

**COUNCIL OF DEANS
SPRING MEETING
April 25-28, 1974
The Wigwam, Litchfield Park
(Phoenix), Arizona
Sachem Hall East**

PROGRAM

“ZERO INSTITUTIONAL GROWTH: IMPLICATIONS FOR VITALITY AND LEADERSHIP”

Evening Session—April 25

8:00 p.m. **WELCOME AND OVERVIEW OF THE MEETING**

Emanuel M. Papper
Chairman, Council of Deans

**KEYNOTE ADDRESS:
“NEW PROBLEMS IN
UNIVERSITY MANAGEMENT.”**

James M. Hester
President, New York University

Morning Session—April 26

8:30 a.m. **INTRODUCTION TO THE SESSION**

Moderator: J. Robert Buchanan
Dean, Cornell University
Medical College

8:45—
9:15 a.m. **“THE FUTURE OF MEDICAL
EDUCATION: YOUR FORECAST”**

Marjorie P. Wilson
Director, Department of
Institutional Development
AAMC

9:15—
9:45 a.m. **“PLANNING YOUR FUTURE”**

Charles J. Hitch
President, University of
California

9:45— Reactor—Discussant
10:15 a.m. **General Discussion**

Cheves McC. Smythe
Dean, University of Texas
Medical School at Houston

10:15-10:45 **COFFEE**

10:45— **“COPING WITH THE RESOURCES
11:15 a.m. CRUNCH”**

William Carey
Vice President,
Arthur D. Little, Inc.

11:45—
11:45 a.m. **Reactor—Discussant
General Discussion**

Richard Janeway
Dean, Bowman Gray School of
Medicine, Wake Forest University

11:45— **“SPACE—GIVE AWAY, PURCHASE,
12:15 p.m. LEASE OR RENT?”**

Jane Elchlepp
Assistant Vice President,
Health Affairs—Planning and
Analysis, Duke University

12:15— Reactor—Discussant
1:00 p.m. **General Discussion**

Russell H. Morgan
Dean of the Medical Faculty
Vice President for Health Services
Johns Hopkins University

Evening Session—April 26

**“AFFIRMATIVE ACTION MEANS
ACTION”**

8:00 p.m.—
10:00 p.m. **Moderator: Emanuel M. Papper
Dean—School of Medicine
Vice President for Medical Affairs
University of Miami**

**“IF I WERE A MEDICAL SCHOOL
DEAN:**

**‘—WHAT I WOULD ASK MY
LAWYER’**

David B. Frohnmayer
Associate Professor, School of Law
Special Assistant to the President
University of Oregon

**‘—SOME PRIORITIES I WOULD SET
IN DEVELOPING AN AFFIRMATIVE
ACTION PROGRAM’**

Cyrena N. Pondrom
Assistant Chancellor
University of Wisconsin—Madison

**‘—WHAT I WOULD KEEP MY
EYE ON IN WASHINGTON—’ ”**

Sheldon Elliot Steinbach
Staff Counsel, Assistant Director
of Governmental Relations
American Council on Education

Morning Session—April 27

8:30 a.m. **INTRODUCTION TO THE SESSION**

Moderator: William J. Grove
Executive Dean, University of
Illinois College of Medicine

8:45— **“USES AND ABUSES OF TENURE”**
9:15 a.m.

Norman Hackerman
President, Rice University

9:15— **“WHAT TO DO WHEN THE
10:15 a.m. FACULTY STARTS TO ORGANIZE
FOR COLLECTIVE BARGAINING:**

‘—WHY THEY WOULD’

Charles D. Jeffries
Department of Immunology and
Microbiology, Wayne State University
School of Medicine

'-WHAT WE DID (OR SHOULD HAVE DONE)' "

Thomas W. Mou
Provost for Health Sciences
State University of New York

10:15-
11:00 a.m. Reactor-Discussant
General Discussion

Ronald Estabrook, Chairman
Council of Academic Societies
Chairman-Department of Biochemistry
University of Texas-Health Sciences
Center at Dallas, Southwestern
Medical School

11:00 COFFEE

11:30-
12:00 Noon "HOSPITAL REGULATION-
A FACT OF LIFE"

H. Robert Cathcart
President, Pennsylvania
Hospital

12:00-
12:30 p.m. "WHO IS RESPONSIBLE?"

Gustave H. Levy
Partner, Goldman, Sachs and
Company, Chairman-Mt. Sinai
Hospital and Medical Center,
Member-Board of Governors
Tulane Medical Center

12:30-
1:00 p.m. Reactor-Discussant
General Discussion

Robert Derzon, Chairman
Council of Teaching Hospitals
Director, University of
California Hospitals and
Clinics

Evening Session-April 27

8:00- A DISCUSSION WITH THE AAMC
10:00 p.m. PRESIDENT

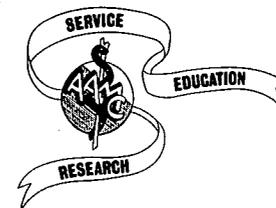
John A. D. Cooper

Morning Session-April 28

8:30 a.m. "THE COUNCIL OF DEANS IN
REVIEW, 1971-1974"

Panel: Emanuel M. Papper, Chairman
Sherman M. Mellinkoff
Merlin K. DuVal
Marjorie P. Wilson

11:30 a.m. Adjournment



ASSOCIATION OF
AMERICAN MEDICAL COLLEGES
COUNCIL OF DEANS
SPRING MEETING

ZERO INSTITUTIONAL GROWTH:
IMPLICATIONS FOR VITALITY
AND LEADERSHIP

April 25-28, 1974
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AFFIRMATIVE ACTION: A Sketch of the Law and Its Implementation

Jane Becker and Joseph Keyes

Division of Institutional Studies
Association of American Medical Colleges
April 1974

AFFIRMATIVE ACTION: A Sketch of the Law and Its Implementation

Jane Becker and Joseph Keyes

Affirmative Action, as the term is used here, refers to that body of federal law and regulation which has as its objective the rooting out of presently operative discriminatory employment practices and remedying the present effects of such practices operative in the past. Equal employment opportunity, equity of access, and equity of treatment, for all persons regardless of sex, race or religion is the goal. Most importantly, a deliberate attempt to change institutional behavior is required, where to perpetuate the status quo would be to perpetuate a situation having an uneven and adverse impact on a particular class of persons. Thus, the law and its implementing regulations call for examination and analysis of employment practices; and where necessary, the implementation of strategies--such as goals and timetables in hiring and promotion--to remedy deficiencies where discovered. While the imminent Supreme Court decision in the case De Funis v. Odegaard may substantially alter the force and impact of what is set out below, we have attempted to describe the outlines of the law as it is perceived today.

The federal laws and regulations concerning discriminatory practices pertaining to educational institutions are: The Equal Pay Act of 1963, as amended; Title IX of the Education Amendments of 1972; Title VII of the Civil Rights Act of 1964, as amended; Executive Order 11246 (as amended by 11375); and Title VII and Title VIII of the Public Health Service Act.

Executive Order 11246 (as amended by 11375)

Executive Order 11246, effective on October 13, 1968, embodies two concepts: nondiscrimination and affirmative action.

A university contractor is required to examine all employment policies to assure equitable treatment of all persons without regard for race, color, religion, national origin, or sex. Those employers with federal contracts of \$50,000 or more and having 50 employees or more, must have a written affirmative action plan. Public institutions were previously exempt from the requirement of a written plan; in January 1973, that exemption was removed.

The Office of Federal Contract Compliance (OFCC) of the Department of Labor establishes policy, but enforcement and review with respect to educational institutions rests with the Office for Civil Rights of HEW. The government may investigate without complaint. Pre-award reviews are mandatory for contracts over \$1 million. Part or all of the institution may be reviewed.

An institution under review must preserve identified records relevant to the complaint or alleged violation being investigated; the Government holds the right to review all records. This is true of all laws and regulations cited herein. By way of sanctions, the Government may hold up contracts, terminate current contracts and deny institutional eligibility for future contracts.

Further, HEW may seek back pay for employees not previously protected by other laws.

Institutions are prohibited from discharging or discriminating against an employee who has filed a complaint or assisted in a complaint process. The name of the complainant is usually given to the institution during the course of the review.

While individual complaints may be filed under the Executive Order, the Office for Civil Rights (OCR) by a memorandum of May 29, 1973, agreed to routinely hand over individual complaints to the Equal Employment Opportunity Commission (EEOC) and OCR confines its activities to class complaints.

Title VII of the Civil Rights Act of 1964 (as amended by the Equal Opportunity Act of 1972)

All institutions having fifteen or more employees are covered under this act, whether or not they receive federal aid. Discrimination in employment (hiring, promotion, salaries, fringe benefits, or other conditions of employment) on the basis of race, color, religion, national origin or sex is specifically prohibited. The act is enforced by the Equal Employment Opportunity Commission (EEOC).

This act is distinguished from Executive Order 11246 in that religious institutions are exempt with respect to employment of persons of a particular religion or religious order, and such institutions may limit employment to persons of one sex.

Complaints are filed with EEOC by individual and/or organizations within 180 days of the discriminatory act. The institutions are notified within ten days after a charge is filed. Like the Office for Civil Rights which enforces the Executive Order, EEOC may investigate part or all of an institution but does so only in response to a complaint-- unlike the OCR, which can initiate review on its own. The complainant may, if conciliation fails, file an individual suit. EEOC's powers were extended in the amendments of the Equal Opportunity Act of 1972, which permits it to instigate court action.

Like the Executive Order: 1) harassment of the employee is prohibited, and 2) EEOC may seek back pay. The individual complainant is named at the time of the investigation though the full nature of the charges are not made public. In neither the Executive Order nor in Title VII, is the complainant bound by confidentiality.

The Equal Pay Act of 1963 (as amended by the Education Amendments of 1972)

The Equal Pay Act, prohibiting sex discrimination in salaries (and in most fringe benefits), is administered by the Department of Labor (the Wage and Hour Division of the Employment Standards Administration.) Complaints may be filed by individual or organizations by letter, phone call or personal visit to the nearest Wage and Hour Division Office. Back pay up to two years may be awarded; in the case of a willful violation, back pay can be awarded up to three years. Periodic reviews may also be

initiated by the Government. In either case, the entire institution is usually reviewed. Failing conciliation, the Secretary of Labor may elect to file suit, or the aggrieved individual may file suit. Affirmative action is not required other than for salary increases and back pay. Harassment is prohibited and confidentiality of complaint maintained.

Title IX of the Education Amendment of 1972

Title IX covers all institutions receiving federal grants, loans or contracts. It prohibits sex discrimination, and is similar to Title VI of the Civil Rights Act of 1964, which prohibits discrimination against students on the basis of race, color, and national origin. Title IX prohibits discrimination against students on the basis of sex in federally assisted education programs. Regulations for Title IX have not yet been released for comment, but are expected this spring. However, the law is currently in effect. Like Title VII of the Civil Rights Act, religious institutions are exempted where anti-discrimination prohibitions conflict with tenets of the religious order. Military schools are also exempt.

Like the Executive Order and Title VII and VIII of the Public Health Service Act, the Office for Civil Rights at HEW is the responsible compliance agent for Title IX.

Title VII and Title VIII of the Public Health Service Act (effective November 18, 1971)

Discrimination on the basis of sex, in the admission of students and in all employment practices related to student programs, is prohibited. Schools of medicine, along with all other health profession schools, are covered by Titles VII and VIII. Proposed regulations for Title VII and VIII were published on September 20, 1973, but have not yet been issued in final form.

In sum, the laws and regulations governing discrimination on the basis of race, color, religion, national origin or sex fall under the purview of HEW, Division of Higher Education's Office for Civil Rights; the Department of Labor; and the Equal Employment Opportunity Commission. To review and compare the Executive Order 11246 and the laws covering non-discrimination and affirmative action, may we call your attention to the enclosed chart entitled, "Federal Laws and Regulations Concerning Sex Discrimination in Educational Institutions." Prepared by the staff of the Project on the Status and Education of Women, Association of American Colleges, this chart offers the most concise data available.



*association of
american colleges*

1818 R STREET, N.W. . WASHINGTON, D.C. 20009 . (202) 387-1300

STAFF: **Bernice Sandler**
Director

Margaret Dunkle
Project Associate

Francelia Gleaves
Information Associate

PREPARED BY THE PROJECT ON THE STATUS AND EDUCATION OF WOMEN

**FEDERAL LAWS¹ AND REGULATIONS CONCERNING
SEX DISCRIMINATION IN EDUCATIONAL INSTITUTIONS²**

October 1972

Federal Laws¹ and Regulations Concerning Sex Discrimination in Educational Institutions²

October, 1972

Compiled by Project on the Status and Education of Women, Association of American Colleges

	Executive Order 11246 as amended by 11375	Title VII of the Civil Rights Act of 1964 as amended by the Equal Employment Opportunity Act of 1972	Equal Pay Act of 1963 as amended by the Education Amendments of 1972 (Higher Education Act)	Title IX of the Education Amendments of 1972 (Higher Education Act) ¹³	Title VII (Section 799A) & Title VIII (Section 845) of the Public Health Service Act as amended by the Comprehensive Health Manpower Act & the Nurse Training Amendments Act of 1971 ¹⁴
Effective date	Oct. 13, 1968	March 24, 1972 (July 1965 for non-professional workers.) (Institutions with 15-24 employees are not covered until March 24, 1973.)	July 1, 1972 (June, 1964, for non-professional workers.)	July 1, 1972 (Admissions provisions effective July 1, 1973.)	Nov. 18, 1971
Which institutions are covered	All institutions with federal contracts of over \$10,000. ¹	All institutions with 15 or more employees.	All institutions.	All institutions receiving federal monies by way of a grant, loan, or contract (other than a contract of insurance or guaranty).	All institutions receiving or benefiting from a grant, loan guarantee, or interest subsidy to health personnel training programs or receiving a contract under Title VII or VIII of the Public Health Service Act. ¹⁵
What is prohibited ¹	Discrimination in employment (including hiring, upgrading, salaries, fringe benefits, training, and other conditions of employment) on the basis of race, color, religion, national origin or sex. Covers all employees.	Discrimination in employment (including hiring, upgrading, salaries, fringe benefits, training and other conditions of employment) on the basis of race, color, religion, national origin or sex. Covers all employees.	Discrimination in salaries (including almost all fringe benefits) on the basis of sex. Covers all employees.	Discrimination against students or others ¹⁴ on the basis of sex. ¹⁵	Discrimination in admission of students on the basis of sex and against some employees. ¹⁶
Exemptions from coverage	None.	Religious institutions are exempt with respect to the employment of individuals of a particular religion or religious order (including those limited to one sex) to perform work for that institution. (Such institutions are not exempt from the prohibition of discrimination based on sex, color and national origin.)	None.	Religious institutions are exempt if the application of the anti-discrimination provisions are not consistent with the religious tenets of such organizations. Military schools are exempt if their primary purpose is to train individuals for the military services of the U.S. or the merchant marine. Discrimination in admissions ¹⁴ is prohibited only in vocational high schools, graduate and professional institutions, and public undergraduate coeducational institutions.	None.
Who enforces the provisions?	Office of Federal Contract Compliance (OFCC) of the Department of Labor has policy responsibility and oversees federal agency enforcement programs. OFCC has designated HEW as the Compliance Agency responsible for enforcing the Executive Order for all contracts with educational institutions. HEW's Office for Civil Rights (Division of Higher Education) conducts the reviews and investigations.	Equal Employment Opportunity Commission (EEOC). ¹	Wage and Hour Division of the Employment Standards Administration of the Department of Labor.	Federal departments and agencies which are empowered to extend financial aid to educational programs and activities. HEW's Office for Civil Rights (Division of Higher Education) is expected to have primary enforcement powers to conduct the reviews and investigations. ¹⁷	HEW's Office for Civil Rights (Division of Higher Education) conducts the reviews and investigations.
How is a complaint made?	By letter to OFCC or Secretary of HEW.	By a sworn complaint form, obtainable from EEOC.	By letter, telephone call, or in person to the nearest Wage and Hour Division office.	Procedure not yet specified. A letter to Secretary of HEW is acceptable.	Procedure not yet specified. A letter to Secretary of HEW is acceptable.
Can complaints of a pattern of discrimination be made as well as individual complaints?	Yes. However, individual complaints are referred to EEOC.	Yes.	Yes.	Yes.	Yes.
Who can make a complaint? ¹	Individuals and/or organizations on own behalf or on behalf of aggrieved employee(s) or applicant(s).	Individuals and/or organizations on own behalf or on behalf of aggrieved employee(s) or applicant(s). Members of the commission may also file charges.	Individuals and/or organizations on own behalf or on behalf of aggrieved employee(s).	Individuals and/or organizations on own behalf or on behalf of aggrieved party.	Individuals and/or organizations on own behalf or on behalf of aggrieved party.
Time limit for filing complaints ¹	180 days.	180 days.	No official limit, but recovery of back wages is limited by statute of limitations to two years for a non-willful violation and three years for a willful violation.	Procedure not yet determined.	Procedure not yet determined.
Can investigation be made without complaints?	Yes. Government can conduct periodic reviews without a reported violation, as well as in response to complaints. Pre-award reviews are mandatory for contracts over \$1,000,000.	No. Government can conduct investigations only if charges have been filed.	Yes. Government can conduct periodic reviews without a reported violation as well as in response to complaints.	Yes. Government can conduct periodic reviews without a reported violation, as well as in response to complaints.	Yes. Government can conduct periodic reviews without a reported violation, as well as in response to complaints.

	mandatory for contracts over \$1,000,000.	Yes. HEW may investigate part or all of an institution.	Yes. EEOC may investigate part or all of an establishment.	Yes. Usually the Wage-Hour Division reviews the entire establishment.	Yes. HEW may investigate those parts of an institution which receive federal assistance (as well as other parts of the institution related to the program, whether or not they receive direct federal assistance). If the institution receives general institutional aid, the entire institution may be reviewed.	Yes. HEW may investigate those parts of an institution which receive federal assistance under Title VII and VIII (as well as other parts of the institution related to the program, whether or not they receive assistance under these titles).
Can the entire institution be reviewed?						
Record keeping requirements and government access to records	Institution must keep and preserve specified records relevant to the determination of whether violations have occurred. Government is empowered to review all relevant records.	Institution must keep and preserve specified records relevant to the determination of whether violations have occurred. Government is empowered to review all relevant records.	Institution must keep and preserve specified records relevant to the determination of whether violations have occurred. Government is empowered to review all relevant records.	Institution must keep and preserve specified records relevant to the determination of whether violations have occurred. Government is empowered to review all relevant records.	Institution must keep and preserve specified records relevant to the determination of whether violations have occurred. Government is empowered to review all relevant records.	Institution must keep and preserve specified records relevant to the determination of whether violations have occurred. Government is empowered to review all relevant records.
Enforcement power and sanctions	Government may delay new contracts, revoke current contracts, and debar institutions from eligibility for future contracts.	If attempts at conciliation fail, EEOC or the U.S. Attorney General may file suit. ¹⁰ Aggrieved individuals may also initiate suits. Court may enjoin respondent from engaging in unlawful behavior, order appropriate affirmative action, order reinstatement of employees, and award back pay.	If voluntary compliance fails, ¹¹ Secretary of Labor may file suit. Aggrieved individuals may initiate suits when Department of Labor has not done so. Court may enjoin respondent from engaging in unlawful behavior, and order salary raises, back pay and assess interest.	Government may delay new awards, revoke current awards, and debar institution from eligibility for future awards. Department of Justice may also bring suit at HEW's request.	Government may delay new awards, revoke current awards, and debar institution from eligibility for future awards. Department of Justice may also bring suit at HEW's request.	Government may delay new awards, revoke current awards, and debar institution from eligibility for future awards. Department of Justice may also bring suit at HEW's request.
Can back pay be awarded? *	Yes. HEW will seek back pay only for employees who were not previously protected by other laws allowing back pay.	Yes. For up to two years prior to filing charges with EEOC.	Yes. For up to two years for a nonwillful violation and three years for a willful violation.	Probably, to the extent that employees are covered.	Probably, to the extent that employees are covered.	Probably, to the extent that employees are covered.
Affirmative action requirements (There are no restrictions against action which is non-preferential)	Affirmative action plans (including numerical goals and timetables) are required of all contractors with contracts of \$50,000 or more and 50 or more employees. ⁴	Affirmative action is not required unless charges have been filed, in which case it may be included in conciliation agreement or be ordered by the court.	Affirmative action, other than salary increases and back pay, is not required.	Affirmative action may be required after discrimination is found.	Affirmative action may be required after discrimination is found.	Affirmative action may be required after discrimination is found.
Coverage of labor organizations	Any agreement the contractor may have with a labor organization can not be in conflict with the contractor's affirmative action commitment.	Labor organizations are subject to the same requirements and sanctions as employers.	Labor organizations are prohibited from causing or attempting to cause an employer to discriminate on the basis of sex. Complaints may be made and suits brought against these organizations.	Procedure not yet clear. Any agreement the institution may have with a labor organization can not be in conflict with the non-discrimination provisions of the legislation.	Procedure not yet clear. Any agreement the institution may have with a labor organization can not be in conflict with the non-discrimination provisions of the legislation.	Procedure not yet clear. Any agreement the institution may have with a labor organization can not be in conflict with the non-discrimination provisions of the legislation.
Is harassment prohibited?	Institutions are prohibited from discharging or discriminating against any employee or applicant for employment because he/she has made a complaint, assisted with an investigation or instituted proceedings.	Institutions are prohibited from discharging or discriminating against any employee or applicant for employment because he/she has made a complaint, assisted with an investigation or instituted proceedings.	Institutions are prohibited from discharging or discriminating against any employee because he/she has made a complaint, assisted with an investigation or instituted proceedings.	Institutions will be prohibited from discharging or discriminating against any participant or potential participant because he/she has made a complaint, assisted with an investigation or instituted proceedings.	Institutions will be prohibited from discharging or discriminating against any participant or potential participant because he/she has made a complaint, assisted with an investigation or instituted proceedings.	Institutions will be prohibited from discharging or discriminating against any participant or potential participant because he/she has made a complaint, assisted with an investigation or instituted proceedings.
Notification of complaints	Notification of complaints has been erratic in the past. HEW is proposing notifying institutions of complaints within 10 days. HEW notifies institutions a few weeks prior to investigation.	EEOC notifies institutions of complaints within 10 days.	Complaint procedure is very informal. Employer under review may or may not know that a violation has been reported.	Procedure not yet determined.	Procedure not yet determined.	Procedure not yet determined.
Confidentiality of names	Individual complainant's name is usually given to the institution. Investigation findings are kept confidential by government, but can be revealed by the institution. Policy concerning government disclosure concerning investigations and complaints has not yet been issued. The aggrieved party and respondent are not bound by the confidentiality requirement.	Individual complainant's name is divulged when an investigation is made. Charges are not made public by EEOC, nor can any of its efforts during the conciliation process be made public by the commission or its employees. If court action becomes necessary, the identity of the parties involved becomes a matter of public record. The aggrieved party and respondent are not bound by the confidentiality requirement.	The identity of a complainant, as well as the employer (and union, if involved), is kept in strict confidence. ¹² If court action becomes necessary, the identity of the parties involved becomes a matter of public record. The aggrieved party and respondent are not bound by the confidentiality requirement.	Identity of complainant is kept confidential if possible. If court action becomes necessary, the identity of the parties involved becomes a matter of public record. The aggrieved party and respondent are not bound by the confidentiality requirement.	Identity of complainant is kept confidential if possible. If court action becomes necessary, the identity of the parties involved becomes a matter of public record. The aggrieved party and respondent are not bound by the confidentiality requirement.	Identity of complainant is kept confidential if possible. If court action becomes necessary, the identity of the parties involved becomes a matter of public record. The aggrieved party and respondent are not bound by the confidentiality requirement.
For further information, contact	Division of Higher Education Office for Civil Rights Department of HEW Washington, D.C. 20201 or Office of Federal Contract Compliance Employment Standards Administration Department of Labor Washington, D.C. 20210 or Regional HEW or DOL Office	Equal Employment Opportunity Commission 1800 G Street, N.W. Washington, D.C. 20506 or Regional EEOC Office	Wage and Hour Division Employment Standards Administration Department of Labor Washington, D.C. 20210 or Field, Area, or Regional Wage and Hour Office	Division of Higher Education Office for Civil Rights Department of HEW Washington, D.C. 20201 or Regional HEW Office	Division of Higher Education Office for Civil Rights Department of HEW Washington, D.C. 20201 or Regional HEW Office	Division of Higher Education Office for Civil Rights Department of HEW Washington, D.C. 20201 or Regional HEW Office

General

1. State employment and/or human relations laws may also apply to educational institutions. The Equal Rights Amendment to the U.S. Constitution, passed by the Congress and now in the process of ratification would, when ratified, forbid discrimination in publicly supported schools at all levels, including students and faculty.

2. Unless otherwise specified, "institution" includes public and private colleges and universities, elementary and secondary schools, and preschools.

3. A bona fide seniority or merit system is permitted under all legislation, provided the system is not discriminatory on the basis of sex or any other prohibited ground.

4. There are no restrictions against making a complaint under more than one anti-discrimination law at the same time.

5. This time limit refers to the time between an alleged discriminatory act and when a complaint is made. In general, however, the time limit is interpreted liberally when a continuing practice of discrimination is being challenged, rather than a single, isolated discriminatory act.

6. Back pay cannot be awarded prior to the effective date of the legislation.

Executive Order 11246 as amended by 11375

7. The definition of "contract" is very broad and is interpreted to cover all government contracts (even if nominally entitled "grants") which involve a benefit to the federal government.

8. As of January 19, 1973, all covered educational institutions, both public and private, must have *written* affirmative action plans.

Title VII of the Civil Rights Act of 1964 as amended by the Equal Employment Opportunity Act

9. In certain states that have fair employment laws with prohibitions similar to those of Title VII, EEOC automatically defers investigation of charges to the state agency for 60 days. (At the end of this period, EEOC will handle the charges unless the state is actively pursuing the case. About 85 per cent of deferred cases return to EEOC for processing after deferral.)

10. Due to an ambiguity in the law as it relates to public institutions, it is not yet clear whether EEOC or the Attorney General will file suit in all situations which involve public institutions.

Equal Pay Act of 1963 as amended by the Education Amendments of 1972 (Higher Education Act)

11. Over 95 per cent of all Equal Pay Act investigations are resolved through voluntary compliance.

12. Unless court action is necessary, the name of the parties need not be revealed. The identity of a complainant or a person furnishing information is never revealed without that person's knowledge and consent.

Title IX of the Education Amendments of 1972 (Higher Education Act)

(Minority women are also protected from discrimination on the basis of their race or color by Title VI of the Civil Rights Act of 1964.)

13. Final regulations and guidelines for Title IX of the Education Amendments of 1972 have not yet been published. This chart includes information which is explicitly stated in the law, as well as how the law is likely to be interpreted in light of other precedents and developments.

14. The sex discrimination provision of Title IX is patterned after Title VI of the Civil Rights Act of 1964, which forbids discrimination on the basis of race, color and national origin in all federally assisted programs. By specific exemption, the prohibitions of Title VI do not cover employment practices (except where the primary objective of the federal aid is to provide employment). However, there is no similar exemption for employment in Title IX.

15. Title IX states that: "No person . . . shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any education program or activity receiving federal financial assistance. . . ."

16. The following are exempted from the *admissions* provision:

Private undergraduate institutions.

Elementary and secondary schools other than vocational schools.

Single-sex public undergraduate institutions. (If public single-sex undergraduate institutions decide to admit both sexes, they will have 7 years to admit female and male students on a nondiscriminatory basis, provided their plans are approved by the Commissioner of Education.)

Note 1. *These exemptions apply to admissions only.* Such institutions are still subject to all other anti-discrimination provisions of the Act.

Note 2. Single-sex professional, graduate and vocational schools at all levels have until July, 1979, to achieve nondiscriminatory admissions, provided their plans are approved by the Commissioner of Education.

17. Under Title VI of the 1964 Civil Rights Act, which Title IX of the Education Amendments closely parallels, federal agencies which extend aid to educational institutions have delegated their enforcement powers to HEW. A similar delegation of enforcement power is expected under Title IX.

Title VII & Title VIII of the Public Health Service Act as amended by the Comprehensive Health Manpower Act & the Nurse Training Amendments Act of 1971

18. Final regulations and guidelines for Title VII and VIII of the Public Health Service Act have not yet been published. This chart includes information which is explicitly stated in the law, as well as how the law is likely to be interpreted in light of other precedents and developments.

19. Schools of medicine, osteopathy, dentistry, veterinary medicine, optometry, pharmacy, podiatry, public health, allied public health personnel and nursing are specifically mentioned in Titles VII and VIII. Regulations issued June 1, 1972, by the Secretary of HEW specify that *all* entities applying for awards under Titles VII or VIII are subject to the nondiscrimination requirements of the act.

20. HEW regulations state: "Nondiscrimination in admission to a training program includes nondiscrimination in all practices relating to applicants to and students in the program; nondiscrimination in the enjoyment of every right, privilege and opportunity secured by admission to the program; and nondiscrimination in all employment practices relating to employees working directly with applicants to or students in the program."

Part II

Affirmative action properly conceived is simply good personnel management. It does not require giving preference to minorities and to women. Such preference would be illegal. Rather, it requires that these groups be included in the search for the best qualified person for a job, that equitable salaries be provided, and that promotion be granted on an equitable basis.

