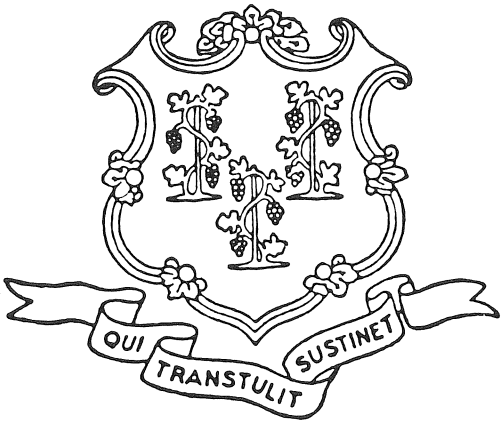
Connecticut General Assembly



Joint Legislative Program Review Committee

Report On The University Of Connecticut Health Center

January, 1975

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Joint Legislative Program Review Committee

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DIRECTOR

January 7, 1975

LETTER OF TRANSMITTAL

TO: THE HONORABLE MEMBERS OF THE GENERAL ASSEMBLY

The members of the Program Review Committee are pleased to submit their Report on the University of Connecticut Health Center to the members of the General Assembly.

The Committee believes that this Report presents an unbiased, comprehensive picture of the Health Center programs and their administration. We have pointed out both the successes and failures of the Center in an attempt to illustrate to the members of the General Assembly a course of action which should be taken to improve health education in Connecticut. The Committee believes that the Health Center provides the citizens of our state with a wide range of valuable services, and hopes that the Center's role in health education will continue to be recognized as worthy of our efforts toward improvement.

The Program Review Committee is confident that this Report will provide a primary basis for these efforts.

Respectfully submitted,

Senator Dave Odegard
Co-Chairman

Representative John Groppo
Co-Chairman

DO:JG/cb

Table of Contents

LETTER OF TRANSMITTAL

INTRODUCTION..... 1

I. HISTORY OF HEALTH EDUCATION IN THE UNITED STATES AND CONNECTICUT..... 6

Development of Health Education in the United States..... 6

Development of State-Supported Health Education in Connecticut..... 9

II. GOALS AND OBJECTIVES OF THE HEALTH CENTER..... 19

III. HEALTH CENTER ADMINISTRATIVE STRUCTURE..... 25

Committee System..... 26

Administrative Decision-Making Process..... 27

Teaching Committees..... 31

General Problems Related to Administration..... 33

Administrative Autonomy and Flexibility..... 37

IV. EDUCATIONAL PROGRAMS..... 42

Undergraduate Dental Education..... 42

Undergraduate Medical Education..... 47

Ph.D. Programs..... 54

Internships and Residency Programs..... 55

Other Educational Programs..... 58

V. PATIENT CARE PROGRAMS..... 64

Outpatient Programs..... 64

Table of Contents

Continued

Inpatient Programs..... 66

Cooperative Agreements..... 68

VI. RESEARCH PROGRAMS..... 73

VII. FINANCIAL REPORTING AND THE DECISION-MAKING PROCESS..... 76

Basic Financial Reports of the Health Center..... 78

Adequacy and Usefulness of Basic Health Center Data for Policy and Decision-Making..... 83

Additional Financial Information Utilized by the Program Review Committee..... 91

Adequacy and Usefulness of Additional Health Center Financial Material..... 94

Ramifications of Health Center Financial Reporting Upon Policy Formulation..... 103

Federal Financial Support of Health Center Activities..... 112

VIII. FACULTY SURVEY..... 116

Faculty Profile..... 120

Faculty Opinions and Comments..... 127

Distribution of Faculty Time..... 131

IX. STUDENT SURVEY..... 134

X. APPENDICES..... 137

INTRODUCTION

Review Procedure and Scope of Study

Compliance Review

General Comments Regarding the Health Center

Introduction

The Program Review Committee of the Connecticut General Assembly is a joint statutory bi-partisan committee of the Assembly authorized under the General Statutes of Connecticut to investigate, study, analyze, and report to the Legislature and the people of Connecticut on the efficiency and effectiveness of selected state programs.

This report is the sixth issued by the Committee and is a review of the operation, administration, and programs of the University of Connecticut Health Center at Farmington.

The Committee selected the Health Center for study at this time because the Center is the largest, most expensive single installation ever constructed by the state. The Center's overall annual budget of approximately 26 million dollars represents a very significant portion of the state's total effort in higher education, and, most importantly, the Center and its programs have been surrounded by various controversies which this Committee believes must be discussed.

Review Procedure

The investigative research leading to the publication of this report took the committee and its staff eight months to complete. As part of this eight-month effort, hundreds of statutes, documents, reports, transcripts of legislative hearings, University board minutes, and books and pamphlets

concerned with the University of Connecticut Health Center and the general problems of health care and health education were reviewed.

Detailed interviews were conducted with high level University administrators both at Storrs and Farmington. Over 60 different individuals now employed at the Health Center were interviewed, including faculty members, professional staff members, and classified employees.

The Committee conducted a day-long public hearing at the Health Center at which time testimony was taken from state officials concerned with health education and health delivery, University and Health Center administrators, faculty and staff members, officers of professional associations, health care practitioners, and the general public. The more than 300 pages of transcripts from this public hearing were carefully reviewed in the preparation of this report.

A detailed survey of current faculty members was conducted and a separate survey of students at the Health Center was conducted. In addition, all 1400 employees of the Center were asked in writing by the Committee for their confidential comments regarding the operation of the Center.

The Committee is pleased to acknowledge the excellent

cooperation that the Committee and its staff received during the course of this study from University President Glenn W. Ferguson, Vice President for Health Affairs and Executive Director for the Health Center, Dr. John W. Patterson, and the students, staff, and faculty of the University at both Storrs and Farmington.

Scope of Study

The Committee is concerned in this report with a number of general issues. These issues include the present goals and objectives of the Health Center in comparison with the goals and objectives of the original legislation that first established the Center. The Committee is also concerned that the Health Center is being managed in the most efficient and effective manner possible. And most importantly, the Committee is concerned with whether the Health Center is being held accountable for its policies and programs by the people of this state through their elected representatives in the Connecticut General Assembly. It is this process of accountability which is the main thrust and purpose of this report.

Compliance Review

It is standard Program Review Committee procedure to follow up initial reports on particular agencies with a compliance review report. This compliance review is an

ongoing process that begins immediately after publication of this initial report and will culminate in the publication of a compliance report approximately twelve months from the date of this publication.

This report on the Health Center contains a number of important findings and recommendations, some of which call for changes in administrative practices and policy and others which suggest possible legislative action.

The Committee wishes to emphasize that this report is not "just another report" to be filed away and forgotten. It is expected that remedial action will be taken where deficiencies have been found. This Committee intends to oversee future compliance with the recommendations contained in this report, and the Committee has instructed its staff to carefully monitor that compliance process.

General Comments Regarding the Health Center

The Health Center is a remarkable institution that functions rather well considering the difficulties that have surrounded it since its beginning. It is graduating physicians and dentists and has been doing so for some time. It is conducting and supporting worthwhile research, and it is making a substantial contribution to the health care delivery system of this state.

No one can analyze the operation of the Health Center in

any depth without becoming aware of the tremendous collection of talented personnel the University has attracted to the Health Center and the equally tremendous potential the Center possesses for increasing the quantity and quality of health care in this state.

The Program Review Committee in its examination of state programs is directed by law to do critical analysis of those programs. The Committee would not wish this report to be construed as implying that the Health Center's programs are not worthwile or that all the people administrating and operating the Health Center are not competent, talented and capable.

The Health Center, like all organizations, has some problems and it is the discussion and possible solution of these problems to which this report is primarily directed.

Chapter I

HISTORY OF HEALTH EDUCATION IN THE UNITED STATES AND CONNECTICUT

Development of Health Education in the United States

Development of State-Supported Health Education in Connecticut

I. HISTORY OF HEALTH EDUCATION IN THE UNITED STATES AND CONNECTICUT

Development of Health Education in the United States

Medical schools that exist today are vastly different from those which existed in the 18th, 19th, and early 20th centuries.

Early medical schools were mostly proprietary enterprises started by physicians whose prime objective was to make money. Such schools proliferated in the 19th century— at one point, there were over 400 medical schools in the United States as compared to about 100 today. Very little in the way of medical skills was taught to students since medical science was quite undeveloped at the time. Basic anatomy and some common symptoms and their cures were the main topics covered.

Until about 1900, there were no licensing boards: thus anyone who wanted to practice medicine could simply announce that he was a doctor. In the early part of the 18th century, 80 per cent of the "doctors" in the United States had no formal medical education, and only about 10 per cent were medical school graduates.

In 1910, the Carnegie Foundation published a study of the problems confronting Medical Education in the United States and Canada commonly known as the Flexner Report .

The report cited numerous deficiencies in the existing medical schools and called for significant improvements in the quality of medical education.

The advent of World War II also had a major effect on U.S. medical schools. Research efforts related to the War (the mass production of penicillin, the preservation and fractionalization of blood, and the development of the atom bomb) strongly influenced the development of American medical education. A very strong emphasis on research in the biomedical field was fostered by the federal government at that time and has continued to this day.

A major change in medical education took place in the late 1940's at Western Reserve Medical School. The dean of that school instituted a curriculum reorganization which emphasized integrated teaching and included the concept of free or unscheduled time. The Western Reserve plan had a very profound influence on many medical schools since it recognized the fact that medical knowledge had not only greatly expanded, but that the boundaries between one subject and another were to a great extent artificial and unrealistic.

Along with expanding their curricula, most post-war medical schools expanded their facilities and faculties. The federal government greatly expanded funds available for both construction and research support. For example, largely because of an expansion in the availability of

federal research funds, the size of the Stanford University medical faculty increased from 140 in 1959 to 290 in 1969. Also, a number of new schools were established in the 1960's to respond to a national call for more doctors and accelerated research into cancer, heart disease, and other killer diseases.

Some medical schools in the U.S. appear to be heading for a fiscal crisis because of their heavy financial dependence on the federal government. Federal grant money is now leveling off and to some extent is even being reduced.

Many private medical schools are feeling a severe financial strain and have raised tuition levels to the point where only wealthy student can attend. State schools, which generally have much lower tuition, are being swamped with applications from middle class students.

Development of State-Supported Health Education in Connecticut

Proposals to establish a state-supported medical-dental school go back as far as the early 1940's. At that time, Governor Raymond Baldwin proposed that such a school be operated by the state, and a special commission was created to study this question. This commission, along with seven other similar commissions created between 1944 and 1959, recommended that a medical-dental school be established and operated by the University of Connecticut.

Three major reasons were cited to justify the need for a medical-dental school in Connecticut. First, the proponents said, the school would provide greater opportunities for Connecticut students to obtain professional education. Medical and dental schools were becoming extremely competitive, and the existence of various types of resident quota systems at out-of-state schools put Connecticut residents at a disadvantage. A state-supported school would enable more Connecticut residents to attend medical and dental school.

Secondly, proponents argued that Connecticut had been in a "debtor" position for too many years. Other states were educating our physicians and dentists at great expense, and Connecticut had not repaid these states in any way.

Lastly, it was thought desirable to improve the ratio of physicians and dentists to population. Connecticut as a whole does enjoy a relatively high ratio compared to the national average, but there are many rural and inner-city areas in the state where there is a severe shortage of physicians and dentists. Proponents pointed to a rapid growth in Connecticut's population and declared that a state medical-dental school was needed to produce enough physicians and dentists to meet the needs of this growing population.

Opposition to the establishment of the school centered around its high cost, in both capital and operating expenses. In 1957, the University of Connecticut Board of Trustees and the State Board of Education made a preliminary estimate that it would cost $4.5 million to build a two-year medical-dental school (using existing hospitals for clinical training). They estimated that it would cost $1 million per year to operate the school. The New York Herald Tribune, in a 1960 article on the proposed school, estimated that to build a two-year school, without a hospital of its own, would cost $10 million, and that operating costs of $5 million per year should be anticipated.

Two years later, a Professional Advisory Committee (PAC), composed of doctors, dentists, and educators appointed by the University of Connecticut president, predicted that capital expenses would run about $30 million and annual operating cost $10 million.

This estimate of capital expense was based on the concept of a four-year medical-dental school, with its own 400- bed teaching hospital. The PAC concluded that this type of school would be far superior to a two-year school which would rely on existing hospital facilities. The PAC believed that the $30 million estimate was reasonable since a similar school had been built in Kentucky a few years prior to that time for about $27 million.

In addition to concern about the total cost of the new medical-dental school, some groups were concerned that the new facility would tend to compete with other units of higher education for the limited funds available.

Despite these concerns about the costs involved, the drive to establish a University of Connecticut medical-dental school achieved its first success in the 1955 Special Session of the General Assembly. The University of Connecticut Board of Trustees and the State Board of Education were authorized to investigate sites in or near Hartford, to estimate costs, and to take any other steps of a prelimiary nature toward the later establishment of a medical-dental college in the Hartford area.

In 1960, a Kellogg Foundation grant of $1 million was received by the University of Connecticut to aid in the planning of a medical-dental school.

In January of 1961, Governor John Dempsey committed himself to the establishment of a University of Connecticut medical-dental school in his inaugural address to the General Assembly. The Legislature held public hearings on the subject and after much controversy, a $2 million bond act for a University of Connecticut Medical-Dental School was passed, and a commission was established to select a site in the Greater Hartford area for the school.

The selection of a site was perhaps the most controversial decision in the entire development of the newly-approved school. In 1957, the University of Connecticut Board and the State Board of Education recommended to the Assembly three possible sites: two near Hartford's municipal hospital (McCook), and one adjacent to privately-owned Hartford Hospital. It was noted that the McCook sites were the Boards' first choices. The City Council of Hartford, eager to have the new schools located in the McCook area, offered to make twelve acres of land adjacent to McCook available to the state.

However, in 1962, a site commission appointed by the Legislature and charged with selecting a site for the school, was informed that legal questions related to obtaining a clear title to the land ruled out the McCook area as a possibility. The Boards also considered sites near each of the private hospitals in Hartford, near the VA Hospital

in Newington, and in several areas unrelated to any existing facilities. There was some discussion of the possibility of establishing the school in Storrs to take advantage of existing science facilities. However, the State Attorney General ruled that Storrs was not in the Greater Hartford area as was required by the bond authorization.

Finally, the Site Commission recommended the acquisition of a 106 acre site in Farmington, a suburban community about six miles west of Hartford. The site was acquired at a cost of approximately $4,000 per acre.

The cost of the land appeared excessive to some citizens, and a special bi-partisan legislative committee was appointed to investigate the possible scandal. No evidence of wrongdoing was found.

Late in 1962, the PAC made its report to the University concerning the general nature and scope of the new medical-dental school. The PAC Report emphasized that "the general objective of excellence in medical and dental education can be the only goal that will meet the needs of Connecticut and the nation in the long run." The report outlined a curriculum which recognized the dependence of medicine and dentistry upon research in the basic and clinical sciences.

It was noted that the needs of Connecticut citizens for family physicians had to be considered in planning for the new school, but that the individual student must make his or her own career choice. It envisioned strong graduate and continuing education programs and pointed to the need for the development of ancillary health programs.

The PAC also recommended that the Medical and Dental Schools have co-equal status, that each school have an entering class of 64 students, and that a 350 to 400-bed teaching hospital be a vital part of the school.

It was agreed that the admission standards of the new school should be comparable to the better medical and dental schools of the nation, and that the attraction of excellent out-of-state students to the schools was important to ensure high academic standards.

The report of the PAC was distributed to all members of the General Assembly, and they subsequently authorized $7 million in bonded funds for the construction of the new school. The 1963 Legislature also authorized the University of Connecticut Board of Trustees to select its own architect, rather than have the selection made by the Department of Public Works, the usual practice for state buildings. It was hoped that the trustees would select a firm to design a building which, as the bond authorization states, would be "an architectural credit to the people of Connecticut."

In 1964, Vincent G. Kling and Associates of Philadelphia was chosen to design the new medical-dental school. A planning group, consisting of two deans and four senior faculty members, advised Kling on the type of building required to implement the programs outlined in the PAC report.

Kling designed the building to be built in three phases. Phase I, which was basically site preparation, would be initiated in 1966. Phase II, construction of the research-academic wing, would commence in 1967. In 1969, construction would begin on the hospital and out-patient wing. The architects estimated that to construct the building outlined by the PAC and the planning group (a 4-year school with research facilities and a 400-bed teaching hospital) would cost about $62 million.

The original $30 million estimate, based on the cost of the Kentucky medical-dental school built in the late 50's, was simply inaccurate. It did not predict the severe inflationary trend which would plague the construction market, nor did it consider the labor cost differences between Kentucky and Connecticut. The $30 million estimate had been made without the aid of architects, engineers, or construction experts and was highly unreliable.

University administrators believed that Kling's $62 million figure was too high and asked the school planning group to reduce the proposed cost by changing building specifications. The size of the University teaching hospital

was cut from 400 beds to 200 beds, although structural provisions were made to make the 200-bed hospital readily expandable to a 400-bed hospital if this were desired in the future.

