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

II. Approval of the Minutes: The minutes of the October 11, 2011 meeting were approved without comments or corrections.

III. Dean’s Comments:
   a. As Dean Krugman was absent, Dr. Doug Jones, Senior Associate Dean for Clinical Affairs, presented information regarding current chair searches and affiliate institutions.
      • Negotiations with Dr. Richard Zane, currently at Brigham and Women’s Hospital, and candidate for Chair of the Department of Emergency Medicine, are still underway. Negotiations with Dr. Richard Schulick, Professor of Surgery and Oncology at Johns Hopkins, candidate for Chair of the Department of Surgery, are also continuing.
      • Patricia Gabow, MD, CEO at Denver Health, is stepping down. The composition of the search committee for her replacement is not yet clear. It will consist, at least, of Dean Krugman, Dori Biester, Ph.D., former President and CEO of Children’s Hospital Colorado, and will be chaired by Bruce Alexander, Board member of Denver Health (DH). There are regular meetings between the Dean, Patty Gabow, and senior staff of DH in an effort to solidify the relationship between DH and the SOM, and to put things on paper prior to her departure.

   There have been no recent meetings with National Jewish Hospital

   b. Poudre Valley Update:
      • Dr. Jones stated that there is little additional to say. Bruce Schroffel, CEO of UCH, has stated that relationships between physicians at the two institutions should proceed at their own pace, similar to the situation between Cornell and Columbia at Columbia-Presbyterian. This is based on his experience with Stanford and UCSF where merger of the faculties was unsuccessful and acrimonious. Therefore, it should be up to the faculty at the two sites to decide on their clinical relationships. Dr. Jones pointed out that there will be no merger of UCH and Poudre Valley Hospital as both are owned by entities that cannot sell them, the state and the county, respectively. They can cooperate, but not merge. There is a question as to what board composition should be; this is in process, and is not final, but may be so by Feb. 2012. On the evening
of November 16\textsuperscript{th} there will be a meeting of the medical staff of Poudre Valley, several of the SOM staff will attend, but this is not mandatory. Dr. Jones asked for questions.

Dr. Chesney Thompson, Past-President of the Faculty Senate, asked about Memorial Hospital. Dr. Jones replied that they have put out an RFP, essentially for a management agreement, and that a response has been prepared. HCA is very interested in acquiring Memorial Hospital. Someone asked if the agreement with Poudre will affect transfers between Poudre Valley Hospital and UCH. Dr. Jones said that he did not know and was not sure if this had been discussed. The SOM has not been involved in this discussion. The Board of Regents has given approval for the discussion between the two hospitals to proceed.

President Gill asked Dr. Jones what the benefit is to the merger with Poudre. Dr. Jones stated that Bruce Schroffel and the Board have been concerned about the ability of UCH to be a stand-alone institution; there are very few of these. Benefits include access to capital, and purchasing power. The only free standing hospitals in the region are Memorial Hospital, Denver Health, UCH, National Jewish, and Boulder Community Hospital. Partnerships with other organizations will make these stronger and more likely to survive. If UCH stays free-standing the concern is that they will be absorbed by another system.

c. Clinical Enterprise Update:

- Dr. Jones next provided an update regarding the Clinical Enterprise. He stated that if the SOM wants to function as an enterprise it needs a management structure. The SOM has traditionally been Department and division-centric; there is a need to bring people together to discuss matters of importance to clinical practice at the SOM as a whole. Policies and practices are not standard. Should there be common standards? If the SOM wants to do this it is necessary to have representatives to discuss this who are clinically active, and not, for example, Chairs, who have multiple responsibilities. The Dean has created a Clinical Leadership Council made up of Vice Chairs for Clinical Affairs and Quality in each Department and major clinical Centers. The co-Chairs are Doug Jones, Joan Bothner, and Steve Ringel. The SOM is a multimillion dollar clinical operation and needs a better coordinated operations management. Philanthropy and state funds are insufficient to meet the School’s needs, making a successful clinical enterprise of great importance. Question: Who comprises this? Answer: Each clinical department, as well as the Cancer Center, the Barbara Davis Center, and the Center for Children’s Surgery. Every clinical department is represented by senior capable people. The Dean has purchased 10\% of their time, and they have agreed to set aside clinical duties for this important task.
d. Question:
- An unrelated question was asked about the current branding of the SOM. This was prompted by a call in to Colorado Public Radio and was regarding the use of both UC and CU. This was clarified by members of the office of Media Relations. Our campuses are UC Denver, UC Anschutz Medical Center, UC Boulder and UC Colorado Springs. Legally UC Denver has two campuses, Denver and Anschutz Medical Campus. We are also the University of Colorado School of Medicine. The use of CU likely is related to the Kansas schools, the University of Kansas became KU. The school logo is a big CU. The URL is expensive to change and will not be changing. It is safe for faculty members to use University of Colorado School of Medicine, without the Denver, or to use UC Anschutz Medical Campus. AMC is not to be used, due to the wishes of our donor, and signs are being changed on campus to reflect this. In short, our e-mail addresses are not changing again.