To establish an affirmative action plan, there are a number of steps to be followed:

1. Develop and issue a policy statement of affirmative action setting forth the medical center's policy and legal obligations, including the guidelines for all supervisory personnel, both in academic and non-academic areas.
2. Disseminate the policy within the campus and make public, i.e. to civil rights groups, professional societies, women's caucuses. Those making personnel decisions need full details about the institution's policy, along with explanation of the laws governing this subject, its interpretation and means of implementation.
3. Appoint an Affirmative Action Officer, who operates at the most effective level, and who is responsible for administering and monitoring the program.
4. Identify problem areas: salary inequity, underutilization, uneven promotion performance, and inadequate grievance procedures.
5. Give top priority to salary equity. A salary review process, if made a part of the annual budget, will correct salary inequities and prove the good faith intent of the medical center.
6. Set goals for hiring. These are targets which an institution attempts to reach by affirmative recruiting and fair hiring standards and procedures. If the institution can document its "good faith" efforts, there is no penalty for failure to meet a goal. Both the courts and the government have differentiated between goals and quotas. Under goals, preference cannot be given to women and minorities; the best qualified can always be hired regardless of race, color, or sex, as long as the obligation of affirmative recruiting and fair hiring procedures have been met.
7. Establish recruitment procedures. Active recruitment of women and minorities in academic institutions can be accomplished by: a search network across graduate departments, professional societies, and through women's and minority colleges. At the non-academic level, widespread advertising at the regional level will alert the target audience, particularly where publications reaching women and minorities are utilized.

8. Examine hiring and promotion practices. Equitable hiring demands appropriate rating of individuals so that experience, background and capability are accurately reflected. Where job relocation is a prerequisite, permit the candidate to weigh this factor, do not foreclose options by your own judgment here.
9. Review anti-nepotism policies. "Policies or practices which prohibit or limit the simultaneous employment of two members of the same family and which have an adverse impact upon one sex or the other are in violation of the Executive Order. For example, because men have traditionally been favored in employment over women, anti-nepotism regulations in most cases operate to deny employment opportunity to a wife rather than to a husband.

"If an institution's regulations against the simultaneous employment of husband and wife are discriminatory on their face (e.g., applicable to "faculty wives"), or if they have in practice served in most instances to deny a wife rather than a husband employment or promotion opportunity, salary increases, or other employment benefits, they should be altered or abolished in order to mitigate their discriminatory impact." (Higher Education Guidelines p.8.)
10. Establish training programs for non-academic advancement. Job skills may be upgraded for women and minorities, particularly on the non-academic side of the center, with the help of remedial work-study and job training programs.
11. Examine leave policies--maternity leave. Sex discrimination guidelines require that women not be penalized in their conditions of employment because they are required to be away from work on account of childbearing. Pregnancy and childbearing are justifiable for leave of absence (regardless of marital status) for a reasonable length of time and for reinstatement following childbirth without loss of seniority or benefits. Childbearing is viewed the same as any other temporary disability.

Encouragement of child care programs will increase employment opportunities for women and minorities, many of whom are heads of households. This is equally valuable to male employees.
12. Analyze grievance procedures. Good grievance procedures can help resolve complaints on the campus and avoid subsequent legal action. In general, grievance procedures should incorporate a formal procedure before an impartial committee, and be available to all employees.

Summary

Much of the above is directed to the work plan for the affirmative action officer. Given the full support of the Dean, that individual will satisfy the multitude of laws enforcing equal opportunity and may protect the center from unneeded and unwarranted legal costs. The Office for Civil Rights, HEW professes its readiness to assist university contractors in meeting their obligations. (See attached list of regional offices.)

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- Region I (Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont):
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Bulfinch Place
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(212) 264-4633
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760 Market Street
San Francisco, California 94102
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Seattle, Washington 98101
(206) 442-0473

**ZERO
INSTITUTIONAL
GROWTH:**

**IMPLICATIONS FOR
VITALITY AND LEADERSHIP**

ZERO INSTITUTIONAL GROWTH:
IMPLICATIONS FOR VITALITY AND LEADERSHIP

Proceedings of the Association of American Medical Colleges
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NEW PROBLEMS IN UNIVERSITY MANAGEMENT

James M. Hester *

In a short time universities have moved from a growth economy in higher education to the prospect of zero growth. The effects of such an abrupt and violent change on university management have been profound.

New York University has experienced fully both phases of the last decade. During the boom years of the early and mid-sixties, we took every possible advantage of resources from governments, foundations, and private donors to remedy physical plant deficiencies and to raise academic quality. The University was hit hard by the 'new depression' in higher education that began in 1968. Remedies to achieve financial viability have been severe. They include selling a 5,000-student campus, merging our engineering school with another institution, merging two liberal arts colleges, lowering the retirement age from 68 to 65, letting almost 100 untenured faculty members go, discontinuing several institutes and programs, and requiring each unit to carry its share of the total burden. We have reduced an annual deficit that exceeded \$10 million last year to \$4 million this year and to zero next year. There has been nothing half-hearted about our performance in either phase of the last decade.

THE BOOM YEARS

The early and mid-sixties were extraordinary years for higher education. While federal support for the health sciences was already growing, Sputnik's stimulus and developing concern for equal rights extended federal assistance into new areas, including basic sciences training and research, student aid and academic facilities. The expectation of an ever-expanding federal commitment to higher education developed. Between 1965 and 1968 federal expenditures for education, manpower, and research programs in higher education doubled--from \$1.5 billion to \$3 billion.

At the same time, foundation and private contributions grew. The Ford Foundation led the way with spectacular challenge grants that stimulated a remarkable outpouring of private contributions. Unprecedented fund-raising campaigns were announced regularly. State governments increased outlays for public systems to accommodate the growing student population of World War II children and the increasing proportion of students seeking graduate and professional training. Higher education expenditures rose from one percent of the gross national product to more than two percent.

In 1968 changes began. Enrollment began to level off, and even to decline, thus eroding state financial support of public institutions and tuition income of private institutions. In 1971-1972, enrollment at large public universities declined almost 17 percent and at large private universities about nine percent, while public liberal arts colleges experienced a decline of almost 28 percent (1).

* President, New York University

An abrupt change in the pattern of federal assistance to higher education occurred at the same time. Between 1968 and 1973 a period of growing inflation, there was no increase in federal expenditures for higher education. In terms of constant dollars, federal support of basic research declined by more than seven percent (2). In 1968 the federal government supported 51,446 graduate students; in 1973, only 19,649 (2).

New facilities begun in the boom years were finally completed in the late sixties, adding \$600 million to annual operating costs, excluding debt service. By 1972, universities had incurred \$10.2 billion indebtedness for construction. Growing inflation meant multiplying maintenance costs. Fixed cost for debt service and operation of plants became an unexpectedly large burden with no compensating growth of income (1).

THE HIGHER EDUCATION CRUNCH

While inflation might be met in industry by increases in productivity, a labor-intensive service such as education has no such counterpart to meet increased costs. Higher education has been far more seriously affected by inflation than the economy-at-large, while higher education's sources of income have stagnated or declined.

Other factors have contributed to the economic squeeze. Foundations have turned from general support of higher education to causes related to the urban crisis and the education of minorities. In response to the same societal issues, universities have launched minority scholarship programs and ethnic study programs. New burdens have been added this year with increased energy costs. At New York University, energy costs have risen from \$1.8 million in 1972-1973 to \$3.8 million projected for next year.

How serious has the economic crunch been? The Carnegie Commission staff estimated that in 1971 about three-fifths of the nation's colleges and universities were either in financial trouble or heading for it (3). Another study of several hundred private institutions found that those with deficits on current-fund accounts rose from 34 percent in 1967-1968 to approximately 47 percent in 1970-1971 (4).

Between 1966 and 1972, the rate of college closings jumped from eight to 44 institutions per year. Naturally, the rate of attrition is much higher among private institutions. If the trend continues, there will be 120 fewer four-year colleges within 10 years (1).

Large universities with substantial federally supported research programs have been among the hardest hit. Most severely hit were large urban research universities with substantial social commitments, like New York University.

In last year's study, The New Depression in Higher Education--Two Years Later, the Carnegie Commission stated that the institutions studied had achieved a 'fragile' financial stability. The Commission also stated that this condition could be altered by any of several unpredictable factors including rates of expenditure, inflation, voluntary giving, enrollment, or by changes of governmental policies (3).

Managerial adjustments to cope with the financial crunch have had to reflect the change in governance style that occurred during the sixties. Many universities moved from a largely paternalistic to a substantially participatory form of governance--a remarkable transformation. I believe a major achievement of American higher education has been the generally successful response to the new interest of substantial numbers of students and faculty in governance. The results are, on balance, far better than some of our more conservative colleagues predicted.

In particular, increased consultation has been of enormous value in helping institutions adjust to the realities of our new economic circumstances.

ADMINISTRATIVE ADJUSTMENTS

Ten years ago successful presidents and deans were those who dreamt big dreams for their institutions, had the confidence to take chances, and had the salesmanship to garner financial support from foundations, government and private donors. If successful, they were permitted substantial authoritarianism in management. Aggressive leadership, vision, and venturesomeness were cardinal virtues. Excessive caution and dependence on faculty consensus were hallmarks of losers.

In 1964 I issued 'The Mission of New York University,' a statement which was largely my own synthesis and general concept. Such a personal presidential statement of institutional goals was not only accepted but expected in 1964. The president was supposed to have his own ideas about how the institution should be changed. While faculty appreciated being consulted, the president was expected to take personal responsibility for the design.

To be able to fulfill his goals, the president, with the aid of administrative associates, controlled the budget. In only a few institutions did anyone expect the faculty to be involved. Extremely rarely, if at all, were students consulted.

Now once again at New York University we are preparing a statement of goals for the decade ahead. This time the procedure for establishing our priorities is quite different. Instead of the president sitting alone in his study chewing over deans' reports to distill a common theme on which he might place his imprint, he chairs a goals study steering committee representative of the faculty, students, and administration. That committee is chewing over the product of a massive goals conference involving 500 participants from all segments of the University.

In the same fashion, instead of the administration privately drawing up the budget, the University Senate Budget Policies Committee plays a major role. Main outlines of the budget are explained by the faculty co-chairman of that committee in a memorandum sent to the entire faculty. There are students on the budget committee and in the Senate. A decade ago there was nothing of the kind.

These consultative mechanisms have set the pattern for our adjustment to the economic crisis after 1968. That year our deficit was \$500,000. For 1969 it was \$1,400,000, and for 1971 it was projected to be \$9 million. A Commission on the More Effective Use of Resources reduced it to \$6,700,000, but cost-cutting gains were quickly eaten up by inflation. Our unrestricted endowment, the only source for underwriting deficits, was quickly being exhausted. Therefore, in 1972 I appointed a Task Force, composed largely of deans, to make whatever recommendations were necessary to eliminate deficit spending. Simultaneously we constructed a Committee on the Financial Emergency made up of faculty, students and mid-level administrators. The committee was to confer with the Task Force and report both to the Senate and to the entire university on the Task Force's recommendations. Due in part to this consultative group, the Senate and the academic community accepted a rather severe regime of budgetary discipline with very few dissenting voices.

The Task Force addressed itself to the interaction of academic units with varying economies, each of which is ultimately dependent on the health of the whole. Up to this time the administration had budgeted each unit separately, using surpluses generated in some schools to cover deficits generated in others. Unit budget information was not widely shared. Each unit had its own problems and assets. The central administration's job was to balance them.

The Task Force rapidly concluded that greater economic discipline was needed throughout the institution. This discipline could be achieved only if everyone believed everyone else was being held to the same standards of performance. Previous attempts at voluntary restraint under a less visible budgetary system had not worked. Everything had to be out in the open, a course which would weaken the power of the central administration to rob profitable Peter to subsidize worthy Paul.

A common measure of economic viability was determined by how much more income than its direct expenses each unit would have to generate if the University were to break even. Only the arts and sciences as the essential and inadequately funded core of the University would be subsidized by other units. All others would generate their share of total University expenses or curtail their programs. Otherwise, they might be discontinued altogether.

In practice this philosophy has been adjusted, but as the guiding doctrine for university budgeting, it has converted a collection of fiefdoms supervised by a paternalistic overlord into a collective of increasingly self-governing units which share much information about each other and about the central administration.

COORDINATED CONSULTATION

The new system requires a new kind of coordination. The deans meet each week with officers of the central administration. Much data are presented. All major budgetary matters are discussed and many are resolved. Each dean is charged now with greater responsibility for his own income and expenditures. He also has a greater voice in resolving central administration budgetary issues. He contracts with the central administration for many services, such as his share of the library. The dean negotiates these transactions, and his entrepreneurship is encouraged.

The theory behind this decentralized method of operation is that the University cannot afford the number of high-level managers that would be required to operate efficiently under a centrally monitored system. Moreover, the necessary bureaucracy would be an anathema in a university. It is our experience that as long as the central administration operates paternalistically, the schools will not discipline themselves adequately. Therefore, local budgetary autonomy is encouraged. To counteract the centrifugal tendencies of such a system, vigorous interchange between the deans and the central administration is critical. Each tub is on its own bottom, but we hold weekly, highly organized regattas. The regattas are crucial.

Two other consultative forums buttress this weekly meeting. The central administration meets regularly with the Senate Budgetary Policies Committee, which focuses on long-range budgetary issues and explains the university budget to the Senate and to the academic community at large. A budget policy committee in each school serves as a link between the dean and his faculty.

If the crunch of scarce resources becomes more severe, internal competition could produce increased friction in universities. So far, however, our experience has been the opposite. The truth has made our colleagues not only freer but more respectful of each other and of the common burden. When faced with the possibility of real economic catastrophe, as we were, a large, complex institution can organize representative groups to make hard decisions that will be accepted by the vast majority. The willingness of faculty, students and administration to face reality and accept strong medicine has been a most impressive lesson of this experience.

NEW MANAGEMENT SKILLS

One requirement of a complex system of consultative decision-making is the availability of fresh, accurate and meaningful data. While no more advanced than any other university in establishing an effective management information system, we have made progress and we are investing heavily in time and equipment to make more progress.

Our experience seems to be much like that of other institutions Earl Cheit analyzed in The New Depression In Higher Education--Two Years Later (3). He pointed out that under the pressure of financial stringency, decisions become more interdependent. No longer can each unit make decisions without reference to long-term effects on the whole institution.

A decade ago change in the University was accomplished through the processes of growth. As Cheit points out, 'Faculty members instituted changes and administrators did what was necessary to accommodate the change.' (3) Now, with a restricted budget, more information is required as change is accomplished by substitution or contraction. While decision-making involves more consultation, it also requires greater information input from the central administration.

Cheit points out that explaining and defending choices under difficult circumstances leads to increasing dependence on information and decision-making systems. To make systems work, decision points must be focused, powers defined and criteria for judgment made measurable, as in the case of our Task Force prescriptions. He describes the new thrust in higher education management: 'When resources are scarce, the planning and decision process must include a statement of the results desired. There will be an increasing effort to measure the outputs of higher education. As these become the basis for decision-making, there will be a relative decline in the influence of individual academic value preferences of faculty members. Thus will questions of money be converted to questions of academic purpose' (3).

This analysis reflects quite accurately the management changes New York University has instituted to cope with the financial crunch. We have institutionalized a decision-making process that recognizes that all major decisions are interdependent and must be made on the basis of informed choices. Increasingly we rely on systems for information and decision-making. Decision points are more clearly defined, and measurable criteria play an important role. According to Cheit, the big change is the increase in the management of universities. Some have done it with more managers. We have done it by increasing management responsibilities and management incentives for existing administrators.

More explicit reliance on economic standards of performance has aroused understandable controversy in the academic community. Resorting to modern business management techniques to control runaway deficits and to answer demands for accountability from state legislatures and coordinating agencies produces the horrible spectre of educational decision-making by the numbers. The laudable attempt of the National Commission on the Financing of Postsecondary Education to develop a practical method of determining costs for various levels of education stimulates the same anxiety.

Unquestionably, the more we measure performance by economic standards, the greater the temptation to seek educational results as cheaply as possible and to disregard elements of quality that are difficult to quantify.

THE BUSINESS MODEL

There are serious questions about the extent to which management theories and techniques

developed in business and government are relevant to the campus. Obviously we could damage the academic enterprise through the misapplication of management practices and the substitution of standards of business efficiency for academic values.

Those who express these fears are by no means opposed to more efficient university administration. What worries us is that economy-minded governors, legislators, bureaucrats, or board members may insist on standards of economic accountability that do not take into account the unique characteristics of our institutions that encourage our most important product: intellectual creativity.

A useful comparison of business and university management is made by Ralph Besse, a Cleveland attorney, in The University as an Organization, published by the Carnegie Commission (5). He points out that business has a unified management structure and its undisputed mission is profit-making. Dollar profits are the means of measuring performance. An explicit system of responsibility accounting can be developed.

In the university, management authority tends to be fragmented between the administrative and the academic hierarchies. Authority to guide and control academic affairs is shared rather than authoritarian. The mission of the university is multi-faceted, and there is nothing equivalent to profit to provide a single purpose and measure of achievement. It is to some degree impossible to quantify and measure either objectives or performance.

Besse concludes that 'Virtually all of the diffusion of authority and mission within a university is essential to the accomplishment of its objectives. No conceivable model of academic authoritarianism is consistent with the freedom required to enable a university to serve a democracy . . . the authoritarian posture of the business does not fit' (5).

Steven K. Bailey, vice president of the American Council on Education, has warned of a new 'cult of efficiency' that may distort worthy efforts to improve university management. He writes, 'There has been, and there remains, a lot of fat in academic management.' But, he adds, 'The very awesomeness of the powers and principalities of the cult of efficiency compels me to argue with some fervor that there are limits to accountability, limits to efficiency, limits to slide-rule definitions of educational productivity. Surely the ultimate philistinism of our culture would be to totally impose management science upon the educational process' (6).

Peter Drucker provides a useful perspective on this subject. Service institutions, such as universities, he states, are constantly being urged to be 'businesslike.' He says, 'What being 'businesslike' usually means in a service institution is little more than control of cost.' Drucker feels that the main point is thus overlooked. 'What characterizes a business is really the focus on results,' he says. Universities then need to be more 'university-like' in the sense that they carefully frame their unique objectives and develop their own performance standards to measure their achievement (7).

'Management is getting institutions to focus on performance and results,' writes Drucker. Universities require efficiency, meaning control of costs. But, he says, above all they need effectiveness, meaning emphasis on the right results (7).

COPING WITH NO GROWTH

Some specific new problems in university management have developed with the resources crunch. Some are common to many institutions. Others reflect the particular approaches of individual institutions.

A general problem affecting all is how to introduce change when enrollments are no longer expanding. During the sixties, administrators were able to finance new programs out of surpluses derived from lower unit costs resulting from increasing enrollments. When enrollments grow slowly, remain constant, or even decline, it is practically impossible to generate surpluses through operating budgets. Largely by substitution or elimination of programs are funds found for new ventures. Maintaining such programs as affirmative action hiring is particularly hard under such circumstances. Introducing new faculty talent of any kind is extremely difficult in a zero growth institution. A large proportion of faculties is already tenured, and more and more will be tenured each year. Clark Kerr points out that a majority of those who will be teaching in the year 2000 is already hired. The problem of renewing the faculty is one of the most delicate and difficult new problems in university management. There is no simple solution.

A number of the problems we face at New York University are special to our location and configuration. New York City, the union town, is a center of the national faculty unionization movement. This year we were threatened by a possible faculty union victory. A new constant concern for our academic administrators is how to achieve greater economies in operations without stimulating unionization. Many of us believe unionization would make it increasingly difficult to operate the university with proper emphasis on both academic values and the economic conditions necessary to realize them. Again, there is no easy answer.

Despite our success in achieving an economic turnaround without creating unlivable dissension, a large, geographically divided institution like New York University faces an enormous problem in communicating information accurately. The hard facts of our economic situation are particularly difficult to communicate, yet such knowledge is essential if the faculty is to take seriously the need to introduce more efficient instruction methods, the need to attract new students in underpopulated areas, or the need to be more considerate of our present students so as to keep them. Even with greatly increased consultation, communication remains a major problem. The job is to get information across so that it stimulates rather than discourages.

In a university that has adopted a policy of budgetary accountability by school, and where deficits are not accepted except as agreed, other management considerations have developed. The first is how to strike a judicious balance between the doctrine of 'each tub on its own bottom' and the subsidization of programs essential to the academic well-being of the entire university. Accomplishing this balance on a collaborative basis requires academic statesmanship all the way along the line, and particularly from those deans and faculties whose surpluses are used to fund other units. Achieving possibilities for students to take courses in several schools when each is eager to build up tuition income is a special problem of our method of budgeting. Determining how the president or dean encourages creativity and experimentation out of one side of his mouth while demanding budgetary balance out of the other is perhaps the characteristic problem of our day.

BUDGETS VS. IDEAS

After bankruptcy, the most serious threat to future institutional viability is a depression mentality that puts the brakes on change and innovation. The task for the president or dean today is to learn how he can be both a no-nonsense budget man and a stimulating idea man, encouraging both prudence and imagination. One without the other is useless for the long term.

Does the introduction of wider participation in university governance, requiring the development of interdependent decision-making with greater reliance on management information

systems and measurable criteria, reduce leadership responsibilities of central administrators and deans? My experience says no.

It is true that we cannot govern in the autocratic manner that was possible a decade ago. Though there are still some academic autocrats in place, they are anachronisms.

However, someone must provide the leadership for a university's sense of purpose, direction, aspiration, and distinctiveness. Systems and committees cannot provide the guiding spirit. In an era in which greater consultation is practiced, the leadership role requires more patience, diplomacy, responsiveness, conversational ingenuity, resilience, humor, imagination and stamina than administration once involved.

But these qualities are not enough. In addition to willingness and capacity to consult, the administrator must possess strong convictions about what is crucial to the educational enterprise, what are the essential purposes and characteristics of the institution, and what must be preserved and advanced at all costs. Unless the president's and deans' convictions give clear signals to the institution, all the data gathering and decision-making systems will mean little in advancing the mission of the university.

The management techniques that seem so promising to some and so forbidding to others are, after all, no more than methods to help make more intelligent, better-informed choices among possible alternatives. Decision-making is meaningful only in relation to objectives. In business, objectives are definable in quantitative terms. In education, some objectives are quantifiable, such as the number of students to be accommodated, and some are not, such as the social values students acquire in the course of their studies. Simply because we cannot quantify some goals does not mean that we should surrender primacy to those goals that can be quantified. It is in protecting qualitative objectives that responsible leadership comes in.

In the past we have wasted resources that might have increased the quality of academic programs because we did not have sufficient information to make wise decisions. Improved data and decision-making systems should save us from errors made in ignorance. We should fear data systems only if we are unwilling to join the battle to make sure their limitations are fully exposed to those who might misuse them.

You may be interested to know how it feels for someone who has been in office 12 years to have to adjust to a new kind of leadership role. A decade or more ago the president was a much lonelier person. It was very difficult to find others in the faculty and administration who gave much thought to the total enterprise. Now more people realize how interrelated all parts of the university are, and there is much more university consciousness. My leadership responsibility is not diminished. It takes more time devoted to meetings and more give-and-take. It takes a more political approach to presenting proposals and decisions. But it is less onerous because more people participate in decision-making and share in risk-taking. Ten years ago most members of the academic community worried about their own thing and left worrying about the university to me. Now I have more company, and that makes more sense. It encourages and inspires me about the possibilities of our future.

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THE FUTURE OF MEDICAL EDUCATION: FORECAST OF THE COUNCIL OF DEANS

*Joseph A. Keyes **, *Marjorie P. Wilson ***, *Jane Becker ****

If one could truly foretell the future, planning would be much simpler and the selection of the appropriate course of action for today could be much more certain. Academic medical centers are recognizing that more deliberate analysis of their social environment is increasingly critical to maintain their vitality and, in some cases, their very survival.

Where will funds come from to support activities of the academic medical center? What will society expect of it? How important will its various missions be in relation to one another? What organizational forms will be best-suited to its endeavors? Who will exert the greatest influences on the health care and health education systems? No one can know the answers to these questions with great clarity or accuracy, but the need for estimates is great. Those in positions of responsibility are constantly making decisions based on their judgment of what the future holds.

To forecast changes in medical education likely to occur within the next 20 years, the staff of the AAMC undertook a survey of deans of U. S. medical schools utilizing the Delphi technique.

Several factors influenced the decision to look at the future of medical education in this way. First, the Spring Meeting was to focus on maintaining institutional vitality and the capacity for self-renewal in a period of constrained resources. It was thought appropriate that the planning and management issues related to this central problem be placed in the context of the deans' own perceptions about the future and the problems to be faced in the planning and management of their own institutions.

A second objective was to respond to the Council's expressed desire that the deans and the AAMC take a long-range look at problems in medical education and its environment so that strategic, rather than merely tactical, approaches to their solution could be designed and implemented.

Third, it was judged that the deans would benefit from participation in such a project by sharpening their focus on factors which would influence their institutional planning efforts.

* Director, Division of Institutional Studies, Department of Institutional Development, AAMC

** Director, Department of Institutional Development, AAMC

*** Senior Staff Associate, Department of Institutional Development, AAMC

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Further, they would become familiar with a forecasting tool which they might find useful in their own planning.

Finally, somewhat irrespective of the meeting dynamics, was the potential value to the medical education community and those served by it of an explicit statement of the deans' view of the role of the academic medical center in the nation's health care system in the 1980's.

METHODOLOGY

The Delphi survey approach was developed during the 1960's as a forecasting technique by Helmer and Gordon of the Rand Corporation (1). It was designed to overcome observed deficiencies in other methods of infusing human judgment into the process of forecasting. Expert judgment, either singly or in combination, has long been recognized as an important supplement to trend extrapolation in forecasting. While the combined judgment of several experts would seem to be more accurate than that of a single knowledgeable person, observation of group dynamics indicated that the outcome was more likely to represent the views of the most articulate member of the group or the person with the greatest perceived authority. Another difficulty perceived was the natural human reluctance to change an opinion once it was publicly expressed, despite persuasive argument and cogent evidence to the contrary.

The key characteristics of the Delphi approach are: (1) the members of the expert panel are anonymous to each other during the survey, (2) there is a statistical analysis of the panel's responses, and (3) each panel member, who receives a controlled feedback of his own responses and their relation to the total panel's responses, has an opportunity to change his own responses.

For the COD project, the Delphi approach used was adapted from the National Center for Higher Education Management Systems (NCHEMS) at the Western Interstate Commission on Higher Education (WICHE) in a 1972 study of the future of post-secondary education (2).

There were four rounds or iterations to the process, beginning with a questionnaire which simply asked the respondent to 'list five facets of the totality of medical education that will change most during the next 20 years.' The questionnaire was mailed to 115 voting deans plus eight deans of satellite programs or campuses. Eighty-eight deans responded to the questionnaire. From their suggestions a list of 54 change statements was developed. *

In Round II the deans were asked to respond to the 54 change statements by judging the probability of each change on a scale of one (impossible) to seven (virtually certain). They were also asked to indicate the predicted impact of the change on a like scale of one (none) to seven (very great).

Round III provided participants with a statistical feedback of responses--range, median, range of the middle 50 percent of responses--as well as the individual's own responses to these questions. Each respondent was invited to compare his answers with the group's responses and change them if desired. In addition, for each change statement the deans were asked, 'Should this change occur, it will occur by 19__?' The choice of responses was five-year intervals from 1975 through 1995 and beyond.

* See Exhibit 1 for the text of the 54 Change Statements.

The final round provided respondents with the statistical feedback to this last question and asked them two additional questions: 'Should this change occur?' (Yes/No) and 'Which of the following will most help and most hinder the change?' Options to the last question were: (1) federal, (2) state, (3) faculty, (4) students, (5) community/consumer, (6) academic, professional and specialty societies, and (7) medical school or center administration.

Several trends were apparent after Round I of the Delphi process. First, the subject of continuing education was mentioned most frequently of all change subjects. Over 50 percent of the deans mentioned it as one of the five change areas. Second, there was little mention of women, minorities, or foreign medical graduates (FMG's) in the Round I responses. Because a discussion of affirmative action was planned for the Spring Meeting and because the AAMC's FMG Task Force report was imminent, these probable change areas were included in the final 54 change statements.

From the responses to the final version of each question a mean value of each variable (probability, impact, etc.) was calculated. This value was selected as the indicator which best represented the Council's composite judgment. The closer the mean to 7, the greater the perceived probability or impact; the closer to one, the smaller its likelihood or force. A series of tables were then constructed which list the statements in rank order from 1 to 54 by the mean value of all statements in the survey, and thus the most likely change. The responses to the question, 'Should this change occur' were analyzed in terms of the percent responding yes, and the statements were rank ordered by descending value of this percentage.

In interpreting these tables, it is important to recognize that the statements are highly skewed toward the probable, the high impact and the highly desired. For example, it is not until the 40th of the 54 statements ranked by mean probability that one finds an assigned value of 4.00, or a likelihood of 50-50. Even the statement ranked 52 on the impact scale has a mean value of 4.00, or medium impact. Similarly, 62 percent of the respondents found two-thirds of the potential changes desirable.