The philosophy behind the new Health Center—to provide comprehensive medical and dental care for the patient—strongly influenced the design of the building. Medical clinics and dental clinics were designed to be located in the same general areas to help break down traditional barriers between medicine and dentistry. Student laboratories were designed to be multi-disciplinary to reflect the philosophy that all the sciences relate to one another and cannot be separated artificially. Offices of clinical faculty are adjacent to the hospital wing of the facility, and offices of basic science faculty are located near the faculty research laboratories. The dental clinic was designed for the practice of "four-handed dentistry" (dentist plus assistant) in keeping with the Center's emphasis on efficient use of auxiliary help.

The original plans for the Health Center included the construction of on-site student housing, thus very few parking spaces were planned for student use. However, funds were never appropriated to build student housing, and, as a result, parking is inadequate. Plans are under way to construct additional parking to correct this problem.

In addition to the influences the school's philosophy had on the design of the facility, the site selected also influenced its design. Because of heavy rock concentrations, some rather difficult slope problems, and a desire to leave room for planned student housing, it was decided to build the Health Center on the top of a hill on the site. A curved arch design which followed the contours of the hill was selected.

The construction phase was very long, difficult, and costly, and generated a great deal of controversy and criticism. A House Joint Resolution of the 1971 General Assembly directed the Assembly's State and Urban Development Committee to conduct an investigation of the Department of Public Works, focusing on its handling of the Health Center's construction.

The Committee held a series of public hearings and concluded from evidence presented that the Health Center facility "could have been built for much less than the approximately $85 million it will finally cost." The Committee attributed the high costs and long delays in construction to: (1) the failure of the General Assembly to maintain sufficient contact with the project; (2) the decision to build a teaching hospital in Farmington rather than to utilize existing clinical facilities; (3) the failure of Phase II contractor to maintain adequate work

schedules due to apparently insufficient financing; (4) the failure of the Department of Public Works (DPW) to authorize any employee on the Health Center site to make major decisions; (5) rampant crime, including theft of tools and materials, padding of payrolls, and kick-backs to some union officials and contractors, on the site; (6) hostility among the various parties on the job, especially the "coolness of the DPW toward UConn because the school had been allowed to select the architect;" and (7) the fact that construction costs escalated rapidly as time passed so that continuing delays in the project raised its price.

The final cost of constructing and equipping the main Health Center buildings was about $92 million. The federal government, through the U.S. Public Health Service, provided approximately $32 million of this figure.

The first students began their studies in temporary quarters in McCook Hospital in the fall of 1968 and were graduated in 1972, when phased occupancy of the Farmington site was begun. Total occupancy of the new facility is expected during 1975.

Chapter II

GOALS AND OBJECTIVES OF THE HEALTH CENTER

II. GOALS AND OBJECTIVES OF THE HEALTH CENTER

In reviewing the effectiveness of any organization, it is most important that some understanding be reached of why the organization exists and to what purpose that existence is directed.

A public hearing regarding the proposed establishment of a medical/dental school in Connecticut was held by the Education Committee of the General Assembly in April of 1961. The transcripts of that hearing show a general concern for three major issues:

(1) The shortage of physicians and dentists in the state,

(2) The inability of qualified students from Connecticut to gain admission to private and out-of-state medical and dental schools, and (3) A concern for the high cost of medical and dental education.

Transcripts from this hearing and the discussion that followed leading to the establishment of the Health Center at Farmington show that the General Assembly had a strong interest in a medical/dental school that would increase the number of general practice physicians and dentists in the state and would primarily serve students who were residents of Connecticut.

However, this concern for the increasing of general practice health professionals was never expressed in the

subsequent legislation. The establishment of goals and objectives for the Health Center was a task that was transferred by default to the trustees of the University.

In December of 1962, the Board of Trustees of the University of Connecticut approved its Professional Advisory Committee's broad proposal for a medical and dental school. This proposal was to be used as the basis for a request by the University to the 1963 Assembly for bond authorization to start construction of a health center.

President Homer Babbidge, in referring to this proposal, indicated to his Board of Trustees that once bonding was authorized the state would be committed "irrevocably" to the proposal: therefore, President Babbidge noted "that it was highly important that all parties concerned have a clear understanding of the nature and extent of the commitments."

The December, 1962, proposal was distributed to the 1963 Assembly. The Assembly subsequently passed the first bond act establishing the Health Center. The trustee proposal, which the Program Review Committee concludes was tacitly accepted by the 1963 Assembly in their enacting of the first bond authorization, is discussed at some length in the preceding section of this report. However, the goals of the proposed Health Center as they were enumerated

in the original proposal deserve repeating. The Health Center was to be dedicated to "excellence," a word which has many connotations and is open to numerous definitions. The Center was also to have a strong dedication to medical science research. While the need for family physicians was to be kept in mind, no special bias was to be established in the curriculum which would steer students into any particular area of medicine or dentistry. Out-of-state students were to have a definite place at the Health Center.

The Program Review Committee concludes that in establishing the Health Center, the General Assembly did not prescribe any goals or objectives for the Center, but did, by its approval of the original bond authorization in 1963, approve the very general goals proposed by the Board of Trustees in December of 1962.

Twelve years have passed since the goals of the Health Center were first formulated. Because these goals are of such a broad and general nature and are open to widely divergent interpretations, the Health Center has constantly been attacked for not doing what it was established to do.

Yet, chief officers of the University have consistently reacted to such criticism by stating that they are operating inside the perimeters established by the 1962 proposal which was approved by the trustees and supported by the Legislature.

The Program Review Committee does not fault the critics of the Health Center nor its defenders. Their actions and reactions are not the problem in this case but are symptomatic of the fundamental difficulty which the 1962 goals have fostered over the past decade. The 1962 goals do not provide any specific guidance as to exactly what the Health Center is to accomplish and how that accomplishment is to be judged.

In June of 1974, Governor Thomas J. Meskill formally requested that Gordon W. Tasker, chairman of the Board of Trustees of the University of Connecticut, report to him on the present and planned activities of the Health Center. In his September 11 reply to this request, Mr. Tasker noted that the goals of the Health Center were defined by the Board in 1962 and that he reaffirmed those goals. However, Mr. Tasker then stated that under "the general objective of excellence" there are four specific goals for the Health Center. They are:

> (1) To provide education programs which will fully qualify students for successful careers in medicine and dentistry, (2) To develop and administer in cooperation with the established practitioners programs of continuing education for practitioners in the health professions, (3) To act as a resource center for Connecticut for improving health care consistent with social needs and scientific advances while working in cooperation with hospitals and other health care facilities, (4) To conduct research directed toward the alleviation of human suffering with the direct cost of such research being covered by grants from federal and private sources which are attracted to the University Health Center by established faculty.

These four statements are a definite refinement of the 1962 document, but they are still very broad and very difficult to use as indicators for the measurement of accomplishment. "To provide," "To develop and administer," "To act as," and "To conduct" are not definitive statements of planned activities. In 1963 the Assembly passed an act "establishing" a medical/dental school. But such words as "establish" or "provide" do not indicate specifically what is to be done, how it is to be done, when it will be done, and most importantly, how we know that it has been done.

Concrete goals and objectives are the cornerstone of good management. Without clear, well defined goals and objectives tied to a system of accomplishment measurement, no institution or organization can definitively demonstrate to both it critics and supporters that it is succeeding.

Furthermore, when an institution or organization is publicly supported, then the citizenry or at least their elected representatives must play an active role in the development of its objectives and goals.

RECOMMENDATIONS:

1. THE GOALS AND OBJECTIVES OF THE UNIVERSITY OF CONNECTICUT HEALTH CENTER MUST BE REDEFINED IN DETAIL SO THAT THEY ARE CLEAR, DISTINCT, AND OPEN TO LIMITED INTERPRETATION.

2. THE GENERAL ASSEMBLY SHOULD ESTABLISH A SPECIAL COMMISSION TO DRAFT SPECIFIC AND MEASURABLE GOALS FOR THE HEALTH CENTER.

MEMBERSHIP ON THE COMMISSION SHOULD INCLUDE THE PRESIDENT OF THE UNIVERSITY OF CONNECTICUT, THE EXECUTIVE DIRECTOR OF THE HEALTH CENTER, THE DEANS OF THE SCHOOL OF MEDICINE AND SCHOOL OF DENTAL MEDICINE, THE CHAIRMEN OF THE COUNCILS OF THE SCHOOL OF MEDICINE AND SCHOOL OF DENTAL MEDICINE, THE CHAIRMAN OF THE UNIVERSITY OF CONNECTICUT BOARD OF TRUSTEES, THE CHAIRMAN OF THE HEALTH CENTER ADVISORY COUNCIL, THE PRESIDENTS OF THE CONNECTICUT CHAPTERS OF THE AMERICAN MEDICAL ASSOCIATION AND THE AMERICAN DENTAL ASSOCIATION, THE STATE COMMISSIONER OF HEALTH, THE CO-CHAIRMEN AND RANKING MINORITY MEMBERS OF THE GENERAL ASSEMBLY'S COMMITTEES ON PUBLIC HEALTH AND SAFETY, EDUCATION, AND APPROPRIATIONS, AND THE CO-CHAIRMEN OF THE GENERAL ASSEMBLY'S PROGRAM REVIEW COMMITTEE. THE CHAIRMAN OF THE COMMISSION SHOULD BE APPOINTED BY THE GOVERNOR AND SHOULD BE A PRIVATE CITIZEN WHO IS NOT A MEMBER OF ANY HEALTH PROFESSION.

THIS COMMISSION SHOULD HOLD ITS FIRST MEETING BEFORE AUGUST 1, 1975, AND SHOULD MAKE ITS REPORT TO THE GENERAL ASSEMBLY ON OR BEFORE FEBRUARY 15, 1976. THE COMMISSION'S REPORT, WHEN ACCEPTED IN TOTAL OR AS AMENDED BY THE GENERAL ASSEMBLY, SHOULD BE THE OPERATING POLICY OF THE UNIVERSITY OF CONNECTICUT HEALTH CENTER.

Chapter III

HEALTH CENTER ADMINISTRATIVE STRUCTURE

Committee System

Administrative Decision-Making Process

Teaching Committees

General Problems Related to Administration

Administrative Autonomy and Flexibility

III. HEALTH CENTER ADMINISTRATIVE STRUCTURE

The Health Center, like any other part of the University, is ultimately responsible for matters of policy to the Board of Trustees of the University. In matters of policy implementation and administration, the Health Center chief administrator, Vice President for Health Affairs and Executive Director of the Health Center Dr. John W. Patterson, reports directly to the President of the University.

Under the Executive Director's office, there are a number of staff offices that report directly to Dr. Patterson. These offices include the Assistant to the Executive Director, the Director of Biomedical Communication, the Director of Data Services, the Publications Office, and the Center for Laboratory Animal Care.

In addition, the Director of Health Center Administrative Services is a direct line officer of the Health Center reporting to the Executive Director. The Director of Health Center Administrative Services staff offices include the departments of the Controller, Personnel, Physical Plant, Purchasing, and Security.

The University Hospital Director and through him, his staff, report directly to the Executive Director.

The Deans of the Medical School and the Dental School are also line administrators reporting directly to the

Executive Director. Both the medical and dental schools have various associate deans who report to their respective deans, and both schools are organized along somewhat traditional departmental lines with the department heads reporting to the deans.

Department heads are responsible for initial preparation of department budget requests and the initial evaluation of faculty members for promotion and tenure. Teaching is conducted by teaching committees. Teaching committee membership transcends department lines. The function of the teaching committee is discussed later in the report.

Committee System

In most institutions of higher education, there are various faculty committees that assist in the process of administrative decision-making and administrative policy formulation. Faculty committees also play a very important role in curriculum development. The Health Center has a large system of administrative committees, policy committees, and teaching committees. These committees are concerned with the operation of the Health Center at large, the Dental School, the Medical School, and the hospital respectively. These committees are set up under both formal and informal systems. The formal committees are essentially permanent standing committees while the informal committees may or may

not be permanent, depending on the special purpose they are to serve.

Members are generally appointed by the deans or the executive director to administrative committees, and are elected by colleagues to policy committees.

Administrative Decision-Making Process

The Program Review Committee finds the administrative decision-making process at the Health Center to be very difficult to assess. The line administration organization is generally rational and logical and is organized along a system that compares favorably with acceptable management systems models.

However, the line organization of the Health Center cannot be evaluated without superimposing it on the very complex, diverse, and large committee system. When this is done, the decision-making process becomes quite unclear. In some cases administrative and policy committees carry absolute authority in their area of interest and administrators are bound by committee decisions. Other committees which in theory are "advisory" also carry absolute authority since by tradition they are never overruled by the administrators they "advise." Faculty members of these "advisory" committees have indicated that if a dean were to ignore the advice of their committee, he would do so at the peril of his position with the University.

There are over forty administrative and policy type committees of a permanent or semi-permanent nature at the Health Center. Most of these committees have a membership primarily composed of faculty members below the associate dean level. There are also numerous ad hoc and special purpose committees which deal with specific personnel matters, physical plant maintenance, and other questions of varied importance. The exact number of committees at the Health Center is a matter of some conjecture, even among officials at the Health Center.

In reviewing the Health Center decision-making process with faculty and administrators, the Program Review Committee found that this labyrinthine system of committees apparently has fostered a remarkable participation in internal political activity on the part of practically every member of the faculty. There is within the faculty a system of informal political leaders that bears little relationship to the formal organization of the faculty. There is also a system of separate political groups or parties, each pursuing the adoption of its own particular programs. While such an informal socio-political structure is common to all organizations, it is quite apparent that the degree and amount of internal political activity at the Health Center is in excess of that at most academic institutions. This activity is resulting in the expenditure of large amounts of faculty and administrative time that may be productive.

Excessive internal political activity becomes even more important when one is trying to assess responsibility and accountability for specific decisions since many times, decisions may have been made by a committee of forty members using a secret ballot.

The Program Review Committee is well aware that in an academic institution faculty committees are desirable aids in the administrative decision-making process. We do not believe, however, that the Health Center's massive system of administrative and policy committees, superimposed on its administrative and departmental line system and combined with a separate teaching committee system, is a management structure that will provide the best utilization of the Health Center's resources.

The problems that the present committee system has promoted are excessive internal politics, slow decision-making, the dissipation and non-productive expenditure of faculty time, and an atmosphere of suspicion and mistrust among faculty and administrators at the Health Center.

The Program Review Committee believes that these problems could be alleviated if the present system of administrative and policy committees were altered. It should be emphasized, though, that we do not believe it necessary or desirable to abolish the administrative and policy committee system. We realize that institutions like the Health Center must function with a degree of

participatory democracy so that the expertise of the professional members of such an institution may be utilized to best advantage.

The Program Review Committee is also well aware that any changes in the present system will be opposed by various groups in the Health Center system because such groups will fear a loss of power and authority.

Strong leadership on the part of Health Center and University officials with the full support of the trustees will be necessary to bring about the changes we propose. We are quite sure that the present administrators of the Center and the present administrators of the University are more than capable of providing this necessary leadership.

RECOMMENDATIONS:

1. THE HEALTH CENTER'S COMMITTEE SYSTEM (EXCLUDING TEACHING COMMITTEES) SHOULD BE RESTRUCTURED SO THAT:
   A. THE TOTAL NUMBER OF COMMITTEES IS SUBSTANTIALLY REDUCED.
   B. THE TOTAL MEMBERSHIP OF THE REMAINING COMMITTEES IS SUBSTANTIALLY REDUCED.
   C. ALL ADMINISTRATIVE POLICY COMMITTEES SHOULD FUNCTION ONLY AS ADVISORY TO SPECIFIC OFFICERS OF THE HEALTH CENTER. (ALL FACULTY MEMBERS AND ADMINISTRATORS CONCERNED SHOULD BE MADE AWARE OF THE MEANING OF THE WORD "ADVISORY.")
   D. THE ONLY COMMITTEES HAVING FINAL AUTHORITY AND RESPONSIBILITY UNTO THEMSELVES ARE THOSE COMMITTEES DEALING WITH STRICTLY ACADEMIC AND CURRICULUM MATTERS. WHEN SUCH COMMITTEES ARE

CONSIDERING SUBJECTS OUTSIDE OF THEIR STRICT ACADEMIC AREA, THEY WILL FUNCTION AS ADVISORY.

E. ALL COMMITTEES, INCLUDING CURRICULUM AND ACADEMIC COMMITTEES, FUNCTION IN AN OPEN AND FORTHRIGHT MANNER. SECRET BALLOTS BY COMMITTEES WILL BE STRICTLY LIMITED TO MATTERS WHICH BY THEIR NATURE REQUIRE SUCH SECRECY, SUCH AS RECOMMENDATIONS FOR FACULTY PROMOTION, TENURE, AND STUDENT PROMOTION.