e. Thanks:
- President Gill took the floor in order to express sincere and deep thanks on behalf of the Faculty Senate to Dr. Celia Kaye, Senior Associate Dean for Medical Education, for her work, and that of her staff, which resulted in the Medical School’s receiving full accreditation for five more years. They had been evaluated in 2009 and the group returned two years later to address several issues, The medical school is now accredited for the maximal possible period.

IV. Discussion Items:
A. Blue Ribbon Task Force on Promotion and Tenure Options: Additional Perspectives: This was to be second on the list of discussion items, President Gill requested that it be moved forward so that Steve Lowenstein, who had to leave early, could bring the discussion of the Faculty Senate back to the BRTF committee. It was reviewed that this is the third time that the report of the BRTF has been brought to the Senate, and that there is some confusion as to where we are with the discussion. It came back to the Senate for the second time after the Executive Committee requested further deliberation. There is good support for the majority of the conclusions of the BRTF, the issue is the requirement for a role for scholarship for promotion. Last month Dr. Zahniser presented three possible options. It was suggested that all points of view were perhaps not given sufficient time. Dr. Jones and Dr. Sloan of Anesthesiology were asked to present their views. Dr. Lowenstein stated that it was felt that the Senate did not talk enough about the advantages of clinical titles and of separate tracks. The three recommendations for consideration presented by the BRTF were: continued appointment, or re-appointment, as Senior Instructor for those who are exclusively clinical; or using a title such as Associate Professor of Clinical Pediatrics, or a clinical track; or to change promotion criteria such that promotion to Associate Professor would be based
on excellence in clinical work, with the additional requirement that one be meritorious in two, rather than all three categories of clinical service, teaching and scholarship. Dr. Celia Kaye, in particular, felt that the advantages of the Clinical title were not discussed enough.

Dr. Jones began the discussion by stating that he and John Moorhead had been the chairs when this was changed years ago. He stated that Joel Levine had been the major force behind the current system. Dr. Levine persuaded the group to make a quantitative change in what scholarship is, using the criteria of Boyer, that is, not to define scholarship exclusively as the scholarship of discovery. At that time lots of MDs started in basic research, then switched to clinical work when they were not successful at this. The impression was that this was not a good idea, and that clinicians should focus on being clinicians from the beginning. It was felt that scholarship had been too narrowly defined, and that clinicians who were not the best at clinical work were being promoted. The system became a one-track system. But in Pediatrics 10 - 12 years ago it became clear that a qualitatively different person was needed, like the neonatologists at Poudre Valley. They were appointed as Senior Instructors, and this created a two-track system, one department based. Now there are several hundred of these individuals in Pediatrics, OB-Gyn, and at Denver Health in Pediatrics. They are superb teachers, and do not wish to fulfill the requirements for traditional faculty appointments. However, there are problems with the name, calling these superb clinicians Instructor and Senior Instructor does not honor them, so the suggestion was to take scholarship away from the requirement for faculty appointment and to make them professors. Alternatively, one could ask what does that say to the outside world? The impression is that a professor contributes to scholarship. Also, the bar that we push people toward, pull and push, is promotion, would the school be the one we want it to be in ten years? Other faculty members have said that is pretty easy to get promoted to Associate Professor here. Is this change what we want? Some people say we have a one-track system and that we should keep that; but we effectively have a two-track system with Senior Instructors in a second group, even if not strictly speaking a track. The Senior Instructor category is Department based, should this be brought to the University? Dr. Lowenstein commented that he does not think that permanent Senior Instructor status is really a track.