For each question, responses were computer-sorted by variables related to the institution represented by the respondent, i. e. public or private, region of the country, age (established before 1946, between 1946 and 1963, after 1963), quartile of research budget, and ownership or non-ownership of a university hospital. Some interesting trends emerged upon examination of these variables. For example, those deans at schools with research budgets in the highest quartile viewed the move of primary care teaching to a community hospital-private practitioner's office setting with far greater skepticism (23 percent approval) than did the deans at schools in the remaining quartiles (70, 76, and 85 percent approval, respectively). Further examination should produce additional insights.

MEDICAL EDUCATION OUTLOOK

From the Delphi Survey results, it is possible to draw a scenario of medical education and its environs circa 1985. While incomplete, the scenario can perhaps serve as a starting point for further planning or analysis by the deans as a group and within their individual institutions. The year 1985 is chosen because predictions as to when the changes would occur was in most cases either 1980 or 1985. It is safe to conclude that the dean's crystal ball is rather dim beyond 10 years. Change predictions fall

into the several categories which follow.

Students. The trend toward increasing enrollments will moderate and their present entering classes generally will be limited to the vicinity of or planned for sizes. Women will make up at least 30 percent of medical school enrollment. Students will continue to be selected for academic and scientific achievement. Other factors, such as geographic origin or willingness to serve in underserved areas, may play an important role but will not be a predominant influence. Ethnic representation may improve, but it is unlikely that it will become proportionate with the population, even though it is the most desired change with respect to students.

Undergraduate Education. No specific changes are predicted, though a number are thought to be desirable. Almost 90 percent of the deans indicate support for new emphasis in the curriculum on behavioral sciences, social sciences and the humanities, but this change is seen as having only marginal probability. There is little likelihood of a return to a more traditional approach to basic science teaching. There is a desire, but only moderate probability, that undergraduate education will be characterized by a flexible, self-study mode. It is unclear whether clinical education will emphasize primary care in the setting of the community hospital and the practicing physician, de-emphasizing the university setting. Biostatistics and computer application may receive greater emphasis, but this is not certain, though the majority desire it. Deans are confident that the six-year B.S.-M.D. programmatic model will not predominate.

Educational Roles. The academic medical center will take on new responsibility for two educational areas: graduate medical education and continuing medical education. Both are considered highly desirable. Also regarded as desirable and moderately likely is that graduate education will focus more on the education of generalists as the number of specialists declines.

Research. Biomedical research will win renewed favor. It will be supported more generously, and it may be more diffused throughout the university. There will be a renewed appreciation of basic research. There is a fear that the most important research will be concentrated in a limited number of research centers because of the competition for funds and the trend toward targeted programs.

Funding. It is virtually certain that funding of medical center activities will grow less vigorously than in the past and will be more specific in purpose. Neither an increase in capitation nor a special tax on physician income will provide new revenue sources for financing medical education. An increase in tuition to bear the funding load is considered highly undesirable and of marginal probability. The states are the single source identified as playing a larger role in the financing of medical education. There is fear of more federal control if the federal government contributes significantly more to medical center activities.

Medical Center Organization. There is some indication that the faculty will become more influential in governance of the medical center. If the deans have their way, the field of medical administration will not be dominated by non-physician, non-scientist professionals. Greater public accountability is likely to result in more emphasis on improved management process at the academic medical center.

Personnel Policies. Ethnic minorities will not be represented on medical school faculties in a number proportionate to the population. Women have a somewhat greater than even chance of reaching 25-30 percent representation on the faculty

and staff. Medical faculties will not generally be represented by collective bargaining agents. As a group, the deans have the least consensus regarding the future of tenure and voluntary teaching. They do not view the disappearance of tenure as highly likely, but most would prefer to see it disappear. Voluntary teaching is given at least an even chance of disappearing, and about half the deans think it would be desirable to pay all teachers. There is no consensus on whether residencies will become more education and less service oriented, with hospitals employing physicians to do the work now done by residents.

Educational Policy. Medical education will retain its present quality, and the influx of foreign medical graduates will be abated. It is not clear whether traditional basic and clinical science disciplines generally will retain their present form or if new organizational patterns in academic medicine will be substituted. Closer articulation between pre-clinical departments and the university is desired and regarded as likely. Medical education will be viewed and conducted as a continuum, beginning after high school and continuing through practice. A progressive development of freestanding universities of the health sciences is unlikely.

Policy Issues. There will be more formal public education in the use of the health care system, and the consumer is likely to exert a more substantial influence on medical center activity, focusing on community health care and health manpower needs. Medical profession involvement in public health and preventive medicine is highly desired and quite possible. There is no consensus on whether enhancing the quality of life and solving the problems of youth will take precedence in medical care and research over the prolongation of life. A system of institutional responsibility for health services replacing reliance on the patient-physician relationship in health service delivery is possible but desired by fewer than half the deans.

The Health Care System. The single most likely change will be the inauguration of mandatory national health insurance, desired by 87 percent of the deans. It is predicted to be in effect by 1980 and to have a massive impact on medical education. It is somewhat less certain that there will be a comprehensive national health policy to structure health care and health education. Primary care will not be delegated to others but will remain the domain of physicians. There is an expressed desire that the team approach to health care become a reality, but the probability is only moderate. The number of specialists will be controlled through a national system governing their training, and there will be effective mechanisms for evaluating physicians in practice.

The academic medical center, which will emphasize tertiary care, will be part of a regional system for providing health services. The network will include community hospitals, satellite clinics, and outreach facilities. While the academic medical center will have an important influence on that system, whether or not it will dominate is not clear. How deeply the academic medical center will be involved in caring for the rural and the disadvantaged also is not clear, though involvement is considered highly desirable and the likelihood of some involvement great. No consensus is seen on whether health services will be financed exclusively on a pre-paid basis.

THE RESULTS

What follows is a series of result groupings and analyses that chronicle those changes most and least likely to occur, those changes considered most and least desirable, and several other aspects of the results.

12 CHANGES CONSIDERED MOST LIKELY TO OCCUR

<u>Statement No. and Precis</u>	<u>Probability Rank</u>	<u>% Desire</u>	<u>Impact Mean Value</u>
48. Mandatory, comprehensive national health insurance.	1	87	6.49
17. Most graduate medical education under aegis of academic medical center.	2	96	5.58
7. Stabilization of first-year places to 15,000 - 18,000 per year.	3	93	4.15
30. Funding growth less vigorous, more specific as to purpose.	4	39	6.02
36. Public accountability as impetus for improving medical center management.	5	98	5.84
10. Women comprising 30% of student body.	6	91	4.00
22. Continuing education becoming equally important as other medical center missions.	7	96	5.82
43. Academic medical center as hub for tertiary care in regional care network.	8	95	5.57
39. Increased and formalized public education on use of health system.	9	99	5.53
27. Decline and then resurgence of biomedical research.	10	77	5.40
19. National system to control number of physicians by specialty.	11	80	6.09
28. Renewed recognition of basic research importance.	12	99	5.33

Statistical figures on the most likely changes show, in most instances, a high correlation between probability and the percent of deans favoring the change. Of the five changes perceived as most likely, as listed in the table above, all but one are considered desirable by a high percentage of deans. The exception is understandable; it is that funding for academic medical center activities will grow less vigorously than in the past. Of interest is that the AAMC is devoting or has devoted considerable attention to the five most likely changes.

Four of the five most likely changes have a very high perceived impact, registering a mean of over 5 on a scale of 1 to 7. Viewed as having only moderate impact is the statement that first-year places will stabilize. This view probably relates to the

form of the statement which poses a moderation of present trends rather than continued acceleration of class size, since the number of students admitted does, without question, have significant bearing on the academic medical center.

Of the seven changes next in order of probability, 91 percent or more of the deans would like to see five of them occur. The two in relatively less favor relate to a decline and resurgence in biomedical research and control of physicians by specialty. Six of the seven changes are seen as having moderately high impact. The one exception, regarding the percent of women students, is perceived as having only a medium impact, but it is considered highly desirable with 91 percent approval. The high probability (96 percent) assigned to continuing education followed the high number of mentions which it received on Round I.

Next to the prospect of less vigorous growth in funding, the change with the lowest level of desirability relates to biomedical research. This response is ambiguous, however, since the statement posits further decline before a resurgence thus requiring the assignment of a single value to opposing trends. More might have favored the change if no further decline were posited.

With the statement regarding the academic medical center as the hub of regional networks, the statement was intended to clarify the underlying issues of control, or the dominant influence, as well as the role of the academic medical center as a referral center. In analyzing the results, this statement (#43), was contrasted with, 'The academic medical center will provide referral (back-up) tertiary care as part of a regional system, but the system will be dominated by community-based primary and secondary facilities.' (#45) Apparently the intended contrast between the two statements was insufficiently explicit, since statement 45 is separated from statement 43 by only 11 places in probability ranking. Thus, the attempt was at most only partially successful in clarifying the concept of regionalization, a subject frequently mentioned in the Round I responses.

12 CHANGES CONSIDERED LEAST LIKELY TO OCCUR

<u>Statement No. and Precis</u>	<u>Probability Rank</u>	<u>% Desire</u>	<u>Impact Mean Value</u>
34. Physicians to pay special tax on income to support medical education.	54	16	4.60
20. Medical practice to become totally specialized, with allied health practitioners handling primary care.	53	13	6.36
25. Medical education to decline in quality, with few centers of excellence remaining.	52	0	6.48
53. Influx of foreign medical graduates to continue unabated.	51	11	5.34
1. Six-year B.S.-M.D. programs to become the prevalent model.	50	30	4.40
33. Medical education financing approximately same, except for increased capitation costs assumed by federal government.	49	80	4.48
40. Progressive development of free-standing universities of health sciences.	48	23	5.06
42. Replacement of traditional disciplines with new categories, organization patterns.	47	56	5.67
46. Medical administration dominated by non-physician, non-scientist professionals.	46	17	5.76
8. Students selected less on academic, scientific achievement.	45	40	5.33
16. Ethnic minority representation on faculties proportionate to total population.	44	84	4.19
12. Unionization of medical school faculties.	43	6	3.59

Changes considered least likely to occur are regarded, for the most part, as undesirable as well. Only three of the 12 least likely changes are viewed with approval by more than half of the deans. The two most desired, capitation increase (80 percent) and ethnic representation on the faculty (84 percent), are viewed as having only a moderate impact on the system.

More capitation support from the federal government is not one of the deans' present expectations (#33). Apparently, they believe the states will pick up a bigger share of medical education costs (#32). It might be suggested that there is an element of unreality in the contrast between the desirability deans' place on more capitation (80 percent) and their aversion to more federal control (#35), which they view as the sixth least desirable change.

Fifty-six percent of the deans feel positively toward the possibility that traditional disciplines will disappear and be replaced by new categories and organizational patterns (#42). While this change is considered highly unlikely, it is viewed as having a moderately high impact.

Clearly, deans are unwilling to turn over primary care to allied health practitioners (#20). This idea of medical practice becoming totally specialized is viewed as highly unlikely but of potentially very high impact.

14 CHANGES CONSIDERED MOST DESIRABLE

<u>Statement No. and Precis</u>	<u>Desirability Rank</u>	<u>Probability Rank</u>	<u>Impact Rank</u>
54. Medical profession to involve itself more with public health, preventive medicine.	1	17	34
39. Increased and formalized public education on use of health system.	2	9	30
28. Renewed recognition of basic research importance.	3	12	31
24. More effective evaluation of student and physician performance.	4	21	14
36. Public accountability as impetus for improving medical center management.	5	5	16
22. Continuing education becoming equally important as other medical center missions.	6	7	18
17. Most graduate medical education under aegis of academic medical centers.	7	2	13
43. Academic medical center as hub for tertiary care in regional care network.	8	8	25
41. Closer articulation between pre-clinical departments and university.	9	29	43
7. Stabilization of first-year places to 15,000 - 18,000 per year.	10	3	48
49. Team approach to health care a reality.	11	32	15
23. Academic medical center involved in developing medical education as a continuum.	12	21	10
10. Women comprising 30% of student body.	13	6	52
44. Academic medical center participation in meeting health needs of rural, disadvantaged.	14	20	24

Ninety percent or more of the deans viewed the above 14 statements as desirable. Most were viewed as fairly likely. Seven of the most desirable changes were ranked in the top 10 on the probability index: (a) institutional responsibility for graduate medical education, (b) stabilization of first-year places, (c) public accountability stimulating better medical center management, (d) women comprising more of the student body, (e) continuing education as a more important medical center activity, (f) the medical center as the hub for tertiary care in the regional care network, and (g) better public education in the use of the health care system.

The most desired change, however, is ranked as only moderately likely by the deans. Ninety-nine percent would prefer to see the medical profession more involved with public health and preventive medicine. While this change ranks only 17th on the probability index, the mean value of its probability is slightly over 5 on a scale of 7. Consumers/community is viewed as the most important force for bringing it about, while the most resistant group is perceived to be the professional, specialty, and academic societies.

Making the team approach to health care a reality, the 11th most desired change, has only slightly more than a 50-50 chance of happening in the deans' view. It ranks 32 on the probability index. While seen as somewhat more probable (4.95 on a scale of 7), the development of more effective methods for evaluating student and physician performance is viewed as a most desirable change, with 99 percent concurring in that judgment. It has a probability rank of 21 out of 54. The federal government is regarded as the greatest stimulus, and the consumer/community as the least support group in this effort.

With respect to impact, the prospect of academic medical center involvement in developing medical education as a continuum is perceived as having the greatest weight (10 of 54) of the most desirable changes. Close behind in impact ranking are: (1) the academic medical center assuming responsibility for graduate medical education (13 of 54), (2) the development of methods for evaluating student and physician performance (14 of 54), and (3) the development of a team approach to health care (15 of 54).

9 CHANGES CONSIDERED LEAST DESIRABLE

<u>Statement No. and Preci</u>	<u>Desirability Rank</u>	<u>Probability Rank</u>	<u>Impact Rank</u>
25. Medical education to decline in quality.	54	52	3
12. Unionization of medical school faculties.	53	43	17
53. Influx of foreign medical graduates to continue unabated.	52	51	29
31. More tuition support by loans, less by capitation.	51	26	21
20. Medical practice to become totally specialized.	50	53	4
35. Federal government as majority financer to have more control over medical centers.	49	27	9
34. Physicians to pay special tax on income to support medical education.	48	54	44
46. Medical administration dominated by non-physician, non-scientist professionals.	47	46	20
29. Concentration of important research in limited number of institutions.	46	22	7

Only nine change statements fall into the category of least desirable, with less than 20 percent approval of the deans. The possibility of a general decline in medical education quality is favored by none. It is closely followed in disfavor by unionization of medical school faculties, desired by only six percent of the deans. The continuing FMG influx follows next as undesirable; it is also considered highly unlikely, ranking 51 out of 54 in probability.

Increased tuition as a revenue replacement for capitation is not desired, but it is regarded as marginally probable. Similarly, the concentration of research in a limited number of institutions is viewed with disapproval by 82 percent of the respondents, but it ranks 22nd of 54 in probability.

Deans take a dim view of anyone other than physicians controlling the medical center. The prospect of the federal government having more control as majority financer is viewed with seriousness, ranking ninth of 54 on the impact index. Similarly, deans do not want professionals who are non-physicians or non-scientists dominating medical administration. This change ranks only 46th in probability, but 20th in impact.

Several other ways of looking at the Delphi survey data are revealing. In viewing

those change statements about which there is greatest consensus among the deans, it is evident that they represent, for the most part, those statements regarded as either most likely to happen, i. e. national health insurance with a probability rank of 1, or as least likely to occur, i. e. physicians paying a special income tax, with a probability rank of 54. Correspondingly, those changes about which there is least consensus represent those about which there is least clarity regarding probability, i. e. women to make up 30 percent of the student body, with a probability rank of 30 out of 54. This observation tends to confirm a feeling that a probability response of 4 (50-50 chance) for a change statement often amounted to a shrug of the shoulder regarding likelihood.

In looking generally at the desirability of the 54 change statements, there is confirmation that the deans suggested more positive than negative changes. Thirty-nine of the 54 statements were approved by more than 50 percent of the respondents. Only 15 changes were desired by less than 50 percent of the deans.

Another dimension of the survey indicates the most influential change/stabilizing agents as viewed by the deans. The federal government is by far the most significant moving force, identified as such in 29 of the 54 changes. Two forces follow in influence with seven credits each: the medical school administration and the community/consumer. The faculty is credited as the main stimulus for six changes. The deans' responses characterize the states as being as resistant to change as the federal government is supportive of it. The faculty also is seen as a major stabilizing influence.

CONCLUSION

Forecasting the future is fraught with difficulty even if the most significant trends can be identified. The late Joseph Murtaugh, a planner of considerable force in medicine, often said that the only thing predictable is that the most significant determinant of the course of future events is the unforeseen. Today we do not have the benefit of a Delphic oracle to foretell our destiny. The technique which claims the oracle's name may well produce results equally illuminating only in hindsight.

Since there is no magic in the conclusions drawn in this or any other forecast, the results should be viewed with caution and tested by other means. The value of this study, however, may be in demonstrating where there is consensus among the deans and where there is not. Their views should be of interest, and they may be of assistance in structuring thought about the future. It is hoped that this study may prove useful in setting a planning agenda for academic medical centers and for the AAMC.

EXHIBIT 1: CHANGE STATEMENTS

1. Six year B.S.-M.D. Educational programs will become the prevalent model.
2. Student centered learning, self-instructional activities, broad elective freedom and flexibility in time will characterize most of undergraduate medical education.
3. Behavioral and social sciences and the humanities will assume a new importance and emphasis in the medical school curriculum.
4. Undergraduate clinical education will emphasize continuity of care, primary care and ambulatory care; it will de-emphasize the university setting and become equally oriented toward the community hospital and the practicing physician.
5. The curriculum will emphasize biostatistics and the application of computers to clinical problems.
6. There will be a return to a more traditional approach to the teaching of basic sciences.
7. The number of first year places will stabilize in the range of 15,000 to 18,000 per year.
8. Students will be selected less for academic and scientific achievements and more on the basis of factors such as geographic origin, willingness to serve in underserved areas or in certain career patterns.
9. Ethnic minorities will be represented in the student population in a ratio proportionate to their representation in the total population.
10. Women will comprise at least 30% of the student body.
11. Faculty organizations will become progressively more influential in the organization and governance of the medical center.
12. Medical school faculties will unionize.
13. Tenure will disappear as a feature of medical faculty appointments.
14. Voluntary teaching will disappear. Part-time faculty will be compensated for teaching on a fee basis.
15. Women physicians, scientists, and administrators will make up 25-30% of the medical school faculty and staff.
16. Ethnic minority representation on medical school faculties will approach their proportion of the total population.
17. Most graduate medical education will be conducted under the aegis of academic medical centers assuming institutional responsibility for the programs.
18. Hospitals will employ salaried physicians to do the work now done by residents; residencies will become more education and less service oriented.
19. There will be a national system for controlling the number of physicians trained by specialty.

20. Medical practice will be totally specialized. Family practice by physicians will virtually disappear, and primary care, diagnostic/therapeutic routine will be done by allied health practitioners.
21. Graduate education for the generalist will increase as specialists and super specialists markedly decline in number.
22. Continuing education will become a function of the medical center of equal importance and status with its other roles, in part because of the pressures for performance evaluation and relicensure.
23. Medical education will be viewed and conducted as a continuum beginning at the post-high school level and continuing throughout practice. The academic medical center will be deeply involved throughout the process.
24. Mechanisms will be developed which will permit effective evaluation of student and physician performance in medical education and practice.
25. Medical education generally will decline in quality. A few centers of excellence will remain.
26. Biomedical research will be diffused throughout the university.
27. Biomedical research will decline in emphasis and support for a period but will see a resurgence thereafter as its importance is recognized anew.
28. There will be a renewed appreciation of the importance of basic research.
29. Competition for research funds, the trend toward targeted programs and center grants will result in the concentration of most important research in a limited number of research centers.
30. Funding of medical center activities will grow less vigorously than in the past and will be more specific in purpose.
31. Undergraduate medical education will be financed in a manner heavily dependent on student tuition supported by loans; there will be a concomitant decrease in capitation support.
32. States will play a larger role in financing medical education.
33. Medical education will be financed approximately as it is now except that the Federal Government will assume more of the total cost as capitation.
34. Physicians will contribute to the funding of medical education through a special tax on their income.
35. As majority financer, the Federal Government will 'own' and control a progressively larger portion of the total medical center activities.
36. Greater public accountability will generate increased urgency and staff interest in improving the management processes of the medical center.
37. There will be substantial consumer influence on all phases of medical center activity.

38. Consumer and community participation will effectively focus medical center attention on community health care and health manpower needs.
39. Public education concerning the use of the health system will be increased and formalized.
40. There will be a progressive development of free standing universities of the health sciences.
41. There will be closer articulation between pre-clinical departments and the university.
42. There will be a progressive disappearance of the traditional basic science and clinical disciplines with the substitution of new categories and organizational patterns within the medical center.
43. Academic medical centers will become specialized tertiary care facilities at the hub of regional networks of community hospitals, satellite clinics and outreach facilities.
44. The academic medical centers will be part of a planned system for meeting the health needs of the rural and the disadvantaged.
45. The academic medical center will provide referral (backup) tertiary care as part of a regional system, but the system will be dominated by community based primary and secondary care facilities.
46. The field of medical administration will be dominated by non-physician, non-scientist professionals.
47. There will be a comprehensive national health policy which will structure health care, health education and their interrelationships.
48. There will be a universal, mandatory comprehensive national health insurance program in this country.
49. The roles, relationships and educational programs of physicians, nurses, and other health personnel will be effectively coordinated; the team approach to health care will become a reality.
50. A system of institutional responsibility for the delivery of health services will evolve and replace the present reliance on individual patient-physician relationships.
51. Health services will be financed on a prepaid basis. Fee for service will be eliminated.
52. Medical care and research will be directed toward enhancing the quality of life and solving the problems of children and youth. There will be decreased emphasis on the prolongation of life.
53. The influx of foreign medical graduates will continue unabated.
54. The medical profession will involve itself to a greater extent with the problems of public health and preventive medicine.

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PLANNING YOUR FUTURE

Charles J. Hitch *

There is no question that something is wrong with America's health care system. We pay more per person for our health care than any other nation in the world, yet we are far less healthy than most of the Western nations. Most Americans have trouble finding a doctor when they need one, and trouble paying for one when they find one. They undergo unnecessary surgery, die from treatable illnesses, and pay for hospitals they don't need (1).

Though I would be hard put to dispute them, these are not my words. Rather, they make up the lead paragraph of a routine story on health care which I read in a San Francisco newspaper earlier this month, and I quote them to illustrate what I believe to be the prevailing sentiment today throughout the country. It's getting so that the health care delivery system is spoken of by the man-in-the-street in the same reverential tones he once reserved for the Postal Service, and this phenomenon is bad news for the health professions. Like education, the health care system is built on public trust, confidence, and support, and once breached, the public's faith is difficult to reassemble.

Medical educators and college presidents aren't directly responsible for either the image or the reality of the health care system--at least not for very much of it--but we are responsible for training the men and women who are running it and who will run it, and in this statement lies both our collective guilt and our hope for redemption. There has been precious little planning going on in the fields of health, and this lack has now caught up with us as our patchwork quilt of a non-system seems to be unraveling before our eyes. Fortunately, a series of problems caused by a lack of something can be cured by a healthy dose of that something, and I believe we already are moving in the right direction, that of coordinated, realistic, programmatic planning for the future. Objectives are being defined, goals set, inputs calculated, and dollars and cents cranked in at an early stage. This process is taking place at the level on which we place primary importance, the medical school, as well as at the levels of operation in the delivery system itself. Thus, I am optimistic about the future even while I lament the failures of the past.

I want to emphasize that I am not singling out medicine for special criticism. The profession may have been dragged kicking and screaming into the twentieth century, but the same can be said for several other fields, most pointedly, education. Nor is this situation particularly mystifying. In all areas, but perhaps especially in those dealing with human lives and feelings, the devil one knows seems preferable to the army of demons which may be lurking in the unknown. Familiarity may breed contempt, but it also carries with it a certain comfort, a rugged obstacle in the path of innovation. The imagined pain of exorcism often seems too high a price to pay, so the way things always were done becomes by default the way things will be done as well.

* President, University of California

FACING FISCAL FACTORS

But if the stance of medical men and women vis-a-vis the future is not very different in kind from that observable in many other areas, there is a difference in degree which, while certainly not unique, is perhaps nowhere assumed more proudly. This special barrier to realistic planning might be called the nobility-of-purpose self-delusion, and it afflicts all of us who see our jobs as a kind of calling. It arises because planning as an activity requires the explicit consideration of money in black and white, and it just doesn't seem right to inject such mundane factors as dollars and cents into an equation which we feel is distinguished by its high purpose. Money seems somehow to contaminate the situation, degrade our purposes, lower our sights. And yet the fiscal factor won't go away; we ignore it at our peril.

During the early 1960's I served in the Kennedy administration as Assistant Secretary of Defense--Comptroller and was thus responsible for a budget which makes even the University of California's look picayune by comparison. The reason I was recruited for the job was that I was supposed to know something about planning and efficiency, and the Pentagon was badly in need of both. With Secretary Robert S. McNamara giving me strong support, we pulled off a kind of David and Goliath act and accomplished a good deal, but the toughest hurdle we had to jump was this attitude of the nobility-of-purpose self-delusion. 'What do dollars matter,' asked the generals and admirals, 'when national security is at stake?' Similarly, hospitals traditionally and proudly have operated on a not-for-profit basis, and doctors and hospital administrators ask, 'What do dollars matter where human life is at stake?' I have heard educators imply the same thing. After all, what do dollars matter when the quality of the next generation is at stake?

The dollars do matter because no organization--no matter how high its calling or large its budget--has access to unlimited resources, as all of us have so rudely discovered over the last few years. Granted that these objectives are all high-priority and that there is a kernel of truth in each protesting cry, the importance of objectives does not justify ignoring the canons of economy and efficiency, which are to achieve the most from whatever limited resources are placed at our disposal.

Economy and efficiency are what planning is all about, though I don't want to imply that the planning process is dominated by economics and can somehow be totally manipulated by technicians grimly pursuing the scientific method. Kenneth Boulding is a brilliant economist who relieves his pursuit of the dismal science with an occasional fling at poetry. Not long ago he wrote a poem that I think bears reciting here for its wisdom as much as for its wit:

*The careful planner, if he can,
Should always plot to change his plan;
And if he follows sound directions
Will not believe in his projections.
For population growth depends
On many contradictory trends,
Though sex can be predicted (maybe!)
We're much less certain of the baby.
And Causes spread throughout the nation,
Determine rates of in-migration.
If economic growth depends
On dollars that the Air Force spends,
The rate of growth might lag, or cease
Upon the outbreak of a Peace.
Then, on the other hand, a war,
Would leave no people to plan for.
The future, then, is most uncertain,*

*And lies behind a heavy curtain.
It's bound to have some kind of stings,
So let's prepare for lots of things
(Especially to switch and swerve)
And not hitch wagons to a curve.*

With Professor Boulding's perspective firmly in mind, I want to discuss planning in universities, with special reference to the University of California and its medical schools. As background, you should know that the University consists of nine separate campuses, with eight of them being general campuses offering a wide range of academic fare. The remaining one, at San Francisco, is a specialized campus devoted to the health sciences. Besides the medical school at San Francisco, we have schools of medicine at Davis, Los Angeles, Irvine, and San Diego, for a total of five. Our general campuses range from quite large--Berkeley and UCLA are just under the 30,000-student level--to rather small--Santa Cruz has something over 5,000 students. The two largest campuses achieved zero growth some years ago; the smaller campuses will be growing over the next six to eight years or so, but very slowly. The health science schools, or some of them, have a little growth ahead of them, but again not much. All in all, the University of California is a formidable planning challenge, in both size and complexity. It is hard to strike the right balance between the central direction required for coherence and coordination of the entire University and the local autonomy so necessary for institutional vitality.

COMBINING PLANNING FUNCTIONS

Although some of you may slice it differently, let me postulate for our purposes that there are two types of planning--substantive and fiscal. Fiscal planning is the planning of budgets--how much money and how to spend it. Substantive planning is the planning of objectives--both ultimate and intermediate objectives. In many industries, substantive planning is called product planning; in education, it's called academic planning. Both fiscal and substantive planning can be short, intermediate, or long-range.

When I went to the University of California in mid-1965, I was not surprised to find there the near-complete divorce of fiscal and substantive planning, for I had just spent four years at the Department of Defense trying to remedy the very same defect. The University, however, presented a new wrinkle inasmuch as it had three kinds of planning--academic, fiscal, and capital--with each of them falling under the jurisdiction of a different vice president. There were two separate policy review boards, one for budget and one for capital outlay. Academic planning was kind of a poor relation, with very little of it done at the University-wide level. Each campus had a long-range academic plan, but they had about as much realism and relevance as the grandiose force plans churned out by the Joint Chiefs of Staff.

By combining the fiscal and capital review functions under one policy board, we made some progress in my first few years, but academic planning was still left out. Academic planning should lead the budgetary process, not follow it. To take the lead it has to be made to be fiscally realistic, which it was not. When the full realization hit us that the golden era of growth and dollars to match had ended, academic planning as the starting point made sense not only in theory. The new austerity--zero institutional growth--almost literally demanded the marriage of our planning processes.

