

Faculty Cabinet Questions for COMPH Faculty Council
Concerning COMPH Clinical Cap Proposal

1. The proposal says it had unanimous support from COMPH FC and that COMPH FC made sure that all Depts. Discussed and vetted the proposal. There might be some interest in COMPH governance structure and how COMPH carried out its role
2. As a general point, clinical faculty have specific teaching competencies that are not part of the usual package offered by more research oriented tenure track faculty. The proposal says that there is increased demand for clinical teaching. Is this a result of a growth in population to be trained. Can you provide the evidence about this and changes in the faculty/student ratio over the last several year?
3. The proposal also says that tenure-track faculty (TTF) have been increasingly used in clinical functions more appropriate to clinical faculty. Is there hard evidence that this is the case.
4. The general point, connected to the 2 prior ones, is: Do the functions of clinical faculty remain the same, or does the removal of the cap allow clinical faculty to take over some traditional roles of TT F to free them up for research.
5. The Ross Hospital as a source of demand. The business plan approved by the Board of Trustees indicates the need of an additional 32 clinical faculty positions. This could easily be met by something less than a complete elimination of the cap for the entire college, couldn't it? Indeed why couldn't this be met by the mix required under the current cap (that is some TTF with clinical responsibilities)?
6. COMPH sets its own standards for the attainments justifying tenure, so why isn't it possible to have to have the appropriate kind of TTF under the current cap (that is, many will resist the argument that there is only one margin to adjust on).
7. There is mention of a deficit of clinical trials for research. What is the role of clinical faculty in providing these?
8. How much patient care can be provided by "staff physicians" without professorial titles?
9. How important are the professorial titles in general?
10. The possibility of financial instability is mentioned a several times. Can you be more specific about this and how it arises without the elimination of the cap?
11. Is it possible that some departments could be made up entirely of clinical faculty, if the cap is removed?

12. What is the essence of an academic dept. with no TTF (or a small minority)?
13. The absence of a cap at most top 50 medical schools is an important part of the proposal. What evidence is there that the absence makes them better than they would be with it?
14. There is some perception that the intermediate alternatives were not genuinely considered (raise cap in depts. with genuinely heavy clinical demands, or do 50% for the college, etc.). What is the compelling reason for the complete elimination now, OTHER THAN SUPERIOR FLEXIBILITY?
15. COMPH is part of the University. The exceptionalism implied by this proposal might tend to undermine that. Any thoughts on this issue?