I. **Welcome:** The meeting was called to order by President Ron Gill, Ph.D at 4:30 PM. Dr. Gill asked any guests or members of the media to introduce themselves. There were no guests.

II. **Approval of the Minutes:** The minutes of the April 10, 2012 meeting were approved without comments or corrections.

III. **Discussion Items:** As the Dean was not present at the beginning of the Senate meeting the Dean’s comments were deferred. The first discussion item was the *Blue Ribbon Task Force Update on Clinical Series* – Nancy Zahniser, PhD, Chair, Blue Ribbon Task Force on Promotion and Tenure Criteria. Dr. Zahniser began by reminding the Senators that she last presented in October of 2011. At that time the committee presented recommendations for updates to promotion and tenure for those primarily in research and education and clinical care, as well as for expanding examples of scholarship. There was great enthusiasm for the recommendations, except for those related to scholarship. Now the committee is back with the current, new recommendations; all members agree that they support this. This is the final recommendation. The members of the BRTF are: Steve Anderson (Pathology), David Barton (Microbiology), Stephen Cass (Otolaryngology), Joseph Cleveland (Surgery), Jim Hagman (Immunology, NJH), Randall Holmes (Microbiology), Madeleine Kane (Medicine), Jean Kutner (Medicine), Linda McCabe (Pediatrics), Thomas Meyer (VA), John Ogle (Pediatrics, DHM), Steven Ojemann (Neurosurgery), Nayana Patel (Radiology), Claude Selitrennikoff (CDB), Tod Sloan (Anesthesiology), Nancy Zahniser (Pharmacology), Faculty Affairs: Steven Lowenstein, Cheryl Welch. The names that are underlined are the members of the subcommittee for the new clinical series.

Dr. Zahniser provided an overview of the proposal; this is a new series in parallel with the Research Professor Series. There is still a tenure-eligible regular series. The new proposal for the clinical series is that the title be: Assistant Professor of Clinical Practice, Associate Professor of Clinical Practice, or Professor of Clinical Practice. There is a concern that this is a bit awkward with the Department name, there is a possibility of using Assistant Professor of Clinical – Department Name. This is for faculty who devote most of their time to direct patient care. They are required to teach; there is no requirement for scholarship, though it is encouraged. These faculty are not tenure-eligible since scholarship is required for tenure. These appointments can be limited, indeterminate, or at-will. Faculty will have an annual review. They could request to switch to a different series; the faculty member would have to initiate this. This would need Chair support and approval by the relevant review committees. The expectation would be that faculty would move from Assistant to Associate Professor by their seventh year, that they have the terminal degree in their field or the equivalent, excellence in clinical care, meritorious performance in teaching, and a local or regional...
reputation for clinical excellence.

The criteria for promotion to Professor are: terminal degree appropriate to their field or equivalent, excellence in clinical care, with continued growth and ongoing achievement in area of expertise. They must have at least meritorious performance in teaching, and one of the following: excellence in teaching; leadership of projects that have assessed and improved the quality, value and efficiency of clinical care; national or international reputation for clinical excellence. That is, for promotion to Professor, they need a second area of excellence. The approval process is as follows - First, approval of revised Rules and Matrix by the BRTF (done in 4/12). Next, Cheryl Welch and Steve Lowenstein will set up a meeting of the SOM Rules Committee. If approved there, this then goes to the Executive Committee, the Faculty Senate, the Executive Faculty and the Regents.

One year ago the Dean said, no major changes, but that was not what was best; this is more far-reaching, but what they thought was appropriate. Question: Will someone be hired as one or the other? NZ: Yes. Question: Is there still a clinician-educator track? Steve Lowenstein (SL): If your career includes scholarship, you should be in the regular faculty series. Comment: But some could be intimidated by this track, which could push them to maintain scholarship, without this I worry about clinician-educators. NZ: This is why the faculty member needs a mentor. The mentor should be sure that the faculty member is in the correct track. SL: The risks of getting it wrong are less here, there is less risk of second-class citizenship. Comment: But one needs to be pushed to do scholarship. Question: What about those who do not want to do this? Comment: This will have to be monitored; it could disproportionately affect women. The chair may not support a well-rounded faculty member.