Teaching Committees

The function and general operation of the teaching committee system at the Health Center is described in those sections of this report dealing with the education program of the Center. However, there is one facet of the teaching committee system that has a direct bearing on the personnel administration of the Dental and Medical Schools.

In brief, faculty members are members of various departments and the chairman of each department is responsible for assessing the performance of each faculty member and recommending him or her for promotion or tenure. A major portion of this assessment is an evaluation of the individual's teaching abilities. However, when a faculty member is teaching he or she does not necessarily serve with, nor is he or she under the control of, the department head.

At the Health Center, teaching is supervised and directed by inter-disciplinary, inter-departmental teaching committees chaired by faculty members who are not department heads. We have found no fault with the use of the inter-disciplinary teaching committee in teaching

at the Center and in fact believe the teaching committee system is an excellent approach to teaching the very complex and technical subjects contained in the curriculum of the modern dental and medical school program.

It does seem, however, that the evaluation of the teaching performance of individual faculty members being considered for promotion and tenure ought to be the responsibility of someone who has had the optimum opportunity to become familiar with such performance.

A teaching committee chairman may on his or her own initiative provide an evaluation of a faculty member to the appropriate tenure or promotion committee after the initial recommendation by the department head has been made. But he or she is not compelled to do so.

The Program Review Committee found the method of evaluating faculty members for promotion or tenure to be dependent on the subjective evaluation of his or her performance by colleagues and department heads. The problem of introducing more objective methods of performance measurement into the tenure and promotion decision-making process is a difficult one, especially in the area of teaching and patient care performance. There is substantial evidence to indicate that various members of the faculty and administration of the Health Center are working

toward increasing the amount of objective input into the promotion/tenure process. The Committee hopes that the Health Center will encourage these efforts.

However, if for the present, subjective evaluation is to be used in evaluating teaching performance, then that subjective evaluation should include those who are most familiar with that performance.

RECOMMENDATION:

1. WHEN A HEALTH CENTER FACULTY MEMBER IS CONSIDERED FOR PROMOTION OR TENURE, ALL TEACHING COMMITTEE CHAIRMEN UNDER WHOM THAT FACULTY MEMBER HAS SERVED IN THE PAST TWO YEARS MUST SUBMIT CONFIDENTIAL STATEMENTS REGARDING THAT FACULTY MEMBER'S TEACHING PERFORMANCE.

General Problems Related to Administration

During the course of this study, the Committee and its staff became aware of the profound morale problem among Health Center non-faculty professional administrative staff.

Low morale can be caused by any number of factors, some of which are clearly beyond the responsibility of the Health Center administration. But the Program Review Committee believes that there are some internal administrative policies that are contributing to low morale.

At present there are no job descriptions for the administrative professional staff. Thus, a person in such

a position is not always aware of exactly what his or her job is and how that job compares with other administrative staff professionals. This lack of job descriptions has led to various complaints regarding salaries, supervision, promotions, and status, and has produced generally negative attitudes among some employees.

The use of job descriptions as a basic management tool is universally recognized as essential in the supervision of lower and mid-level employees in both business and government.

The Health Center's use of job descriptions for mid-level administrative staff would improve employee-employer relationships at the Health Center and would reduce the personnel management problems that have occured in the past due in part to the lack of such descriptions.

RECOMMENDATION:

1. ALL ADMINISTRATIVE PROFESSIONAL STAFF POSITIONS THAT ARE NOW CHARACTERIZED UNDER THE GENERAL TITLES OF "EDUCATION ASSISTANT", "RESEARCH ASSISTANT", AND "RESEARCH ASSOCIATE," AND ANY OTHER MID-MANAGEMENT OR ADMINISTRATIVE STAFF POSITIONS THAT EXIST AT THE HEALTH CENTER SHOULD BE ASSIGNED CLEAR AND DEFINITIVE WRITTEN JOB DESCRIPTIONS.

One of the other personnel problems at the Health Center that may be related to the lack of job descriptions is the problem involving the implementation of "affirmative action" programs. There are now several alleged discrimination-in-

employment-practices cases pending at the Health Center. The Program Review Committee found instances which, in its view, represent situations where all the affirmative action guidelines were not followed in the recruitment and hiring of faculty and staff members at the Health Center.

The implementation of affirmative action guidelines is required by the federal government for recipients of grant money for research and other activities. Without early and full implementation of the federally mandated program for affirmative action, it is possible that the Health Center will not continue to qualify for much of the federal support it now receives.

In addition, the Program Review Committee believes that no publicly funded state institution can risk being charged with discrimination in any phase of its operation because of the ultimate responsibility such institutions have for ensuring just and equitable employment opportunity to all citizens.

RECOMMENDATION:

1. TO THE EXTENT THAT DISCRIMINATORY AND/OR POTENTIALLY DISCRIMINATORY PRACTICES IN THE PERSONNEL POLICIES OF THE HEALTH CENTER EXIST, THEY MUST BE TERMINATED, AND A FAIR AND EQUITABLE PERSONNEL MANAGEMENT SYSTEM MUST BE IMPLEMENTED AND MAINTAINED IN COMPLIANCE WITH THE UNITED STATES DEPARTMENT OF HEALTH, EDUCATION AND WELFARE GUIDELINES FOR AFFIRMATIVE ACTION.

NOTE: AS A VALUABLE FIRST STEP TOWARDS THE IMPLEMENTATION OF THE ABOVE RECOMMENDATION, WE SUGGEST THAT THE HEALTH CENTER ADMINISTRATION ACT ON THE AFFIRMATIVE ACTION PLAN SUBMITTED BY THE COUNCIL OF THE SCHOOL OF MEDICINE'S AFFIRMATIVE ACTION COMMITTEE ON MARCH 27, 1974.

Administrative Autonomy and Flexibility

In March, 1972, the Connecticut Commission for Higher Education (CHE) recommended to the General Assembly "...That legislation be enacted that would establish the Health Center as a public corporation (or foundation or other legal vehicle) that would permit the same implementation of soft funding as in private medical schools. Current state fiscal, personnel and administrative restrictions would not be applicable to the Center and thereby afford it the capability of reducing projected levels of state support."

As a result of this recommendation, the Assembly authorized the Governor to appoint a seven-member commission to study the possibility of creating the Health Center as a private, non-stock corporation.[1] This commission, chaired by Mr. Louis Ball, editor and publisher of the Farmington Valley Herald, is to report to the Assembly during the 1975 Session.

The Program Review Committee is very concerned with this possible change of administrative status for the Health Center. The Committee believes that it is most important that the Health Center be maintained as

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1 Special Act 73-115

a closely related part of the total program of the University of Connecticut. In fact, the Program Review Committee would hope that the relationships between the Health Center and the rest of the University be strengthened, especially in those areas of the University program that involve the preparation of students for careers in health and health-related professions.

The Committee found it most disturbing that while Health Center officials have formulated various proposals for implementing the public corporation recommendations of the CHE, the leadership of the University Schools of Allied Health, Nursing, and Pharmacy have not been consulted regarding their role in any proposed reorganization involving a change in the status of the Health Center.

The Program Review Committee finds that under the present administrative organization of the University, cooperation and coordination among the University schools dealing with health affairs has not been as complete or useful as it should be.

The School of Allied Health, for example, has had very little involvement with the Health Center. Allied health faculty have not been utilized to any significant degree in the instruction of students at the Health Center,

even though graduates of the Health Center will ultimately be required to work with and utilize the talents of allied health professionals. Cooperation among faculty members from the Health Center and the Allied Health School has been very limited even though the Allied Health School has encouraged such cooperation. It is true that some of the problem of coordination and cooperation between the Allied Health School and the Health Center may be caused by the fact that one is physically located at Storrs and the other at Farmington, but the central problem of coordination and cooperation does not seem to be one of geography.

The School of Pharmacy and the School of Nursing have enjoyed a more cooperative relationship with the Health Center, but what effect that a change in the Health Center's administrative status would have on that relationship is not at all clear to the Program Review Committee.

Creating a separate administrative status for what are essentially only two schools of a University made up of many schools and colleges seems rather odd to the Program Review Committee. It has been argued that separate status divorced from standard state administrative control would allow the Health Center to be more flexible in its administration so that it would qualify for more federal and private grant money. While this argument may possibly be

true, it has not been demonstrated that the marginal gain in grants would offset the loss of direct accountability under which the Health Center should function.

The CHE suggested that corporate status might reduce projected levels of state support for the Health Center. This might lead one to conclude that the state would be able to reduce or level off its financial support of the Center. The Program Review Committee found no evidence to support this conclusion.

The dean of the University of Texas Medical School observed that the position of the University of Connecticut, and specifically the Health Center has an unclear relationship to the political leaders of Connecticut and the legislature and appears to involve an attitude of mutual distrust. Divorcing the Health Center from the administrative controls of the state at this time would not better define relationships between the Center and the rest of the state government. Nor would it alleviate any mistrust between the Health Center and the rest of the state government which might presently exist.

The Program Review Committee believes that cooperation and understanding between the University of Connecticut, this state's largest educational institution, and the Legislature is increasing as is evidenced by the cooperation received by

this Committee in preparing this report. The Program Review Committee would not wish to recommend anything that might limit the growth of that cooperation and understanding.

RECOMMENDATIONS:

1. GREATER COOPERATION BETWEEN THE VARIOUS SCHOOLS CONCERNED WITH HEALTH CARE DELIVERY AND HEALTH PROFESSION EDUCATION BE ENCOURAGED BY ADMINISTRATORS AT BOTH THE UNIVERSITY OF CONNECTICUT HEALTH CENTER AT FARMINGTON AND THE UNIVERSITY OF CONNECTICUT AT STORRS.
2. THAT NO ACTION BE TAKEN BY THE GENERAL ASSEMBLY THAT WOULD GIVE THE UNIVERSITY OF CONNECTICUT HEALTH CENTER AT FARMINGTON PUBLIC CORPORATION, FOUNDATION, OR OTHER LEGAL STATUS DIFFERENT FROM THE REST OF THE UNIVERSITY OF CONNECTICUT.

Chapter IV

EDUCATIONAL PROGRAMS

Undergraduate Dental Education

Undergraduate Medical Education

Ph.D. Programs

Internships and Residency Programs

Other Educational Programs

IV. EDUCATIONAL PROGRAMS

Undergraduate Dental Education

Program Description

The word most often used to describe the dental medicine program is "innovative."

The major innovation of the program is its very strong emphasis on the basic life sciences. During a dental student's first two years, he or she attends joint classes with medical students. The first year is spent studying cell and tissue structure, while the second year focuses on the various organ systems. In this way, the student theoretically gains a thorough knowledge of the whole body and sees the teeth and mouth as parts of the larger biological system. Dental students also attend classes in Correlated Dental Science one afternoon a week during their first two years in order to obtain an introduction to the clinical aspects that are emphasized during the third and fourth years.

All dental students, as well as all medical students, are required to pass Part I of the National Medical Boards at the end of their second year. This exam, considered to be quite rigorous and difficult, tests the students' knowledge of the basic sciences.

Teaching at the Health Center is done on a team or "committee" system. The subject matter to be taught is divided into various biological systems (cell and tissue biology, the central nervous system, the cardiovascular system, etc.), rather than into the traditional departments of chemistry, biology, physics, etc. Various kinds of scientists and clinicians work together to ensure that the most important basic science material forms the core of the curriculum.

During the course of their third and fourth years, dental students learn to assume responsibility for the complete dental care of patients. The efficient use of auxiliary personnel (dental assistants and hygienists) is emphasized in this program.

Elective clerkships in various speciality areas are offered to fourth year students. Students may choose to concentrate their learning in one or two specialties, or they may take a group of electives to gain a generalist approach.

Upon graduation, the majority of dental students decide to take internships or residencies. Although dental internships/residencies are a fairly new phenomenon, the recent national trend has been for dental graduates to extend their training beyond the four-year dental school.

Students are admitted to the School of Dental Medicine on a competitive basis, judged by scores on national exams, college grades, recommendations, and a personal interview. Last year, some 1143 applied, while only 48 were actually admitted. Ninety-six per cent of those admitted were Connecticut residents. This selection process has resulted in a dental class that is well above average in preparation and motivation. Special emphasis is being placed on recruiting qualified minority and female applicants.

A strong emphasis is placed on developing dentists who will be able to adapt easily to future trends in dental medicine. Students are taught preventative as well as restorative dentistry, and learn the role of dental medicine in the total health care system. A great deal of research into decay prevention is carried on by faculty members, many of whom hold Ph.D. degrees in basic science areas as well as dental degrees.

Problem Areas

Since the inception of the School, a poor relationship with the practicing dentists in the community has existed. Many practicing dentists are skeptical of the School's approach to dental education, especially its strong emphasis on basic sciences. The town-gown problem was further aggravated by a former administrator

who was quite vocal in his criticism of the practicing community's professional abilities. Although this individual has since left the School, it has been very difficult to undo the damage his negative comments caused. The present acting dean, Dr. Philip Levine, is to be commended for his efforts to involve community dentists in the operation of the School as volunteer lecturers, consultants, and as students in continuing education programs.

The Dental School has also suffered from a rather unsettled leadership. The present dean has been "acting" dean for over a year, and several departments in the School are operating with "acting" chairmen, awaiting the decisions of various search committees. Search committees have apparently been organized to fill all vacancies at one time or another, but several have disbanded without reaching a decision, and several others are taking overly long periods of time to reach a decision. Temporary, "acting" officials simply do not have the same sort of authority afforded to those whose appointments are permanent, and departmental organization and morale have been adversely affected.

Morale in the Dental School has also been adversely affected by what is seen as the "dominance" of the Medical School over the Dental School. The Medical School

faculty control the basic science program that serves as the first two years for both medical and dental students.

The "clinical" portion of the dental curriculum (third and fourth year) is controlled by the Council of the School of Dental Medicine, a group composed of administrators and faculty members representing each dental and basic science department.

The Health Center has seven Basic Science departments, while there are nine "clinical" departments in the School of Dental Medicine. However, two of the "clinical" departments (Behavioral Science and Community Health, and Oral Biology) in fact have more of a "basic science" curriculum than a "clinical" curriculum.

Hence, representatives on the Dental School Council with "basic science" orientations outnumber those with clinical dentistry orientations, which has resulted in the belief by a number of clinical dentists that they are unable to control even "their own" area of the dental curriculum.

Some members of the Dental School faculty and student body are opposed to the requirement that dental students take Part I of the National Medical Boards. They feel that this is another example of how the Medical School

and the basic scientists "dominate" the Dental School. Proponents of the exam for dental students argue that since all students take the same basic science courses, it is reasonable for them to be required to take the same exam on basic science material.

This conflict between "clinicians" and "basic scientists" in the development of the Dental School's curriculum has contributed to the overall morale problems in the School of Dental Medicine.

RECOMMENDATIONS:

1. EFFORTS TO ESTABLISH A MORE POSITIVE RELATIONSHIP WITH THE PRACTICING COMMUNITY SHOULD BE CONTINUED.

2. VACANCIES AT THE DEPARTMENT HEAD LEVEL SHOULD BE FILLED AS SOON AS POSSIBLE. FUTURE SEARCH COMMITTEES SHOULD BE GIVEN REASONABLE DEADLINES AND SHOULD REPORT THEIR CHOICE BY THAT TIME.

3. THE REQUIREMENT THAT ALL HEALTH CENTER STUDENTS TAKE PART I OF THE NATIONAL MEDICAL BOARDS SHOULD BE CONTINUED AS A METHOD TO ASSURE THAT ALL STUDENTS ARE COMPETENT IN THE BASIC SCIENCES.

4. THE PRESENT RELATIONSHIP BETWEEN THE MEDICAL SCHOOL AND THE DENTAL SCHOOL SHOULD BE EXAMINED CLOSELY BY THE HEALTH CENTER ADMINISTRATION TO ENSURE THAT NEITHER SCHOOL DOMINATES THE OTHER.

Undergraduate Medical Education

Undergraduate medical students follow approximately the same type of program that dental students follow: two years of basic science, followed by two years of clinical experience and research.

Basic science courses are organized around the various organ systems, rather than the traditional separate disciplines of biology, chemistry, physics, etc. Faculty from the various basic science departments work together on teaching committees to decide what material should be covered and to arrange for appropriate faculty members to handle the actual instruction.

An important point is that on each teaching committee there are faculty members from clinical as well as basic science departments. Efforts are made to ensure that the relationship of theoretical knowledge to patient care is apparent.

An Introduction to Clinical Medicine is the one course during the first two years that medical students do not share with dental students. One afternoon a week is spent in this course.

After the first year, every student is required to conduct an in-depth research project into a topic of his or her choice. This project is designed to strengthen the student's ability to obtain and assess new information and to find answers to specific problems. These skills aid the development of good diagnostic methods and give students an understanding and appreciation of scientific research.