As a result, in December of 1971 I created a University-wide Academic Planning and Program Review Board (APPRB) which assumed all the planning tasks of its predecessor bodies, plus some new ones as well. We now have a mechanism for considering together the different and

difficult problems of academic planning and policy and fiscal planning and management. For the first time since the 1870's--when the president did it all singlehandedly--we have at least the necessary machinery for integrated planning.

The APPR Board has 14 members: Seven administrators, including vice presidents, who are intimately involved in planning; four faculty members; two undergraduate students; and one graduate. The Board is responsible for developing the operating budget and the capital budget, for supervising the academic planning process, and for conducting as much academic program review as is appropriate at the University-wide level. What is appropriate is not a constant; the University-wide role definitely is greater in conditions of zero growth than with rapid growth.

The planning process--both fiscal and academic--is basically an ongoing series of interactions between the campuses and the Board, an iterative process which has no end but two beginnings. Activity must be generated both at the campus level and at the University-wide level. The Board provides the campuses with guidelines to make their planning adequately realistic, i. e., to make them face up to the hard choices. The campuses make known to the Board their needs, priorities, and creative new ideas. The Board then reviews each campus submission for consistency with University-wide objectives and with the plans of the other campuses. An important feature is that we have left the initiative for generating academic programs with the campuses and schools. As I have hinted, there is a great temptation in a time of constrained resources to move toward greater central control. While some more control is necessary, by and large I hope we can resist the temptation. The benefits of centralized decision-making are readily apparent but frequently illusory; the costs are hidden but great. What the Board must do in reviewing plans is to make sure that all essential functions of the University, even the less popular ones, are provided somewhere. On the other hand, it must seek to eliminate undesirable programmatic duplication.

The acerbic San Francisco journalist, Ambrose Bierce, composed in 1911 a satiric lexicon he called The Devil's Dictionary. In it he defines planning as 'bothering about the best method of accomplishing an accidental result.' He also defined a physician as 'one upon whom we set our hopes when ill and our dogs when well,' so you know what sort of fellow he was. Our planning process does indeed focus on best methods, but we hope the results are not accidental but the logical ends of those methods, though we certainly don't reject serendipitous findings. The way we go about it is by a combination of tough questions and common sense. No fancy methods, no computer programs, no hard-and-fast rules, no authoritarianism, no hunch-playing, and no astrological forecast can substitute for good questions.

DEFINING THE PROBLEMS

The job of planning and managing is tough enough without the superstructure of mystique with which some would burden it. In terms of theory, though admittedly not of practice, the job is almost simple. Peter Drucker has written that 'the basic job of management is not making decisions and solving problems, but determining what the problems really are' (2). To do the basic job of finding out what the problems really are, there simply is no better way than to ask those who are responsible for implementing whatever finally is decided. If you ask enough people enough questions in a way which forces substantive answers, eventually you will come up with a fair idea of what the problems really are.

In this respect I am very encouraged by the AAMC Delphi survey project to define the future of medical education. I spent 13 challenging years at the Rand Corporation, where this technique was refined, and I am a believer in what it can do. Some of the real problems were raised in your survey, and I'd like to express my appreciation to the AAMC staff whose

handling of the Delphic technique is a fine example of how it is supposed to work.

It all comes down to tough questions. For example, what is the purpose of a medical school? Is it to educate students? Conduct high-quality research? Provide patient care? Correct the maldistribution of physicians? Improve the health care delivery system? All of these? What is the ideal mix? If the mix gets lopsided, in favor of which area would you like the school to lean? How do you cope with success?

This last question may seem odd, but it can be just as troublesome as all the rest. As an example, the technique of kidney transplantation had reached a very high level at our San Francisco medical school and, since organ transplants are considered very newsworthy by the media, medical success bred popular reputation which in turn resulted in greater demand. It got to the point where the campus could almost have converted itself into one huge kidney transplant clinic. Then came the tough questions--the research vs. teaching, public service-patient care vs. education kinds of questions which pit the different missions of a school against each other. The solution at San Francisco was to emphasize the consultative function. The campus is de-emphasizing the direct care of kidney transplant patients and instead will help to train and provide consultation to others who are doing work in this field.

I have one last question to raise, but first I want to place the issue of health sciences planning vs. university planning in clear perspective. Planning at the University of California for programs in the health science schools has historically been conducted separately from, and often in more detail than, planning for the general campuses. This mode may have been acceptable when major sources of support for the health sciences were earmarked for those programs and represented essentially incremental resources. Increasingly, however, health science programs have been coming into competition for resources, directly or indirectly, with other University programs at a time when the general programs are already disadvantaged compared to the health sciences. It is clear now that the laissez-faire policy of the past won't do for the future, so we are integrating health sciences planning with the other responsibilities of the Academic Planning and Program Review Board.

Among other implications, this step means that the medical schools must increasingly consider themselves part of the University rather than independent fiefdoms. They also may be subject to comparisons with general campuses in regard to programs, resources, and perhaps even perquisites. We're not so naive as to overlook the fact that service-related activities of medical schools represent a funding source which is large as compared to all other sources of medical school funding, but future patterns of payment for these services may well change.

Integration, of course, is not all bad, even for medicine. Closer relationships between medical schools and their universities can bring resources of non-health science programs--for example, economics and city planning--more to bear on health problems to the benefit of all, especially the public, and spread the impact on medical schools of meeting the challenges to provide community service on a broader base.

HOW TO SUCCEED

Now to the last question of the planning process: will it work? Perhaps it should be the first question. Will all the carefully integrated plans and theories actually work when plugged into the real world? If you have asked all the right questions, set substantively and fiscally responsible objectives, and viewed your institution as a whole unit, you have a good chance, all other things being equal. Unfortunately, however, all other things rarely are equal. What may be perfectly logical in terms of purely internal considerations may be wildly unrealistic in the external context and, make no mistake about it, we live increasingly in active contact

with the wider community. If ever there were an ivory tower, it has long since fallen. The fact is that many of the decisions we must make are reached not only through the process of advocacy, bargaining, and negotiation. What we do in many cases must be politically popular, in the best sense of the phrase--that is, our actions must ultimately coincide with what people really want. Let me give you an example from another field.

The firm of Ernst and Ernst has made a number of technically excellent cost-effectiveness studies of air pollution control strategies in American cities. They discovered, for example, in Kansas City,* that to require each pollution source to reduce its emissions of suspended particulates by one-half (an eminently reasonable and fair performance specification) would cost \$26.4 million, whereas a least-cost strategy, i. e. minimizing cost for the whole area but requiring some polluters to reduce more than others, would achieve virtually the same results in terms of reduction by one-half of all particulates for the city at a cost of only \$7.5 million. But different performance requirements for different sources are involved. It is not manifestly fair, however cheap. For example, the proposal prescribed a 97 percent cut for nonferrous foundries, but only 38 percent for chemical plants. Not too surprisingly, the report was not well received. The Wall Street Journal carried the story under the headline 'Sometimes the facts aren't what people really want to hear.'

We learned this lesson all over again last year with the plans we had drawn up for a new dental school at San Francisco. Despite the care of their preparation, the logic of their design, and the fact that the obsolete plant of the existing school threatened loss of accreditation, the plans came to nothing. The reason was that the Chairman of the State Assembly Committee on Ways and Means comes from San Francisco, and for him and apparently for many of his constituents our new dental school didn't make much sense in the form in which we had proposed it. As far as Chairman Brown was concerned, our dental school was politically infeasible, and that was enough. No money for it was voted last year. Since then, a politically feasible compromise has been worked out, so at least the story has a happy ending.

The story also has a moral, one that we should have caught some years ago when Bob Dylan sang about it: 'The Times, They Are A' Changing.' Fields and institutions which once carried an inherent and automatic level of authority now come under regular questioning, doubt, and criticism. This affects medicine and education every bit as much as, say, organized religion or government. Latest polls say that doctors and university administrators are held in higher esteem by the public than congressmen and the President, but not much higher.

I come originally from Missouri, the 'show-me' state. It seems now that the whole country is saying 'show me': show me honesty in social and political policy, show me no hidden agendas, show me no isolated agencies, show me no authority without earning it. We can tell people that the medicine we prescribe is good for them, but a lot of them just plain won't take it on our say-so any more. They want to know what's in it, will it make them feel good in the long-range as well as the short, what does it really cost including the mark-up? Some of them are a great nuisance, and some are misguided, but most are also asking some good questions, and we had better have good answers. For in the final analysis we must be accountable to the people we serve.

* ERNST AND ERNST. A Cost-effectiveness Study of Air-pollution Abatement in the Greater Kansas City Area (Submitted to the Kansas City, Kansas-Kansas City, Missouri Air Pollution Abatement Conference), July, 1969.

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REACTOR -- DISCUSSANT

*Cheves McC. Smythe **

I live in a different world apart from zero growth. The Texas Medical Center is in a period of exuberant growth. At a recent site visit there, Gus Swanson⁺ asked a few of us why we had elected to seek further professional opportunity in this particular hothouse. My answer to Gus was that I had come on the advice of a respected friend who said that Houston and the Medical Center were the last fairylands in America where opportunity was absolutely unlimited and where dreams came true. Gus's report following his visit characterized the Medical Center as the Disneyland of medical education.

Shortly after coming to Texas Medical Center, I became quite nervous about the level of planning preceding commitments. Conversing with a very powerful official of the University and an even more powerful Regent, I made the plea that it would be a good idea for us to do some planning. The responses were immediate. From one came, 'Absolutely not. Planning would reduce my options.' From the other came, 'Absolutely not. Planning would reduce my power.' Although exaggerated, these responses are real, and it is worthwhile to consider the basis of resistance to planning, for resistance is a very real issue for anyone involved in such endeavor.

The basis for resistance is found in planning's definition as a response to constrained resources, whether the constraints be on dollars, people, space, or opportunity. Planning is a reality which compromises everyone's agenda. As with many realities, there is an inherent tendency to resist, no matter what the rhetoric in praise of planning may be. Thus, planning is in somewhat the same category as saving money or not having a second drink before dinner.

There is an aphorism, 'To every bureaucrat, the purpose of his organization eventually becomes self-evident.' Deans of academic medical centers should not forget that we are bureaucrats. One reason for caution about the Delphi Survey, and for not extrapolating too far from that exercise, is that we responded to our own questions in our bureaucratic roles. To deans of academic medical centers the mission of our institutions is self-evident; to the world that surrounds us this mission is not so apparent.

We share with President Hitch the perception that our environment is not entirely friendly. We also perceive that one of our mandates has changed from 'Grow or die' to 'Change or die.' The results of the Delphi Survey should be seen not as a miraculous statement but rather as a planning tool. They set before us a quite specific agenda. How seldom it is that a problem comes across the desk as a simple statement with the perceived probability of the power of its impact, the perceived extent of those who would resist and not resist a change, and the perceived forces stabilizing and not stabilizing the issue. No problem so clearly stated has crossed my desk in the last year. Looking at the most likely changes from the Delphi Survey--national health insurance, the control of residency and specialty education, responsibility for continuing education, and a stable enrollment--we see statements supported by the characteristics I have outlined.

* Dean, University of Texas Medical School At Houston
+ Director, Department of Academic Affairs, AAMC

If one really believes that these issues are important, and if he believes in the need for and efficacy of the planning process as outlined by President Hitch, there is an implicit and an explicit charge to begin to activate forces or teams in response to what are straight-forward, programmatic statements for all of our institutions. We seldom enjoy this clarity of charge.

COPING WITH THE RESOURCES CRUNCH

*William D. Carey **

Medical schools find themselves in trouble now because public policy in our system is basically unstable. With all the talk of managerial sophistication, lead times, trade-offs, and the other sacramental rites of modern management style, private as well as public, the fact is that public policy is whatever the administration in power at any given time says it is. The trouble is that when a course correction has to be made, the turning distance is about the same as for a 500,000-ton supertanker. Fast reactions and responses just can't be accommodated, and institutional structures are prone to snap when too much sudden strain is placed on them. It's getting so that on a clear day you can see practically nothing.

THE SHORT-TERM VIEW

For something more than a decade, government had a passion for institution-building. It arose from a view of national needs and the realization that resource underpinnings had to be put in place which would make it possible, in time, to reach certain public-interest goals. These include the elimination of diseases, the realization of universal health care, and the establishment of an infra-structure of teaching, research, and service institutions capable of bringing it all off. There was to be a governmental commitment to investment in human resources. The difficulty with this thrust was that government has never been clear in its own mind about the nature of investment, as compared with speculative risk.

I have not been able to persuade my fellow clergy in Washington that investment means that you are in to stay, that the returns are long-term, that the object is growth and appreciation of assets over time, and that if we want social capital to grow we must take a very long view of things. One would think that in this most fully developed, enterprising society, such a view would be common sense and the conventional wisdom. Not so. High resolutions have short half-lives and tend to be overtaken by quiet revolutions, failures of nerves, changing priorities, breakdowns of advocacy, and seizures of compulsive rationalism in decision-making. It does not make for stability or continuity in public policy, and it is especially fatal to the whole notion of investment in institution building. I am saying that government's decision-making is faulty, that it suffers from a kind of jet lag, and that it is not yet commensurable with the scale and the implications of its power. Instead, it displays all the behavioral symptoms of a very confused, impulsive, nervous, and near-sighted elephant on the loose.

Some perspectives are necessary when government has so vast an influence upon outcomes. In some areas of national policy-making, like national security or economic policy, I think the arrangements do provide perspectives, though they are hardly foolproof. In other areas, such as science, education, human development, and social change, the perspectives hardly exist at all. When they are forcibly formulated--remember the Kerner Report, the numerous Rockefeller reports, the Johnson task force reports, the spate of Nixon commission reports?--

* Vice President, Arthur D. Little, Inc.

they are all brief candles which soon flicker out. So we are in a predicament, as my friend John McHale, Director, Center for Integrative Studies, State University of New York at Binghamton, likes to put it, where we not only don't know what we need to know, but we don't know what we don't know.

The Times ran a review recently of a new book by Peter Schrag, titled The End of the American Future. I haven't yet read it, but if I can believe the Times, it's about the collapse of the grand postwar consensus that produced all the social reforms of the recent past. The reviewer says the book belongs to the growing literature of liberals' despair over their apparent inability to master the nation's problems. The reviewer observes that the author 'fails to see that if an age has come to an end, it was more likely an age of wishful thinking that tended to inflate expectations and cover up the conflicts that have always been there.' To that he adds that the Americans who appear in the book seem 'so sapped of resilience, so humorless, woe-begone and besieged that it's a wonder they can get through the day' (1).

MANAGING DEFENSIVELY

The troubles and pinched nerves that afflict the medical schools are part of this larger malaise that seems to have taken us all over and produced a kind of arrest of life--an unplugging of the corporate sense of purpose which supplied so much energy and at least some accomplishment in the recent past. If, wherever we look, what we see are people besieged and sapped of resilience, we see a people who do not build but merely burrow. It is not a time when people care much about putting things right because too much has been going wrong and because there is a great shortage of belief in anything. This malaise is a shabby vestibule, indeed, to greet a bicentennial.

As an outsider looks at the cascading problems of the medical schools in today's climate, several impressions come to mind. First, that the same set of reactions and hedges one finds in the corporate business world are likely to show up--the managerial anxiety created by the difficulty of predicting what the future holds in store, postponement of innovation requiring front-end capital, a turning-off of experimental activities that no longer seem affordable or justifiable at the margins, a hard-nosed search for cost reduction opportunities, a conservative recalculus of growth targets, a stripping down to basic core operations for which quality and cost control can be maintained, and a concentration of services upon the most dependable market sectors. These are the things that any manager turns to if he is to minimize the risk of being caught in an over-extended position which may take several good years to make up. He hedges, cuts his risk, throws off excess weight. And, often enough, he is secretly glad of the excuse to do what would have been politically unacceptable under different conditions. He weeds out deadwood, levels off the pay line, concentrates workload in a smaller work force, lets job vacancies go unfilled on one pretext or another, repairs equipment instead of replacing it with new-generation equipment, watches cash flow with a jaundiced eye, and adopts a hard line in bargaining with employee organizations. A manager in a production industry takes these steps in adversity.

In a service industry, the problem is worse. There are created expectations. There is goodwill to protect. The service industry manager must think twice before reducing service standards or skimping on quality. The options are fewer because costs tend to be uncontrollable, being a function of your service standards. So it is necessary to re-examine the menu of services and find out which of them meet the tests of need and user-demand, and which are heavy losers to be culled out.

There is a name for this kind of management. I call it defensive management. It can neither be helped nor ducked. But it leaves painful and longlasting after-effects. The patient survives

but is not really well. Underlying defensive management is the assumption that in due course the cramps will subside and the situation will return to normal.

WHAT IS NORMALCY?

That is where the real trouble may lie--in the assumption. It's like the business of 'getting from here to there' only to find that 'there' isn't there after all and wasn't there in the first place. So it goes with the assumption that there is a pattern that can be taken as normal. It turns out that normalcy is in the eye of the beholder, and it may have little or no reality.

Management in a time of trial and trouble doesn't have to be exclusively defensive. It can also be decision-forcing, through a very healthy process of running the film backwards--tracing the assumptions and the choices which brought the medical school system to where it is; working out alternative forecasts of the professional, institutional, and political environments which may come to be in the decade ahead; identifying the impacts and probabilities that these different milieus will have on the prevailing idea of the medical school model; defining the options and constraints that accompany them; and breaking through to take new, if experimental, ground that can project the medical schools into the future environment instead of having them dragged there after the fact.

Every major industrial corporation and financial institution today is in this frame of mind. The demands for forecasting, for anticipations of change, for assessments of the significance of these changes upon present strategies is epidemic. The business world is learning that the time-cycles for introducing change are growing shorter, and that the corresponding reaction times must also be shortened. Otherwise, miscalculation can wipe the business out. We know what some of the uncertainties are: the evidence of erosion in the U. S. natural resource position, indicating future dependence on third-world countries for critical materials and minerals on which our manufacturing hinges; disruption of the price system because of externalities that perturb costs; declining U. S. productivity and technological lead as a result of our overseas export of know-how; changes in birth rates and family formation; government regulation of consumer product standards; international retaliation against multinational corporations; and chronic worldwide economic inflation from which we will not be spared. Trials and troubles are not confined to the medical schools.

ACCEPTING THE RISKS

Risk is escalating as a problem of management in every sector of our production and service enterprise. Uncertainty is here to stay. It can't be wished away. It is folly to base hopes and plans on a linear resumption of conditions that prevailed when there were seasons in the sun. Medical schools have become social enterprises upon which many hands are laid; they have been threaded into the larger process of socialization, whether consciously or unconsciously. The scale has changed. The benefits may have been considerable, but they have exacted the usual price--intervention, manipulation, regulation, accountability, and integration with national goals and objectives. To live, much less prosper, in this system takes a lot of doing and a kind of policy-making capacity that can preserve the diversity and creativity of medical research, education, and service with its own values. Medical schools must dig in somewhere short of finding themselves a nationally regulated public utility system, which is the present drift of things.

If the medical school today is a composite representation of a troika of responsibilities--teaching, research, and service--I would ask whether this model is viable in the long run. I

don't know the answer, but given the growing trend to make health care a universal right, given the prospects for continued cost escalation across all three missions, and given the barriers to fiscal flexibility that are coming thick and fast, I am asking whether the assumptions on which this three-dimensional model is based remain valid. If you have to make a choice, what will the risk analysis show to be the best alternative? Who should make the choice? Is the choice yours, the university's, the community's, the profession's, or the state's? Does the policy system for reaching such a choice even begin to exist?

Let's look at one or two of the medical school roles. First, medical research, which has been a growth industry for about 20 years. Is consistently high quality a certifiable fact across the spectrum of medical school research? Do the politically sexy research categories drive out meritorious and needed work in less-favored sciences while escalating institutional costs without commensurable benefits to teaching and service? Is the research element of the medical school really run by the federal funding process, and is it time to break that control? Should some capacity boundaries be placed on the appetite for research effort, and, if so, what are the trade-offs?

Next, the education function. Does it support research and service, or is it the other way around? What are the objectives of medical education--to produce primary care physicians; to produce enough manpower to meet demand; to equip everybody equally to opt for specialties; to train physicians for urban medical care or for rural care; or to keep the research manpower pipeline filled? Are these objectives explicit? Are the costs of these options known, and do they show a marked spread? Is the per capita cost of medical education really way out of line with other kinds of graduate scientific training at prestige institutions, or is this a myth that dies hard? Did federal incentives for medical education and research lead you up a garden path that you wouldn't and couldn't have taken on your own and which is not really sustainable under current ground rules? Is the faculty/student ratio really untouchable?

NEW APPROACHES

Beyond these kinds of questions and choices there is another dimension. Perhaps the changed environment of the medical school justifies playing a wild card or two. I suspect that within almost every institutional enterprise there exists a suppressed itch to break the mold and make a fresh start. In the business sector this usually is translated into technological innovation, product diversification, penetration of new markets, or gambles with venture capital. Without such moves the business world would be a dull and second-rate affair.

In medical schools, what wild cards can be played? Is it barely conceivable, for instance, that a medical school could become an affiliate of a major business corporation desiring to spin off some of its assets and improve its public image as a good corporate citizen? Why not? What would be wrong if a medical school were to be sponsored and supported by a major labor organization? Is there that much difference between the AFL-CIO, on one hand, and church-supported medical schools, on the other? Can some imaginative consortia be assembled along these lines while keeping the university in the picture as it should be kept? Would it be so unthinkable if undergraduates were enrolled in the medical schools as joint degree candidates, to shorten the training period and help with the cost burden? Isn't there a role for the medical school to contribute to the work of other graduate departments, to say nothing of undergraduate training and education, even while recognizing that the university has budget problems, too? Why shouldn't the medical school draw substantial income from an array of services to industry in areas of preventive health, occupational health, clinical services, and health counselling? What would be wrong about reducing the school's financial indenture to government programs, instead of drawing the noose tighter?

The answers to these questions are more complex than defensive management can handle by itself. The answers will be dusty. But medical schools have a better chance to find them if they see the schools not just in a narrow setting or in an immediate and acute bind, but in the perspectives of the many changing environments that will determine, in the longer run, what the outcomes are likely to be. Some of the answers might just possibly lie in thinking and trying the unthinkable.

Unlike the author of The End of the American Future, I think we are far from worn out or washed up, and even an ex-budget critic can believe that the sun also rises.

But the future should not be built on visions of Disneyland with striped candy, balloons, and discount package trips for everybody. Not if it is to last. Peter Peterson, who was Secretary of Commerce for a few brief months in 1972 before the roof fell in on him, went to Wall Street to head Lehman Brothers. A newspaper reporter dropped in on Mr. Peterson after he had been there a few weeks, and he asked the former Secretary what his priorities were going to be at Lehman Brothers. The answer he got might help us to make some sense out of the future we want. Mr. Peterson thought for a minute, and he said: 'My priorities? I'd say there are three: defining who we are; deciding where we want to be excellent; and doing a few things, excellently.' That really is what I have been trying to say.

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REACTOR -- DISCUSSANT

*Richard Janeway **

An important theme of Mr. Carey's eloquent presentation is that the recent discontinuities imposed on an historical progression of the governmental passion for institution-building carries with it the potential that we will respond by retreating to defensive management. I call this response the 'turtle syndrome.' Rather than retreating we might reorder our thought processes to become more autonomous of federal whimsy.

Whimsy it is, although in response to Mr. Carey I believe it is not government per se, but the political process that inhibits a clear differentiation between investment and speculation. It is unrealistic, in my opinion, to expect anything other than instability of policy. It is more realistic to assume that the elected representation of society will almost always choose solutions most satisfactory to its perceived short-term self-interest. The safest political course for any elected body is to capitalize on the present by mortgaging the future. This course results in short-term solutions to long-term problems, wherein lies the essence of unstable policy.

We are a pendular society. Our societal aspirations often exceed our resolutions and capabilities for achievement. We never reach a dynamic equilibrium because of an archetypal misapprehension that equilibrium and stasis are synonymous.

THE DISAPPEARING DEFICIT BUDGET

As conservative creatures in the main, we as deans are highly susceptible to the turtle syndrome. We should be aware of this facet of our nature and guard against its emergence as a dominant behavior trait. Although we might not admit it, we have helped to bring the turtle syndrome upon us as we projected future dollars for institution-building during the halcyon days of the defensible deficit budget with the same elan that insurance companies project dividends.

Parenthetically, if we were to affiliate with any non-university organization, the insurance industry might be the direction to look. They surely would not cast upon us the pre-Flexnerian, proprietary diploma-mill image. Such an image might be an inadvertent fallout of the full-cost tuition posture of our federal friends, the current majority stockholders of this particular conglomerate.

We are fond of the phrases 'general economic uncertainty,' 'multi-source financing,' and 'contingent upon grant support.' We rely on them when presenting the budget to vice presidents for business and finance, trustees, and legislative committees. We have also been known to say, 'Sure, this is today's budget, but it doesn't mean all that much. It will change tomorrow.' Then we use all three phrases again in the most appropriate order. Entranced by institution-

* Dean, The Bowman Gray School of Medicine, Wake Forest University

building, the trustees nonetheless stamp their approval. All too often the budget presentation has amounted to a 'deficit defense.'

The day of the defensible deficit budget is over. At the risk of academic heresy, I am convinced that accountable management of academic medical centers requires that we do better than merely balance our budgets. Extramural support, the result of our lemming-like annual search for new dollars, is dwindling. To compensate, I believe we should strive for a 'net positive cash flow' position at each year-end. Net cash should be derived from the internal management of liquid assets and from creative portfolio management at higher organization levels. Cash created by program inhibition is too costly in the long run. As a prime product, internally developed new dollars can serve as a powerful reversed-carrot for the attraction of extramural venture capital. As a by-product of necessity, incremental dollars can be budgeted ahead for use by established programs so that they don't stagnate.

I am not a supporter of incremental budgeting. I am convinced that any organization that depends on extramural support for program development is in trouble unless it plans to abandon the incremental concept. However, this abandonment is just not going to happen overnight, any more than Aphrodite sprang full-grown from the head of Zeus.

In theory, the replacement of incremental budgeting by a more rational system of resource allocation is the correct response to the 'zero-growth' environment. However, the degree of organizational trauma generated by the introduction of PPBS or zero-base budgeting renders instantaneous application a practical impossibility unless there is an unconscionable amount of fat in the budget.

If one accepts this potential trauma as a constraint, institutional managers must assume responsibility to produce certain portions of the incremental dollars internally. Implicit in this statement is that the responsibility for the provision of other portions, and eventually all of the increment, becomes the responsibility of the established program.

Although this suggestion may initially jolt program directors, it reflects nothing more than the philosophy that any program which could be self-supporting should support itself, thereby freeing funds for programs that are no less valuable but which cannot possibly be self-supporting. For this philosophy to succeed, there must be a corporate understanding of institutional goals among the faculty.

There is one other substantive rationale for advocating a net cash flow budget in a non-profit corporation. This rationale assumes that the institution has the responsibility to provide internally-generated venture capital. Initial internal support of innovation is far more impressive to potential grantors and donors than is incremental support of established programs. Since it appeals to the entrepreneurial spirit, this approach is also satisfactory to responsible program directors as long as they understand and accept the process at the front end.

Front-end acceptance of the congruence of individual and institutional goals is the first step toward the acceptance of budget adjustment and resource allocation. Continuing visible support of individual and institutional goals by the administrative leadership of the institution is the second step, but the vital element in the process is the demonstration that goals and objectives are being achieved to mutual advantage.

There are many mechanisms suitable to provide this framework, but as Mr. Carey points out, environmental assessment which will allow reliable 'future forecasting' is essential to goal setting and planning. Faculty involvement in generating shared goals is the only assurance of the exercise's success. We cannot expect the support of our faculties or trustees if we do not appropriately manage the finances and programs in a direction reflecting our commitment to

the validity of shared goals.

BENEFICIAL OUTCOMES

Is the situation today totally bad? I believe not. At least two strategic opportunities are available to help us cope with the resource crunch. They involve effective utilization of medical service income and decentralization of financial management within the university structure.

Faculty salaries, many of which are already too low, will be further constricted under federal initiatives which conclude that the teaching physician is worth less than his non-teaching counterpart. This imbalance must be redressed if we are to compete successfully for faculty to maintain excellence in education, research, patient care, and responsibility to our communities.

This situation can be redressed to individual and institutional advantage if there is a consensus among full-time faculty to participate in private patient care within the rubric of a carefully designed medical service income plan and if institutions are prepared to move toward the single-class-of-care concept, which will be one of the major tenets of any national health system. I contend that faculty involvement in private care and the single-class-of-care concept enhance the quality of the training environment and of patient care. If we as academic medical centers are capable of producing the best in patient care, we should participate and demonstrate our excellence.

A controlled medical service income plan can be a major step toward organizational financial stability. There is a direct interrelation between the responsibility for production and receipt of funds and the resultant prudence of their management.

The second opportunity is in decentralization of financial management within the structure of the university. This does not imply separation from the academic functions of the university, but rather a recognition of those centers wherein financial management is best handled by personnel most knowledgeable of the intricacies of a particular profession.

Were this decentralization to be the rule rather than the exception, I believe we would see fewer academic medical centers with sponsored-program expenditures far in excess of regular operating expenditures; many more deans with a clear understanding of the difference between controllable and uncontrollable costs, many more schools with well-defined strategies for improved cash flow management through short-term investment of operating funds; many more deans with a clear understanding of the meaning and appropriate use of indirect costing, amortization and funded depreciation; and far fewer centers in financial distress. Much as the production and receipt of medical service income promotes prudence in expenditure, so, too, in my opinion will the pinpointing of financial responsibility on the person charged with conceptualization and implementation of programs reflect itself in general university efficiency and cost-effectiveness, as well as more prudent and stable governance.