Question: Nurse Practitioners and Physician Assistants are Senior Instructors; is there an option for promotion for them? If they possess a terminal degree in their field, they are eligible for academic promotion. Dr. Lowenstein - This is an interesting issue, Senior Instructor could be used for the busy clinician (but volunteer faculty are clinical professors) if we leave our faculty as Senior Instructors then there is no distinction between PAs, NPs and physicians.

Comment: As a clinician-educator up for promotion I do not think that the requirement for scholarship is onerous. Let’s keep it the way it is. Dr. Lowenstein, most of the feedback has been, it is not broken, don’t fix it. The question is, is there a better way to honor and retain clinical faculty?
Comments: What about the option discussed previously of coming in at Assistant Professor and staying there for 15-20 years, and needing scholarship to advance to Associate Professor? Or what about having a combined title of Senior Instructor and Clinical Associate Professor, this would be like being a volunteer faculty member and a Senior Instructor?

Dr. Lowenstein: We do not strictly have a one track system, there is a research professor series. This is for individuals who are scientists, and who are not teachers. There are about 75 individuals in this series, this is a full track, from Instructors to Assistant, Associate, and full Professors. They are free of any teaching obligation. This was recommended by the basic science chairs 8-9 years ago. These individuals are all “at-will”, they are exclusively funded by grants. Their teaching portfolio is not reviewed for promotion.

Comment: I am strongly opposed to removing scholarship as a criterion for promotion at a university. This denigrates both our previous promotions, and the University. Why are we discussing this? Are there people who want this, or are people worried about something? Dr. Tod Sloan, Dept of Anesthesiology - the Dept of Anesthesiology faculty were concerned that physicians will be Instructors, like our nurses. At a national level nurses are taking jobs from MDs in Anesthesia. Many clinicians are very busy, they cannot do scholarly work, but they do not want to be at the same level as the NPs in Anesthesia. We will have trouble retaining and recruiting faculty if we do this. For example, a faculty member at Denver Health may not meet criteria for promotion and leave. Anesthesia faculty members do not want to be forced to become Instructors.

Comment: Volunteer faculty can be professors, sister institutions have found a way for people doing clinical work and teaching to be promoted. If we apply the current criteria for clinical work, the faculty member will get a title, the Instructor title could be used for someone who does not teach.

Dr. Doug Jones - Steve Daniels and David Schwartz represent a lot of faculty. Both say that it is hard to recruit to the Senior Instructor level. It has been done in Pediatrics, but it is harder now, and is not easy in Medicine. Comment: It will be a problem to have faculty in the school staying at the Assistant Professor level when they see volunteer faculty promoted.

Question: how are volunteer faculty promoted? Dr. Lowenstein: There are school-wide and department specific criteria. It is not an option to remove the titles for these faculty members; they are essential for the residency programs.

Comment: We had two tracks, we changed this in 1997, it is not 1997 anymore. In some departments already there is a dual track system. If there are stringent requirements for promotion, if it is clear individuals have to reach a certain bar, then all will be happy. We will have to re-work the by-laws. Dr. Lowenstein - We do need to ensure that the standard of clinical work is rigorous, we already have criteria for this. The options seem to be to use the
title Professor of Clinical Medicine, or to say that individuals can be meritorious in teaching or scholarship, rather than teaching and scholarship. At this point President Gill ended the discussion, saying that later this month the BRTF would meet again to consider this input, and further recommendations. The recommendations of the BRTF will go to the Rules and Governance Committee, the approval of the Senate is required before the Executive Committee votes.