The Health Center makes extensive use of audio-visual aids in both the medical and dental programs. All teaching laboratories, many conference rooms, and a variety of patient treatment areas are equipped with closed circuit television receivers and transmitters. All classroom lectures given to undergraduate students are video-taped by the Department of Bio-Medical Communication so that students can replay any session they may have missed. Students and faculty are also able to make use of a central computer to handle varied tasks, including computer-assisted learning programs.

The clinical years include participation for six months in a series of clerkships in medicine, surgery, obstetrics, pediatrics, and psychiatry. A six-month elective period is also offered, during which the student can take additional clerkships, undertake additional organized studies, or carry out independent study projects. The elective period allows a great deal of flexibility and facilitates individualization of the student's program.

Four general hospitals in the Hartford area, the University Hospital, and the V.A. Hospital in Newington provide the clinical setting for third and fourth year students. In addition, a number of other Connecticut hospitals are associated with the Health Center and in-

dividual students may arrange clerkship opportunities with them.

Throughout a student's education, the ability to work closely with other health professionals to meet society's needs is stressed. A preference for group practice is apparently fostered -- over fifty per cent of students surveyed indicated they plan to be in group rather than private practice.

Students are selected for admission on a competitive basis. Only one of every twenty-eight applicants is accepted. Because of this heavy competition, quality of students accepted has been exceptionally high. The Medical School catalog states that "Strong preference in the selection process is given to Connecticut residents; in past years no more than five or six non-residents per class have been accepted for admission." An unofficial, but strictly observed, admissions policy requires that at least eighty-five per cent of those accepted in the undergraduate programs must be Connecticut residents.

The Medical School is fortunate to enjoy a good working relationship with physicians in the area. A number of local people serve as clinical associates, teaching or consulting on a part-time basis. There is a liaison program between the local American Medical Association chapter and the Health Center administration

which provides a good channel for continuing communication.

Problem Areas

The Medical School has come under fire for fostering a preference for specialization. A number of local physicians, politicians, and citizens have called for the production of more general practitioners and an end to turning out doctors who specialize in narrow fields.

In order to deal reasonably with this criticism, it is first necessary to understand basic facts about different kinds of physicians.

The general practitioner, the traditional "family doctor" who graduated from medical school and took one year of general internship, is becoming a rarity in American medicine. He or she is being replaced by a "primary care physician," that is, a physician whom a patient would see first when he or she was ill or needed preventative care. Primary care physicians include, for example, the pediatrician for infants and children, the general internist for most adults, and, for some women, the gynecologist. These primary care physicians have all received specialized training through post-graduate hospital residencies of two to five years.

A new specialty of "family medicine" is presently being developed to provide primary care for males and

females of all ages. The "family physician" is perhaps the closest equivalent to the traditional general practitioner. However, the family physician is required to undertake a two-year residency to learn how to deal effectively with the patient within a family environment.

The Health Center also prepares students for careers as "secondary" physicians -- physicians to whom primary care doctors refer patients for specialized treatment.

A heavy majority of Medical School faculty members are specialists, but only about half are in secondary care fields.

The fact that the family medicine program at the Health Center has divisional rather than departmental status is indicative of the slow acceptance among Health Center faculty of family medicine as a legitimate field of medicine. Steps are being taken to develop the division to a point where it will become eligible to attain departmental status in the near future. This will mean increased faculty, space, and other resources for the family medicine program, and will also make the program more visible and attractive to students.

It is important to remember that the Health Center itself can exercise very little control over undergraduate students' career choices. The Health Center can provide role models and encouragement for students in certain

medical fields, but it cannot determine which field a student will ultimately choose. From its survey of students, the Program Review Committee learned that availability, location, and attractiveness of residency opportunities, societal needs, and family influences all figure more strongly into a student's career choice than his teachers at the Health Center.

After carefully weighing all the above facts, the Committee concludes that the call for "more G.P.'s" may be the result of a misunderstanding about the kinds of physicians the Health Center is producing. True, most of the faculty are "specialists," but half of the "specialists" are involved in primary care. A survey conducted by the Program Review Committee of Medical School students indicated that approximately half (forty-seven per cent) of the students plan to specialize in secondary fields, about a third (thirty-two per cent) plan to go into "family" or primary care, and about a fifth (twenty-one per cent) are undecided as to their future field. This ratio appears reasonable to the Committee. (For discussion of the family practice program, please see the section on Interns and Residents.)

RECOMMENDATIONS:

1. UNDERGRADUATE EDUCATION PROGRAMS SHOULD CONTINUE TO PROVIDE THE FUNDAMENTAL MEDICAL EDUCATION NECESSARY FOR PRACTICE IN ANY FIELD.

2. EFFORTS SHOULD BE MADE TO INCLUDE BOTH PRIMARY AND SECONDARY PHYSICIANS ON TEACHING COMMITTEES TO ENSURE THAT STUDENTS HAVE ADEQUATE NUMBERS OF ROLE MODELS IN EACH FIELD.

3. THE MEDICAL SCHOOL COUNCIL SHOULD OFFER A CLERKSHIP IN FAMILY MEDICINE IN ADDITION TO THOSE PRESENTLY OFFERED IN MEDICINE, PEDIATRICS, SURGERY, OBSTETRICS, AND PSYCHIATRY. SUCH A CLERKSHIP WOULD ALLOW STUDENTS TO BECOME AWARE OF AND INTERESTED IN THIS EMERGING FIELD.

4. THE DIVISION OF FAMILY MEDICINE SHOULD BE UPGRADED TO DEPARTMENTAL STATUS TO REFLECT THE HEALTH CENTER'S STATED COMMITMENT TO EMPHASIZE FAMILY PRACTICE.

Ph.D. Programs

Graduate programs leading to the Ph.D. degree are offered at the Health Center through the University Graduate School. Courses are given in anatomy and cell biology, biomaterials, immunology, molecular biology and biochemistry, experimental pathology, and pharmacology. Approximately fifty students are enrolled in the various programs.

The focus of the Ph.D. program is to provide competent basic science researchers and medical school faculty members.

Graduate students surveyed indicated they were generally satisfied with the quality of their programs. (Seventeen per cent said "very good"; sixty-three per cent said "good.") However, a significant percentage

— twenty per cent — rated their programs as "poor", (ten per cent "poor" and ten per cent "very poor"). The negative responses were apparently due to the feeling among some students that not enough time is being devoted to the Ph.D. students because of a major emphasis on medical and dental education. This situation appears to be getting better gradually as all authorized faculty members are recruited and teaching loads are shared by a larger number of faculty.

A sizeable number of students were quite enthusiastic about the high level of competence among basic science faculty.

RECOMMENDATION:

1. BASIC SCIENCE DEPARTMENTS SHOULD RESTRICT THE NUMBER OF GRADUATE STUDENTS ACCEPTED IN ORDER TO PROVIDE INDIVIDUAL ATTENTION FOR EVERY STUDENT.

Interns and Residents

Both the Dental School and the Medical School offer a number of programs in graduate clinical education. All students graduating with the M.D. degree in the United States pursue some type of graduate clinical education, and an increasing number of D.M.D. degree graduates in the United States also take some form of internship or residency. Of the Health Center's ten 1974 D.M.D.

graduates, seven decided to take some graduate work before going into practice.

The Medical School offers an internship in general medicine. Also available are residencies in family medicine, pediatrics, general surgery, clinical pathology, anatomic pathology, obstetrics-gynecology, opthamology, otorhinolaryngology (ear, nose, and throat), psychiatry, and urology. Residency programs in anesthesia, neurosurgery, and radiology are currently under development. All graduate clinical programs are reviewed by both the School of Medicine's Committee on Graduate Medical Education and the Council on Medical Education of the American Medical Association.

The Dental School offers a variety of one to five year residency programs in clinical and academic dentistry.

Programs are available in endodontics, general dentistry, orthodontics, pediatric dentistry, periodontics, oral maxillofacial surgery, oral biology, oral radiology, behavioral sciences, and dental public health.

Graduate students in the medical and dental programs receive training both at the Health Center and at other clinical facilities associated with the Health Center. This arrangement is beneficial for both the students and

the participating hospitals. Students have the opportunity to deal with many kinds of patients in rural, urban, and suburban settings, and learn to make the best use of differing sizes and types of clinical facilities. The participating hospitals supplement their own clinical staff with University interns and residents, and the presence of these additional physicians and dentists helps to improve the quality of patient care at the hospitals.

The placing of University interns and residents in area hospitals is also a good step toward attracting additional physicians to the state, since national studies show that physicians tend to practice medicine in the state in which they took graduate education. The existence of high-quality internship and residency programs will help to attract physicians to Connecticut.

Top quality graduate clinical programs may be the most important contribution the Health Center makes to improved health care in Connecticut.

One medical internship/residency of particular interest to the Program Review Committee is the Family Practice Program developed in cooperation with the Connecticut Academy of Family Medicine. This program is designed to produce "all-round" physicians who can provide primary care for the entire family. Six stu-

dents, including one University of Connecticut graduate, are presently taking family medicine residencies.

RECOMMENDATIONS:

1. TOP-QUALITY RESIDENCIES SHOULD CONTINUE TO BE OFFERED IN BOTH MEDICINE AND DENTISTRY, WITH AN EMPHASIS ON DEVELOPING PRIMARY CARE PHYSICIANS AND DENTISTS.

2. SPECIAL EMPHASIS SHOULD BE GIVEN TO EXPANDING THE FAMILY MEDICINE RESIDENCY PROGRAM.

Other Educational Programs

In addition to operating undergraduate and graduate medical/dental and Ph.D. programs, the Health Center conducts a number of other educational programs.

Continuing Education

Continuing education courses are offered for both physicians and dentists. A number of courses are given in cooperation with local professional societies. Local practitioners are surveyed to determine what their needs are, and courses are developed in response to these needs.

The importance of continuing education cannot be overemphasized. New advances in prevention, diagnosis, and treatment of disease are rapidly occurring, and it is vital that practicing dentists and physicians learn to utilize such advances.

Some medical and dental societies have recently required practitioners to attend a certain number of continuing education courses in order to retain membership in the societies. This requirement recognizes that the medicine or dentistry most professionals learned in school is vastly different from current practice, and that patients of established practitioners deserve the same up-to-date treatment that newly graduated practitioners can provide.

The Program Review Committee believes that this requirement makes a great deal of sense. Health professionals in Connecticut are responsible for the good health of several million people. Some of these individuals, particularly physicians, face the responsibility of making life-or-death decisions concerning the diagnosis and treatment of major illnesses.

PROBLEM AREAS

Continuing education courses have taken a back seat to undergraduate medical/dental educations in the brief history of the Health Center. This is not surprising, since the first educational priority of the Health Center has been the undergraduate program. The continuing education program for practitioners is in the process of being strengthened as the Health Center develops.

RECOMMENDATIONS:

1. THE HEALTH CENTER SHOULD CONTINUE TO DEVELOP A COMPREHENSIVE PROGRAM OF CONTINUING EDUCATION COURSES FOR AREA PRACTITIONERS IN ORDER TO IMPROVE THE QUALITY OF PATIENT CARE AFFORDED TO CONNECTICUT CITIZENS.

2. THE STATE MEDICAL AND DENTAL SOCIETIES SHOULD SERIOUSLY CONSIDER REQUIRING THAT ALL MEMBERS TAKE A MINIMUM NUMBER OF CONTINUING EDUCATION COURSES IN ORDER TO RETAIN MEMBERSHIP IN THE SOCIETIES.

Nurse Practitioner

The Nurse Practitioner program, which leads to the master's degree is designed for nurses who hold the Registered Nurse certification. The program is given at the Health Center as part of the School of Nursing graduate curriculum and is a joint venture of the School of Nursing and the School of Medicine.

Students in this program are trained to perform a number of routine tasks that a physician would ordinarily perform. Nurse practitioners take medical histories, perform routine tests, and give detailed instructions to patients on nutrition, family planning, and specific treatments prescribed by physicians. Graduates of this program are also often responsible for supervision of other health paraprofessionals.

Pediatric Nurse Associate

This program initiated by the School of Medicine

is presented in cooperation with the School of Nursing to give additional training to nurses with the R.N. certification.

Students in this four-month program learn to assume routine jobs that a pediatrician would ordinarily handle. The nurse associate is often responsible for total care and counseling of healthy children, and evaluates minor illnesses. If a prescription is required to treat an ill child, the nurse associate asks a physician to prescribe an appropriate drug. A graduate pediatric nurse associate can handle, on his or her own, approximately eighty per cent of the patients whom a pediatrician generally sees.

About sixty-five students have graduated from this program to date. Many of these graduates are caring for poor children through city Public Health Services or in hospital clinics.

There may be difficulty in continuing this program beyond next year when the program's federal funding expires.

RECOMMENDATION:

1. A CONCERTED AND COORDINATED EFFORT SHOULD BE MADE BY THE SCHOOL OF NURSING, THE SCHOOL OF MEDICINE, AND THE UNIVERSITY TO ARRANGE FOR CONTINUATION OF THE PEDIATRIC NURSE ASSOCIATE PROGRAM.

Dental Assistant

A program for the training of dental assistants is operated at the Health Center under the auspices of Manchester Community College. Students receive both classroom and clinical training at the Health Center and receive the nationally recognized Certified Dental Assistant diploma upon completion of the one-year program. At present, eighteen students are enrolled in this program.

The Health Center is currently planning a two-year dental hygienist program to be run in cooperation with Tunxis Community College. If approved by the Council on Dental Education of the American Dental Association, this program will enroll approximately twenty-four students in each class.

Emergency Medical Technician (EMT)

The Health Center, through its Security Division, operates a six-month, part-time course in emergency medical services for ambulance personnel, fire department rescue squads, and other persons interested in emergency medical care. This program, funded by the federal government through a State Health Department grant, can accept about one hundred students (two classes) at a time. Because numbers of applications for the program are

much greater than spaces open, priority in acceptance is given to commercial ambulance drivers, who are required by law to have EMT Training.

The course, taught primarily by Health Center physicians, is a greatly expanded version of the Red Cross First Aid course. Graduates are awarded official certificates of competency by the State Department of Health.

An advanced course is presently being developed and should be offered within the next few months.

Chapter V

PATIENT CARE PROGRAMS

Outpatient Programs

Inpatient Programs

Cooperative Agreements

V. PATIENT CARE

Outpatient Services

Out-patient clinics for both medicine and dentistry are presently in a state of transition from temporary sites at the McCook Hospital in North Hartford to their permanent homes at the Dempsey Hospital at the Farmington Health Center. Three dental clinics have already opened at the Health Center, and the other dental clinics and the medical clinics are opening.

Dental clinics are organized in the manner of a group practice with licensed dentists, students, and auxiliaries functioning as a complete team. Each adult dental chair is enclosed in a private "office," which is outfitted with an intercom system by which a student can call for assistance. Children's dental chairs are grouped together since studies have shown that children prefer to be treated where they can see other children. Instructors aid students with complex techniques and also observe students' handling of patient care.

An effort is made to centralize supply, sterilization, storage, and records facilities for all the dental "offices" in an attempt to maximize efficiency and quality of care. Qualified auxiliaries are used wherever possible to aid student dentists both in clinical care and clerical functions.

Medical clinics are to be operated in much the same manner. Both general clinics and specialty clinics will be operated, so students will have the opportunity to practice in both types of settings.

Fees at the clinics are set by the Health Center and are designed to be competitive with other area hospitals. Fees are reduced up to fifty per cent when patients are treated by the students.

Although shuttle busses have been established between North Hartford areas and the new dental clinics at Dempsey, ridership has been quite low. The dental clinics have, however, been able to attract a sufficient number of patients for the students. Although some patients have been coming from North Hartford, the majority of patients are currently relatives or friends of Health Center students and staff. Some patients are also drawn from the surrounding community, and as the existence of clinics becomes more well known, this group is expected to grow larger.

The use of shuttle busses has been severely criticized because of their relatively high cost (approximately $180 per day) and low ridership (averaging about two or three riders a trip). Health Center officials acknowledge that the bus runs are not as productive as they had hoped, but note that when the medical clinics

open early in 1975, ridership should increase. The bus is also used to transport personnel and medical records from McCook/Burgdorf to Farmington, and provides transportation to the Health Center for some staff members who live in North Hartford.

Inpatient Services

Inpatient services are also in a state of transition. Since 1967, the Health Center has operated the former Hartford municipal hospital, McCook, as the University Hospital. This 190-bed hospital has served as the base for clinical training of students and has been supplemented to a great extent by the use of "affiliated" and "allied" hospitals around the state.

McCook Hospital was a woefully inadequate facility for modern medical education. The building was quite outdated, and relatively little effort was made to renovate it since a move to new facilities in Farmington had been planned for January of 1975. When the University took over McCook in 1967, it was expected that that facility would only be used until 1970 when the Dempsey Hospital would be opened. Thus, McCook Hospital was used much longer than originally intended.

The new John Dempsey Hospital building in Farmington includes a modern 200-bed hospital, complete diagnostic and treatment labs, and a complete pharmacy. The

design of the hospital is innovative. The patients' rooms surround a completely open circular nurses' station. This arrangement allows optimum surveillance of the patients, and the fact that the patient can always see the nurse from his or her room also affords a sense of security for the patient. The central area of each hospital floor contains facilities for dispensing prescriptions and serving meals.