This course will take environmental assessment, planning, and goal setting, but it may allow organizations to capitalize on the pressures that are forcing them to pre-ordained goals. One caveat: inherent in the development of a strategic plan is the assumption that one can forecast on the basis of past data. If the environmental assessment is unreliable, the plan has lesser probability of success.

I agree with Mr. Carey that risk is escalating as a problem of management and that uncertainty is here to stay. This does nothing more, in my view, than make it imperative to play an occasional wild card. To pull in our necks, play turtle, and become afraid to make mistakes would be one of the biggest mistakes of all.

I have been told than an optimistic nature and high tolerance for ambiguity are desirable managerial attributes. The courage to play a wild card ought to be on the list.

SPACE - GIVE AWAY, PURCHASE, LEASE OR RENT?

*Jane G. Elchlepp **

Space has three major components for management considerations: (1) acquisition or capital building cost; (2) recurring building cost, including maintenance and operations costs as well as depreciation; and (3) utilization. The latter has two components. One is the obvious element of use; the other is the operations cost of the program activities carried out in the space.

Management of these three components can be addressed at two or three levels, varying with the institution. The two levels are: (1) institutional or school level and (2) departmental or divisional level. In large institutions with multiple schools, there may be three levels of management: (1) overall institutional level, (2) individual school level, and (3) departmental or divisional level.

This paper addresses different modes of handling both the acquisition of space and the continuing use of space, focusing on financial implications. For purposes of this discussion, some specific definitions are assumed.

'Give away' refers to the acquisition or use of space that involves only a decision by the user of 'Do I want the space?' Such is the case if a benevolent donor proffers dollars for conversion to space or presents the space itself without imposing substantial restrictions on the user. Specifically, the user does not use his own funds in acquiring give-away space, nor can he substitute his own priorities for those of the donor.

'Purchase' assumes a substantive choice for the institution or institutional sub-unit. The user must decide about the kind of space to be purchased by funds he has acquired or by budget funds that are available. He may have to make a choice in commitment of funds between space and salaries, space and equipment, etc.

'Lease' assumes that, once again, the user faces substitutive budget choices and also that constraints of time or use are related to the space. Leasing of space does not usually occur on a long-range basis except under certain contract situations. On the other hand, institutions have frequently used what might be called 'lease-purchase' arrangements, where a combination of their own funds and external funds are used to acquire space for a specific purpose for a specific period of time. I would classify the National Institutes of Health (NIH) research construction monies as an example of this. In this case, the federal money together with the institution money, in some predetermined ratio, are applied to the acquisition of space for a specific program and for a specific period of time, usually 10 to 20 years. This kind of space is subject to specifications, surveillance and monitoring by the external provider of funds, leading frequently to added capital costs.

The last category, 'rent,' is seldom used to acquire space for an institution. It usually represents a temporary mode. For our purposes, it is assumed that renting involves exchange of money for the space, no restrictions on the use of the space, and a fairly open-ended arrangement on time.

* Assistant Vice President, Health Affairs - Planning and Analysis, Duke University Medical Center

Up to this time, the auditing of capital acquisition of space has not been a significant problem for most institutions. In the give-away situation, the benefactor may want to visit the space which his money provided, but he does not usually attempt to audit its use.

In the lease-purchase situation, I know of only one effort where the federal government has attempted to audit the use of its construction monies. Six or seven years ago, inquiries were sent to institutions which had received federal research construction funds. The institutions were asked to reconcile current use of the space with the purposes stipulated in their construction grant applications. There was no feedback from this questionnaire, which was fairly detailed, and it has not been repeated. There generally are routine assurances of use requested after completion of projects.

Last year a space-utilization survey was sent to all health professional schools, but the questionnaire instrument was generalized and vague. Most attention was given to educational space which might have been constructed or renovated with health professions education assistance money.

Space leased or rented under contract situations is audited primarily pre-award on a cost-per-square-foot basis, but there are no inspections or regularly recurring reports required in connection with this space.

COPING WITH COSTS

On-going recurring costs of space are too infrequently addressed at the time of capital acquisition. Usually the depreciation period for a permanent building will run from 30 to 50 years. Funding of depreciation has been accepted for health care facilities, but it usually has not been a consideration in research or educational buildings. However, it is possible to include depreciation as an element for consideration in indirect cost recovery.

The problem in costing building depreciation is that there are variable rates of depreciation for the different components of the building. On a structural basis, there is a 50 to 60-year or better life span. However, mechanical or utility components of the building may vary from 15 to 30-year life. If one did not consider appropriateness of the interior for changing use, the life of the interior layout of the building could well approach its structural life. In practice the least permanent component of a building is an interior wall in a particular area.

During the first five to 10 years of the building's life, maintenance and operations costs will usually run per year between three to five percent of the total capital costs. Compounded inflation takes its toll and can quickly get to a level where in the tenth or eleventh year of the building's life, annual maintenance and operations costs are running better than 10 percent of the building's capital cost. In the first 20 years or less one may pay out the capital cost in maintenance and operations. This estimate excludes any renovation costs, which usually do not significantly add to the building's capital value and are undertaken primarily to optimize the use of given segments of space by particular users.

In assessing utilization costs - that is, the operating budgets of the occupants of a building - one finds that within three to five years of occupancy, the capital costs have been equalled or exceeded by the cumulative annual operating budgets of the occupants. An example comes from the Duke campus where a major research building with a capital cost of approximately \$7 million dollars is occupied by departments whose combined annual operating budget currently approximates \$3.7 million dollars. The departmental operating budgets for two years is slightly greater than the capital costs of the space. In this case,

even looking only at the so-called hard-money portion of the budget, the capital cost of the building would be equalled in slightly less than 10 years.

The biggest problem for an institution is, of course, the recovery of its investment in space and the provision of funds for maintaining and operating space. Business procedures of building depreciation funding involve a detailed cost allocation of both the depreciation and the maintenance and operation costs to the user components. These costs are then incorporated into a charge structure for the business's product.

To act similarly in an educational institution, one would first have to look at sources for these cost-recovery funds. True income-generating space in the medical center is not the problem. The hospital component can, and usually does, incorporate space in its costing and charging structure. In research functions, building maintenance and operating costs have been an element in indirect cost-recovery negotiations for many years. Funding depreciation of research buildings is a relatively new concept, but it has been done in several institutions. Auditable documentation of both capital expenditures and space use allocation is required for successful negotiation of recovery of depreciation in indirect cost recovery. For educational activity components similar recoveries would be possible with appropriate documentation. Such documentation would be necessary if cost allocation for educational activities is extended to development of true cost tuition levels.

BUILDING A DATA BASE

At the Duke University Medical Center, our basic space inventory is computerized. There is a building identification, plus a floor and a room identification for each space. The type of room is indicated, using the HEGIS terminology in which 'non-class lab' is the term applied to research labs. We add a fourth digit to the three-digit HEGIS code to enable us to identify hospital and clinic space in more detail. Other information includes the activity component or cost center, how much (100 percent or less) this cost center uses the space, title of the cost center, functional use of the space, physical dimensions of the room, and square footage of the room.

From this data base, many reports can be generated. One of the more useful ones is a display of one building with a listing of the various activity components in it. The report shows the percentage of the building that a specific activity occupies, the actual maintenance and operations cost of that particular component, and the forward year budget projection for maintenance and operations cost. We can also generate a report which takes a single component or an aggregate of components and shows the summary of the space they occupy, its location, and the maintenance and operations cost for the space.

Another report shows by activity component a summary of the types of rooms occupied by the component, tabulating the number of offices, research labs, or other category and breaking the space into functional allocation to show the number of square feet that are applied to each activity such as education or research. Maintenance and operations costs of the building as well as the depreciation can then be split either with regard to function for cost-recovery purposes or tied back to specific departmental components for cost allocation.

The ability to recover maintenance and operations as well as depreciation costs through indirect cost-recovery negotiations can be significant for the institution. For example, in a recent negotiation approximately 52 percent of the total indirect cost eligible was attributable to maintenance and operations plus depreciation. Half of this total was identifiable as depreciation.

When one looks at cost recovery or utilization management of space on an activity component level rather than on an institutional level, the problem becomes more complex. Hospital and clinic space is relatively simple, since it has become customary to deal with allocation of the maintenance and operations and the depreciation costs in developing charge structures. As noted earlier, this model is now being used in dealing with research space cost recovery. If funding support for education develops like that for research or if true costs are built into tuition levels, education space costs can be handled on the same basis.

RECOVERING SPACE COSTS

Management of utilization of space and detailed procedures for cost allocation and charging for space at departmental levels lead us immediately into political and economic problems. The concept of renting space to departments or divisions has been tried in some institutions. In these cases, building maintenance and operating costs are sub-allocated among the occupants of the building, and over a period of time departmental budgets are increased to accommodate these charges. After this distribution has occurred, an attempt is made to deal with the activity component so that the manager of that activity makes a choice on use of space money in his budgeting. If he elects to give up space, he can apply the money for purposes other than space. If he elects to pick up space, he must then divert funds from salary or equipment to pay for that space. This mode could create problems in the event that a number of activity components simultaneously decided to return space to the institutional space pool, theoretically leaving the institution with empty space on its hands. This possibility seems extremely remote, and this allocation approach does force the activity component manager at department, division, or other levels to examine space utilization carefully and to use it effectively.

An additional possibility with regard to research space is to relate occupancy of space to recovery of space cost. It is my understanding that in some institutions if a functional unit is not recovering all indirect costs (including those of space) related to operation of the building, the functional unit is asked to vacate the space. There are a number of problems with this mode of handling space. One is that it chokes off the developing functional unit which has not yet acquired the strength to generate its own funds. Another is that over a period of time there can be considerable movement in and out of space, which has another kind of cost associated with it.

Another way of handling space cost-recovery is to maintain sub-unit allocation of cost for purposes of institutional monitoring but to make no attempt to assign specific cost to specific activity units unless there is an overall institutional deficit. In this mode, one would find some units generating far more indirect cost recovery than can be directly related to the space that they occupy. The pattern of federal negotiation for indirect cost-recovery which relates to wages and salaries rather than to actual cost allocation, accentuates this situation. One can have a functional unit occupying a relatively small amount of space and/or relatively inexpensive space with a high wage and salary line in the budget. A similar amount of space which is very expensive to operate may be occupied by a functional unit having a lot of equipment and relatively small wage and salary line in the budget.

For purposes of long-range growth and development patterns, it is probably better to approach the problem of space cost-recovery on the basis of the overall institutional balance sheet rather than on the detailed activity component basis. However, it is useful for the component managers to be able to see the specific costs attributable to their activities when negotiating space allocations with them.

MANAGING SPACE USE

The problem of institutional management of the use and occupancy of space is a quicksand area with very few safe pathways through it. Institutions have used space utilization committees consisting of faculty members and/or combinations of departmental chairmen. Such committees usually suffer from chronic progressive impotency and frustration, the basic pathology being conflict-of-interest and lack of objectivity.

There does not seem to be a good solution to the problem of evaluation of the utilization of space. Even those rooms lying empty are identified as space being saved for recruitment of faculty members or development of expected programs. Space and salary dollars are the primary tools for the departmental or divisional manager to use in developing and maintaining his programs. Even where 'ownership' of space clearly resides with the dean, specific allocation and utilization of space is always a matter for extended and difficult negotiations. The principal problem for space use management is the same as for budget negotiations--in far too many instances very little is done in the way of substitutive program negotiations. Most dealings with space start from the assumption that addition of space is the only solution to the institution's problems.

Decentralization of space management is probably the most effective way to handle this. If large blocks of space are assigned to a departmental manager who controls the subdivision of this space, he will have to referee internal negotiations for space occupancy and use. He is probably the most effective judge of the needs for his department. The concern at the institutional level is to protect the 'have-not' activity components and to maintain standards for relationship of support space to direct activity space.

It might be useful to apply the lease-purchase concept within the institution. This plan would involve allocation of blocks of space or buildings to departments or programs with reversion to institutional administration after 10 years or so. At the time of reversion, a zero-base type of review of the space allocation would be undertaken and fresh decisions made on future commitments of the space.

REACTOR -- DISCUSSANT

*Russell H. Morgan **

Management of space constitutes one of the most difficult problems faced by a dean. Often space administration involves conflict management. Widely divergent points of view must be resolved. I remember when I announced to my departmental chairmen that the dean's office would periodically review all space assignments. One chairman commented, 'This is a great idea, just as long as it isn't my space you're talking about.'

At those institutions where space is well managed, two basic ingredients prevail. First, the administration maintains an excellent space information system; second, the administration takes the lead in a process of participatory decision-making, where all individuals affected by the decision have a role.

I visited Dr. Elchlepp at Duke University and saw first-hand the superb information system she has developed for space management at her institution. It is not surprising that there are few situations with which Dr. Elchlepp deals where she does not have the information available for sound decision-making.

The second step in space management is also handled well at Duke. Dr. Elchlepp has expressed a very low regard for space committees in this process, and I agree with her. Instead, it is important that the dean's office bring together parties affected by any change in assignments and work with these parties until a mutually agreeable solution is reached. In most instances when this plan is followed, the parties themselves make the decision. Only seldom does the administration have to decide unilaterally. The administration's role is a guiding one marked by four steps: (1) identifying the contentious aspects of the problem, (2) bringing together pertinent information, (3) devising alternative solutions to the problem, and (4) summarizing the consensus position finally reached.

Dr. Elchlepp has dealt with three major aspects of space management: planning, maintenance, and utilization. In each, she has discussed both the fiscal and operational components to be considered. She has emphasized the need for an excellent data base, an essential element for any administration which hopes to manage space well.

Dr. Elchlepp has identified space utilization as a most difficult problem, due in part to difficulties in assembling good information. If one asks a departmental chairman for utilization data on the space assigned him, the information is frequently unreliable. I have found that some of the most impressive fiction written in the United States today is in the space reports of departmental chairmen setting forth justifications for poorly utilized space.

Dr. Elchlepp has suggested two solutions to the utilization problem. One is the decentralization of space management, with large blocks of space assigned to departmental managers who then have the responsibility of allocating units of space to individual faculty members. This solution has the benefit of having space assignments made by individuals who are close to the space and knowledgeable of its use.

* Dean of the Medical Faculty and Vice President for Health Sciences, The Johns Hopkins University School of Medicine.

A second solution is the use of the lease-purchase concept, in which blocks of space are allocated to departments or programs with reversion to institutional administration after the lapse of several years. This proposal sounds like an interesting idea, and I would like to know of institutions in which it actually has been put into use.

IF I WERE A MEDICAL SCHOOL DEAN: WHAT I WOULD ASK MY LAWYER

*David B. Frohnmayer **

Equal employment opportunity is a matter of federal and state law and is therefore something with which medical colleges must come to terms. A complete review of the issue as it affects medical colleges must include (1) developments in federal law that pertain to medical colleges in particular and higher education in general and (2) some of those unresolved issues of equal opportunity affecting the medical profession.

UNDERSTANDING THE LAW

At the outset, one must be familiar with the many legal jurisdictions involved. Therefore, as a medical school dean I would ask my lawyer whether he or she were familiar with the following sources of federal law.

Executive Order 11246 as amended by 11357. These Presidential directives to federal agencies establish non-discrimination standards required of agencies contracting with the federal government. Institutions of higher education, as federal contractors, must comply with these standards. The orders require examination of the equity of personnel practices. Even where deficiencies are not discovered, a requirement called 'affirmative action' is imposed. Through implementation of the affirmative action concept, the Department of Health, Education and Welfare has come to exert its influence forcefully on the planning and internal personnel decisions of higher education institutions.

Title VII of the Civil Rights Act of 1964 as amended by the Equal Employment Opportunity Act of 1972. As of July 1, 1972, the Civil Rights Act of 1964 covers state and other private educational institutions. Since all medical schools are covered by Title VII, I would want to know whether the Equal Employment Opportunity Commission--based in Washington, D. C., with regional offices around the country--had made an investigation or had received a complaint about sex or race discrimination in employment practices in my institution. Because the law permits assessment of back-pay liability referring back to 1972 for wages and salary inequities since that time, I would want to know when such complaints had been filed.

Equal Pay Act of 1963, as amended by the Education Amendments of 1972. The 1963 law is part of the Fair Labor Standards Act of 1938, as amended. The Equal Pay Act became applicable to institutions of higher education as of July 1, 1972. Important and complex, the Equal Pay Act states that persons of different sexes, performing equal work, measured by substantially equal skills, responsibility, effort, and similar working conditions must be paid the same amount of money. The federal government is therefore saying, 'We will compare not what the job titles are, but what people actually do.' A rash of suits has been filed against educational institutions, and most have been won by the complainants.

* Associate Professor, School of Law; and Special Assistant to the President, University of Oregon

If there are different classifications for people who are doing substantially the same work, these individuals should have been receiving the same salary. For example, in many institutions 'domestic worker' is a category that is predominantly female, while the category of 'custodian' tends to be predominantly male. The division administering the act in the Department of Labor has taken the enforcement policy position that 'cleaning is cleaning,' and that is the end of the inquiry. Back-pay settlements in thousands of dollars have been awarded against school districts, colleges, and universities for the differentiation between predominantly male-centered and predominantly female-centered occupations which basically involve cleaning.

The subject is more difficult in the professional categories. Degrees and distinctions in the allied health professions are legion, particularly in hospitals and medical centers in the United States. There are degree nurses, registered nurses, practical nurses, ward clerks, and so forth. But the Equal Pay Act pays no attention to titles or to educational degrees. It looks at actual job functions. If there are credentialed occupations in the allied health professions which are segregated and segmented, and if persons of different sexes occupy different strata but perform essentially the same function, there is a serious argument that an institution must pay all the same. The appropriate pay is determined not by lowering the salary of any one, but, with a so-called 'ratchet effect,' by giving the lower-paid person the salary of the higher paid.

As a medical school dean, I would ask my lawyer whether it is justifiable to pay a differential salary between Ph.D. and M. D. to a person teaching in a clinical program. In medical schools where a female Ph.D. teaches substantially the same courses in the first two years of medical school as an M. D., one may well face in the future an Equal Pay Act allegation on the basis that the work performed is essentially the same, and that there exists an illegal differential in pay.

Title VII and Title VIII of the Public Health Service Act as amended by the Comprehensive Health Manpower Act and the Nurse Training Amendments Act of 1971. The federal government is monitoring violations on a complaint basis of these laws which prohibit sex discrimination in admissions to institutions for the education of health professionals. An individual may not be prohibited on the basis of sex from equal competition in medical school admission. There are subtle ramifications. The law means that the Admissions Committee cannot view negatively the application of an attractive, unmarried female simply because she may be likely to marry and have children. This action would be sex discrimination pure and simple. A negative rating on that basis defies federal statutes which have been on the books for three years and are being enforced. The only relevant question is the individual's potential performance as a good physician. If there are not internal procedures checking such an admission decision, there clearly are serious problems ahead.

The Nurse Training Act has substantially similar restrictions on sex discrimination. Several federal agencies enforce these acts: HEW's Office for Civil Rights, the Justice Department's Civil Rights Division, the Equal Employment Opportunity Commission, and various health manpower administering boards, all with separate audits and separate compliance reviews. The influence of these overlapping agencies is not likely to diminish, but interagency coordination has thus far been minimal.

Revised Order 14. This order, issued February 6, 1974, by the Office of Federal Contract Compliance of the Department of Labor, implements the Executive Orders and has particular significance for the academic community. It specifies that 30 days after the Office of Civil Rights requests an affirmative action plan, it must be filed with the Office, which then has 60 days after receipt of the plan to rule whether or not the plan places the institution in compliance. If it does not, the Office must move immediately to file a show-cause order in federal court to determine whether the university's contracts will be suspended.

This regulation imposes a sense of urgency on the entire affirmative action process. Freedom of action and discretion is substantially reduced. Both the academic institution and the Office for Civil Rights are in a time straitjacket unless sound working agreements are developed about the development and acceptance of affirmative action plans.

Title IX of the Education Amendments of 1972. This law provides that no person shall, on the basis of sex, be subject to discrimination by any institution receiving federal monies by way of a grant, loan, or contract. Regulations implementing the law will unquestionably have many ramifications. They will cover equal access to facilities, programs, and activities as well as employment at an institution. [Editor's Note: The draft regulations were released by Secretary Caspar Weinberger on June 18, 1974, and comments are due by October 15, 1974.]

OTHER LEGAL CONSIDERATIONS

Quite apart from these federal statutes and regulations, educational institutions are also often subject to specific state laws. If I were a medical school dean, I would ask my attorney to determine the extent that state laws, particularly those dealing with human rights and civil rights, apply to medical school admissions and to employment policies. Further, in some cities, such as New York, the City Human Rights Commission has legal jurisdiction over the employment practices of an individual institution, even if it is a state agency.

Finally, a body of laws having profound implications for personnel policies are those contained in the field of collective bargaining. Affirmative action and collective bargaining generate enormous pressures on institutions, but pressures which do not always move in the same direction. For example, union pressures to create secure seniority systems may well run counter to the requirements of sex and race discrimination regulations.

In spite of ambiguous and serious unresolved problems, the laws are on the books and are being enforced. The problems of the medical school dean are in many ways unique and different from those of higher education in general. That is why, in addition to advising the dean to seek competent legal help, I would urge that he constitute an institutional task force to work on policy problems of equal opportunity.

Medical schools have diverse sources of federal support--Social Security patients in teaching hospitals, scholarship support for students, institutional support from the Bureau of Health Resources Development, and research grants and contracts from the National Institutes of Health. The interrelationship of the medical school and the teaching hospital further complicates matters. Hospitals as employers are notorious for employment discrimination. They employ a wide variety of allied health personnel and support services that are different from those involved in other sectors of higher education.

As if problems of employment discrimination were not enough, there are a whole range of other pressures for change and innovation in the health care delivery system generally--establishment of HMO's, reconstitution of allied health professions, revision of licensure requirements, and acceleration of medical education, to name a few. Therefore, it ought to be recognized, although I am not sure that the federal government enforcement agencies do recognize, that the federal pressure on educational institutions, quite apart from the Civil Rights thrust, imposes enormous and often conflicting demands on the limited resources of an institution.

UNRESOLVED ISSUES

Some of the important legal developments and problems that we have confronted so far in the civil rights enforcement area require more careful analysis.

Professional Evaluation. This issue--the legitimacy of traditional procedures for personnel evaluation--is the one institutions and enforcement agencies have yet to resolve. Federal techniques for enforcing civil rights have evolved largely in the context of industrial employment, where jobs are reasonably fundable and where local residents can easily become part of the work force. That characteristic does not apply to professional employment, in general, because there are vast differences in prerequisite skill and effort. Moreover, in most professional areas, there are no objective tests by which one can determine the individual's capacity to perform a job. One does not give an I. Q. test, an Iowa test, or any of the standard aptitude tests and expect that performance can be assessed or predicted. Professional credentials are measured in higher education generally, and in the professions in particular, through peer judgment, a process which calls on fellow professionals to give a candid evaluation about how another person performs. This process depends on a subjectively administered, but generally recognized, standard of quality which only fellow professionals in the field can be expected to administer with fairness and understanding.

The question confronting medical educators is whether that subjectively administered test of professional peer evaluation can survive the criteria being imposed by federal civil rights investigators who argue that it is, in fact, a disguised vehicle for sex and race discrimination. For those who believe in a professional standard of peer review, this accusation strikes at the heart of the educational structure and academic quality. Peer review is under attack in other areas, i. e. the person who is expelled from a hospital medical staff because he or she is not able as a medical professional to meet the standard of post-operative reviews. But in rebutting allegations of sex and race discrimination, this kind of question becomes critical and calls for creative answers.

Confidentiality. Access to personnel records, one of the most serious issues, is particularly sensitive as it relates to the common practice of conducting confidential peer reviews. What happens if the individual in that subject review asks to see the records and rebut statements made about his or her performance? There is an increasing tendency in federal civil rights investigations for aggrieved parties and federal enforcement agencies to demand and obtain access to confidential, evaluative material in an individual's confidential personnel file. The extent to which the federal government has the legal right to inspect confidential personnel files to determine whether or not there has been illegal discrimination is unclear. But it should also be acknowledged that in many cases, federal civil rights investigators have discovered damning evidence. Assertions of confidentiality cannot, therefore, simply become smokescreens for non-compliance with the law.

The larger question, however, is one of personal privacy and academic freedom. To what extent must the principle of confidentiality be observed and to what extent can the open file system exist without losing the candor needed for quality personnel decisions? This question becomes particularly important in two areas. One is whether outside evaluators will continue to provide assistance if confidentiality cannot be assured. The second is whether faculty members not party to a complaint have any rights to privacy if their files are sought to be examined for comparative purposes.

While the entire thrust of federal civil rights agencies has been to require turnover of the files, the question is legally unresolved. There is at present inadequate protection of these files. The question poses a classic conflict between civil liberties and civil rights.

Re-examination. Title VII of the Civil Rights Act of 1964 is administered by the Equal Employment Opportunity Commission (EEOC), a powerful enforcement agency currently laboring under an enormous backlog of cases. Under Title VII, the EEOC has required many personnel actions and procedures which earlier the Supreme Court had viewed as not constitutionally required by the due process clause. The EEOC has re-examined the academic merits of personnel decisions and has required the institutions, in effect, to base those decisions on a preponderance of evidence. These decisions have been retried in the federal courts to determine whether the university can prove that an individual does not deserve promotion or tenure. There are several cases, most of them involving medical schools, in which this shifted burden of proof has been established.

Internal and External Pay Differentials. There is no assurance that Equal Pay Act administrators will not cross departmental lines. If medical schools pay professors of surgery more than professors of ophthalmology, these administrators may well say that 'medicine is medicine,' instead of looking at market forces and extent of training. One may have to evaluate the relationship between internal pay differentials and those which the outside market requires. While no one has had to make that consideration yet, I would ask my lawyer whether or not he or she has considered the question.

CONCLUSION

The decision to be made by medical school deans is what makes sense as medical education policy. First to be considered should be the policy question. Then it is necessary to make sure that those who give legal advice are attuned to those considerations which make good educational sense. Finally, the two must go in tandem.

Though I am convinced that federal enforcement officials are people of good will and that they believe devoutly in enforcing the law, they are not attuned to, and cannot be expected to be attuned to, the questions of educational policy that concern the medical school dean. Therefore, the dean and his legal counsel must undertake to examine and resolve those questions together. If they do not, medical education and the law generally will be the net losers.

Institutions must pull together or they will be picked off one by one in a cumulative process of adverse precedent-setting cases. The Equal Employment Opportunity Task Force of the American Council on Education, on which I serve, wants to know whether what it is saying is relevant to medical schools, and whether it is responsive to the questions medical schools have encountered. The Task Force must anticipate problems in order to handle them creatively. We should not put roadblocks in the federal government's way to the extent its efforts legitimately concern the legal enforcement of equal employment opportunity. It is possible to deal creatively with the law if questions are anticipated before they arise. As such questions come up, I hope medical school deans will share them with the Task Force.

IF I WERE A MEDICAL SCHOOL DEAN:
SOME PRIORITIES I WOULD SET IN DEVELOPING AN AFFIRMATIVE ACTION PROGRAM

Cyrena N. Pondrom *

Affirmative action is an expression that has been widely used in the past few years. Its concern is with under-utilization of minorities and women. Under-utilization is defined as the employment of fewer minorities or women than availability figures would predict. When that situation occurs, one is obliged to take affirmative steps to recruit members of those groups, to review their credentials, and, when qualified, to offer them appointments.

The theory behind affirmative action is a straightforward one: that there are sections of our society in which the prevailing social and professional linkages have been completely free of women or minorities. Consequently, the routes customarily adopted to bring more people into those areas do not touch women and minorities. If employers continue without review of these practices, they will fail to consider available and qualified members of particular groups.

Affirmative action assumes that equal opportunity and selection of the best qualified person is in the best interest of society and its institutions. An institution which endorses the principle of selection on the basis of excellence must make every effort to ensure that extraneous, a priori judgments do not deny it the opportunity to appoint individuals whose quality would merit appointment.

AFFIRMATIVE ACTION PRIORITIES

Establishing priorities is the central issue for achievement of equal opportunity on the campus, not only in employment but also in admissions and teaching practices. There are six top priorities, which can be linked in pairs:

(1) Salary Review and Hiring Goals. The first two priorities help to satisfy the requirements of Executive Order 11246, as amended. The review of all academic salaries to establish equity and the review of the representation of women and minorities on the work force are the heart of an affirmative action-equal opportunity program. Salary review can be accomplished directly through the annual budget process and in a cross-college fashion. It does not require as many individual decisions as is usually the case in making faculty appointments.

One consistent fact about our society, whatever the implications of this observation, is that faculties as well as the rest of the population recognize that we mean business when we put our money where our rhetoric is. If one conducts a salary review program at the outset, followed by actual correction of inequities where they are found, fewer faculty members will doubt the importance of the affirmative action program as a significant aspect of college policy. That measure of cooperation alone will be essential to its continuation.

The hiring goals program takes longer to develop and involves the adjudication of a number of complicated decisions. This program should be initiated at the same time as the salary

* Assistant Chancellor, University of Wisconsin - Madison

review programs, but it is not likely to come to fruition by the time the salary review program is completed.