Question: The requirement for advancement from Associate Professor to Professor is excellence in just one additional area; why not two or three? NZ: The input of the chairs of the clinical departments was that they did not want any requirement for scholarship. Comment: That is stunning. NZ: Regarding time to promotion it would not be expected that someone would be promoted before 5 years, and an extension could be requested before 7 years. Comment: Doesn’t this ignore that we are hiring new faculty at affiliate sites; these are major changes? SL: There is no final understanding about this, some will be volunteer faculty. NZ: This addresses faculty here primarily doing clinical care. They are contributing and would like to be recognized. Comment: Could you only be promoted to Associate Professor of Clinical Pediatrics or Associate in the regular track, rather than starting at Assistant Professor in this track? SL: That is a nice idea. This could mitigate the concern above of tracking too early. Comment: Not everyone should get to be a Professor, this requires something special. To have such flimsy requirements is degrading to the name. The only ones who should be professors are those who have performance to warrant this. NZ: Here it is a demonstration of being a leader or a resource. SL: You have to have one of three additional areas of excellence.
Comment: What is the Chairs' reticence about this? NZ: The Chairs have not seen this. SL: it is hard to have a national reputation as a requirement, if you excel here that is what we pay you to do. Comment: Then they shouldn't be professors; set the bar higher. NZ: We went around and around on this. We are giving credence to clinical care. This is where they excel. This may not go forward. Comment: But providing excellent clinical care in an academic medical center or an affiliate requires excellence in teaching. Comment: If you are an Associate Professor, clinical excellence is assumed. SL: It is not assumed. Comment: But that is our goal. Comment: I can see some scenarios in which the Chair would push people in to these tracks. NZ: What about the decision happening at the time of promotion to Associate Professor? SL: This could work. NZ: I have heard that some people want to do scholarship but that their Chairs do not want them to. Comment: What about taking out the Assistant Professor and Professor roles? Then you would not have someone being a Professor without scholarship. NZ: People will get a chance to vote.

SL: I have made notes. I want to correct one thing, in the Research Professor series all faculty are “at-will”, that is a Regent law and a state law. Question: Could you define that better? SL: The majority of faculty have limited appointments, one year, two years or three years. They expect notice at some time. At-will appointments could be for any non-tenured faculty member; there are increasing numbers of these, they can have their appointment revoked at any time, except for some legal reason. The 3rd category is indeterminate; this is used by Chairs for faculty members on soft money. Their appointment is dependent on grants. The fourth category is tenure. Question: How is this title different from that of the community, private practice physicians? SL: That is true, we agree, there is confusion, overlap and ambiguity. NZ: We tried to come up with a title that identifies the faculty member’s primary focus. Thanks for the discussion and feedback; these are important concerns. We made our best effort, we will come to the point at which we will say this is the proposal. It may be that people will not be supportive of this and we will need another task force. SL: All rules come here. We will summarize everything. We will need action on a much bigger package than this. President Gill: Thank you, this is a wonderful compromise on an issue with competing interests.

IV. Standards for Notice of Non-Reappointment Policy Update – Steve Lowenstein, Associate Dean. The Administrative Policy Draft 3/13/2012 on Standards for Notice of Non-reappointment for Faculty was attached to the Agenda for this meeting. Dr. Lowenstein began by explaining the history of this policy. There is a history of appearance, disappearance and reappearance of this policy. This is about non-reappointment, not dismissal. The latter must be done for cause. Non-renewal or non-reappointment is that the contract will not be renewed after the contract ends. The notice requirements have been around since the 1960’s, and were codified in 1984 in the Faculty Handbook. Faculty members with less than one year of university service required 3 months notice, with 1 year of service required 6 months notice, and after two years of service faculty required 1 year notice. Since 1990 this has applied to all faculty members.
Then a case came up, and the faculty member won. Notice had been given to her in the middle of her contract period; she lost a period of notice. One needed to give notice prior to the expiration of the current contract. Then this disappeared. It was published in the Faculty Handbook until 2006, and in 2011 the requirement for notice was just deleted. It simply disappeared.