The original architect's plans for the Health Center envisioned a twin tower, 400-bed hospital. Because of rising construction costs, one of the two 200-bed towers was eliminated. The remaining 200-bed hospital is relatively easy to expand, since all ductwork, elevator shafts, air conditioners, etc., necessary for a second tower are already installed and are simply covered by "knock-out panels." However, there is little possibility that the University itself will add an additional 200 beds because the combined bed capacity of the new Dempsey Hospital and all the hospitals associated with the Health Center is quite adequate for supplying a good clinical base for the medical school. Unless the health care needs of the capital area or the clinical needs of the Medical School increase significantly, it is unlikely that the state will add beds to the new hospital.

There is, however, a possibility that the Veterans

Administration will construct a replacement for the Newington V.A. Hospital on the Farmington site. The Newington facility is quite outdated and undersized, but federal law prevents the addition of new beds at existing facilities. The Veteran's Administration is currently in the process of making a final decision on whether to build at Farmington. If the decision is affirmative, construction of the new V.A. hospital could begin as early as 1976.

Cooperative Agreements

The Capital Area Health Consortium, Inc., of which the Health Center is a member, is an organization of eight hospitals in the Greater Hartford area which attempts to coordinate overall planning, certain operational matters, and certain control functions.

The Consortium, established in May of 1974, is a joint effort by the hospitals involved to improve services to patients through more efficient management of available resources.

There are nine long-range purposes of the Consortium:

1. To approve the purchase of equipment or construction or acquisition of capital improvements worth more than a specified amount;

2. To approve the institution of new health services or procedures;
3. To review summary annual budgets and periodic statements of financial condition of members;
4. To monitor the quality of patient care and prescribe standards of patient care;
5. To make studies of the health needs of the area and to establish programs to meet these needs efficiently;
6. To eliminate unnecessary duplication of services and facilities;
7. To establish criteria for the appointment of medical staffs of its members;
8. To establish standards of administration and record-keeping; and
9. To develop and coordinate educational programs.

The full-scale operation of the Consortium will be a very gradual process. At the present time, only one of the major functions is fully implemented: a coordinated system of staff appointments at area hospitals. Member hospitals have agreed that each physician on the staff of any Consortium hospital will have a "primary" appointment at one hospital and will automatically receive "secondary" appointments at all other member hospitals.

The Program Review Committee believes that the es-

tablishment of the Capital Area Health Consortium is a positive step towards providing a high quality of medical care at the lowest possible cost to all Hartford area citizens who require such care. The Health Center is to be commended for participating in this very worthwhile organization. The Program Review Committee sees this involvement as evidence that the Health Center is not only training physicians and dentists for the future, but is having a very positive effect on the current health services in the area.

Affiliated and Allied Hospitals

About half the hospitals in Connecticut have affiliated or allied with the medical and/or dental school. These arrangements are useful to both the hospitals and the schools. The hospitals provide clinical training for Health Center students and supply some faculty, and the school provides staff, consultations, and continuing education for the staff of the hospitals.

The Newington V.A. Hospital

The Health Center enjoys a particularly close working relationship with the U.S. Veterans Hospital in Newington. All hospital staff physicians at Newington serve as faculty members at the Health Center, so the V.A. Hospital can be considered a branch of the Health Center for educational

purposes. In addition to providing clinical facilities for undergraduate students, the V.A. Hospital also serves University resident physicians, nursing students, and Ph.D. candidates.

The relationship between the Health Center and the Newington V.A. Hospital has been advantageous for both institutions. Students and residents are exposed to patients with different types of diseases than are generally found in a community hospital, and are given a great deal of responsibility for providing direct care to these patients. The hospital gains the advantage of an increased level of patient care, both in terms of numbers of physicians available and in terms of educational backgrounds of these physicians. V.A. administrators point out that because hospital staff are offered teaching posts at the Health Center, the V.A. Hospital is now able to recruit a higher quality of staff than they were previously able to attract, given their relatively low salary scale.

As mentioned previously, there is a possibility that the Veterans Administration will eventually close its Newington facility and construct a new 200-bed hospital on the Health Center site. This development would intensify the close working relationship between the V.A. and the Health Center, and would serve as a model project to demonstrate federal/state cooperation in health edu-

cation and patient care.

Other Patient Care Services

In addition to providing direct patient care, the Health Center also provides library and consultant services for practicing health professionals in the state. Textbooks and journals on literally thousands of topics are available to Connecticut dentists and physicians at no cost. Health Center faculty members are often asked to consult on cases within their particular fields of expertise. These services are another example of how the Health Center is contributing to the improvement of health services within the state.

Chapter VI

RESEARCH PROGRAMS

VI. RESEARCH

From the very beginning, research has been one of the major functions of the Health Center. The report of the PAC notes that "...The dependence of medical and dental practice upon research in the basic and clinical sciences must be recognized as a modern fact of life" [but that] "we do not consider that these commitments [to research] will mean that the new schools of the University of Connecticut will graduate students turning chiefly to research or to specialties for their professional careers. Instead, we consider that this environment is necessary for educating future physicians and dentists, regardless of the pattern or form of their professional practices, who will be constantly alert to change and innovation in their fields."

The Health Center administration considers research to be one of the necessary functions of an academic medical center in that it "enriches educational programs and prepares students for the future demands of practice." The vast majority of faculty members contacted through surveys or personal interviews were in complete agreement with this philosopy.

Numerous kinds of research are carried on at the Health Center. Basic science research explores many of the key questions concerning cell structure, dif-

ferentiation, and growth. Work has been done by Health Center faculty members in the fields of immunology, enzyme research, and cell membrane analysis.

Clinical faculty members are also quite active in research activities. Research into the causes, prevention, and cure of many diseases, including cancer, lupus, sickle cell anemia, lead poisoning, and hypertension, is carried out by clinical faculty. Other clinicians explore the nature and prevention of tooth decay, develop new methods in the diagnosis and treatment of various illnesses, and develop innovative programs for delivering quality health care to many client groups.

Approximately eighty-five per cent of the cost of this research is funded by outside grants, mainly from the federal government. The University indirectly funds the remaining portion by paying the salaries of faculty members who engage in research. Despite the fact that the Health Center pays faculty for their privately funded research efforts, all faculty salaries are considered payments for "instruction and departmental research" for financial reporting purposes. (This area is discussed in the section on "Financial Reporting and the Decision-Making Process".)

The Program Review Committee believes research into

better methods of providing good patient care is vitally important. New discoveries about the causes of diseases and new ways to treat them are of little value unless efficient ways to use these discoveries are also developed. Efficient methods of delivering health care will ultimately result in lowered costs to patients, and this is, of course, important during a time of skyrocketing medical and dental expenses.

Problem Areas

A number of critics of the School's heavy emphasis on research have charged that this emphasis encourages students to pursue careers in research and teaching, rather than in clinical practice. A student survey conducted by the Program Review Committee finds that this charge is unfounded. Two per cent of dental students and none of the medical students replying to the questionnaire said they plan careers in research or teaching. It is as yet too early to tell how many past medical and dental graduates will eventually go into research and teaching careers, since nearly all graduates of the Schools are still completing clinical residencies. The Committee concludes, however, from all available data that Medical and Dental School graduates are not being "pushed" into research and teaching careers.

Chapter VII

FINANCIAL REPORTING AND THE DECISION-MAKING PROCESS

Basic Financial Reports of the Health Center

Adequacy and Usefulness of Basic Health Center Data for Policy and Decision-Making

Additional Financial Information Utilized by the Program Review Committee

Adequacy and Usefulness of Additional Health Center Financial Material

Ramifications of Health Center Financial Reporting Upon Policy Formulation

Federal Financial Support of Health Center Activities

VII. FINANCIAL REPORTING AND THE DECISION-MAKING PROCESS

Government institutions and agencies generally prepare and submit financial reports to serve two major purposes: (1) To satisfy the auditing function, which oversees the propriety of expenditures; and (2) To provide information to the policy and decision-makers who bear basic responsibility for government programs and spending. This chapter is primarily concerned with the latter function, as the state auditors provide close ongoing vigil regarding proprieties of expenditures.

This chapter is comprised of the following six sections:

A. BASIC FINANCIAL REPORTS OF THE HEALTH CENTER
   A brief description of the basic financial reports of the Health Center and their preparation.

B. ADEQUACY AND USEFULNESS OF BASIC HEALTH CENTER DATA FOR POLICY AND DECISION-MAKING
   A discussion of limitations of basic financial data as presently prepared and presented.

C. ADDITIONAL FINANCIAL INFORMATION UTILIZED BY THE PROGRAM REVIEW COMMITTEE
   Includes material provided by the Health Center as well as national information on medical-dental education costs.

D. ADEQUACY AND USEFULNESS OF ADDITIONAL HEALTH CENTER FINANCIAL MATERIAL

Includes discussion of Health Center computations of costs of medical-dental education.

E. RAMIFICATIONS OF HEALTH CENTER FINANCIAL REPORTING UPON POLICY FORMULATION

How financial reporting affects the roles of policy and decision-making.

F. FEDERAL FINANCIAL SUPPORT OF HEALTH CENTER ACTIVITIES

Brief description of federal funding and the inherent implications.

A. BASIC FINANCIAL REPORTS OF THE HEALTH CENTER

The basic financial documents prepared by the Health Center are the Budget Request and the Annual Program Budget submitted to the Budget Division of the Department of Finance and Control, and the information provided to the University, which is published in its Annual Financial Report.

1. The Budget Request

Although the Health Center is a functional part of the University of Connecticut, its budget is prepared and presented separately. Basically, the budget request is formulated by completion of specific forms provided by the Budget Division of the Department of Finance and Control. The budget officer of the Health Center requests department heads to submit their financial need estimates for the coming year. The material is then assembled in the Health Center Budget Office and is reviewed by the deans. The budget request moves up the hierarchy through the Executive Director of the Health Center, and the President of the University, who ultimately makes a formal budget presentation to the Board of Trustees. The Board of Trustees eventually submits the proposed budget to the Budget Office of the Department of Finance and Control and the Commission for Higher Education. As the budget document moves up through the Health Center and the University,

it is trimmed and re-arranged, as each level takes a broader perspective. The Department of Finance and Control reviews and generally trims the budget request further, before sending its budget recommendations to the Office of the Governor. The Governor's Budget is submitted to the General Assembly, whose Appropriations Committee conducts public hearings and ultimately prepares the budget bill for the General Assembly. The Assembly may modify the budget bill and eventually passes the bill, which becomes the law which funds the institutions and agencies supported by the state.

The Governor's Budget document basically presents requested and recommended funding for the following three categories: (1) Personal services, (2) Equipment, and (3) Other expenses.

Funding levels are provided for the following eight "functions" which comprise the "current expenses" of the Health Center:

School of Medicine

School of Dental Medicine

basic science

library

physical plant

Health Center administrative service

Health Center education support service

hospital subsidy

Funding levels for each of the above categories are given for (1) personal services, and (2) "other expenses."

2. The Annual Program Budget

For the past several years, the Budget Division of the Department of Finance and Control has published a Program Budget for the institutions and agencies of the state. This document provides financial data for specific programs as well as information on program objectives, descriptions, output indicators, and personnel summary.

The Program Budget for 1974-75 lists the following four programs as comprising expenditures for the Health Center:

1. Medical-dental undergraduate education
2. Doctoral education in medicine and dentistry
3. Interns and residency education
4. Continuing education for physicians and dentists

Modifications of program budgeting are found in many states, where it is regarded as useful input to the decision-making process. The State Department of Finance and Control has recently decided to eliminate program budgeting in Connecticut. Programmatic data was not requested of institutions and agencies pertinent to the

1975-76 budget formulation, and no program budget will be issued by the Department of Finance and Control. Ramifications of the elimination of program budgeting are discussed subsequently in this section.

3. University of Connecticut Annual Financial Report

This report is basically used in the following three ways, according to University of Connecticut financial officers:

(1) As a basic auditing tool

(2) As a source of information exchange with other universities and higher education organizations and

(3) As a public information document.

It is in the third category that this document assumes importance as an informational source for the legislators in their role of policy and decision-making.

This document is an elaborate collection of financial exhibits and schedules and includes no narrative. Information is presented separately for the Health Center, and includes the following items:

(1) Balance sheet - all funds

(2) Summary of Loan Funds

(3) Principal of Endowment and Funds Functioning as Endowment

(4) Investment in Plant

(5) Summary of Income and Expenditures

(6) Summary Statement of Net Expenditures - from State Funds

(8) Funds Received and Remitted to the State General Fund

(9) Expenditures from State Appropriations

(10) Expenditures from Other Than State Funds

(11) Summary of Expenditures by Function

(12) Auxiliary Services Fund

(13) McCook Hospital Fund

(14) Research Fund

The important "Summary of Expenditures by Function" (#11 above) lists the following items as functions of the Health Center:

(1) Instruction and Departmental Research

(2) Organized Activities Relating to Educational Departments

(3) Libraries

(4) General Expense

(5) Student Aid

(6) Organized Research

(7) Operation and Maintenance of Physical Plant

(8) Center Administrative Services

(9) Center Educational Support Services

(10) Auxiliary Enterprises

(11) Non-functional

The schedule for "Expenditures from State Appropriations" breaks out spending for the School of Medicine, School of Dental Medicine, and Basic Sciences. All expenditures for each of these three categories are listed under the function of Instruction and Departmental Research.

The Financial Report presently does not include financial material relating to the programs of the University. The forthcoming report will, however, contain some material arranged programmatically.

B. ADEQUACY AND USEFULNESS OF BASIC HEALTH CENTER DATA FOR POLICY AND DECISION-MAKING

Although the Health Center complies with the requirements of the Department of Finance and Control and the University of Connecticut Finance Office, the information provided is inadequate for policy formulation and decision-making.

Much of the information provided is confusing, conflicting, and may be construed as misleading.

This is true even though the data is capable of audit.

1. Comparisons between the Governor's Budget Document and the University of Connecticut Financial Report

These two documents represent the basic financial data generated by the Health Center. They are briefly described in Section A of this chapter. Both of these documents should be vital tools for the legislator as well as the private citizen who wishes to grasp at least a basic knowledge of the Health Center's financial operations. A financial report of any institution should be considered a fundamental document for those determining policy and making decisions.

The data included in the two documents is conflicting. This pertains not only to dollar figures, but to different categories bearing the same or very similar titles in each report and to conflicting usages of identical terminology in each report.

The Health Center does not provide any material explaining the discrepencies between the reports, nor is a warning issued to prospective readers. Because of the conflicting information, the material is confusing to a reader perusing both documents. If only one of the documents is analyzed, the information becomes misleading, as only one perspective is available, without the reader's knowledge of the existence of a second set of documents.

No initiative has been taken by Health Center officials in providing the General Assembly with a concise,

meaningful summary of the type of information pertinent to policy and decision-making.

The Program Review Committee asked Health Center officials the following question: "What information, if any, is provided to the General Assembly (in addition to the formal Governor's budget) at appropriations time?" Health Center officials responded, "The University provides committees of the General Assembly with any available information that may be requested."

It would be very difficult to request explanations of conflicting usages of identical terms, differing components of virtually identical categories, or conflicting dollar figures if one had no way of readily ascertaining that such conflicts even existed.

On the other hand, the General Assembly has been remiss in never requesting a succinct document, usable for policy- and decision-making.

One of the reasons cited by Health Center officials for fiscal discrepancies between the reports is a "time lag." The material for the 1974-75 Budget Report may not have included "year-end adjustments" for fiscal 1972-73 figures. Yet the figures in the Budget for 1972-73 current expenses are marked "actual," while figures for 1973-74, which appear in the adjacent column, are clearly

labeled "estimated." This makes the situation even more confusing.

The balance of this sub-section presents comparisons between the two volumes for fiscal 1972-73, which is the last year for which comparable data is available. The data appears in the Governor's 1974-75 Budget and the 1972-73 University of Connecticut Financial Report.

1. Comparison of "Distribution of Current Expenses by Function" - BUDGET REPORT and "Summary of Expenditures by Function" (only those listed as "current") - FINANCIAL REPORT

The Budget Document lists eight functions. The Financial Report lists eleven functions including one titled "non-functional." Only four of the functions are found in both documents. Dollar totals for each of these differ. The Financial Report lists the entire McCook Hospital Fund of $7.4 million. It is not included in the Budget Report. The "current" Dollar totals are:

Budget Report	$13,339,564.00
Financial Report	$21,951,286.08

2. Comparison of "Distribution of Current Expenses by Function" - BUDGET REPORT and "Summary of Net Expenditures from State Funds" (only those listed as "current") - FINANCIAL REPORT

The Budget Report lists eight functions. The Financial Report lists nine categories, although they are not designated as functions. Seven of these categories are the same in both documents. Of these seven, none of the dollar figures are the same for both reports. An eighth category appears to be related. In the Financial Report, "University Hospital" listed current expenditures of $162,693. In the Budget Report, "Hospital Subsidy" listed current expenses of $2,784,293. The dollar totals are:

Budget Report	$13,339,564.00
Financial Report	$10,718,112.35

3. Comparison of "Distribution of Current Expenses by Function" BUDGET REPORT and "Summary of Income and Expenditures" (only those listed as "current") - FINANCIAL REPORT

The Budget Report lists "Hospital Subsidy" as $2,784,293. The Financial Report lists "McCook Hospital" as having income of $1,900,000 from state appropriations, but no money is listed under expenditures.