B. Medical School Admissions Report. Robert Winn, MD, Associate Dean for Medical School Admissions, presented. Dr. Winn began his presentation by stating that he has good news. As the Dean of Admissions for 2 years he has struggled with diversity issues. When he began the Medical School had 4-8% underrepresented minorities (URM), in a short period of time the racial, ethnic and geographic diversity of the students have improved. Dr. Winn pointed out that the CU SOM is the only medical school in a 500 mile radius. No expansion is planned soon, though the medical school is in discussion with Colorado Springs about a campus there. Currently there are 160 – 200 students at CU SOM, and the school will remain at this number for the next several years. In the last several years AMCAS applications have risen, from 2,150 in 2001 to 4,550 last year. As of this morning, there were greater than 5,000 applications for next year. This is the first time the applicant pool has been this large in the history of the medical school. Is this due to the economy? Yes, country-wide admissions are up 2-6%, but our increase is greater than that. Secondary applications are up from 857 in 2001 to 3,400 in 2011. This is great, though there is more work to do. Why has this increased? We have a great program. We tell people this. We have increased the number of people in the office, there are now two additional staff members. This staff now covers 98% of the colleges and community colleges in Colorado. We have added regional and strategic national recruitment. Last year 612 applicants were interviewed, 304 were offered positions, 160 matriculated, the acceptance rate was 49%, which is good. Two years ago the interviewers were a small group of 67 and were primarily emeritus faculty. There were no basic scientists, and no active practicing physicians. There are now 215 interviewers, most of whom are actively practicing physicians. This puts a new face on the school, and the applicants now have access to faculty. 52% are practicing physicians, 22% are emeritus faculty, 6% are basic science faculty and there are student interviewers. Student interviewers are up to 18% from 11%. Students interviewing students is as good as faculty doing this, there is data for this. The snapshot of our students is that 70% are in-state, 30% are out-of-state, 49% are female, 51% are male, the median GPA is 3.74 and the median MCAT 32Q, there are 9 MSTP students and 151 MD students.

Dr. Winn stated that when he started he was concerned that we couldn’t get students from Duke, Harvard, Stanford, the challenge is that if we are competitive we should allow them to come here. Why not recruit them? 29% of students came off the wait-list. We have an obligation in this state to take a 2nd or 3rd look at applicants from Colorado, 26% were re-applicants. The 25th percentile for GPA was 3.57, for MCAT 30, the 75th percentile was 3.90 and
MCAT 35. Regarding diversity: 50.1% is the current class diversity, as follows: 32.5% Underrepresented in Medicine (URM): 4 American Indian or Alaska Native, 9 Asian Vietnamese, 9 Black or African American, 13 Mexican, Mexican American, Chicano/Chicana, 17 Spanish/Hispanic/Latino/Latina; 8.8% Other Asian American: 8 Asian Chinese, 3 Asian Indian, 1 Asian Japanese, 1 Asian Korean, 1 Asian Other (Turkish); 8.8% Rural - As represented by the number of students enrolled in the Rural Track. Fourteen students are enrolled in the Rural Track of which 11 self-disclosed having grown up in a rural community. We have had a strong showing, we are up 85% in minority applicants. We have also increased our geographic diversity, applicants are from every region of the US. We are trying to recruit and we provide a great education.

President Gill asked, “How do you cover the state, what do you do?” Dr. Winn replied that the staff attend recruitment fairs, but they had only one year and two staff members to do this. They contacted every pre-med advisor in the state and asked if they could visit, 15% said no. We covered 90% of all 4 year colleges. We went all over the state and visited schools in clusters. “Congratulations, this is a great accomplishment” Dr. Winn – We had to provide education about our school. We have been confident in what we have. We are looking for excellence in different ponds. The school will look different.

C. Appointment of Faculty Assembly Representatives: President Ron Gill stated that last month the Faculty Senate had had a plea from the President of the Faculty Assembly (FA) to contribute members to this body from the School of Medicine. There are now three names of individuals to be nominated to the FA. To be voting members of the FA the Faculty Senate must provide their stamp of approval.

The following individuals have been nominated, Colleen Dingman, Assistant Professor, Anesthesiology; James Davidson, Assistant Professor, Radiology; Lee Shockley, Professor, Emergency Medicine. In addition Tod Sloan, Professor, Anesthesiology, and Hari Koul, Professor, Surgery, have been representatives in the past. A motion was made to approve all five. This was passed, with none opposed.

The meeting was concluded at 5:54 PM.

Respectfully submitted, Renata C. Gallagher, MD, PhD