Today, notice is no longer required by the Regents. Now there is a prepared draft statement. The current draft states: 1 year or less of service, three months notice, 1-3 years of service, 6 months notice, more than 3 years of service, 12 months notice. This eliminates what was required by the Subryan decision; that is, this notice can be given at any time. This started with the Chairs, administrators were advising short notice periods, Chairs said no, we owe them one year. You need to to be here for three years to get one year’s notice. This is what we will do, with the appropriate vote from the governance group. Faculty members should have an expectation of a longer appointment. Longer notice would give Chairs incentive to put faculty at-will. Comment: Someone won a lawsuit before, why will this be acceptable? SL: That is because the court was interpreting the Regents’ policy. That doesn’t exist anymore, there is no Regent policy.

Question: The appointment starts in July, I give you notice in August, does the appointment expire in July, or the next July? SL: That is the change: after three years of service a faculty member will have one year from the time of their notice.

Question: Why is there a trend of having more at-will faculty? SL: Some say all should be at-will, it is superior for management and budgeting. There is so much pressure on Chairs, they can’t manage a 2-3 year obligation; they see this as an albatross. But this has only adverse consequences; it is important to preserve notice. But I do not have to go to the Dean, as they do. Ron Gill: If one is not promoted from Assistant to Associate Professor, is one given a year’s notice? Yes. They could move to the clinical series. Question: In the correct series, if you do not advance from Assistant to Associate Professor and move to the new series do you get another seven years to advance? SL: This has to go under review. Comment: That should be clear.

V. The Dean provided his comments at this point:

Dean’s Comments: The Dean began his comments by stating that the SOM has contracted with Navigent consulting firm. Six firms responded to the bidding process to assist us with the strategic process Navigent, came out on top. They are excited to be working with a school that is asking this question; that is, how do we reorganize to be maximally successful in all that we do, research, clinical care, teaching, and community service. There will be a meeting next week, and we will have a process by June. The Dean stated that he wants to have as many faculty involved as possible. This is our future, yours and mine. The state purchasing process is finished, and the Dean looks forward to getting this started. This will take off in the late summer, speed up again in the fall, and will be done in the winter.

Regarding current searches and affiliate institutions: There is a search for a Dean of the College of Nursing; there is an internal candidate and an external
There are expected to be two to three candidates for the head of the Center on Bioethics and the Humanities shortly. Clinical Sites: We are still negotiating with Colorado Springs; Bruce Schroffel hopes that this will be done in early June for the August vote. University of Colorado Health still needs an IRS letter; it cannot function as a health care organization until they have the IRS letter, but it is behaving like a health care system even without the letter. At lunch there was a key information meeting, and all agreed that Bioinformatics is crucial. I feel very positive about this; we can’t not do this. We need 10 million dollars to get this started. The critical part is what you will talk about now.

C. Approval of New Division of Computational Biology and Personalized Medicine, David Schwartz, MD, Professor and Chair, Department of Medicine; Mark Johnston, PhD. Professor and Chair, Department of Biochemistry and Molecular Genetics.

Dr. Gill indicated that this would be presented by Dr. Schwartz, and that there would be comments and questions at the end. He hoped that the Senate would enthusiastically support this. David Schwartz (DS): This is a new program and center, and could be a real game changer. This started a year ago when Dean Krugman asked Mark Johnston how to support Biomedical Informatics, because a review of the CCTSI said that Bioinformatics needs a home. Mark Johnston led a great committee that met weekly for 4-5 months for 1-2 hours and that took their charge very seriously. The committee came up with something that the Dean had not imagined. This will change what we all can do. The group interviewed 20 individuals and looked at what others are doing in computational biology and personalized medicine. This is computational biology connected to health care, connected to the EMR, connected to computational biology connected to the EMR; this will change how we deliver health care. This is an opportunity for the whole campus.