Officials of the Health Center were asked, "What is the justification of having no expenditures listed for McCook Hospital?"

The response was as follows: "McCook Hospital is operated

as a revolving fund with a subsidy from the state appropriation to cover educational costs. It is proper accounting procedure to transfer funds to the hospital operating fund and reflect the expenditure of these funds in the expenditures of the hospital operating fund. To consider this transfer as an expenditure to the General Fund would have the effect of reporting the expenditure in two places."

The question then arises of why the "hospital subsidy" figure of $2,784,293 was listed as a current expense in the Budget Report.

The large discrepancy between the dollar figures adds to the confusion.

4. Comparison of "Capital outlay" as used in Budget Report and University Financial Report

"Capital outlay," a basic financial term, is defined differently in the Budget Report than in the Financial Report.

In response to a Program Review Committee question Health Center officials replied, "The term "capital outlay' is used generically in two different reports and includes different items."

The Committee then asked, "Why is 'capital outlay' (which

appears as part of General Fund money) not included as part of "total current expense" in the Governor's Budget, while 'capital outlay' is included as an "operating expenditure" in the chart in the University Financial Report?"

Health Center officials' response was as follows: "The organization and display of items in the Governor's Budget recommendation is determined by the Budget Division. In developing charts for display purposes, the University Vice President chose to display total amounts regardless of the source of funds. The detailed figures are shown in the appropriate tables." (Because the charts have no dollar base given, however, it is extremely difficult to locate the appropriate tables.)

In addition, the charts include bond funds in the category of "State Appropriations." This is at variance with common usage.

The Governor's Budget Report and the University Financial Report are the two major financial documents available to the Legislature and to the public. Although differences between them might be capable of reconcilation by professional audit, the examples cited of (1) dollar discrepancies, (2) multiple definitions of the same terminology, and (3) highly similar category titles comprised of dissimilar elements make these documents grossly inadequate for policy planning and decision-making.

2. Comparisons between the Governor's Budget Document and the Program Budget (1973-74)

The Program Budget issued by the Department of Finance and Control is discussed in Section A of this chapter. The recent termination of the use of this document by the Department of Finance and Control is unfortunate. Not only is program budgeting seen as a useful tool in the planning process, but its absence will hinder program evaluation efforts, by executive as well as legislative groups.

Comparison between the Health Center's budget request for 1974-75 and the comparable figures appearing in the program budget document discloses the following:

Budget report "Current expenses" = $18,416,000

Program budget "Current expenses" = $19,158,000

Analysis of the programs listed in the Program Budget Document are at variance with the basic program description listed in the Governor's Budget Report. The latter document recognizes the three traditional elements of Health Center activities: "The Health Center is responsible for -- educational programs, research activities and patient care."

However, in the Program Budget all of the Health Center's resources are allocated to educational pro-

grams (see Section A). This is an important discrepancy as the programs reflect the goals of the Health Center. This issue is discussed further in the sub-section on Health Center costs.

Comparison between Health Center material presented in these two documents for the decision-makers shows variances in monies requested as well as the programmatic utilization of those funds.

C. ADDITIONAL FINANCIAL INFORMATION UTILIZED BY THE PROGRAM REVIEW COMMITTEE

In addition to the basic financial documents prepared by the Health Center, other material was obtained and utilized by the Program Review Committee in the preparation of this report. Important financial data and operational explanations were provided by the Health Center in the form of official written responses to specific Committee questions, and testimony by Health Center and University officials at a public hearing held by the Program Review Committee in October, 1974. The Health Center also provided Committee staff with access to internal documents (computer print-outs) which provide ongoing information pertaining to financial matters.

A faculty survey conducted by the Program Review Committee included information pertaining to utilization

of faculty time. This relates to analyzing the cost of medical and dental education. This financially-related information gleaned from the faculty survey was intended to be exploratory rather than definitive. The material appears elsewhere in this report in the section devoted to the faculty survey.

In addition to material mentioned above, the Program Review Committee sought sources which dealt with programmatic, administrative, and financial material of national scope. One such document was a study which Health Center officials used as a source at the public hearing. It is entitled "Costs of Education in the Health Professions." This report is by the National Academy of Sciences/Institute of Medicine and was arranged by the Secretary of Health, Education, and Welfare, under direction of the 1971 Comprehensive Health Manpower Act.

The report estimates costs of education per student in eight health professions, including medicine and dentistry. Realizing that "the activities that constitute education must be defined before costs can be assigned," seminars were held for prominent educators in three of the health professions to determine and quantify the portion of research and patient service activities carried out by the institution which are essential to the education

process. Medicine and dentistry were included.

Two major features of the Institute of Medicine's study are the following:

(1) "Construction" of models of hypothetical schools and assignment of costs to the constructed models. This was done for both medicine and dentistry. The education of first degree (M.D. and D.M.D.) students was designated as the primary program of the institution.

In medicine, the panelists based their judgments on the current education philosophy in this country. The constructed costs model in medicine was developed to define "what is" rather than "what should be."

In dentistry, the panel believed that historical financing patterns for dental schools have resulted in inadequate clinical facilities for the education of the modern dentist.

Their constructed model, therefore, reflects the clinical requirements for an adequate dental education.

(2) Sample schools were surveyed in medicine and dentistry, and the costs of education, research, and patient care were developed for each school.

The medical school sample was comprised of fourteen medical schools. Six of these were public, and

eight were part of a health science center.

The dental school sample consisted of eight schools. Five of these were public, and seven of the eight were part of a health science center.

D. ADEQUACY AND USEFULNESS OF ADDITIONAL HEALTH CENTER FINANCIAL MATERIAL

1. The monthly personnel listing print-out contains inaccurate data regarding faculty functions

The previous section of this Chapter discussed internal documents of the Health Center. Some of the material generated is used to produce the data appearing on the Health Center's basic information documents. This information is "available as required for managerial decisions." It therefore must be considered as input into the decision-making process and thus falls within the purview of this section.

A Health Center monthly print-out, "Personnel Listing," was used in conjunction with the Committee's faculty survey. This report is "circulated each month to the Personnel Department for their information."

The listing of personnel includes their salary and whether they are full or part-time. Personnel are listed by fund (for instance, whether a person is paid from the

General Fund, or the research fund, which is non-state) as well as by "function" (for instance, "instruction and departmental research," which is state-funded, and "organized research," which is not). In addition, designations are included as to whether an employee is "faculty," "professional," or "classified." Also included is a designation of the employee's faculty rank or job title.

Analysis of this "Personnel Listing" discloses that a large number of faculty members, who are paid from the state general fund and whose function is listed in "instruction and departmental research," spend a substantial amount of their time in "organized research," which is by definition "sponsored research which is funded by gifts and grants."

This was disclosed in the Program Review Committee's faculty survey, which is discussed elsewhere in this report. This fact was substantiated by personal interviews with faculty conducted by Committee staff.

The purpose of this sub-section is not to dispute the essentiality of a portion of faculty effort for research. Rather, the issue is the inaccurate reporting of important data which ultimately is used to show how state dollars are spent.

If the faculty members' efforts in organized research are the actual cost sharing contribution of the state to federal research, why is this not listed as such in the University Financial Report?

2. The Health Center has provided no accurate data for the General Assembly pertaining to the relative expenditures for education, patient care, and research. It is doubtful whether a mechanism for producing meaningful data in this vital area is presently in operation at the Health Center.

Schools of medicine and dentistry are traditionally comprised of a triad of elements: education, research, and patient care. Cost information for decision-making focuses on these components.

Although there is a degree of interrelatedness and interdependence among these elements (obviously some research and patient care are essential to medical/dental education), each component stands alone.

The National Academy of Sciences/Institute of Medicine has determined the amount (percentage) of research and patient care deemed essential to education. It was determined that a higher amount of both research and patient care are essential for medical as compared with dental education.

The schools in the Institute of Medicine's survey sample varied widely in the percentages of total operational expenditure which were devoted to research and patient care.

Once the school has provided patient care and research which is considered essential to the educational component, the emphasis given to each element becomes a matter of choice. There is absolutely no evidence that emphasis upon either education, patient care, or research creates an institution with a higher "degree of excellence."

Setting relative priorities for the three goals is a policy choice. Two goals - education, and patient care - represent immediate approaches to the health service delivery problems confronting our nation and state, while research represents a more long range objective.

At the recent hearing conducted by the Program Review Committee, the following statement was issued by the executive director of the Health Center regarding distribution of faculty effort among education, research, and patient care: "It should be emphasized that in university health centers all of these activities are considered essential." No mention was made of the fact that only a portion of patient care and research are considered

essential to education.

This statement, presented by the executive director of a University Health Center to a group of laymen, might be construed as indicating that all of the patient care and research conducted at the Health Center is essential to education. Such an assumption would be erroneous. The interpretation of this point is crucial.

If all of the research and patient care conducted at the Health Center were essential to education, the determination of the amounts of each component would be merely an operational decision, and as such, fall within the purview of Health Center administrators and officials. But when research and patient care exceeds the amount considered essential to education, the relative emphasis given to education, research, and patient care actually defines the institution. The decision becomes one of basic policy by deciding relative support for three distinct goals. Such a basic policy decision is obviously one to be decided by the community (in this case the state) through its elected representatives.

Since its inception, the Health Center has been assigning relative priorities to the three elements of the triad, and thus has actually been defining the nature of the institution. Appropriations have been voted yearly by the General Assembly on the basis of the incomplete in-

formation provided by the Health Center that research and patient care are "essential and interdependent."

At the recent hearing conducted by the Program Review Committee, the Health Center presented as testimony comparison data on the "Distribution of Faculty Effort." Comparisons were made among the Health Center and the sample medical schools and model medical school presented in the National Academy of Science/Institute of Medicine study on health education costs.

The hearing was held in October, 1974. The Health Center data presented was developed in 1968 and represented "a quantitative estimate of the expected distribution of faculty effort by program." No additional data reflecting actual costs were presented.

Because a substantial proportion of faculty costs appearing in the University of Connecticut Financial Report as costs for "instruction and departmental research" are actually expended on organized research and patient care, this information cannot be regarded as useful. A more realistic picture of faculty effort could be obtained merely by surveying faculty members on their relative efforts in instruction, research, and patient care. Such information was a part of the faculty survey conducted by the Program Review Committee. At the time of this writing, no such survey of the entire faculty

has been undertaken by Health Center officials.

3. Relative cost comparisons presented by the Health Center in testimony at the public hearing are meaningless and misleading.

The 1968 Health Center projected faculty effort costs for combined medical and dental education were presented in comparison with the National Academy of Science/Institute of Medicine data for their sample schools and model school for medical education only. This is like comparing apples and oranges. Health Center testimony made no allusions to existing figures (both sample and model schools) for dental education, which were also developed by the Institute of Medicine.

The Health Center's comparison is misleading because the operational costs for a dental education institution are substantially less than a similar institution for medical education, according to National Academy of Science/Institute of Medicine data. Even more importantly, the distribution of faculty effort is markedly different for dental education. For example, the model medical school assigns 44.3 per cent of faculty effort to research while the model school developed for dentistry assigns only 26 per cent. The Health Center percentage presented for "M.D. instruction" was 17 per cent. The corresponding Institute of Medicine normative figure for instruction in dentistry was 30 per cent.

The exclusion of this material from testimony greatly limits the scope of the picture presented to the Program Review Committee.

4. Health Center officials have interpreted the mandating guidelines for the Dental School and Medical School to mean equal proportionate funding for each. Such an interpretation is illogical and possibly wasteful.

The Health Center cites as the guidelines for this matter the Report of the Professional Advisory Committee - December, 1962. This report indicated:

"Guidelines for planning [include] Dental program equal to Medicine and quality." (emphasis added)

In testimony before the Program Review Committee, the Executive Director of the Health Center referred to the 1962 PAC report as follows: "It was very clearly stated in these [guidelines] that the School of Dental Medicine should be developed along with the School of Medicine and that they should have the same quality consideration in terms of support." This interpretation of "equal quality" considerations has resulted in equal proportionate funding for the two schools.

However, the operational cost for a school of dental education is considerably lower than essential costs for a

similar school of medicine. The two model schools constructed by the Institute of Medicine resulted in twice as many faculty for the medical school compared to a dental school with the same number of students. The total annual operating cost of the model medical program was fifty per cent higher than that of the dental school program.

The logical response to a mandate for a medical-dental program "of equal quality considerations" would be, "How much would such a program cost? Would the dental component expenses be seventy per cent of medical component costs? Eighty per cent? Eight-five per cent?"

The omission of this step, in the fact of the considerably lower costs of operating a dental education facility, may have resulted in waste. There is no evidence than an increase in financing, beyond a certain point, results in a proportionate increase in program quality. Increased expenditures may possibly result in a "more" rather than a "better" situation.

Funds expended by each of the institutions and agencies of the state represent merely a portion of the totality of state funding. State legislators view funding of state programs as a whole, while officials and administrators of state programs have a perspective which primarily focuses on their narrow area.

The intent of this sub-section was not to suggest lowered funding levels for the School of Dental Medicine. Rather, it is to point out that this issue has not been dealt with in a logical or appropriate manner. The relationship of funding levels between medical and dental educational programs is a matter of vital concern to the General Assembly, as policy issues are involved. Usable material must be developed by the Health Center and presented to the General Assembly in this area.

E. RAMIFICATIONS OF HEALTH CENTER FINANCIAL REPORTING UPON POLICY

The preceding sections of this chapter have cited examples of Health Center data and information which are confusing, conflicting, and which may be construed as misleading. Although the Health Center complies with the reporting requirements of the Division of Finance and Control and the University of Connecticut Finance Office, the information provided to the General Assembly is inadequate for policy formulation and decision-making.

As a result, policies are implemented by the Health Center and decisions are made by the General Assembly each year which are based on data and information which do not properly relate costs to programs, nor to the objectives of the Health Center, and which are often incomplete.

No initiative has been undertaken on the part of the Health Center in providing the General Assembly with understandable, usable financial and programmatic data for its policy deliberations.

The attitude of the Health Center toward the General Assembly with regard to providing information may be described as one of mere "compliance." When asked by the Program Review Committee, "What information, if any, is provided to the General Assembly (in addition to the formal Governor's budget) at appropriations time?" the official response of the Health Center was as follows: "The University provides committees of the General Assembly with any available information that may be requested."

The financial administration of a health science center is a highly complex affair, involving many technical aspects.

Most state legislators are laymen with regard to medicine. The administration of the Health Center is basically responsible to the General Assembly for continued funding. An expectation on the part of Assembly members for the Health Center administration to provide more in the way of financial information than the completion of annual budget forms and the availability to "answer questions" would be reasonable. In such a highly technical area, the vitally pertinent questions are not

readily available to laymen.

It is reasonable to expect a higher degree of leadership and initiative in this vital area of information from highly-salaried Health Center officials than is evidenced by the present policy of compliance.

Much of the confusion surrounding the Health Center which is reported in the local media is a result of the failure of the Health Center to volunteer usable and understandable material which the public seeks with regard to this major institution.

A major result of the General Assembly's receiving inadequate, confusing, and misleading information is the fact that the Health Center has encroached upon the area of basic policy formulation, which is essentially within the purview of the General Assembly, acting as representatives of the people.

The most serious instance of unauthorized policy determination on the part of the Health Center is the arbitrary determination of priorities for the three major components of operations. This section has previously discussed the fact that the relationship among these elements actually defines the nature of the institution and as such transcends the boundaries of an "operational" decision and becomes a policy matter dealing with the goals and objectives of the state government.

In addition, the relative funding balance between the medical and dental components of the Health Center has been discussed as a policy issue, rather than a mere operational decision.

The relationship between the Health Center and the General Assembly is characterized by a lack of communication. This is only partially caused by the lack of information provided to the legislators.

This communication gap is essentially the result of a basic misunderstanding by Health Center officials of the role of the General Assembly in policy formulation. The formal response of the Health Center to the question, "What do you perceive the role of the General Assembly to be in establishing and maintaining overall policy of the Health Center?" was as follows:

"The Board of Trustees is accountable to the people of the state and the General Assembly evaluates the stewardship of the Board through the annual appropriations and capital authorizations which are made in support of the University."

The Health Center apparently sees the General Assembly as the "evaluator of the stewardship" of the operation of the Health Center rather than as an active partner in policy formulation once the enabling legislation has passed.