(2) Admissions and Student Facilities. This pair of items responds more to Title VII of the Civil Rights Act of 1964 and Title IX of the Education Amendments of 1972. A review of admissions procedures and entering records is needed to ensure that an institution is indeed using the same standards of admission for men and women, for minorities and non-minorities.

A review of facilities also is essential. In medical schools, as perhaps nowhere else on the campus except in athletic programs, the physical facilities available for women have been inadequate. One of the requirements, which can be carried out rather rapidly, is the assessment of adequate physical facilities for women medical students, women doctors, and nurses to see if they are equivalent to those provided males in the medical school.

(3) Disparate Effect and Attitude. The last pair of priorities applies both to the student laws--Title VII and Title VIII of the Public Health Service Act and Title IX-- and the employment laws--Executive Order 11246 and the Civil Rights Act of 1964. A review of policies should be made to determine whether specific policies have a negative impact upon the probability of hiring women and minorities. A study should also be made on the matter of attitudes which prevail in the college.

Now I should like to review three of these priorities in greater detail.

SALARY CONSIDERATIONS

In carrying out a salary review, the administrator may be able to rely upon the assistance of a central staff which designates a particular proportion of the merit or position budget as a sum set aside for equity review. If so, one begins to build at this point.

I believe that it is common to find the situation which prevailed at the University of Wisconsin-Madison. In advance of an analysis of the actual salary of women staff members on the campus, most campus faculty assumed that salaries were equitable and that discrepancies that did exist pertained to men and women alike. Indeed, there are discrepant salaries assigned to men. But evidence suggests that discrepancy stacks up much higher with women's salaries. We found that at the level of full professor the salary discrepancy on our campus was almost \$4,000 per individual. It is particularly significant at this rank because these are individuals who have advanced through the multiple steps of review in research, teaching, and the varieties of scholarship practiced to assume a position of leadership on the campus.

The salary discrepancies at Wisconsin four years ago were highest in the full professor category, chiefly because small inequities in successive years are cumulative. Assistant professor salaries started out more or less the same. For those with the longer period of service and, incidentally, the strongest record, the salary differential was generally the greatest. We found in the College of Medicine several salaries in which a \$6,000 inequity existed.

Once those facts were in hand, we found there were few individuals who opposed the salary correction. One device which is particularly useful in this respect is a salary average print-out which shows the relationship of every individual to the average salary by rank and department. The existence of a departure from the average does not, of course, indicate that an inequity necessarily exists, but it does flag a salary that needs examination.

Another useful tool is requiring a review for every woman academic, and entry of that

record on a form bearing the signature of the budget committee or dean, indicating whether that individual requires a correction. It is easy to 'lose' people, particularly those in large, research units where individuals are off-budget, appointed on federal contract funds, or otherwise not processed through the routinely scrutinized channels that a computerized budget provides. If an institution is like mine, a large number of employees in the College of Medicine, perhaps well over half, will be appointed off-budget. Consequently, such scrutiny is essential to reach more than the top 25 percent of employees on the campus.

In addition, when a salary remains below average, a justification for the salary determination should accompany the review. If the individual is a new employee and most of the individuals of the same rank have been there four years, the simple statement of that fact is sufficient. If, however, the allegation is that the individual is performing below average, the vita and research record of the individuals at that rank in that department, in addition to the vita and research record of the individual whose salary is below average, provide useful documentation.

One of the problems consistently encountered in the equitable establishment of salary as well as status is simply a failure of awareness. The legend of the invisible woman is one that is current in circles concerned with compliance. By requiring that a vita be provided with the salary determination, there will be awareness among a large number of people formerly oblivious to inequity. If the determination is not accurate, most of these people will not send it forward in the first place. Aware of the inequity, they will make the correction and will be pleased to take credit for having established equity where it did not exist before. A higher standard in the college as a whole will result.

Two other technical details about the process of salary review warrant consideration. If the option to do so exists, it is useful to combine the use of position money and the use of merit money in achieving equity when there are substantial corrections to be made. Relying on merit money exclusively will markedly depress the pool of merit money available for assignment to non-minority or to male staff. Relying exclusively, however, on position money will not shift the relative position of the individual. An equity correction of a thousand dollars at the same time the individual's peers receive an increase of a thousand dollars will merely move the entire group up simultaneously. One of the fine points of equity correction is establishment of appropriate relations among individuals based upon quality of performance.

The second technical consideration is one consistently encountered in the allied health schools: the problem of finding an adequate reference point for departments which are all female or nearly so. At Wisconsin, we have used as a reference other departments in the university in which the incumbents are charged with clinical care of patients but are not required to have the M. D. degree for practice, i. e., clinical psychologists or individuals in counselling and guidance. If an average of the salaries at the respective ranks in those departments is taken, an appropriate salary for all-women departments, such as occupational therapy, physical therapy, or nursing, can be established.

This approach does not touch the question of support staff, which those who supervise hospitals face in a painful and important degree. In the hospital environment, the all-female areas and the areas with a high representation of minority staff often have consistently lower salaries. An example is dieticians, who consistently have a lower salary than persons with a similar level of training and responsibility in the hospital. I think the hospital is probably one place in the University in which a very high priority needs to be placed on the review of non-professional support staff.

THE HIRING PROCESS

Perhaps the most characteristic expression of the prevailing hiring practices in the academy-at-large is an informal communication, frequently a phone call, between colleagues. The result is usually the recommendation of one or two males, students of the colleague, who assumes that is what is wanted.

To develop an equitable approach to hiring, one can take a close look at the actual availability of minorities and women in particular areas. Some data touchstones are useful in this determination. For clinical departments, the filled residencies at affiliated hospitals can be checked and the percentages of minorities and women in filled residencies obtained. This information on women and minorities is published annually in the November issue of The Journal of American Medical Association, and also appears in the AMA's Directory of Approved Internships and Residencies. From these figures a percentage of people with credentials suitable for appointment in clinical departments can be derived.

For departments in which the clinical degree is not the issue, one can use statistics from the major graduate institutions in the country. At the University of Wisconsin - Madison a list of the 33 top degree-producing institutions which have granted 2,000 or more Ph. D.'s since their inception indicates numbers and percentage of degrees for men and women. To it is added, discipline by discipline, those schools in which the graduate department is rated strong or excellent by the American Council on Education, in the event that they do not appear on the foregoing list. In some specialties, schools not large enough to have qualified as one of the largest and strongest graduate schools should be added to the list. For each discipline there will be a group of between 33 and 50 institutions which are highest rated in the country, giving the number and percent of men and women granted the degree in these disciplines for the past four years. From this figure is derived the percent of doctorates granted to women in recent years.

The figures for minorities are much more difficult to obtain. HEW is in the process of letting contracts to determine the availability of minorities more precisely. As yet, there is no single reliable guide listing earned degrees for minorities.

Percentages derived will indicate the desired overall composition of a department in hiring of qualified individuals on an equitable basis without preference for one sex or for one race. At Wisconsin we ask then that new hires in a department be at least equal to availability and, if the department is under-represented, that for a period of time, depending upon the competitiveness of the department, new minority and female hires be greater than the figure listed as available. That request assumes that we can compete successfully with other institutions in seeking staff. The decision will vary from department to department, depending upon its strength.

The next step in the process of establishing a program of hiring goals is a review of existing staff. One may find a large number of women in off-tenure-track positions in adjunct faculty or clinical faculty positions. A systematic review of credentials may lead to placement of some of these individuals on tenure track or into tenured appointments.

Post-doctoral requirements for non-clinical departmental appointments is another area to study. Some of our life-science departments chiefly hire post-doctoral appointees who have taken a Ph. D. from one university, a two-year post-doctoral from a second university, and then seek an appointment at the University of Wisconsin - Madison. Any policy which requires two moves in three years is apt to reduce markedly the number of women candidates who can qualify, particularly when the age period is between 25 and 30. One must ask whether it is a job-related requirement for the individual to have been in three institutions in four or five years.

Studies have consistently shown that if credentials are submitted with the names varied to change sex, there is a consistently higher rate of selection of the male applicant when the credentials are the same. When there has been a careful definition of the requirements of the position, the bias drops markedly because the selector apparently does not fall back upon a priori judgments which are supplied as addendum to the vita, but rather matches the credentials and requirements of the position rather precisely.

ADMISSIONS REVIEW

Title IX of the Education Amendments of 1972 and Titles VII and VIII of the Public Health Service Act are the federal regulations which require equality of opportunity in admission of students. One immediate check is the Admissions Committee's reports, to see whether the cut-off points on the Medical College Admission Test, the Science Aptitude Test, and the grade point average are the same for men and women. By this time in most colleges it ought to be. There is no single set of documents that will result more rapidly in a clear prima facie case of discrimination.

The other side of this coin is that raised in the De Funis case. To what extent, should you, must you, or may you alter admissions requirements in order to address the responsibility of trying to extend medical education to representatives of different segments of society? Thanks to the Supreme Court's decision to duck the issue, the question remains fundamentally unresolved. Let me suggest that there is an appropriate way to deal with this issue. Take the predictor used for the majority population, which may not be as accurate a predictor for a minority population or a particular group, and add to it other predictors to help accurately estimate the probability of success in medical school for that group. Such an approach will strengthen the admissions process and better withstand the kind of court test mentioned.

In extending affirmative action to admissions it may also be necessary and desirable to adopt certain kinds of policies unnecessary for dealing chiefly with white males. One such policy permits women medical students to leave for maternity and return to the curriculum. Permitting no leaves of absence will obviously mean disaster should a married woman student happen to get pregnant. One must ask whether such a lock-step curriculum can be replaced by an alternative in the case of maternity leave.

Additionally, it may be that minority students apply with more limited science background than non-minority students. If the indicators predict success, it is valuable to provide these students with additional preparatory work in basic science.

ATTITUDES

Finally, there is the question of attitudes. When all suggested steps have been followed, attitudes may change of their own accord. In the interim, it is important to ensure that the atmosphere, whether of extemporaneous comments in the classroom or of informal teaching, creates equal opportunity for members of both sexes and all races. One of the most frightening experiences to a young minority student or a young woman in medical school is the sense of total isolation that may accompany being a tiny minority in a white male world.

At Wisconsin we found that when we were admitting five or fewer women medical students at a time, the dropout rate corroborated the direst predictions of those who didn't want to admit women at all. However, when the number of women passed 13 percent and moved up to the 20 percent range, where it is now, the dropout rate dropped correlatively. We had some-

how reached the point of 'critical mass' where the women medical students were supporting themselves psychologically in medical school. The isolation which had apparently contributed substantially to the problem of survival in medical school had fallen away. The same psychology pertains in admitting and continuing the education of minority students. Indeed this generalization may well apply to all of affirmative action: the more success we have, the more success we can expect, whether in the area of student admissions or employment.

IF I WERE A MEDICAL SCHOOL DEAN -- WHAT I WOULD KEEP MY EYE ON IN WASHINGTON

*Sheldon Elliott Steinbach **

In the past several months, the focus of college and university administrators dealing with equal employment opportunity problems on campus has shifted from the Office for Civil Rights in the Department of Health, Education and Welfare to two agencies which have recently acquired expanded jurisdiction over employment discrimination at institutions of higher education: the Equal Employment Opportunity Commission (EEOC) and the Wage and Hour Division of the Department of Labor.

To meet the increasing problems generated by the number of federal agencies dealing with employment discrimination, the American Council on Education, in collaboration with other major Washington associations of higher education, established in June, 1973, the Equal Employment Opportunity Task Force. The Task Force works with colleges and universities to facilitate interpretation and implementation of affirmative action laws and to provide a forum for discussion of policy issues with the respective federal agencies.

ACADEMIC ISSUES

In 1972, Title VII of the Civil Rights Act of 1964 was extended to include all employees at colleges and universities. The EEOC, the enforcement agency for this act, is presently considering those characteristics which distinguish higher education from industry in rendering their decisions. The Commission has therefore moved slowly in exercising its jurisdiction over colleges and universities. There are some procedural difficulties in handling complaints, as there is a purported backlog of approximately 70,000 cases, over 1,000 of which have been filed by employees at colleges and universities.

In April, 1972, the EEOC published regulations in the Federal Register which banned sex discrimination emanating from separate lines of progression and seniority systems, marital status, helpwanted advertising, employment agency actions, pre-employment inquiries, fringe benefits, and employment policies relating to pregnancy and childbirth. Several of these rulings are being challenged in various forums.

Perhaps the most controversial section of the published EEOC Guidelines relates to pregnancy. The current EEOC position states that pregnancy must be treated by employers as a temporary disability and must be included in an employer's sickness and accident policy. The foregoing position is presently being tested in the courts, in the case of Gilbert v. General Electric Co. in the Federal District Court for the Eastern District of Virginia.

A major current concern for academic administrators is fringe benefits. The concept of equal retirement benefits for men and women is currently being developed. For many years, under the Equal Pay Act of 1963, institutions that provided either an equal pay-in or equal pay-out for men and women similarly situated were deemed to be in compliance with respect to annuities.

* Staff Counsel and Assistant Director of Government Relations, American Council on Education

But EEOC regulations now require an equal periodic pay-out of retirement benefits for all employees. Under discussion in new regulations under Title IX of the Education Amendments of 1972 is the idea of equal pay-in and equal pay-out through the use of unisex mortality tables for annuity payments. EEOC argues that the cost of living for a woman at age 65 is the same as for a man, and, therefore, that a woman should receive the same monthly retirement benefits. The argument that women receive, in the aggregate, the same retirement benefits as men because actuarial tables indicate a longer life-span for them is being questioned. All colleges and universities using Teachers Insurance and Annuity Association of America--College Retirement Equities Fund (TIAA-CREF) have had charges filed against them. In addition, the Department of Labor reported on December 27, 1973, that it is questioning its present position on insurance, pension, and retirement benefits.

One of the disturbing developments for universities in Title VII law is the way in which the government or private plaintiffs can use statistics to allege illegal discrimination. In a recent case (Johnson v. University of Pittsburgh), statistics and other evidence demonstrated the imbalance of men and women in tenured positions in a school of medicine. Statistics were used to support the establishment of a prima facie case of discrimination which requires that the defendant institution present rebutting evidence. The court said 'We do not necessarily have to agree with a statistical finding that the probability of no discrimination shown in the figures is one chance in 400 million, but we would agree that the chances are very small.' The court further related that 'the defendants offered no contradictory statistical testimony and did not in any way cast doubt on the statistician's figures.' This ruling demonstrates the importance that courts are willing to ascribe to statistical evidence as tending to establish discrimination.

Regulations of Title VII of the 1964 Civil Rights Act raise several other questions regarding employment practices at colleges and universities. Do tenure policies have a disproportionate impact on women and minorities? If so, can the policies be sustained under Title VII as a business necessity? As financial stringencies increase, there is the question of using seniority ('last in - first out') as the basis for termination decisions, thereby negating recent affirmative action hires. A recent federal district court decision indicates that in some circumstances a straight seniority lay-off is a violation of Title VII.

TWO SIGNIFICANT CASES

One of the most instructive devices on Title VII law for colleges and universities is a comparison of two recent cases dealing with nonrenewal of untenured faculty. In the initial case, Johnson v. University of Pittsburgh, decided in the U. S. District Court for the Western District of Pennsylvania in May, 1973, the court held that a female biochemistry professor in the medical school was entitled to a preliminary injunction restraining the university from discharge and denial of tenure until her court claim is litigated. The court took note of the fact that there was a strong likelihood that the professor would succeed on the merits of her case since she had made out a prima facie case of intentional discrimination by showing that: (1) statistical evidence revealed a pattern and practice of discrimination against women in medical schools; (2) comparable male medical professors were granted tenure through disparate treatment based upon sex; (3) male professors, regardless of rank or tenure, were given larger yearly salary increases over a five-year period; (4) procedures followed in considering whether to discharge the professor were never used before in such situations; (5) the university affirmative action program had taken no substantial steps to eliminate sex discrimination in the medical school; and (6) the number of women faculty members in medical schools decreased while complaints of sex discrimination were pending.

Although the case itself has not been decided on the merits, it would seem from the basic guidelines provided by the court that in this instance the University of Pittsburgh failed to set out its criteria for promotion and then to validate those criteria as being related to the job to which the individual might be promoted. The institution then failed to conduct fairly and uniformly whatever procedures were available for testing the individual's credentials against the criteria stated. The use of different standards for women and men, a post facto attempt by the institution to develop sufficient evidence to support a previously arrived at decision, and a series of good employee reports and pay raises for the plaintiff before termination for poor performance all indicated to the court that the plaintiff had a sound basis for her claim.

The court cited an earlier decision in Green v. Board of Regents of Texas Tech in which the District Court found as a matter of fact that there was no pattern of discrimination operating at the school, that all established criteria for promotion had been considered, and that they were reasonably applied in the particular case. The court, therefore, stood ready to defer to a decision rendered in the traditional academic manner.

The second case in point, Faro v. New York University, was decided in the U. S. District Court for the Southern District of New York in December, 1973. The court ruled that a woman employed as a laboratory assistant and occasional teacher at a medical school, who was denied a tenured position and continued employment, should not be able to obtain a court order keeping her in the job until her claim of sex discrimination was finally determined. It was held that a preliminary injunction keeping her in the job was inappropriate because she failed to show that she could win her sex bias claim against the medical school. The court found that the school had accorded her fair treatment and that its employment statistics reflected objectivity, indicating intrigue by the courts with statistical evidence once again. The ruling stated that the record showed that the university medical school had provided equal employment opportunity. The faculty of the medical school was over nine percent women, while the total percentage of women M. D.'s in the nation was 7.1 percent. The court dismissed the plaintiff's contention that concentration of women in the department of pediatrics ('an obvious woman's field') and pathology ('the trusts and estates of medicine') represented discrimination, stating that the argument ignored the fact that three of the 21 tenured faculty members in the defendant's own department of rehabilitation medicine were women. The court noted that though such statistics are far from conclusive, they do bear some weight in the determination of the presence of discrimination. In distinguishing the Faro case from the Johnson case, the court found that there was no evidence that women at NYU School of Medicine were uniformly paid less than men, nor was their average salary lower. The court also found 'no intentional wrong doing' as was discovered at the University of Pittsburgh.

VALIDATION QUESTIONS

One of the major concerns of employers generally emanates from the U. S. Supreme Court's decision in Griggs v. Duke Power, which held that tests and other employment criteria must be related to the particular job and validated to demonstrate their predictive value. Since that decision, EEOC has construed bonafide occupational qualifications (BFOQ) even more narrowly. As set forth in Griggs, if an action or policy though neutral on its face is discriminatory in effect, it is unlawful except in cases of business necessity. Further clarification is required for college administrators to determine whether a Ph. D. is indeed a BFOQ for teaching in institutions of higher education and whether publications can be utilized as a meaningful basis for judging performance and for making initial hiring decisions.

The question of test validation is presently being considered by the Equal Employment Opportunity Coordinating Council (EEOCC). The EEOCC consists of representatives from

the U. S. Civil Service Commission, the Commission on Civil Rights, the Equal Employment Opportunity Commission, and the Departments of Justice and Labor. In late 1973 it published 'Uniform Guidelines for Employee Selection Procedures.' The premise of the Guidelines is that properly developed and validated tests can contribute to the development and maintenance of an efficient work force as well as the implementation of equal employment opportunity requirements. The Guidelines' stated purposes are : (1) to assure that selection procedures do not discriminate against any group on the basis of race, color, religion, sex, or national origin; (2) to improve personnel and placement systems on the basis of merit; and (3) to set out a uniform federal position on achievement of these goals. Traditional testing procedures are covered by the Guidelines, along with other selection procedures, including interviews and assessment of training and experience. The Guidelines are intended to apply to all public and private institutions of higher education and all other employers subject to Title VII of the Civil Rights Act and executive Order 11246.

The ACE Task Force, after reviewing the document, was particularly concerned about its impact on faculty and professional employees. The Guidelines appear to have been developed for testing specific competency and therefore are not adoptable to positions in which evaluation of the individual requires assessment of a large number of variable characteristics not amenable to objective measurement.

The Task Force also has expressed concern that the costs of implementing such a selection and testing program as outlined in the Guidelines would be enormous and would impede positive efforts in affirmative action. Developing and validating tests and accumulating data would also divert an employer's efforts from energetic recruitment to defensive recodification of testing procedures.

OTHER ISSUES

The Higher Education Amendments of 1972 extended the Equal Pay Act of 1963 to the formerly exempt categories of administrative, executive, and professional employees. The law itself provides that men and women in the same place of employment who perform substantially similar tasks must receive the same pay. The Wage and Hour Division of the Department of Labor, responsible for enforcement, has experienced substantial difficulty in interpreting this expansion to administrative, executive, and professional employees. The statute sets out equal skill, equal effort, equal responsibility, and similar working conditions as the four-part test to determine whether the jobs themselves are equal. All of these determinants are difficult to translate into an academic setting.

Beyond these basic equal pay requirements, other questions remain unresolved. Must equal pay be established for part-time as well as full-time employees? What constitutes part-time or full-time status? To what extent are market factors valid determinants in establishing salaries? How does one deal with the apparent conflict between affirmative action and the Equal Pay Act, where individuals who are relatively scarce in the labor market have demanded and received a premium for doing the same work as other individuals? Will comparisons be made across various departments within a school, between various schools within a university?

Under the Equal Pay Act one cannot reduce the salary of a higher paid employee, but must bring all lower paid employees up to the higher standard. In view of the unique nature and employment practices of institutions of higher education, it appears essential that the Wage and Hour Division of the Department of Labor either amend the existing Equal Pay guidelines or publish new regulations which pertain to instructional personnel in colleges and universities.

The Office for Civil Rights (OCR) in HEW still maintains an important position with respect to equal employment opportunity issues on campus. However, a recent paper developed by the ACE Task Force has noted a number of deficiencies in OCR's operations, including lack of uniform action by regional offices of HEW, inadequate standards and procedures for maintaining confidentiality of personnel records, failure to accord due process to institutions before the withholding of a contract, and failure to accord institutions due notice, a full and fair hearing, and a right of review.

Other issues raised relate to the activities of OCR field staffs. These issues include inadequate training of field and regional personnel; intrusion of OCR personnel into the internal affairs of the institution; failure to conduct impartial investigations prior to issuance of letters of finding; and excessive reliance on verbal communications. The ACE Task Force is engaged in dialogue about these issues with the OCR and with the Office of Federal Contract Compliance in the Department of Labor, which has ultimate authority over this program.

A new set of regulations to implement Title IX of the Education Amendments of 1972 is presently being drafted in Washington by HEW's Office for Civil Rights. These regulations will elaborate the statutory mandate which provides that no person shall, on the grounds of sex, be denied educational benefits or be subject to discrimination in any federally supported educational program or activity. There is little doubt that these regulations will have enormous ramifications for institutions of higher education with respect to utilization of facilities; award of single sex scholarships, some of which may be based on endowed funds; the status and membership of various social and honorary fraternities and sororities; and athletic programs.

Among the regulations being discussed with respect to Title IX is that fringe benefits be paid to part-time employees on a basis proportional to the hours worked, a novel concept in American employment practice.

How all of the issues posed by affirmative action will be resolved is not yet apparent. It is almost certain that in the years ahead colleges and universities will encounter increasing regulation by the federal government of activities and functions formerly governed by the institution. It is imperative, therefore, that the college and university community be vigilant about existing and future federal regulations to ensure that the regulatory system established is administered in an even-handed manner and is compatible with the field of higher education. At the same time, it is not in the best interest of higher education to consistently resist or delay implementation of federal laws geared to the protection of all individuals.

In sum, institutions should not wait for federal intervention in order to put their employment policies in order. Rather, they should establish sound personnel procedures that will redound to the benefit of both the institution and its employees.

USES AND ABUSES OF TENURE

*Norman Hackerman **

In debating the tenure question, there is always a question of credibility. Saying one thing and doing another is a problem with tenure, partially because it is hard to put into practice what makes sense in theory. But credibility is also a problem of perception. Tenure as seen through the eyes of laymen is different than tenure as seen through the eyes of educational administrators. It is seen still differently by the faculty itself.

There have been many pieces written about tenure. Kingman Brewster had a very thoughtful article in the December, 1972, Bulletin of the Association of American University Professors (AAUP) (1). In April, 1972, Nature editorialized on tenure in a characteristically well-done piece entitled, 'Is Tenure Tenable?' (2). There have been innumerable articles in The Christian Science Monitor and in the general press. Some have been incisive, but in my view most have been based on ignorance and misunderstanding.

The basic document on tenure is the 1940 Statement of Principles on Academic Freedom and Tenure (3) prepared jointly by AAUP and Association of American Colleges (AAC). More recently the AAUP and the AAC sponsored a commission on Academic Tenure in Higher Education which issued a comprehensive report on tenure in 1973 entitled Faculty Tenure (4). It is here that a definition is found.

A glossary in Faculty Tenure defines academic tenure as: 'an arrangement under which faculty appointments in an institution of higher education are continued until retirement for age or physical disability, subject to dismissal for adequate cause or unavoidable termination on account of financial exigency or change of institutional programs' (4). This last clause is often lost as a part of the concept and overlooked in much of the debate.

What is meant by 'adequate cause?' The glossary says: 'the term refers especially to demonstrated incompetency or dishonesty in teaching or in research, to substantial and manifest neglect of duty, and to personal conduct which substantially impairs the individual's fulfillment of his institutional responsibilities' (4). It is important to recognize that this definition is very broad. It contains a far more encompassing limitation on the expectations of continued employment than most would expect.

To whom does tenure pertain? Basing a definition on the important AAUP-sponsored documents (3), it potentially includes all faculty members, whether full or part-time. Individual institutions may vary in their specifications of who should be covered. For example, at Rice University part-time people are not covered, and I think this is true at many other institutions. What appears to be consistent is that tenure usually does not apply to administrative appointments. No dean, provost, vice president, or department chairman has the right to hold his position any longer than the current day, even though his appointment may have been expressed as a three- or five-year term. An administrator serves at the pleasure of his supervisors. The appointment of an individual to the chairmanship of a department is not in question when discussing tenure. A department head may have tenure, but only with respect

* President, Rice University

to his faculty status, not his administrative .

USES OF TENURE

The uses, or purposes, of tenure are several-fold. From the point of view of the scholar, the most important purpose is to provide untrammelled time to do scholarly work. It is hoped that all faculty members are scholars. Everyone realizes, I believe, that one cannot do creative work 'on order.' In response to a demand that one solve a problem, the best that one can do is try. The scholar, a creative worker, simply has to be able to let his thoughts organize themselves. Even the appropriate setting for the scholar's work varies from individual to individual. Some work best in a wild thunderstorm; others, in a setting so quiet it would be unnerving for many.

In addition to providing necessary time, tenure was devised to protect individual rights of the scholar, whose creative work sometimes alters the truth. The need for such protection becomes apparent when one looks at the nature of research and what it involves. The researcher re-examines what is taken as the truth and reformulates it in light of new perceptions and insights. This tampering with the truth carries with it the potential for trouble. New ideas will be resisted by those with a vested interest in the truth as currently perceived. Highly organized societies produce their dogmas and their priesthoods committed to the preservation of orthodoxy. It is therefore impossible to do creative research in a highly organized society without adversely affecting the interests of some sector and encountering charges of heresy from defenders of the faith. Tenure, viewed as one means of protecting the unorthodox, was devised to protect the rational examination of ideas, concepts, and propositions from personal bias and dislike.

SOME ABUSES

Unfortunately, in the administration of tenure there have been many abuses. I am an advocate of tenure but not of its current application. One problem is that personal considerations have reduced the qualities of judgment in tenure decisions severely. Likes and dislikes, political differences, and other kinds of personal differences have been involved in tenure considerations.

The six-year time limit for making a tenure decision espoused in the AAUP statement has become the standard and in most cases at most places the full six years are used. This practice is a distortion of the original intent to serve as the standard for the maximum time. Where competent scholars and teachers can be identified in a shorter period, the decision to award tenure should not be delayed. For many cases, however, six years is too short a time for an administrator to make a judgment.

Tenure considerations involve making an estimate of whether a person will be an important teacher-scholar in his field. In any 10 such judgments, inevitably perhaps two will be mistakes. But administrators have no way of knowing now which two persons will represent the errors. Of 10 granted tenure, two will not justify the confidence. Of 10 refused tenure, two would have served the institution well. Administrators must accept and live with the errors. The intent must be to minimize the effect of an error, so that living with it is a little easier.

At Rice University we have a young faculty. During the period of expansion in the sixties, about 55 percent of our faculty were hired. They are now being considered for tenure. Because all are relatively good, our decisions are very difficult. We may be keeping more of them than we should, but we are trying to reduce the serious errors we will have to live with 10 or 20 years from now.

A serious abuse of tenure is the extreme difficulty encountered in any attempt to dislodge a tenured professor from his post. Dismissal is so difficult to accomplish that few attempts are made. In my 40 years of university work, I have seen only one excision from a tenured position. This case involved a person who refused to attend class because of a personal dispute with the university president. The president suspended him and gave the case to the tenure committee. After one year of deliberation the committee came to the conclusion that the president had acted properly. In my judgment the low number of tenure dismissal cases are traceable in part to the inhibitory effect of having to provide courtroom proof of the case against the individual.

