3) communication, so that when there are consultative structures in place, the faculty know about them and decisions are not seen as made by a cabal.

It was suggested there was a fourth:

4) there are two cultures in the AHC, the basic sciences and the clinicians, the latter of which will say they have no time, and that they are not paid attention to anyway, and who are basically "tuned out"; it is important to get them "tuned in." (Someone must extend a hand to invite participation, and that could probably come best from deans and department heads. Clinical faculty have fallen between the cracks in terms of representation, do not feel well-represented, and it may be that a parallel system of representation for them will be needed.)

Only a couple of small steps can come out of this meeting, Professor Evans concluded. One is work on consultation (FCC will jointly work with the AHC FCC on this). FCC can help by bringing a University perspective.

Professor Evans also promised that there would be report(s) back to this group, and invited suggestions on other ways in which FCC might be of help. She observed that the health of the University depends on the AHC working through its current difficulties.

2. Discussion with Academic Health Center Senators Department Heads

Professor Evans next welcomed several department heads from the AHC, and a number of the senators and AHC FCC members stayed for this portion of the discussion. After introductions, she explained that FCC is holding a meetings with groups of faculty--senators, assistant professors, department heads--in order to obtain perspectives on issues before the University and how faculty can help resolve them.

A number of points were made in the discussion.

-- The AHC is treated as an IMG unit, and that creates a situation where things will not work no matter who holds the administrative posts. One problem is that services are degraded when the only consideration is cost; services to departments (e.g., grants management) are reduced in quality because of centralization in the AHC in order to save money, and valuable staff members are lost. IMG is supposed to promote a devolution of authority; whether or not because of IMG, in the AHC authority and funds have flowed the other direction.

A related concern is the growth in the number of non-faculty professionals in the central AHC office who set strategic plans and priorities and duplicate University services, while there is insufficient funding to hire people to teach basic courses. This growing central staff is drawing funds away from the colleges

--- There is much last-minute consultation on the part of the AHC administration, and it is not evident the advice has been followed. It appears that faculty are notified of decisions already made, rather than consulted about proper courses of action.

-- Many faculty fought against re-engineering and in favor of keeping the tenure system. Re-engineering can still be seen, and although tenured faculty do not worry about it, for new faculty there is a new paradigm (e.g., many are appointed as non-tenure-track faculty).

-- The problem of ICR funds has not been solved, and simply calling money fungible is not an answer. In some cases, loss of state funds has meant that teaching programs needed to funded from ICR dollars.

-- The University MUST get off exceptional status with NIH.

-- There is a creative tension between interdisciplinary/cross-disciplinary activities and strong departments. In some cases, new money is going to interdisciplinary programs, not strong departments, and new departments are interdisciplinary. But disciplines are important as a home and grounding for junior faculty. Interdisciplinary endeavors have become sacred cows. They are also a way to weaken departments.

-- Most departments in the AHC are not ranked by the National Research Council, and there are no formal rankings of clinical departments. There is also on the books, although not practiced, the possibility of a center becoming a tenure home for faculty. One cannot in good conscience hire junior faculty without a clear disciplinary home, because they need that to be developed.

The question of the strength of departments is an important one, and related to consultation. What is being sought is a better University for patients and students, and to do things that will raise the view of the University in the eyes of the world. Consultation is not to make people feel better, it is to make the University better, so there must be FUNCTIONAL consultation in order to raise the esteem and effectiveness of the University. What needs analysis is what has been done to improve the University. It may be that the pressure for survival in the AHC is so great that it is unable to be forward looking.

Professor Evans noted that in the FCC discussions of the intellectual future of the University, the role of departments has emerged as a topic. It is being identified here as a place to nurture and nourish disciplines, in an environment where research is becoming increasing interdisciplinary; one question is how to retain the culture of the department and discipline without re-creating the boundaries that stifled interdisciplinary work.

Does department = discipline? Departments are an organizational structure that can be related to any substance; they are an administrative convenience. If one defined

disciplines and then were to create an organizational structure to reflect them, what would one call it? There are departments with several disciplines, and there are several departments that have no discipline. What is the future of departments? What it SHOULD be is a place to develop faculty and students in an intellectual activity that is a whole, which in turn can be brought to interdisciplinary activity. The discipline, however, is critical. In the case of clinical departments, they are departments because of the area they serve, which makes sense.

-- Are there good things about the AHC? People are working hard, have great colleagues, and they do not worry about these problems except when they must. Dr. Cerra is a great cheerleader, and that does not hurt. It must be remembered that the AHC is a much different--much more positive--place than it was under Dr. Cerra's predecessor. The AHC office has also been very good at obtaining funding. Dr. Cerra, moreover, has been very helpful in articulating to the central administration the issues that face the AHC.

The question that should be asked is whether the value added is worth the cost. One should ask that about one's own department or unit; it can also be asked about the AHC central office. Has the increased spending led to an increase in quality? But if there are no quality indicators measuring outcomes, how can one decide if the money is worth it?

In addition, one could understand the need for a vice president for the health sciences when there was a hospital to run. The hospital has been sold, so the health sciences should look more like the rest of the University, and should have fewer layers of management. In the Medical School, however, there is the overlay of the business side of the practice plan. The problems in the Medical School sometimes lead other AHC units to think they would be better off in a unit with the English Department.

-- Were there to be proposed a limit on the size of the NTTT faculty, are there units in the AHC besides the Medical School that would seek an exemption? In one case, the ratio should apply to the teaching program, but units have a need for Ph.D.-trained people outside the teaching program--the clinical and research programs should be allowed to hire whom they need to survive, with staff prestigious enough for the work that is to be done. At the same time, there is a concern for NTTT faculty. This concern varies by AHC unit. In some cases, there is really no problem with NTTT faculty; in others, it is enormous, and will affect the reputation and quality of the unit.

Professor Evans thanked everyone for coming and adjourned the meeting at 1:15.

-- Gary Engstrand