The statutory mandate to the Board of Trustees of the University of Connecticut is basically for the "operation"[1] of the state's public institutions of higher education. Such matters as the apportionment of the objectives (long-range vs. short-range) which define the Health Center certainly are not merely operational, but represent basic state policy.

The Health Center also cites a 1957 report by "a committee .... organized by several leading educational associations which 'emphasizes the importance of granting full authority for the operation of a university to the Board of Trustees in order that the state may receive the best return for its investment.'"

Such a response to a question posed to the Health Center regarding their perception of the "role of the General Assembly in establishing and maintaining overall policy" clearly implies (1) The Health Center feels itself more qualified to determine what would be the best return for the state's investment rather than limiting its role to how to obtain this, after the General Assembly has participated fully in policy formulation, and (2) The Health Center sees itself as responsible for the "operation" of the Center and apparently includes policy matters which pertain to priorities of goals and objectives as within its authority as the operators

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[1] Connecticut General Statutes, Sec. 10-326.

of the Health Center.

Some of these priority decisions (particularly those of short-range vs. long-range goals) reflect values rather than mere "operations," and as such clearly fall within the responsibility of the elected representatives of the people.

Encroachment into the policy-making area by medical men as well as other technical professionals is not unique to Connecticut, nor is the problem in the health-delivery field limited to education. Dr. Eliot Friedson, a prominent medical sociologist has recently written,[2] "Consulting the profession, the state obtains not only expert opinion on how to serve the needs the public perceives, but also partisan opinion about what the public's needs are irrespective of public opinion. Social policy is coming to be formulated on the basis of the profession's conception of need and to be embodied in support for the profession's institutions. But if those conceptions and institutions no longer conform to the public's conception, they have lost their justification. Professional 'knowledge' cannot therefore properly be a guide for social policy if it is a creation of the profession itself, expressing the commitments and perception of a special occupational class rather than that of the public

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[2] Eliot Friedson, Profession of Medicine (New York: Dodd, Mead and Co., 1970), pp.350-355.

as a whole."

Dr. Friedson summarizes, "When service to the community is defined by the profession rather than the community, the community is not truly served."

The instance of differing perceptions of problems and policies between medical men and the public has been recently validated by a public-opinion survey undertaken by a non-partisan research and analysis organization, Potomac Associates.[3] Two of the most prominent public-opinion polling organizations (the Gallup Organization and Erdos and Morgan, Inc.) were commissioned to survey (1) a cross-section of American citizens, and (2) a stratified national sample of U.S. physicians. The surveys focused on attitudes of these two groups on the critical current issues of national health care.

"The perceptions of the people and the doctors about the most important problems in American health care obviously do not precisely coincide. The public's first priority is getting care when they need it ... Doctors, on the other hand, tend to think of the cost problem first."

This extensive report also presents statistics

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[3] Stephen P. Strickland, U.S. Health Care; What's Wrong and What's Right (New York: Universe Books, 1972).

pointing toward attitudinal differences between physicians primarily involved in "teaching and research" and the national sample of physicians. The "teaching and research" physicians were the only one of seven categories of physicians who considered increasing basic and applied research as one of the five "most important items when it comes to meeting the medical and health care needs of the nation."

Because of the small sample size of the "teaching and research" group, the differences in response may not be viewed as definitive, but are nonetheless suggestive. Pertinent tables from this study appear as Appendix A.

This sub-section has summarized and discussed the major ramification of the Health Center's failure to provide the General Assembly with adequate and useful data and information for policy and decision-making. This has resulted in the gradual encroachment of Health Center officials into the realm of basic policy formulation, which is the mandate of the General Assembly members, as representatives of the people.

In fairness to the Health Center, it must be mentioned at this point that the General Assembly has been remiss in failing to actively seek usable data and information from the Health Center. Although the Assembly is severely limited by the lack of professional staff

and the part-time status of a great majority of the lawmakers, the option to request or demand meaningful information from the Health Center was available at all times to the General Assembly.

RECOMMENDATIONS:

1. THE HEALTH CENTER SHOULD DEVELOP AND IMPLEMENT A MONITORING SYSTEM THAT WOULD PROVIDE REALISTIC AND USABLE DATA ON COSTS FOR EDUCATION, PATIENT CARE, AND RESEARCH.

2. THE HEALTH CENTER SHOULD BE REQUIRED BY THE GENERAL ASSEMBLY TO ANNUALLY PRESENT A BRIEF, UNDERSTANDABLE DOCUMENT THAT WOULD PROVIDE USEFUL AND USABLE DATA FOR LEGISLATIVE DECISION AND POLICY-MAKING. SUCH A DOCUMENT SHOULD:

   A. BE PRESENTED TO THE GENERAL ASSEMBLY BY FEBRUARY 15.

   B. FOLLOW A FORMAT ACCEPTABLE TO MEMBERS OF THE FOLLOWING GROUPS: (1) HEALTH CENTER OFFICIALS, (2) MEMBERS OF THE COMMITTEE ON PUBLIC HEALTH AND SAFETY, (3) MEMBERS OF THE EDUCATION COMMITTEE, (4) MEMBERS OF THE PROGRAM REVIEW COMMITTEE, AND (5) MEMBERS OF THE APPROPRIATIONS COMMITTEE.

   C. INCLUDE DATA RELATING COSTS TO PROGRAMS AND OBJECTIVES OF THE HEALTH CENTER.

   D. INCLUDE ANNUAL DATA ON COSTS OF EDUCATION, PATIENT CARE, AND RESEARCH.

   E. INCLUDE FUNDING ALTERNATIVES AND PROJECTED RESULTS.

   F. DEFINE ALL FINANCIAL AND TECHNICAL TERMS UTILIZED.

3. THE GENERAL ASSEMBLY SHOULD FORMALLY RECOGNIZE THE FOLLOWING AREAS AS ISSUES OF PUBLIC POLICY WITHIN THE LEGISLATIVE PURVIEW, RATHER THAN MERELY ADMINISTRATIVE MATTERS:

   A. THE RELATIVE FUNDING AMONG THE MAJOR GOAL AREAS OF EDUCATION, PATIENT CARE, AND RESEARCH.

B. THE RELATIVE PER-STUDENT FUNDING LEVELS FOR MEDICAL AND DENTAL STUDENTS.

F. FEDERAL FINANCIAL SUPPORT OF HEALTH CENTER ACTIVITIES

Over $30 million in federal grant monies has been awarded toward construction costs of the University of Connecticut Health Center.

In addition, $5.7 million is estimated as the federal contribution toward the operation of the Health Center for fiscal 1973-74. The Connecticut General Fund contribution for this period is approximately $15.3 million.[1]

An estimated eighty per cent of the annual federal contribution is awarded in grants for research.

The remaining twenty per cent of federal funds is provided by the Health Manpower Training Act of 1971, which authorizes annual operating grants to health professional schools, based on the number of students enrolled — a "capitation" formula.

However, federal support for the operation of health education has traditionally been heaviest for the research component of the education/patient care/research triad

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1 See Governor's 1974-75 Budget Document, page 303.

which comprise such institutions.[2]

The extent and nature of future federal funding is uncertain at the time of this writing. This is because health professional education is just one aspect of the national health delivery system, which is presently undergoing scrutiny by the U.S. Congress. Selection of a suitable method for the financing of the system is a major priority of the ninety-fourth Congress.

The recently released report by the National Academy of Sciences/Institute of Medicine, described earlier in this section, concludes that the "considerable" effects of federal policy actually "alter the nature and the missions" of health professional schools.

In addition, the report discloses that numerous separate Congressional committees and executive agencies oversee health policy matters and that coordination of their efforts is "infrequent." "Policies that aid research and education have little relation to each other or to those that pay for patient care."

Also, "different government agencies separately purchase research, education and patient care in isolated efforts that can cause duplication in one part of

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[2] A summary of federal legislation affecting health professional education is presented as Appendix B.

the system, neglect in another part, and confusion throughout."

The federal contribution to the operation of the University of Connecticut Health Center is less than thirty per cent of the state effort. The National Academy of Science/Institute of Medicine's disclosure of the fact that the effect of federal policies is considerable and "alters the nature of the institutions, coupled by the charge that these policies are marked by "confusion," presents serious considerations to the state Legislature.

While it is true that the federal government is channeling money into the state, mostly in research grants, it is also true that the "nature and the missions" of the Health Center are being altered in Connecticut as well as elsewhere.

This dilemma is compounded by the fact that the data provided by the Health Center to the General Assembly does not provide monitored information pertaining to the relative expenditures in education, patient care, and research. The actual contribution from the General Fund for "cost sharing" in research activities remains obscured at this point. (The lack of realistic data on General Fund salaried faculty in the areas of patient care and research has been previously discussed in this chapter.

The National Academy of Sciences/Institute of Medicine report states the following:

"Agencies that support the products of the educational process must be able to know the combined effects of their support in order to achieve a rational financing program."

The preceding statement emphasizes the importance of providing appropriate and usable financial and program data for the policy and decision-making functions of the Connecticut General Assembly.

Chapter VIII

FACULTY SURVEY

- Faculty Profile
- Faculty Opinions and Comments
- Distribution of Faculty Time

VII. FACULTY SURVEY

A survey questionnaire was designed by the Program Review Committee staff and mailed to all members of the Health Center faculty who were listed as being paid from the General Fund appropriations. Prior to mailing of the survey, the questionnaire was reviewed by the deans of the Medical and Dental Schools and the executive director of the Health Center. Their suggestions were incorporated into the questionnaire.

Names for the mailing were taken from the "Personnel Listing" computer print-out sheet, which is described elsewhere in this report. A total of 253 faculty members comprised the mailing. Seventy-nine per cent of the faculty were designated as having full-time status under General Fund appropriations. Because of the Health Center procedure of designating some assistant professors and instructors as "professional" rather than "faculty," (which is discussed elsewhere), sixteen per cent of the sample were designated as "professional" in the Personnel Listing, even though their job titles would generally be considered as faculty rank.

The general response from faculty members was very good. The following are the final response percentages:

	Mailing Number	Response Per cent
Medical School Faculty	112	51%
Dental School Faculty	72	40%
Basic Science Faculty	69	45%
TOTAL FACULTY	253	46%

The survey was designed to elicit information in the following three areas:

A. Faculty Profile.

B. Faculty opinion and comments. Open-ended questions were included to invite faculty comments on the "strengths" and "weaknesses" as well as "suggestions for improvement." These questions had a high rate of response, a fact which was probably partially a result of assurances by the Program Review Committee that all comments would be held in strict confidence.

C. Distribution of faculty time. All faculty members were asked to list the average number of hours per week devoted to "professional activities related to your faculty position." They were then asked to separately list the number of average hours devoted to activities in teaching, patient care, research, and "general support activities."

This last category included the following items: (a) general administration, (including all but teaching committee work), (b) public or community service, (c) professional development (conferences, seminars, etc.), and (d) writing (non-research).

Instructions were included which enabled the separation of "joint activities" (joint teaching-patient care, joint teaching-research) into categories.

It is important to note that this part of the survey was intended to be informative rather than definitive. Because the Program Review Committee was interested in faculty time devoted to general support activity (including administration), a strict assignment of faculty time into the three categories of teaching, patient care, and research was not developed. Comparison with the sample survey conducted by the National Academy of Sciences/ Institute of Medicine was not an objective of the survey and such comparisons are not valid, since the National Institute of Health/Institute of Medicine did not include a comparable category for "administration." This portion of the

survey demonstrates: (1) A feasible method (survey) is available to Health Center administration for realistically developing faculty costs for each element of the triad (education, patient care, and research) and
(2) All of the faculty members surveyed are paid from the General Fund and their function is listed in the University Financial Report as "instruction and departmental research." However, a substantial portion of this faculty time is reported as being spent in patient care and research. The ramifications of this disparity are discussed in the section on financial reporting.

The differentiation between "departmental research" and "organized research," which is funded by non-state grants, remains obscure. Health Center officials did not respond to the question which was submitted by the Program Review Committee, "How does 'organized research' differ from 'department research' (qualitative and functional differences)?"

Faculty Profile

The following information was recorded as general faculty profile material for faculty in medicine, dental medicine, and basic science:

1. Advanced degrees held
2. Percentages of clinicians, basic scientists, specialists, primary care physicians, board certified specialists, sub-specialists
3. Average age
4. Faculty rank
5. Teaching experience
6. Clinical experience
7. Institutional experience
8. Number of years at Health Center
9. Tenure

This profile is included as Table I (A,B, and C).

TABLE I A

Faculty Profile
Medical School Faculty

A. Advanced degrees held

M.D.	72%
Ph.D.	13%
Both M.D. and Ph.D.	7%
Master's	4%
Other	4%

B. Faculty self-description

Clinicians	81%
Basic Scientists	19%

Clinical physicians only

Specialists	97%
Generalists	3%

Per cent of specialists board-certified	95%
Per cent of specialists with sub-specialty	55%
Per cent certified for sub-specialty	10%

C. Average age

Average age	41.8 years
Range	27 - 63 years

D. Faculty rank

Professor	33%
Associate professor	13%
Assistant professor	40%
Instructor	4%
Other	10%

E. Teaching experience

Total average	10.3 years

Total average years when teaching was "primary endeavor"	4.2 years

F. Clinical experience (clinical faculty only)

Average	10.5 years
As a primary care physician	1.7 years

G. Institutional practice (clinical faculty only)

(includes military, public health service, not-for-profit clinic, etc.)

Total	9.5 years
As a primary care physician	2 years

H. Years at Health Center

Average	4 years
Range	5 - 9 years

I. Tenure

Yes	35%
No	65%

Average length of tenure = 3.6 years

TABLE I B

Faculty Profile
Dental School Faculty

A. Advanced degrees held

D.D.S. or D.M.D.	35%
Ph.D.	15%
Combination of above	42%
Other	8%

B. Faculty self-description

Clinicians	73%
Basic Scientists	27%

Clinicians only

Specialists	79%
Generalists	21%

Per cent of specialists board-certified 33%

Per cent of specialists with sub-specialities 33%

None of the respondents were board-certified in sub-specialities.

C. Average age

Average age	39 years
Range	28 - 61 years

D. Faculty rank

Professor	31%
Associate professor	12%
Assistant professor	57%

E. Teaching experience

Total average	8.9 years
Total average years when teaching was "primary endeavor"	5.4 years

F. Clinical experience (clinical faculty only)

Average	11.7 years
As primary care dentist	0.8 years

G. Institutional practice (clinical faculty only)

(includes military, public health services, not-for-profit clinic, etc.)

Total	5.1 years
As a primary care dentist	2 years

H. Years at the Health Center

Average	3.3 years
Range	1 - 7 years

I. Tenure

Yes	35%
No	65%

Average length of tenure = 3.6 years

TABLE I C

Faculty Profile
Basic Science Faculty

A. Advanced degrees held

Ph.D.	69%
M.D.	19%
Combination Ph.D. and M.D. or D.D.S.	12%

B. Faculty self-description

Basic scientists	85%
Clinicians	15%

Clinicians only

Specialists	100%
Percent of specialists board-certified	75%

C. Average age

Average age	36.8 years
Range	27 - 56 years

D. Faculty Rank

Professor	19%
Associate professor	35%
Assistant professor	42%
Other	4%

E. Teaching experience

Total average	17.9 years
Total average years when teaching was "primary endeavor"	5.6 years

F. Years at the Health Center

Average	4.1 years
Range	0.5 - 10 years

G. Tenure

Yes	50%
No	50%

Average length of tenure = 2.7 years

Faculty Opinion and Comments (Tables II and III)

The item listed most frequently as a "strength" of the Health Center by its faculty was its faculty. The physical plant and facilities received the second highest number of favorable comments and were particularly highly rated among the Basic Science faculty. Positive comments regarding the students was the only other category to receive favorable comment by over twenty per cent of the total faculty sample.

The "weakness" mentioned most frequently by the faculty was the administration. Although this category has been tabulated to included criticisms of the Medical and Dental School administrations, most of the comments pertained the the administration of the Health Center. Conversely, most of the favorable mentions of administration specifically singled out the Dean of the Medical School. Dental School faculty members were most critical of the administration, with fifty-five per cent of their number listing negative comments.

This is amplified by the fact that no member of the Dental School faculty made a positive comment on the administration.

Delays in completion of the facilities of the Health Center was the weakness mentioned next most frequently by

the faculty sample. Survey results indicate this as a major problem for clinical faculty in both the Medical and Dental Schools. This was the category mentioned most frequently as a "weakness" by the Medical School faculty.

Bureaucratic red tape was the third most frequently mentioned category of negative comments and represented the major concern of the Basic Science faculty. However, only three per cent of the Dental School sample listed this as a problem.

Difficulty in recruiting and retaining personnel was the negative comment category listed fourth most frequently. This included criticisms of the salary structure as well as citations of poor morale. These matters were of particular concern to faculty of the Dental School, and over forty per cent of their sample listed this as a weakness.