This inhibition clearly works to the detriment of higher education. If a university administrator is unable to remove 'mistakes,' a cadre of nonproductive scholars and poor instructors is built up. There is a whole segment of a faculty who, in effect, retire upon acquiring tenure. They then become part of a system which influences the next tenure group, and so the problem is amplified. A partial approach is to be selective in deciding which faculty may be involved in the tenure-producing process.

In the last two years, removal of a tenured professor has become an even more problematic process. Some who have been removed have challenged their removal in court. While the rulings are mixed--some have been ordered reinstated, others have not--it is now apparent that the ultimate decision no longer rests purely with the academic institution. The court is the final arbiter.

In a non-expanding system, tenure works not only against the university but against young talent. At Rice, tenure percentages are approximately 55 percent. In our faculty of about 350 we have many good, young people coming along year by year. Currently approximately 15 people a year cannot be continued for no other reason than our own lack of space to expand. Perhaps this reason will be tested in court.

One is almost tempted to disregard percentages and put everyone on tenure. This solution would at least preclude the necessity for this nearly intolerable sacrifice of the young faculty members. In fact, one ought to consider whether the ossification problem is as bad as we have always taken it to be. It could be terrible for the institution if many mistakes are made since it would take a generation or two to recover. However, if the number of mistakes were average the system would work. Yet at some time there would be no place for the new young people without involving expansion.

SOME SUGGESTIONS

What can be done to correct the tenure system? One way to reduce abuses in administration (personal bias, mistakes in judgment, etc.) is to create a clear set of standards and practices for hiring, promotion, and dismissal. Definitions are needed of what an effective scholar should be, what the intervals of evaluation will be, and how performance will be measured. Everyone would then have to follow those rules and regulations and see that the requirements are fulfilled. To have a case reach the courtroom and a reasonable decision overturned because procedures weren't properly followed is debilitating and unnecessary. There is no reason for any of our institutions to get caught in that difficulty.

Some mistakes in judgment concerning a person's future academic career could be corrected if, after gaining tenure, the individual's competence were periodically reviewed. The individual could be reviewed for adequacy. If it is found that his performance as a scholar-teacher is inadequate, provisions for his dismissal could be made. In determining adequacy, one should not compare the individual to others available in the 'marketplace.' Instead, one must ask how far along the person is in his development and if he is going to make a sizeable or suitable

contribution. I do not mean that anyone has the right to remove somebody who is just adequate, but inadequacy ought to be determined on a regular basis rather than on an ad hoc basis.

An administrator who suggests re-evaluation immediately comes under attack because re-evaluation implies, and should, that someone has the right to remove the individual if he hasn't lived up to his promise. Unfortunately, under most systems you cannot even look at a tenured faculty member's performance without being accused of harrassment, though the administrator is realistically trying to maintain the quality of an institution.

How often should the evaluation process occur if it is accepted? Perhaps five years after the tenure decision and then five years later. After 10 years the administration would assume that an individual is capable and leave him alone for 15 years. Recognizing that in most cases there would be a downward trend at that time, another evaluation would be made.

An alternative would be to provide tenure at six years maximum time and re-evaluate the individual at a certain later age. Another method is to set an age standard, for example, by not providing tenure to anyone below age 37, on the basis that one does not mature until then. At Rice I have gently advocated re-evaluation and have been ungently beaten down.

An alternative to re-evaluation is to do away with tenure entirely, replacing it with a term procedure, i.e. five-year terms renewable as long as adequacy is demonstrated. I do not recommend this alternative as I believe it is as dangerous as a year-to-year appointment, merely multiplied by five.

In short, I believe that tenure has its place. I find the reasons advanced in justification of its existence persuasive. But there are problems in its application which warrant serious attention. Some of these problems can be alleviated through more attention to definitions and procedures. Others may require changes in the structure of the process itself.

In my view, the least acceptable alternative to tenure is a term contract system. The most viable suggestion is the idea of combining tenure with periodic evaluations.

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WHAT TO DO WHEN THE FACULTY STARTS TO ORGANIZE FOR COLLECTIVE BARGAINING: WHY THEY WOULD

Charles D. Jeffries *

In June of 1972, the Wayne State University faculty, including the School of Medicine, was declared to be represented by the Wayne State University Chapter of the American Association of University Professors (AAUP) within a definition set by the Michigan Employment Relations Commission. The following paragraph spelled out just whom the AAUP was to represent:

All teaching faculty of Wayne State University including professors, associate professors, assistant professors, and instructors, fractional time teaching faculty who teach more than half time, all academic staff employees of Wayne State University including, intra-alia, librarians, archivists, academic advisors, counselors, but excluding adjunct faculty, research assistants and associates, professional and administrative staff, department chairmen in the colleges of liberal arts, monteith, engineering, medicine and business administration, deans and other executive and supervisory employees and all other employees.

The designation of the American Association of University Professors as bargaining agent was the culmination of a contest that had lasted for about a year-and-a-half. The faculty of the School of Medicine was dragged into this situation kicking and screaming all the way. Some of the reservations and fears held by the medical faculty at the outset have been realized.

MEDICAL FACULTY INITIATIVES

The School of Medicine faculty, in an attempt to avoid collective bargaining, formed the Wayne Medical Faculty Association (WMFA) to argue before the Michigan Employment Relations Commission (MERC) for exclusion from the bargaining unit determined for the University. It was felt that because of special interests and duties, the position of the School of Medicine faculty was sufficiently distinct from that of the other University faculty to warrant exclusion from a University bargaining unit. The WMFA group was never well-supported, either fiscally or functionally. After hearings before MERC, the medical school was declared to be included in the University bargaining unit, and the petition of the WMFA was dismissed because the WMFA expressed no interest in representing the defined unit. This decision came almost a year after the first hearing before MERC.

The parties initially seeking election as agent for the University bargaining unit were the Wayne State University Federation of Teachers, the Wayne State University Chapter of the AAUP, and the Wayne State University Faculty Association (Michigan Educational Association-National Educational Association affiliate).

Because the position of the Wayne Chapter of the AAUP had been the most reasonable and conciliatory toward the special concerns of the School of Medicine, a group in the school

* Professor, Department of Immunology and Microbiology, Wayne State University School of Medicine

launched an active and effective drive for election of the AAUP as bargaining agent for the faculties of the University. Faculty meetings were held, and a final flyer was issued just before the primary election to discourage a 'NO' vote. A massive, organized effort was mounted to encourage each individual to vote during the primary election. The main thrust of this drive in the medical school was to insure a reasonable choice in the final decision. The drive was successful to the extent that the Wayne State Federation of Teachers unsuccessfully opposed the Wayne Chapter of the AAUP in the runoff election.

The AAUP was cognizant of the special interests of the medical faculty and expressed an interest in accommodating these interests. While no sections of the present contract specify these concerns, the AAUP has secured a reasonable flexibility in the contract which allows for some recognized needs of the School of Medicine faculty.

WHY UNIONIZE?

Among the strongest explanations for collective bargaining at Wayne State University was the loss of trust in the institution's administration, as reflected in the administration assuming managerial responsibility normally considered by the faculty to be within its purview.

Many see economic issues as a strong influence, but I view them as frequently a facet of managerial credibility. Certainly, job security is becoming of great importance as professional mobility declines in an era of lessening resources. The rubric of academic freedom also is of great concern.

All of these issues, however, hinge on the service the administration gives the faculty--the managerial competency supporting the institution--and thereby the degree of credibility as viewed by the faculty.

Lynn William Lindeman, in the November, 1973, issue of Intellect, cited five primary reasons for the recent increase in collective bargaining. The reasons he arrived at from review of over 100 articles are: (1) inadequate compensation, (2) dissatisfaction with the faculty role in governance, (3) the statutory right to bargain, (4) inept administration, and (5) competition for members among the National Education Association, the American Federation of Teachers, and the AAUP (1).

I have used the first reason, inadequate compensation, as a definite basis for collective bargaining. I have lumped the second and fourth reasons under the umbrella of credibility. Essentially, I have discounted the third and fifth reasons as being of fundamental importance in the case of Wayne State University, although the initiation of the petition by the Wayne State Federation of Teachers may have been of greater importance than what may be viewed as dissatisfaction among the faculty.

Credibility of the administration as viewed by the faculty has many facets. The feature of University function which complicates the relationship between the faculty and administration is that the institution must be managed. In managing today's institution of higher education, the administration sometimes issues directives which are or appear to be capricious. Admittedly, there may be directives from state agencies or other governmental units which influence administrative function. However, faculties react negatively when asked to ratify major policy changes or matters of lesser importance on unseemly short notice. The implication is that the action will be implemented regardless of the views of the faculty. I don't know which is the worse path--implementation without consultation or implementation with the approval of the faculty under the gun. In either case the administration will lose credibility and the faculty may move to institute some mechanism to protect faculty rights.

Both credibility and economic issues are reflected in some situations. One such upsetting administrative action at Wayne State University occurred when in December, 1970, many persons with contracts terminating in June, 1971, were sent warning letters that due to financial constraints their contracts might not be renewed. This action raised the hackles of the faculty and caused great commotion. Very few of those so notified were in the School of Medicine.

The economic issue is of great importance today. Monthly reports of the Department of Commerce detailing the cost of living rise emphasize the faculty's feeling of being left behind in compensation. The college-level faculty member looks over his shoulder to see the public school teacher gaining ground quickly as a result of collective bargaining. The college teacher requires services performed by building tradesmen or other domestic service people at hourly rates he calculates to be higher than his hourly rate. He hears that the unskilled laborer is pushing at the same, or even higher, level of income as he. Other areas of pecuniary dissatisfaction are frequently referred to in informal gripe sessions.

The effect of such events can be demoralizing and ego-shattering. To salvage some satisfaction the faculty attempts to induce the administration to strongly support, before the body which determines revenue available to the institution, just improvements in faculty compensation. The most effective means for the faculty to exert such pressure appears to be through collective bargaining, with work stoppage as the ultimate threat.

TURNING TO TENURE

The current employment situation in institutions of higher learning presents a great economic threat to the faculty. Medical schools largely have not been as severely threatened as other university units. Shrinkage in medical school enrollments seems remote, but zero institutional growth is an immediate problem. How do you move the marginally productive, or worse, faculty members of your institution aside for replacement by more promising people? Who is to decide that a faculty member is not meeting standards of productivity appropriate to his position and institution?

The limited time for granting tenure complicates the issue. If it is possible to place such faculty members in another institution, with some improvements in status, the problem is largely solved. But, if it is necessary simply to release the individual to fend for himself, the faculty may read the situation as a Machiavellian, sinister plot to disrupt the faculty, research, and teaching programs. The faculty finds it important to protect the weakest members, for with their removal a new class of the weakest develops, and no one wants to be the weakest.

The important issue is who determines, and by what procedure, the weak, the incompetent, and the non-productive, as well as the strong, among the faculty. The faculty wants to determine the methods and to have the major evaluation of fellow faculty in its hands. The ideal is to have established rules and procedures so that some degree of protection for the individual is built into the system, neutralizing the arbitrary action of the administrator--department chairman, dean, vice president, or gent.

This protection becomes even more important as attacks are mounted upon tenure, which has come to be viewed as a sacred right for the protection of the adequate faculty. The more resounding the attacks on tenure, the greater will be the move to collective bargaining. As simply a matter of economic self-preservation, the faculty member will want to rely upon the evaluation of his peers to determine who should be released and who retained. By having the collective bargaining contract, one can arrive at mutually acceptable guidelines and rules for determining that the faculty member should be granted tenure.

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WHAT TO DO WHEN THE FACULTY STARTS TO ORGANIZE FOR COLLECTIVE BARGAINING: WHAT WE DID (OR SHOULD HAVE DONE)

*Thomas W. Mou **

In my experience, there is no middle ground in labor negotiations. At the State University of New York (SUNY) we tried the oval table concept and tried to maintain collegiality, but negotiations forced an identification of the parties as either 'labor' or 'management.' By law, a representative of the Governor's Office of Employee Relations was required to sit with the University and faculty negotiators and conduct the negotiations for the State.

We also found it difficult to identify a middle ground in the emotional reaction to collective negotiation. Early on, we were amused. Now we are anxious about the acrimony. We have little to show for two years of collective negotiation: a modest salary increase, much discontent among the faculty, and some badly fractured egos. Nevertheless, I am optimistic about future negotiations at our health sciences centers, when we can get past these initial stages.

BACKGROUND SCENARIO

SUNY, one of the youngest state university systems in this country, is also one of the first to find itself in a negotiating position with physician and dentist faculty members. Labor negotiations are one of the few areas where state universities have faced this dubious 'new achievement in management' before the private sector.

The New York State Legislature passed the Condon-Wadlin Act in 1947. It was designed to prevent strikes by public employees. Interestingly, this legislation, with vengeful penalties, was in response to strikes by educators. In 1947 school teachers in three New York cities--Yonkers, Rochester, and Buffalo--walked away from their jobs. Later, in 1965, the act failed to prevent sanitation and transit worker strikes in New York City because penalties were so severe that amnesty was traditionally granted.

With the failure of the Condon-Wadlin Act, New York State established a Committee on Public Employee Relations, chaired by Dr. George W. Taylor† of the Wharton School at Pennsylvania. The committee's charge was to advise on legislation to establish a better pattern for unionization and negotiation by public employees.

The committee's recommendations became a legislative bill known as the Taylor Law. Passed in 1967, it applies to all public employees in the state of New York at either state, county or municipal employee levels.

In the public system in New York State, the legislature is the final arbiter. The legal theory is that the legislature is more representative of the general population than the Governor's Office. Since services provided by public employees often have public health aspects, such as a sanitation workers' strike, or tend to hurt the poor, such as a transit workers' strike, no-

* Provost for the Health Sciences, State University of New York, system-wide.

† Harnwell Professor of Industry, The Wharton School, University of Pennsylvania

strike provisions are deemed necessary.

SUNY requested exemption of its faculty from the provisions of the Taylor Law. But in 1967 the legislature specifically stated in the law that the faculty and staff of SUNY were public employees, and the request was denied. The law made the governor the principal negotiator with all state employee negotiating groups. In turn, he assigned this responsibility to his Office of Employee Relations, created as a cabinet office of the Governor.

In 1967, when the Taylor Law was enacted, the University Senate became immediately involved in the first battle which was to determine which group might represent the University faculty in collective bargaining negotiations. There were four immediate contenders:

- (1) the Civil Service Employees Association (CSEA), a traditional public employees association whose membership was primarily classified service employees.
- (2) the AFL-CIO, as represented by the American Federation of Teachers, an organization which had very little strength outside metropolitan New York City.
- (3) the American Association of University Professors (AAUP), which was having a serious national organizational debate as to whether it would be willing to act as a negotiating group for any faculty.
- (4) the Faculty Senate of the University, which assumed that if it did not control the negotiating unit, it would have no power to speak for the faculty on University matters and would become little else than a debating society.

The SUNY Senate tried to affiliate with the CSEA and discovered it would be treated like any other classified service group. It then arranged a better alliance with the National Education Association, and the Senate Professional Association (SPA) was created and voted into power as sole negotiating agent by the university-wide faculty.

There are now approximately 13,000 eligible faculty at SUNY, but only about 4,000 have joined the SPA. About one-tenth of the SPA members are from the medical and dental faculties. (Non-teaching professionals [NTP's] are included with the faculty group in negotiations by ruling of the Public Employees Relations Board [PERB]. NTP's include administrators below the level of dean: admissions officers, financial aid officers, research and teaching assistants, and dormitory counselors.) Because faculties of the University colleges did not understand the importance of maintaining control and may have been unwilling to 'dirty their hands' in labor negotiations, they found the leadership of the SPA in the hands of the non-teaching professionals, one-third of the total negotiating group.

Negotiating objectives of the non-teaching professions are usually more akin to those of the Civil Service Employees Association, i. e., across-the-board rather than merit increases and increased status for the non-teaching professional group. These goal differences have been troublesome. However, the University faculty has this year assumed a stronger leadership role and will be more adequately represented in future negotiations.

In 1970 the medical and dental faculties became very active in the negotiation process when they realized that the university-wide faculty would not opt for 'no representation' on the part of the medical and dental faculties. To assure themselves a voice in the negotiations, they organized a voluntary group known as the Medical Caucus, assessed themselves, and became an active bloc in the SPA. Their actions led to the unusual arrangement whereby all negotiations for the medical and dental faculties were done by a separate group and extended over a much longer period of time than negotiations for the State University faculty-at-large.

There is now a fascinating evolutionary process going on. At stake is whether the medical

and dental groups will continue to have separate negotiating sessions. There are new pressures to fold all health sciences, not just the physicians and dentists, into a single negotiating unit. This issue is precipitated by the fact that pharmacy, nursing, allied health, optometry and other health professional faculty are not sympathetic to separate negotiations for medical and dental faculty.

WHAT WE DID

Several factors initially caused problems in negotiating a contract for the medical faculty of the SUNY schools:

- (1) The union and the university management lacked expertise in the field of labor negotiations. Last year, for example, the union held out so long that the legislature went home, and the 1973 salary increases were not paid until May, 1974.
- (2) The University is decentralized, with most management-faculty issues traditionally settled on the local campus level. SUNY comprises 34 university campuses and 38 community colleges.
- (3) With the exception of Stony Brook, a new school, the state system of medical and dental institutions had been put together by acquiring financially weak schools that had previously worked out complex local practice and hospital arrangements in an effort to stay afloat. This situation made negotiations on a uniform practice plan complex.
- (4) The medical and dental schools traditionally were almost autonomous on their own campuses with regard to faculty-administration relationships.
- (5) There was no good documentation or in-depth understanding of current clinical practices on the campuses.
- (6) There were expectations of union and campus administration 'piggy-backing,' similar to the occasional 'piggy-backing' of which some accrediting teams and administrators are accused by some presidents and budget directors.

We examined the existing situation and found that each of the six schools interpreting a permissive 1959 University Trustees' Resolution regarding supplemental practice income to meet local needs. The Trustees' resolution imposed a 50 per cent limit, after expenses and annuity programs, on clinical practice income. One school required a confidential actual dollar earnings report, with an option for tax review. Another school asked only a simple statement: did you stay below the 50 percent additional earning level? The school also used the less-than-full-time appointment device to circumvent compliance with the 50 percent earning limitation. Two other schools required no report. The other two had true full-time systems and no need for a report.

We found also that each school had a different arrangement for handling research fund supplementation, hospital staff appointments, capitation monies, and general support dollars.

Further, we examined the initial union salary demand in terms of appropriated state dollars, and found it high. While the initial SPA proposal simply asked for continuation of the 50 percent salary supplementation from clinical earnings, early in the negotiations it became clear that clinical practice income also would become a subject of negotiation. The final settlement in 1973 requires the establishment of six school-wide public benefit corporations. Clinical department participation is required. However, separate department identities and accounts are permissible in each corporation. A seven percent salary increase (four percent across-the-board, two percent to correct inequity, and one percent merit) was negotiated as well as an increase from 50 percent to 75 percent in the additional clinical earnings supplementation permissible. The

latter was a component of the public benefit corporation concept.

During the long negotiating period we managed to avoid punitive actions by the division of the Budget and the Department of Audit and Control. Each of these agencies had some influence in the negotiations, and we repeatedly assured them that the clinical practice plans would be better supervised via agreements achieved at the negotiating table.

As negotiations began, the University took the following positions with respect to medical and dental faculty issues:

- (1) that the salary scale for the basic sciences faculty and for the clinical sciences faculty in the medical and the dental schools would be maintained at par. The maximum professor-chairman salary for all departments, from state dollars, is now \$44,000 (1973-74 fiscal year). No minimum salary levels were negotiated, conforming with existing University policy.
- (2) that, with the exception of the Stony Brook medical and dental schools which had been planned as true full-time operations, no dollars would flow to the state from the schools.
- (3) that the University wished to achieve a better means of accounting for earnings on state property. There was no intent to take funds away from any department except for a small 'flexible fund' for each dean that might be used for appropriate campus purposes. We wished to avoid future confrontation with the Division of the Budget and the Department of Audit and Control, whose traditional fiscal policy is that all money earned on state property is the property of the state. We hope, through the public benefit corporations, for a good system, good records, and easily defensible uses of clinical practice overage funds in order to minimize criticism by fiscal agencies of the State.
- (4) that each president or vice president and each dean, with the provost, would attend all negotiating sessions as advisors to the actual negotiators. The typical short notice of negotiating sessions by the union and the Office of Employee Relations posed problems in implementing this position.
- (5) that we hoped to eliminate those rare but painfully embarrassing financial capers that come to light every few years during an audit report. This issue was overly sensitive to the faculty, and we probably tried too hard to correct minor problems in the initial contract.
- (6) that because of the protracted negotiations, the medical and dental faculties would receive in July, 1971, and July, 1972, the same salary increases as the remainder of the University faculty.

As the process evolved, and especially after the union negotiators accepted the compromise agreement in May, 1973, we learned of problems that were a result of earlier, shrewd arrangements and ad hoc agreements. These problems were the result of liberal interpretation of University policies at the separate schools. One example was the use of part-time appointments for entire departments, in which substantial state-funded salaries were paid on a part-time basis, similar to the Veterans Administration seven-eighths* time model. This practice theoretically absolved the faculty member of the 50 percent supplementation limit and permitted unlimited income.

* A VA Hospital policy which permits a 'part-time' staff member, one who works less than full-time, to supplement his income through other sources.

We could not accurately determine the total income levels in the case of some part-time faculty, a few of which were probably in excess of \$100,000. Our practice plan did not accommodate these faculty members, and it is doubtful that we would have been able, under any circumstances, to bring the higher income part-time faculty into happy conformity or consistency. Had we been more aware of this specific problem, we would have addressed it in a different manner.

WHAT WE SHOULD HAVE DONE

There were several problem areas that emerged from the process:

(1) Delay. A militant union would never have permitted negotiations to extend over a year-and-a-half period. Once the contract was drawn up in May, 1973, the union had great problems achieving ratification. It took eight months and two separate ballots before acceptance by the union membership.

(2) Misunderstanding. Overwhelming fears of the plan prevented rational thinking, caused great anxiety about the state system, and reduced willingness of an influential few individuals to work constructively toward implementation of the clinical practice plans. The University and the union negotiators have been accused of achieving a 'sweetheart contract.'[†]

(3) Litigation. A complaint seeking an injunction has been filed against the University charging infringement of due process and of equal protection of constitutional liberties with respect to the use of clinical research funds to bring the clinical practice income to the 75 percent level. Another suit, also charging similar infringement of constitutional liberties, has been threatened. This brief is expected to state that the University has no right to limit the earnings of any faculty member.

(4) Grievances. One SUNY health sciences center has challenged the University system on delay in the implementation of the 75 percent earning agreement. The University imposed this delay until public benefit corporations were established. The funds in question are being held in escrow until the legal questions are answered.

Looking back, I can identify what we should have done differently from what we did. First, we should have better prepared our negotiators, including deans of the health science schools, University administration, and the Office of Employee Relations negotiators. It is now obvious that University management must know every detail of current practices at all schools and every departmental arrangement, including those 'under-the-table' arrangements that never appear in state or national salary data compilations or in the Association of American Medical Colleges (AAMC) salary data. When we quoted AAMC salary data and other salary information related to clinical income that we had acquired by direct inquiry, the faculty union was merely amused. The union quoted very attractive offers recently made to some of its own members which were far above the upper limits provided to us by schools included in the salary surveys.

[†] A labor-management contract accomplished quickly in secret meetings with the hope that the rank-and-file will accept it. Collusion between management and the union at the expense of employees is suspected.

Second, we should have communicated through our vice presidents and deans with every leader in the departmental hierarchy, even if the union representatives did not. Department chairmen in the SUNY system are union members. Frankly, a few of our leading senior department chairmen and faculty leaders looked down on the negotiating sessions until they found they had no control or input into the most important steps in the negotiations. Involvement of department chiefs continually is essential; the faculty needs to be fully informed every step of the way. Faculty members also must understand that negotiators may be an important key to their entire future on that campus. Therefore, the most influential and best-informed members of the faculty must be at the negotiating table. Their approach must be constructive rather than destructive because without some element of collegiality a worthwhile operating milieu cannot be developed.

Further, we should have avoided secrecy in the final weeks of negotiations. Secrecy was a major factor leading to the 'sweetheart contract' accusation. In the private sector, direct management discussion with rank and file union members would constitute unfair labor practice. While secrecy might work in private industry, it won't work where professional faculty are heavily involved in the conduct of the institution. When we discovered that union spokesmen were not communicating fully with their constituents, we should have taken steps to conduct full discussions with the faculty.

On reflection, we should have accepted the Internal Revenue Service guidelines for expenditures. Trying to be too idealistic and tie up every loose end created many problems.

A composite salary package was proposed early in the negotiations; it should have been explored more fully. In the composite approach, the dean, department chairman, and faculty member would jointly determine a salary that would be a composite of all sources of income for that faculty member. Since this process would have been very complex to negotiate, there was no willingness or enthusiasm by the union or the negotiators to use it. We should have corrected existing improprieties at the various schools by other means rather than a new practice plan, and we should have prepared a clear definition of what constitutes research income and how it is to be integrated with the total salary package of each faculty member.

In future negotiations, we should explore other approaches to limiting clinical practice income, instead of using an absolute maximum amount based on a percentage of base salary. This approach has tended to reduce the incentive for the high earner since he soon reaches his maximum salary and no longer shares in the income he generates. Other approaches to the solution to this problem, such as regressive or progressive taxes that never quite reach 100%, will be explored in our effort to develop a method of compensation that will permit the faculty member to share fairly in the fruits of his effort but yet will keep his income within the competitive range for academic physicians and assure his commitment to teaching activities and research endeavors.

Deferring agreement on exact definitions of full-time, strict full-time, true full-time, geographic full-time, and part-time led to more problems in the area of faculty compensation.

In retrospect, each chief administrative officer should have been present at every negotiating session. When they were not present, or when those present were not aware of specific practices at their schools, those in attendance and knowledgeable had the greatest influence at the negotiating session. It was unfortunate that the University could not control when negotiating sessions would be held and that there was little advance warning. In my view, attendance by those responsible is one of the most critical issues. As the representative of the medical or dental faculty, there is no more important responsibility

for the dean or the vice president, except perhaps a budget hearing.

Finally, in future negotiations the University must take a stronger stand to give its wishes more credence at the negotiating table. To have a third-party agency responsible for the negotiations is extremely difficult. Also, if the position presented to the negotiating team is not a unified University position, there is great difficulty. This problem arose when the views of the administrators of the six schools and of the central administration offices did not always coincide. In that circumstance, the Governor's negotiator could not take a strong stand with firm support by our school administrators. Faculty negotiators, realizing this dilemma, took advantage of the situation at the negotiating table with some spectacular 'piggy-backing' by faculty and administrators.

In reviewing the SUNY collective bargaining experience, I have outlined some of the highlights of a fascinating play in which I've been one of the players for the last two years. There are more acts to come, some with comic relief, and others with more tragic overtones for health sciences education. Either way, the play will have implications for all of us.

REACTOR -- DISCUSSANT

*Ronald W. Estabrook **

The question of tenure policies and faculty unionization are two of the top concerns reflected by deans of academic medical centers in the recent Delphi Survey on the future of medical education. Tenure is of concern to the faculties because criteria for tenure selection is in a process of change. The decreased mobility of faculties as well as the loss of competitive spirit that may exist as middle age approaches contribute to the present insecurities of the faculty.

DEFINING TENURE

Tenure is a problem that has been generated largely because of misunderstanding of its definition. The Council of Academic Societies recently held a debate titled, 'Resolved, that academic tenure is outmoded and should be abolished.' Dr. Carol F. Van Alstyne, a member of the law faculty at Duke University and recently elected chairman of the American Association of University Professors, debated with Dean Cheves Smythe of the University of Texas Medical School at Houston. Dr. Smythe took the approach that tenure is outmoded only because it is not strong enough. The debaters ended up with a great deal of commonality regarding the interpretation and intent of tenure. They agreed on the definition: academic tenure is a system by which faculty appointments are continued until retirement for age or physical disability, subject to dismissal for adequate cause or unavoidable termination because of financial exigency or change of institutional programs. Dr. Smythe pointed to the weaknesses of tenure, while Dr. Van Alstyne stated that the present question on tenure mainly revolves around the right of the individual to academic due process when terminated. The process of termination must include suitable procedural review, such as the reverse pattern of the appointment to tenure, according to Dr. Van Alstyne. Responsibility is placed on the administration to suitably support its case, using as justification financial or programmatic changes as well as competence of the individual.

As I see it, the major problem is the rather indefensible position of the administration since it has not rigorously defined the qualifications for tenure, making it difficult to support the case that any individual faculty member does not now meet these ill-defined criteria.

Tenure has been likened to the Mafia--one becomes a member by being born into a selected family or by the possession of special talents. The Mafia has its own means of removing a member if the rules of the game are violated. Extending the analogy, the deans must take on the job of the hit-man if a faculty member is to be terminated--a most uncomfortable role to assume.

The solution is simple: define criteria for tenure and apply these criteria after suitably notifying those individuals to be promoted to tenure. This simple solution, however, does not answer the problem of how to pay for the transgressions of predecessors made many years ago--how to remove those faculty who have lost their luster and promise. Many young, bright

* Chairman, AAMC Council of Academic Societies; Chairman, Department of Biochemistry, University of Texas - Health Sciences Center at Dallas

people stand in the wings waiting for appointments. Further, many older faculty who have been associated with schools for 10 to 20 years have priced themselves out of the market place.