How do we put this together so that it meets the needs of the campus and the CCTSI? It needed to be a center that spanned the campus, so it was put in the Vice Chancellor for Health Affairs Office. It is part of all health sciences. This also needs an academic home in a department, because it needed to be connected to clinical medicine. We will use the EMR to understand disease at a different level; we will re-conceptualize how we care for patients and train our physicians. The goal is to have 7-10 faculty in the Department of Medicine. They will also have secondary appointments. This could grow in time, and could be its own department in the school. This could span schools; we did it small so it could succeed. We wanted a Center to span all health sciences schools and span an operational component. This is the data warehouse for information commons. This is highly operational, it needs to function outside the academic environment and assimilate data across the campus.

Mark Johnston (MJ): Faculty need an academic home in order to develop their scholarship. We need to serve the campus; that is where the center comes from. All we do will be centered around biomedical informatics. Question: Why isn’t this in the CCTSI? Dean Krugman: It is not a department; centers have space and
resources but can’t appoint faculty. We want to give centers the flexibility to move in different directions; the Department needs to care for the faculty. All need to agree that if the Center goes in a different direction, the Department will keep that person. The CCTSI is a center, but Ron Sokol does not appoint faculty.

DS: The facility will be very close to the CCTSI, and may change the direction of the CCTSI. Question: Is there buy in from the Cancer Center? DS: Yes, they are two steps ahead of everyone. It is possible that the head will be a cancer oriented person. There are lots of activities and opportunities in cancer. MJ: The nascent Bioinformatics Core is funded by the Dean, the Cancer Center, and the CCTSI. President Gill: Why is this not in the School of Public Health? Are they on board? David Schwartz: There are two members of the CSPH on the deliberation committee. We talked about putting it in the CSPH, but then it wouldn’t have a connection to clinical care. We need to interface to change care. Vanderbilt is way ahead of us; they base care on the kind of program. The Dean of the CSPH agreed with this.

MJ: Intellectually this should be in Biostatistics, but this needs to be linked with the clinical enterprise. Dean Krugman: I talked about this with the CSPH incoming Dean, Dean Goff. He is fine with this. The Center needs to be across all schools. Individuals in Pediatrics and Emergency Medicine, for example, will have homes in their academic program with secondary appointments in Medicine. President Gill: Is there an associated PhD program? David Schwartz: Larry Hunter directs the Computational Biosciences PhD program; this is funded through a T32. This was recently re-funded; Larry Hunter wants to participate in this program. That academic program is important to this whole program. Whether this will be in parallel with us or within us is not clear. President Gill: Can we vote on this? Do we approve, or not, an Interdisciplinary Center for Biomedical Informatics in the Department of Medicine? The motion was moved and seconded, the vote taken; the Center was approved unanimously.

President Gill: At the Faculty Assembly meeting folks doing a campus-wide visionary plan had disappointing and not positive discussion. For example, they want to have a new building on the other side of the Education buildings. They are not thinking carefully about faculty, staff, patients, transportation. There will be two more meetings in which folks can share information. Please go back and share the importance of going to these with your faculty. We don’t want decisions made that we can’t live with. Steve Lowenstein: This needs grass roots faculty input. Question: Will they come to us? Dean Krugman: The meetings are in May, they can report in June. There is tension around this. Open space on campus is important. The next research building is to be west of here, this will balkanize the campus more, or we could connect RC1 and RC2 with a building; there could be a big cafeteria. Ron and Steve are right, we need more input. We came here with just UCH and the SOM, now we have the VA, Children’s and the FRA (Fitzsimmons Redevelopment Association). People cannot get here, we have 1.1 million outpatient visits per year, and we are projected to have 1.5 million visits per year in 5 years. People who want to come here need to get here. We need space for students, researchers and patients. We don’t need one over-
arching concept, we need a functional campus. Comment: There is not enough input from the SOM.

President Gill: We need a President-elect candidate for the upcoming Faculty Senate elections, this person must come from a basic science department.

The meeting was adjourned at 5:55 P.M.

Respectfully submitted, Renata C. Gallagher, MD, PhD.