TABLE II

FACULTY OPINIONS AND COMMENT

Health Center "Strengths"
(Comments pertaining to the "strengths" of the Health Center)

	Total Faculty	Medical	Dental	Basic Science
Faculty	39%	39%	24%	55%
Plant; physical facilities	28	18	28	48
Students	23	23	24	23
Program; curriculum	16	14	31	6
Financial support	11	9	10	16
Administration; Medical school dean	10	14	0	13
Inter-departmental interaction; cooperation	8	5	14	6
Intellectual environment; standards	7	4	10	10
Community Service	4	9	0	0
Good Potential	4	2	14	0
Research	4	2	3	10
Location	3	0	10	3
Library	3	2	3	6
Faculty-student interaction; small class size	3	5	0	0
BASE:	(117)	(57)	(29)	(31)

TABLE III

FACULTY OPINIONS AND COMMENTS

Health Center "Weaknesses"
(Comments pertaining to the "weaknesses" of the Health Center)

	Total Faculty	Medical	Dental	Basic Science
Criticisms of Health Center administration[1]	31%	21%	55%	26%
Delays in completion of facilities	24	30	31	6
Bureaucratic red tape	22	28	3	29
Faculty criticisms[2]	18	12	34	13
Difficulty in recruiting and retaining personnel[3]	16	9	41	6
Program criticisms	15	11	28	10
Inadequate facilities, space[4]	10	9	0	23
Internal communications problems[5]	9	5	21	3
Poor relations with community	6	5	7	6
Lack of goals; priorities	6	5	14	0
Criticisms of amount of research	5	5	3	6
Lack of central teaching facilities	3	4	0	3

[1] Includes criticisms of Medical and Dental School administrations, but primarily refers to Health Center administration.

[2] Refers to quality, composition, and size of faculty.

[3] Includes criticisms of salary structure and citations of poor morale.

[4] Refers to available facilities and space after completion of the Health Center.

[5] Includes criticisms of organizational structures..."too many committees."

Distribution of Faculty Time

Table IV displays the distribution of faculty time by element (or function). It has been noted that (a) all of the faculty surveyed were paid from the General Fund and (b) the material is not intended for comparison with other institutions, because of the fourth category ("other") which has been included.

Tabulation of this data was hampered by the fact that much of the material returned by the faculty was conflicting and unusable or only partially usable. (For example, in many cases total weekly hours listed did not match the total of each of the elements).

The faculty also were asked to provide data pertaining to the average number of students taught, classification of students taught (M.D. or D.M.D. student, graduate student, continuing education student), and the average number of weeks the individual taught. Because of the wide diversity of responses in these areas, no tabular information has been developed for presentation.

The majority of the activities listed by faculty members in the "other" category were described as general administration duties.

Answers to the question, "Average hours per week of

professional activities related to your faculty position?" included responses ranging from 1/2 hour to 77 hours. Because of necessary editing, the figures for weekly hourly averages may be somewhat inflated. The following two aspects of this portion of the survey were of particular interest to the Program Review Committee:

1. The high percentage of time which is devoted to "general support" activities by clinical faculty. Most of this time is listed as general administration. (See Appendix C) This is particularly interesting in view of the fact that administration related to teaching committees, patient care, and research is not included.
2. The small percentage of time devoted by members of the Dental School faculty to patient care, coupled with relatively large research effort. Twice as much time is listed by Dental School faculty as "other" activities (18 per cent) as on patient care (9 per cent).

All of the faculty surveyed are paid out of the state General Fund. All of their activities are listed in the University of Connecticut Financial Report as "instruction and departmental research."

This portion of the survey discloses that such a designation of faculty activity is erroneous.

TABLE IV

DISTRIBUTION OF FACULTY TIME

Total Average Hours (Weekly)

Medical School Faculty = 58 hours
Dental School Faculty = 56 hours
Basic Science Faculty = 59 hours

Distribution of Faculty Time

	Medical School	Dental School	Basic Science
Teaching	34%	43%	31%
Patient Care	22%	9%	2%
Research	25%	30%	55%
Other[1]	19%	18%	12%

1 "Other" category includes the following:

(a) General administration (not including teaching committee work, patient care administration, and research administration)

(b) Public or community service

(c) Professional development (conferences, seminars, etc.)

(d) Writing (non-research)

Chapter IX

STUDENT SURVEY

IX. STUDENT SURVEY

In July of 1974, all current medical, dental, and Ph.D. students, including 1974 graduates, were surveyed by mail. An overall return rate of 38 per cent (45 per cent of dental students, 37 per cent of medical students and 24 per cent of Ph.D. students) was achieved.

Several questions in the survey brought responses of great interest to the Program Review Committee. Students were asked to rate the quality of their program. Responses were overwhelmingly positive - 94 per cent of the total respondents said "very good" (top rating) or "good." There were, however, notable differences among responses from students enrolled in each of the three programs (medicine, dentistry, Ph.D.).

Thirty-eight per cent of dental students rated their programs "very good," but sixty-one per cent of medical students gave their program this top rating. Only seventeen per cent of Ph.D. students considered their program "very good."

"Good," the second highest rating, was chosen by 52 per cent of dental students, 39 per cent of M.D. students, and 63 per cent of Ph.D. students.

It is important to note that at least 90 per cent of the students in all groups gave positive responses, but the

differences among the groups are significant. The Committee is aware that there is dissention within the Dental School concerning curriculum, and attributes the fewer number of "very good" responses by dental students to this fact.

As previously noted, some Ph.D. students complained about insufficient attention from instructors. This would explain much of the apparent dissatisfaction within this group.

The Committee was surprised to find that seven per cent of the students responding (12 per cent D.M.D., 4 per cent M.D., and 9 per cent Ph.D.) stated that they had established Connecticut residency for the purpose of attending the Health Center. An additional 12 per cent of the students indicated that they had been Connecticut residents for fewer years than they had been enrolled at the Health Center. It is doubly advantageous for out-of-state students to establish Connecticut residency if they want to attend the Health Center, since very few out-of-state students are accepted for undergraduate programs and student fees are approximately twice as expensive for non-residents as they are for residents.

Forty-seven per cent of medical and dental students responding plan to reside and practice in Connecticut after they complete their professional education. Only five per cent plan to practice outside the state; forty-eight per

cent indicated they have not yet decided where they will practice. Students who were undecided said their choice would be strongly influenced by availability of attractive residencies, favorable living and working conditions, and family considerations.

The student survey contained a questions designed to test students' reactions to the proposal that Health Center students be required to serve a specified length of time at a moderate salary in an area of the state's choosing as partial repayment for their education and to help alleviate the maldistribution of health professionals in Connecticut.

This question was asked in two parts. The first part asked if the student would still have chosen the Health Center if this proposal were adopted, if he or she were accepted only at the University of Connecticut. Eight-five per cent said yes. The second part asked if the student would have chosen the University of Connecticut if this proposal was adopted and he or she had been accepted at one or more other schools. Thirty-one per cent said yes.

Since seventy-five per cent of the medical and dental students responding indicated on another question that they had indeed been accepted at at least one other school, it appears that the adoption of this proposal would have serious ramifications for the attractiveness of the Health Center to highly qualified students.

APPENDICES

APPENDIX A

The survey data presented in Appendix A is based on a study conducted by Potomac Associates, Washington, D.C. The study appears in published form as "U.S. Health Care; What's Wrong and What's Right," Stephen P. Strickland. (New York: Universe Books, 1972)

TABLE A-I

PUBLIC RANKING OF FIVE TOP PROBLEMS IN AMERICAN HEALTH CARE*

QUESTION: There is a lot of talk nowadays about a national crisis in the health and medical area. People have suggested a number of reasons for this crisis. Please look this card over carefully and tell me which two or three of the items you, yourself, think are likely to be most responsible for the crisis.

1. Shortage of doctors
2. Costly and complicated insurance
3. Unnecessary treatment raises costs
4. Insurance too limited
5. Doctors refuse house calls
6. Poor living conditions
7. High cost of medical treatment
8. Inadequate hospital staff

* Respondents were asked to identify only two or three items; the rankings here represent aggregation of all replies.

TABLE A-II

DOCTORS' RANKING OF TOP FIVE PROBLEMS IN AMERICAN HEALTH CARE*

QUESTION: Whether or not you consider the present national health situation very serious, which two or three of the following items do you feel represent the most pressing problems for national health?

	National Sample of Doctors	Teaching/Research Doctors
High cost of medical treatment	1	1
Shortage of doctors	2	2
Malpractice suits	3	-
Unnecessary hospitalization	4	-
Insurance too limited	5	3
Rising expectations	6	5
Costly medical insurance	7	4

* Doctors were asked to identify only two or three items; the rankings here represent aggregation of all replies.

TABLE A-III

DOCTORS' RANKING OF FIVE MOST IMPORTANT ITEMS IN MEETING NATIONAL HEALTH NEEDS

QUESTION: Which two or three of the following items do you feel are the most important when it comes to meeting the medical and health care needs of the nation?

	National Sample of Doctors	Teaching/Research Doctors
Expanding and improving medical schools	1	3
Instituting national service requirement for new M.D.'s	2	2
Training more M.D.'s assistants	3	5
Providing national health insurance	4	1
Regulating drug prices	5	-
Expanding and improving hospital facilities	6	-
Increasing basic and applied research	7	4

TABLE A-IV

INDEX OF DOCTORS' CONFIDENCE IN MAJOR GROUPS INVOLVED IN HEALTH POLICIES BY TYPES OF PRACTICE*

QUESTION: A number of groups will influence the health programs and policies that Congress will soon enact into law. Please indicate how much trust and confidence you have in each group listed below when it comes to supporting policies that are fair and workable.

	National Sample of Doctors	Fee for Service Doctors	Teaching/ Research Doctors
American Medical Association	+32	+38	-3
Medical school faculties	+20	+15	+50
Health insurance companies	+17	+19	+8
Hospital administrators	+4	-2	+31
American Public Health Association	-2	-6	+11
Consumer groups	-11	-15	-20
Drug manufacturers	-17	-6	-64
Federal health officials (HEW)	-18	-35	+19
Owners of profit-making hospitals	-48	-40	-94
Labor unions	-62	-64	-50

* To define the index of confidence for each category of doctors, the combined percentages of those replying "not so much" or "none at all" have been subtracted from the combined percentages for "a great deal" or "a fair amount." For example, doctors nationally expressed confidence in the American Medical Association by a margin of 65 percent to 33 percent, yielding a confidence index of +32. Those replying "no opinion" in each case have been excluded; this category averaged under 5 percent for each group or organization rated.

APPENDIX B[1]

Major Federal Legislation Affecting Health Professional Education, 1930-1971

Year	Title	Summary of Major Provisions
1930	Ransdell Act	Consolidated Federal biomedical research activities under the National Institute of Health (NIH).
1944	Public Health Service Act	Public Health activities consolidated into one Act. NIH received legislative authority to conduct a broad program of biomedical research. Represented conscious policy choice to use universities as a base for the advancement of biomedical knowledge.
1963	Health Professions Educational Assistance Act (P.L. 88-129)	Authorized matching grants for construction and renovation of teaching facilities in eight categories of health professional schools. Authorized loans for students in medical, dental and osteopathic schools.
1965	Health Professions Educational Assistance Amendments of 1965 (P.L. 88-290)	Authorized basic and special improvement grants to five types of health professional schools for increased enrollment. Provided for loans to low income students to continue their education in health professional schools.
1965	Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act)	Through Federal support of medical care costs for the aged and indigent, provided financial relief to health professional institutions through third-party payments, which unified the rate structure and permitted salaries of house staff (interns and residents) to increase.
1968	Health Manpower Act of 1968 (P.L. 90-490)	Extended provisions of P.L. 88-129 with a $25,000 grant for health professional schools ($15,000 for nursing schools). Bonuses to be distributed on basis of increased enrollment. Special project grant expanded to include awards for financial distress.

APPENDIX B

(Continued)

Major Federal Legislation Affecting Health Professional Education, 1930-1971

Year	Title	Summary of Major Provisions
1970	Health Training Improvement Act of 1970 (P.L. 91-519)	Authorized special funds for medical and dental schools in financial distress and requested HEW to conduct a study on how best to alleviate financial distress. Modified the institutional grant provisions to be responsive to new schools.
1971	Comprehensive Health Manpower Training Act of 1971 (P.L. 92-157)	Authorized capitation grants for health professional schools; initiative awards to alleviate manpower shortages to expand or improve training; increased loans and scholarships; traineeship and fellowship grants in family medicine. Reduced authorization amounts for financial distress grants.

1. Institute of Medicine, Costs of Education in the Health Professions (Part II), (Washington, D.C.: National Academy of Sciences, 1974), p. 5.

APPENDIX C

"GENERAL SUPPORT ACTIVITIES" PERCENTAGES

	Medical School Faculty	Dental School Faculty	Basic Science Faculty
General administration (including all but teaching committee work)	55%	70%	46%
Public or community service	15	8	9
Professional development (conferences, seminars, etc.)	19	14	34
Writing (non-research)	11	8	11
TOTAL GENERAL SUPPORT ACTIVITIES	100%	100%	100%

AGENCY RESPONSE

THE UNIVERSITY OF CONNECTICUT

BOARD OF TRUSTEES

January 25, 1975

The Honorable David Odegard and John Groppo
Co-Chairmen, Program Review Committee
State Capitol
Hartford, Connecticut 06115

Dear Senator Odegard and Representative Groppo:

The University of Connecticut Board of Trustees appreciates the effort the Program Review Committee has extended in its study of the University Health Center.

In Mr. George Schroeder's letter to me of January 16, 1975 enclosing the Program Review Committee's Report on the University of Connecticut Health Center, a request for a response by January 27, 1975 was made. I am pleased to enclose a response which is that of the Health Center Committee of the Board of Trustees. The period of time between my receipt of the report and the date for response did not permit a timely review and response by the Board, however the report will be presented and reviewed by the full Board at the earliest opportunity.

Should additional comment be desired we will be pleased to oblige the Committee in the most expeditious fashion possible.

Sincerely,

Gordon W. Tasker

Gordon W. Tasker
Chairman

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Enclosure

RESPONSE TO THE REPORT OF THE LEGISLATIVE PROGRAM REVIEW COMMITTEE ON THE UNIVERSITY OF CONNECTICUT HEALTH CENTER

The Senate and House members of the Program Review Committee of the Connecticut General Assembly along with their staff, under the leadership of their Executive Director, Mr. George Schroeder, have made a study of the complex operation and relationships of the University of Connecticut Health Center. This study has delved into the operation of the various units within the Health Center and has sought to present an objective, fair and unbiased view of this major component of the University of Connecticut. The Board of Trustees of the University would like to express its appreciation and compliment the Committee and its staff for its effort. Many of the suggestions are being implemented or studied at the present time.

The Program Review Committee noted that cooperation and understanding between the University and the Legislature are increasing and it is the belief of the Board of Trustees that this cooperation and understanding will grow. Certainly, the Program Review Committee's efforts and Report have and will continue to foster such cooperation and understanding. It is with this spirit in mind that recommendations related to proposed actions by the General Assembly are of particular concern to the Board of Trustees since the Board of Trustees believes that the existing statutory authority of the Board is sufficient to accomplish the broad policies of the Health Center as the Legislature may properly determine.

It is respectfully submitted that the University of Connecticut, acting through its administration and the Board of Trustees, has endeavored to supply to the

Legislature all of the financial data and supplementary information which the Program Review Committee has suggested is essential for proper financial analysis. The form of the presentation of this material may have been less useful to the General Assembly than it could have been had the University employed the procedure and form now suggested by the Program Review Committee. However, the formats utilized for the classification and presentation of financial data by the Health Center have been consistent with that required by the Budget Office and that utilized by similar educational institutions. Thus, it is our belief that to characterize a comparison of two presentations developed with different objectives as "misleading" does not take these factors into consideration.

The Board of Trustees further believes that the people of the State of Connecticut and the medical and dental professions can be most effectively served by the University of Connecticut Health Center if it operates under the specific and measurable goals which the Board of Trustees has and will continue to establish in accordance with the existing statutes under which it obtains its authority rather than through additional legislation. The University of Connecticut Health Center is in its embryonic stage of growth and is deserving of continual monitoring and variation of approach as the evolution of medical science and higher education progresses. With this in mind, the Board of Trustees has a standing subcommittee of the Board which monitors the activities of the Health Center on a continuing basis and reports to the Board of Trustees at each of its monthly meetings.

Report On State Grants-In-Aid To Municipalities Vol. I, December, 1974

Community Colleges In The State Of Connecticut, July, 1974

Summary of Community Colleges In The State Of Connecticut, July, 1974

Secondary Vocational Education In Connecticut, March, 1974

Summary of Secondary Vocational Education In Connecticut, March, 1974

Land Acquisition By The State Of Connecticut, September, 1973

Special Education In Connecticut, April, 1972

Additional copies of any of the Reports produced by the Program Review Committee may be obtained by contacting Mr. George L. Schroeder, Director, Program Review Committee, Room 402, State Capitol, Hartford, Connecticut - 06115