Dr. George S. Odiorne, dean of the College of Business at the University of Utah, once spoke to the Association of Chairmen of Biochemistry Departments and berated us when we asked him what to do with faculty members beset with early creeping mental senility. He suggested applying management-by-objective techniques, asking each faculty member to complete each year in writing answers to the following questions:

- (1) Describe your present situation--your position, activities, and obligations related to teaching, research, and service.
- (2) Define where you will be in one, three, and five years if nothing changes--i.e., funding, space, research support, teaching responsibilities, etc.
- (3) Do you like the answer to Question Two?
- (4) If you do not like the answer to Question Two, what do you intend doing about it?

By requiring the faculty to define its goals and with appropriate yearly review, Dr. Odiorne claims that the faculty member, in a brief number of years, establishes his own file documenting his mediocrity or loss of direction, thereby generating the strongest case that can be brought against him.

WHY UNIONIZE?

Regarding unionization, the Council of Academic Societies also held a debate titled, 'Resolved, that collective bargaining by the faculty will strengthen both research and educational progress in Universities.' Dr. Otto M. Lilien, a urologist at Upstate Medical Center at Syracuse spoke for the motion, while Dr. John N. Lien, Associate Dean, Continuing Education and Development, at the University of Washington, debated against the motion. Dr. Lilien took an approach similar to that outlined by Dr. Mou. That is, the Taylor Law legislated the need for unionization and since the medical school faculty must become involved, the very best, most persuasive, and most responsible members of the medical school faculty should take a leadership role in union activities. Dr. Lilien also mentioned that the faculty union was joining together with the administration to face the true adversaries--the state government Division of Budget and the Department of Audit and Control.

I am not convinced that the faculty wants to do something about making decisions. Once the decision has been made to unionize, many reasons can be given to support the role of a union, i.e., the faculty Senate is a charade, the administration never communicates anything important, rumors of favoritism regarding salaries, space, teaching, or the support of research. When this dissatisfaction is expressed, I believe it is better to join the dissenters than fight them, shifting the common enemy from the school administration to another focal point in the system.

Despite major efforts to publicize the program of debates for the Council of Academic Societies spring meeting and despite the central location of the meeting in Washington, D. C., only about 25 people attended the debate on tenure and only 10 attended the debate on unionization. This lethargy on the part of the faculty points to a major problem that will compound the complexity of any solution.

HOSPITAL REGULATION--A FACT OF LIFE

*H. Robert Cathcart **

Regulation is a continuing fact of life for those providing health services. The extent of regulation varies markedly from state to state and between regions within a state. But the fact that the health care industry will be regulated more next year than this year, and more five years from now than today, is a certainty.

Regulation is not a new condition for hospital management, having become apparent as an inevitability in the past 10 years. Some of the more common forms of regulation can be noted in order to establish a working definition of what hospital regulation is in the United States in 1974.

TYPES OF REGULATION

Regulation can be defined as a rule or order governing conduct prescribed by an authority. Often the authority is governmental and accomplishes its regulatory action by law, regulation, or contract. However, the health care industry is becoming increasingly regulated by non-governmental authorities. When accrediting bodies define what institutions must do to gain approval, these bodies are, in effect, regulating. If a hospital wishes to buy malpractice, public liability, or workmen's compensation protection, insurance underwriters require certain behavior. Third-party payers regulate when they stipulate what the hospital must do to be reimbursed for the services it renders. Labor union contracts also regulate the personnel policies of the employer.

Rapidly increased costs, sluggish response to community wishes, and a breakdown in communications has resulted in desires to discipline hospitals at both federal and state levels by means of comprehensive regulations. State control has increased in the past 50 years and is now frequently shared with local governing units. Such regulations reflect the more traditional areas of governmental concern: safety, sanitary standards, and labor relations.

More recently, state efforts have included other areas of concern. Licensure gives the licensing authority the right to enter, inspect, and determine the suitability of the applicant and the premises, and judge the continuing conformity of the license. It is difficult to challenge such authority since institutions cannot function without a license.

Certificate of need is a second regulatory measure available to the states. States choosing this form of regulation control the operation, lease, or construction of a health care facility by prohibiting such action without a certificate authorizing the action. Presently, 22 states have such laws, 11 states have legislation pending, and 17 states are considering legislation.

Cost control acts are a third form of state regulation. They require each hospital to file a rate form projected to raise sufficient funds when added to other unrestricted revenues for the total financial requirements of the provider. By the end of 1973, 11 states had some form of rate review legislation. When a state has all three regulatory elements--licensure, certificate

* President, The Pennsylvania Hospital

of need, and cost control acts--each control becomes stronger than any would be independently. When all three are functioning simultaneously, the state can begin to effectively discipline the system.

A hospital's survival is contingent upon its conformity to scores of regulations. Such conformity is difficult. Seldom is a single, up-to-date, complete list of regulations available. As important as a working knowledge of all regulations is a recognition that regulations may have other consequences more pervasive than the regulations themselves.

Consider the similarities between taxes and regulations. Those being regulated or taxed recognize the importance of the event when it first impacts. Slowly they accommodate to it, and just as slowly their perspective of the matter is diverted. Finally, they have changed their way of doing things, but they have forgotten the original premise for the change.

The similarity between taxes and regulations is also apparent in how man and his social organizations react to the presence of regulations. We try to minimize their impingement, perhaps delaying their influence or redirecting our activities so that the regulations no longer apply. The impact may be so subtle that as we modify our behavior we may not realize why we are acting as we are.

For many years, political scientists have advocated the use of taxes to direct the efforts of society, to speed up or slow down the economy, to encourage or discourage the import or export of commodities, and to modify the production process by controlling the mix of labor and capital. Until now, most of the hospital industry has successfully avoided this type of social direction because significant elements of the system have a tax-exempt status. As more and more of the industry comes under the direction of investor-owned managements and as the voluntary sector becomes increasingly subject to taxation, the protective blanket of tax exemption may be withdrawn.

In the meantime, society will want to use regulation increasingly as a substitute for tax control to insure more responsiveness and accountability since the tax-exempt status of many institutions makes regulation by taxation difficult. It is well that hospitals conform both to taxation and regulation. But it is important to realize that these external directors have a powerful influence on a hospital's activities, an influence so subtle that it could become dangerous. It could cause the hospital to alter its patient-centered, rational approach. The hospital's methods of meeting issues may become distorted, less patient-centered, and more expensive than they would be under other conditions. Society has permitted many health providers to escape from the tax collector. When doing so it has lost an income source but also a regulatory mechanism.

ISSUES PROMOTING CONTROL

Lack of public understanding, grandstanding by politicians, incredibly naive statements and actions by medical and hospital leaders, and increased third-party financing of the health system will insure increased regulation. Also contributing to this trend are the variety of national problems in the health delivery industry which the industry itself has failed to solve. Society demands solutions.

Issues likely to promote new controls include: (1) increased use of foreign medical school graduates who do not meet the same minimum quality standards of graduates of domestic schools; (2) uneven distribution of physician and nurse manpower; (3) alleged success of the Cost of Living Council regulatory mechanism of the Economic Stabilization Program, which has made regulation appear socially useful; (4) popularity of the licensure mechanism, the

certificate of need concept, and rate control devices in regulating professionals; (5) shortage of primary care which will be cited as proof of the need to control the way services are delivered and the way manpower is prepared; (6) obvious surplus of facilities, which has reduced the cost effectiveness of the industry by staggering amounts; and (7) recognized poor utilization of available health manpower.

Another reason for outside regulation of the hospital industry penetrates the heart of the present voluntary system. In too many instances, the internal power struggles among the governing board, the faculty, and the hospital management boil over into the community and give the impression that no one is in charge. If there is someone in control, those in opposition encourage outsiders in the belief that grave inefficiencies and misfortunes are being fostered within the organization. Too often medical centers have become fertile fields for a growing number of home-grown curbstone health delivery experts. This tendency has helped create a critical audience that will encourage more controls, not unlike the recent increased public clamor for more control of the oil industry when many new energy experts came before the public claiming new expertise that conveniently would enhance their own importance and standing.

Government agencies providing financing sources will want control to protect their treasury. It is possible to analyze their influence on post-graduate medical education. These costs are large--one-half to three-quarters billion dollars annually, \$15-\$17 per patient day in our large teaching hospitals. Large costs will bring regulation. Once accepted the academic administrator has a choice: should the financing be via the patient-service dollar, the sick bed fund (in accordance with the current stance of the AAMC), or from some educationally oriented mechanism such as fees, endowment, or state educational funds? If the choice is via the sick bed fund, educational regulation will come from the Social Security Administration, the local Blue Cross office, and the state department of health or welfare. Regulatory personnel will be, at best, accountants, but often liberal arts graduates working under a merit system security blanket with little understanding of the complex interrelationships of the medical education process. Or regulators might well be a more educationally oriented administration from the Office of Education or the state education department.

A recent example of the proposed regulation of the educational control mechanism is the Kennedy-Mills bill (H. R. 13870) which takes a giant step toward further educational regulation by a non-education agency board in the Department of Health, Education and Welfare. Among its provisions:

- (1) **Establishing educational priorities:** 'In consultation with comprehensive health planning agencies designated pursuant to sections 314 (a) and (b), the Board shall promptly establish (and from time-to-time review) schedules of priority for the recruitment, education, and training of personnel to meet the most urgent needs of the national health insurance program established under the Social Security Act by the Comprehensive National Health Insurance Act of 1974. The schedules may differ for different parts of the United States.'
- (2) **Supplying categorical assistance:** 'The Board is authorized to provide, to physicians and medical students, training for the general or family practice of medicine and training in any other medical specialty in which the Board finds that there is, for the purposes of such system, a critical shortage of qualified practitioners.'
- (3) **Authorizing new educational programs:** 'The Board shall provide education or training for those classes of health personnel (professional, sub-professional, or nonprofessional) for whom it finds the greatest need, if other Federal financial assistance is not available for such education or training.'

- (4) Testing effectiveness of new personnel: 'The Board may make grants to public or other non-profit health agencies, institutions, or organizations to pay a part of all the cost of testing the utility of new kinds of health personnel.'
- (5) Authorizing institutional grants and contracts plus student stipends: 'Education and training under this section shall be provided by the Board through grants and contracts with appropriate educational institutions or such other institutions, agencies, or organizations as it finds qualified for this purpose. The Board may provide directly, or through the contractor, for the payment of stipends to students or trainees in amounts not exceeding the stipends payable under comparable Federal education or training programs.'
- (6) Giving special benefits for practice in areas of acute shortages: 'The Board shall undertake to recruit and train professional practitioners who will agree to practice, in urban or rural areas of acute shortage, in health maintenance organizations.'
- (7) Preparing medical directors: 'The Board shall undertake to recruit physicians to serve hospitals as their medical directors and to train such physicians (among other matters) in advising on and managing the development and implementation of medical policies and procedures and their coordination with planning and operational functions of the hospital, with its financing, and with its program of utilization review.'
- (8) Issuing guidelines: 'The Board shall from time to time issue guidelines designed to relate the clinical education and training conducted by providers of services more closely to the relative need for the several classes of such personnel.'
- (9) Considering institutional budgets of section 1122: (The guidelines shall be considered in making awards in their review of institutional budgets required under section 1122 of the Social Security Act, and shall be adapted to take account of the capacity of providers to conduct such clinical education or training, and (to the extent the Board deems appropriate) to take account of any special manpower needs.'

SUGGESTED STRATEGY

Every health care facility can do a better job of demonstrating its accountability to the public--the people who are paying our bills. If hospitals can better demonstrate and document this accountability, there will be less demand for regulation. Publication of annual reports and the distribution of news reports, news quarterlies, and institutional magazines are all essential parts of this accountability. But there is more. Accountability is a state of mind--a willingness to come out of the ivory tower, to listen to the Naders, the Denenbergs, the students, the local clergymen, and even those who seem least likely sources of information.

Almost all academic health centers, public and private, have a formal structure that insures public accountability if allowed to function as designed. The problem is that the established mechanism has been neglected and overwhelmed by the informal power centers. Thus, the informal system--the politics and patient-referral patterns of the medical staff, the struggle for certain committee appointments, the trade-offs for space control, and alliances to influence appointment of the next departmental chairman--may have more influence on the hospital's function than the original structure which was carefully designed to provide for adequate institutional accountability. The informal system has made perfunctory the

original system of handling appointments, policy decisions, and the review of evaluations through such bodies as faculty committees and trustees. Avoiding mechanisms established to provide accountability makes the institution subject to other controls, often from the outside. The academic health center should make use of its already approved organizational framework to help keep its accountability visible to all.

If these centers are to make their present organizations demonstrate a greater degree of accountability, they must consider the role of their boards of trustees. Do the faculties, clinical staffs, and the university administrations encourage the trustees' involvement? Frequently, there is little desire for this type of trustee participation. Even the most sophisticated faculty often regards the trustee as a fund-raiser or as a trade-off to local community pressure. The fund-raising role of the voluntary trustee is rapidly diminishing. These trustees may well serve in a trade-off role, but they also can act as advocates for the public. True trustee involvement may encourage an institution to approach a level of accountability that can block moves for more formal outside public regulation and the accountability that might follow.

It is important that the medical center leadership make its trustee group effective. Often trustees are intelligent, capable, and dedicated. If the public knows that trustees have clout and that serious issues are discussed with faculty leadership, much of the drive for outside regulation can be redirected. But this redirection will not come about until the public is certain that internal regulation is effective. The more the faculty and administration is internally accountable, the less it will be forced to be externally accountable.

Teaching hospitals are particularly vulnerable to increased public regulation because many have permitted educational goals to manipulate the delivery system. Those paying for the services are not satisfied with this management pattern. Their unrest may surface with refusals to finance this pattern of care and with a new series of regulations. Instead of inviting new controls, teaching hospitals would be wise to find new ways to demonstrate that the patient-care objective of the institution is independent of and superior to the educational objective.

Even with the best of conditions, there will be external controls. But medical centers can live with them. To do otherwise would jeopardize accreditation systems and probably destroy a viable reimbursement pattern. Yet medical centers should not invite or permit more regulation than is absolutely necessary.

By cooperating nationally, hospitals can keep track of proposed regulations and insure that only those necessary are promulgated. It is not surprising that teaching, community, public, religious, urban, rural, western, specialty and investor-owned hospitals find it difficult to agree on any issue. But if hospitals do not 'hang together,' they could very well hang separately. Common interests unite all hospitals, and it is wise to stress the positive common interests. It may be humbling for the proud and often aloof academic health center to recognize that it has common interests with the 40-bed hospital. Yet, such recognition is simply good business. Statesmanlike leadership is required of all academic health centers. Such leadership will be eagerly accepted and most rewarding to those providing it.

Most health centers can monitor the legislative process on both the federal and state level as it moves toward final form. The centers have a responsibility to be involved in legislation, either directly or by delegation to institutional representatives who have established governmental liaison offices. Direct and fast action can often salvage a disaster and turn it into an acceptable social action. Too often, we permit other individuals or the paid help in Washington or the state capitol to carry this responsibility. Much of the unsatisfactory regulation now on

the books came about because of faulty government relations at so many institutions. Professional lobbying staffs at government centers are essential. They can collect needed data and organize it, monitor governmental action and report on it, and recommend appropriate approaches to problems. But the rewarding political contacts must be made by those of us at home who represent an important constituency.

Increased regulation will add to administrative cost. Twenty-five years ago, a hospital administrator could manage hospital regulation if he had reasonable diligence, good reading comprehension, and a moderate-size file folder. The health care institution that survives today must have staff members who devote time to insure that the regulations are observed by that institution and that the institution complies with regulations in a manner most advantageous to it. Just as there is no reason to pay more taxes than required, there is no reason to modify institutional behavior beyond that required by minimal regulatory compliance. Health center administrators must recognize the administrative cost of regulation and prepare to finance such costs. In return, the institution can expect optimal management of its regulatory restraints.

As hospitals become larger and more complex, they find it increasingly difficult to maintain a sense of caring for each individual, his personal needs, and his fears. Patients have become alienated, frightened, and hostile. They are willing, if not eager, to join and lead a public drive for more hospital regulation. Those who are genuinely concerned about hospital regulation should recognize the human needs of each patient. If the health delivery system can maintain a warm, human relationship with its patients, the growth of industry regulation will be controlled.

A NECESSARY EVIL

There are few who defend regulation, yet freedom for all could result in general disaster. Such a warning--the tragedy of the commons--was expressed by Garrett Hardin:

The tragedy of the commons develops in this way: picture a pasture open to all. It is to be expected that each herdsman will try to keep as many cattle as possible on the commons. As a rational being, each herdsman risks to maximize his gain. . . the rational herdsman concludes that the only sensible course for him to pursue is to add another animal to his herd. And another, and another. . . but this is the conclusion reached by each and every rational herdsman sharing a commons. Therein is the tragedy. Each man is locked into a system that compels him to increase his herd without limit--in a world that is limited. Ruin is the destination toward which all men rush, each pursuing his own best interest in a society that believes in the freedom of the commons. Freedom in a commons brings ruin to all (1).

If academic health center leaders can cope with regulation in a responsible manner, greater efficiency and effectiveness of health delivery systems may result. Many present and future regulations will help health care organizations demonstrate and document their public accountability. Such accountability is difficult to oppose. The appropriate attitude toward regulation would seem to be: (1) to achieve the best type of regulation initially; (2) to keep regulations simple; (3) to provide for continued evaluation of the regulations; (4) to provide a mechanism for changing regulations to meet the changing needs of society; and (5) to provide for enlightened enforcement of regulation. If these attitudes are adopted, the \$94-billion-a-year health care industry might well be a better industry, serving people in a more responsible manner and providing a more rewarding and satisfying environment for those workers in it. The industry might not only recognize the necessity of regulation, but actually foster and encourage it.

Society is demanding controls for the health care industry to make it more publicly accountable. Hospitals must accept these controls as a fact of life. The industry can accommodate regulations best by: (1) keeping controls to a minimum by making existing formal organization patterns within its institutions work, as the original governing mechanism was designed, to provide a significant amount of public accountability; (2) reducing the educational manipulation of the delivery system; (3) formulating an effective hospital grouping that can develop uniform positions among a heterogeneous group of hospitals to lobby for a workable public regulatory policy; (4) encouraging the academic health center leadership to enter the political process as regulations are being administratively or legislatively formulated; (5) recognizing that increased regulation is going to be costly and will merit specialized administrative talent and expense; and (6) acknowledging that regulation can be managed adequately to bring desired improvements in the efficiency and effectiveness of the health care system.

The political and social environment in which the health care industry functions in the 1970's mandates significant industry regulation. The health care industry can and must assume a positive attitude toward regulation that will provide for better health services with an increased and necessary public accountability.

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WHO IS RESPONSIBLE?

*Gustave L. Levy **

Not long ago, a group of leaders from medical colleges and government met for a seminar at Mt. Sinai: Dr. John Cooper, president of the Association of American Medical Colleges; Dr. Robert Stone, director of the National Institutes of Health; Dr. Kenneth Endicott, director of the Health Resources Administration; Eli Ginzberg, professor of Economics, Columbia University; Anne Somers, research associate, Industrial Relations Section, Princeton University; and from Mt. Sinai, Dean Thomas Chalmers, Hans Popper, David Pomrinse and Sherman Kupfer.

We talked frankly about current and future problems in financing a private medical school. We went away with more questions than we answered, but the panel did come to some fundamental conclusions.

As summed up by Dean Chalmers:

(1) We agreed that our continuing goal must be to strive for excellence of medical teaching and training.

(2) We expect the majority of our graduates to become specialists, but many will have a strong orientation towards community medicine.

(3) We should increase our student bodies only if we can obtain the funds necessary to maintain the quality of education offered.

(4) We should seek more funds from a wider variety of sources.

(5) Tuition increases should remain modest.

(6) Research funds should be sought because research is such an integral part of the educational setting.

(7) Patients should contribute to the educational costs in a teaching hospital because they receive more expert care there.

(8) Finally, endowment is increasingly crucial to the private medical college because it represents the only truly unencumbered funds available.

In short, medical education is a many-faceted involvement best supported by a multiple source of funds.

STARTING A SCHOOL

As a trustee, I would like to share my experiences in helping launch a private school of medicine in New York City. I believe there is pragmatic meaning for all of us.

Back in 1965 a group of us was convinced we could and should build a new school of medicine based upon the rich clinical experience of our century-old, renowned teaching hospital, Mt. Sinai.

We appreciated the magnitude of such an undertaking. We were aware that monies needed for

* Partner, Goldman, Sachs & Co.; Chairman, Mt. Sinai Hospital and Medical Center; Member, Board of Governors, Tulane Medical Center

construction of a medical school and recruitment of faculty were so awesome that in New York City only one other medical school under private auspices had been established since 1897--the Albert Einstein College of Medicine.

Many people told us it couldn't be done. They said it would cost too much. They said the community would not support an enterprise of such magnitude.

Some said we were going about it backwards in that we were reversing the usual practice and creating a medical school from a hospital, rather than the traditional university.

For more than a hundred years, Mt. Sinai has been blessed with trustees whose courage matched their vision. We took a deep gulp and plunged. When we needed seven-million dollars to transform an old Fifth Avenue bus garage into a basic sciences building to house our initial class of students in 1968, it was the trustees, for the most part, who put their money where their mouths were.

That has been the experience in our medical school growth these last six years. The greatest source of encouragement to our development program has been our own trustees. Trustees have been unbelievably generous in devoting time and effort in discussing launching of our school of medicine with their friends and business associates and in enlisting financial contributions. Most important has been their own personal generosity.

Our original goal was \$107 million. Inflation in construction costs and equipment costs has forced us to raise our goal to \$152 million. Nearly \$40 million of the \$104 million raised thus far from private sources has been contributed directly by our trustees. Federal, New York State and City government have contributed \$36 million.

The key to our development effort has been to seek large gifts. When we dedicate our Annenberg Building, the names of nearly 200 founding sponsors of the school will be inscribed in perpetuity. A sponsor is an individual, foundation or corporation which has contributed \$100,000 or more to our school of medicine fund. Ninety percent of the total raised has been contributed by sponsors. Sixty percent has come in 34 contributions of \$1 million or above. By far the most significant share of our monies raised has come from the private sector.

Trustees can and should play other constructive roles in addition to fund-raising. At Mt. Sinai, for example, two trustees serve on each of our search committees, adding balance and varied experience to the selection. The interaction keeps the knowledgeable trustee involved and interested in medical school and hospital affairs.

The wise dean can utilize skills of the lawyers and other business and professional experts on his Board of Trustees. Many doors have been opened by interested trustees who were happily and thoughtfully involved in their institutions.

FINDING THE FUNDS

It might not seem necessary to affirm that private philanthropy be encouraged to give more of its resources to medical education. But there are those who threaten to discourage this giving. Fortunately, some wisdom has prevailed. Recent federal tax laws have sought to stimulate private-sector giving. We would not be completely happy if federal and state governments absorbed all the costs of the private medical college. Private philanthropy must play its vital role. The federal government can finance projects on a matching basis, stimulating private annual giving needed to balance institutional budgets.

Private philanthropy traditionally has been more dedicated to funding capital projects than to meeting operating deficits. There's certainly more glory to having one's name on a building or facility than in meeting a million-dollar deficit on the bottom line.

It is in this context that endowment funds constitute a most crucial part of our development efforts. Endowment funds, generally unrestricted funds, give an institution a level of autonomy. Furthermore, the income from the endowment is relatively stable.

Our experience at Mount Sinai in this respect has been quite encouraging. A number of our trustees have endowed professorial chairs with gifts of one-million dollars each. In all, we have raised about \$35 million in endowment funds, which we must more than double to meet our deficits.

At the seminar mentioned, we asked ourselves, how shall we raise money to pay for the private medical school? Eli Ginzberg informed us that medical schools now spend about \$2 billion a year but that tuitions and fees bring in only about \$80 million. Raising tuition fees to meet operating deficits would not get the job done. One way of making up the deficit is to increase the public subsidy of tuition--what is called capitation. The reality of optimism regarding capitation is questionable.

Someone has observed that it is hard to understand all the talk about the federal government enacting sweeping new health legislation without accepting the obligation of keeping medical schools viable.

I believe a partnership--of government and private philanthropy--is needed. Programs are needed that would encourage matching gifts: added tax encouragement for large-scale individual giving and new tax incentives to encourage people of modest means to increase their gifts to medical education.

Dependence on federal, state and city government alone is illusory. Grants are given and grants are taken away. Administrations change; priorities change. What remains constant, however, is the loyalty and support of those closest to the individual institution.

I therefore strongly urge medical schools to forge the closest possible partnership with the private sector, alumni, trustees, business leaders, foundations, and grateful patients--all represent a most valuable source for your sorely needed operating funds. People should answer the question of 'Who is responsible?' with their generous reply: 'All of us.'

REACTOR -- DISCUSSANT

*Robert Derzon **

Gus Levy indicated that he thought, or at least some critics thought, that one was going backwards by developing a school from the foundations of a superb teaching hospital. In my experience, limited primarily to New York City and California, I have seen quite a consistent pattern of excellent 'backward' deans who have been building strong medical schools from great teaching hospitals.

Mt. Sinai Medical Center represents an extraordinary success story. In building a strong and bright future for this new school, its Board of Trustees has shown tremendous courage, compassion, heart, and an ample supply of 'chutzpah'--that wonderful physiological commodity which our bioscientists have been unable to synthesize.

Bob Cathcart provides an excellent background and a complete description of the multiple facets of regulatory mechanisms presently at work. I share his outlook on a number of points. First is the very evident requirement for hospitals to provide input collectively for the regulatory and legislative process. Teaching hospitals must seek help from their medical schools in that process. They must also provide a strong defense and a strong offense for the things they do and do very well. Further, these hospitals must disclose their operations to the public. In California and a number of other states, disclosure is being required. Also needed is a very real understandings of the regulatory world by faculties and deans. These faculties are the medical staffs for the nation's teaching hospitals.

Administrators must better understand the implications of controls upon the academic health science centers. Controls fall into three basic areas: (1) planning controls, which can have an especially serious impact on medical school programs; (2) economic controls, which can have serious constraints on hospital and health care costs; and (3) quality controls, which are present mechanisms to regulate the quality of medical practice through hospitals.

The call for involved trusteeship by President Hester and President Hitch and by Bob Cathcart is strengthened by the frenetic pace of external pressures upon our field.

There is need for special internal administrative machinery to cope with regulations. Within the California academic health science center, we will soon be required to develop offices of 'statutory compliance,' staffed with lawyers and accountants to help us cope with the unending restraints on our enterprises.

On the financial front, there is an acceptance, by those of us who believe that the sick fund should continue to provide a portion of the cost of education, that reimbursement for patient care will remain controlled. That understanding implies accepting regulation of the sick fund.

Bob Cathcart reminded us that patients represent an enormous source of public goodwill and that the hospital owes its clients individual and humane care. Hospitals must recognize this element of patient care.

* Director, University of California Hospitals and Clinics

I disagree slightly with Bob in his position of separating the delivery-of-care mission from the education mission. This disagreement may be really a matter of degree. I am not convinced that most centers have allowed educational goals to manipulate the delivery system and, therefore, that these missions should be made independent of each other or mutually exclusive. Where sound medical education is the joint obligation of hospital and school, and where the school and its faculty recognize that such education can only be achieved with well conceived delivery programs, there need not be unresolvable conflicts. I would agree that the correct strategy requires starting with a rational delivery system. Teaching hospitals have always pressed this strategy. Competitive care programs are necessary to protect the flow of patients for our teaching programs. This flow is the life line of hospital financing. Further, it seems important to provide real-world settings for our medical students, interns, and residents.

It is my feeling that the fortunes of medical schools and their principal teaching hospitals are absolutely inseparable. Teaching hospitals must be able to develop program capacity, to develop strong responses to new clinical ideas, and to provide an adequate clinical environment for our medical schools. If teaching hospitals succeed, chances are that the medical schools with which they are affiliated will succeed. The strength of schools, in substantial measure, is built on the vitality and strength of their primary teaching hospitals.

Julie Krevans, Dean of the University of California--San Francisco, School of Medicine, and I, not only practice these principles in our institution; we genuinely believe in these principles.

Deans must understand the stresses of new demands upon all hospitals. Controls on costs, planning, and quality are likely to raise new stresses on school and hospital relationships.

Deans and faculty members must understand and appreciate hospital financing. Ninety-nine percent of a hospital's controllable income comes from patient care services. When the chairman of medicine becomes concerned over census decline, chances are the administrator has already reached a panic state. Whether it is an affiliated or a wholly-owned hospital, the greatest potential economic threat is patient volume reduction. Perhaps in reviewing reward systems for faculty members, patient-care productivity should be considered along with other more traditional measures.

Conversely, hospital directors must become sensitized to the financial pressures on medical schools. Teaching hospitals may be obliged to open up income opportunities for the faculty or to be more responsive to changes in academic program. Hospitals soon may have to adjust to shifts toward less subspecialization as important medical science centers take this course. It appears, too, that directors of teaching hospitals may have to deal with another unionized group--the faculty.

With respect to regulation, teaching hospitals are faced with an enormous range of external monitoring devices. The important compensating factor is that for every regulator there are at least 100 institutions being regulated. In the last analysis, if these institutions are alert, they will insist that regulations be sensibly and intelligently drawn.