

# Duke University

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## Minutes of the Regular Meeting of the Academic Council

Thursday, November 18, 2004, 3:30 - 5:00 PM

The minutes of the October 21<sup>st</sup> Academic Council meeting were approved without dissent.

### *Announcements*

Nancy Allen (Medicine, Chair of the Council): The Executive Committee of the Academic Council (ECAC) meets with the Executive Committee of the Board of Trustees once a year and generally chooses two topics for discussion. This year the topics were the Palestinian Solidarity Movement Conference and Central Campus Planning. We had a very lively discussion during that evening, and I think the give and take we have with our Trustees is quite valuable. I think President Brodhead enjoyed the session as well, hearing different opinions.

The Council then went into Executive Session (all non-faculty-members left) to consider honorary degrees; after which the Council returned to the issue of the

### *Ph.D. Program in the School of Nursing*

Nancy Allen: The proposal was distributed prior to the October 21<sup>st</sup> Academic Council meeting. We had a wonderful presentation by the team at our last meeting and we are ready for any further discussion. We have representatives from the School of Nursing here again with us today, and I will open the floor for any further questions or comments. If there are none, we can proceed to a resolution prepared by the Executive Committee:

**Whereas**, the School of Nursing, through its Doctoral Program Steering Committee, has submitted a proposal to the Graduate School for a Doctoral Program in Nursing, and

**Whereas**, this proposal has been reviewed and received the support from the Executive Committee of the Graduate Faculty, the Academic Programs Committee, the Chancellor for Health Affairs, the Provost, and

**Whereas**, the Academic Council Executive Committee, finding the review process to be sound and the proposal to be extremely well documented, recommends approval:

**Therefore, be it resolved**, that the Academic Council enthusiastically endorses the establishment of a Ph.D. Program in Nursing. The Academic Council commends the School of Nursing for this innovative proposal, which will produce future nurse-scientists and academic leaders and contribute significantly to interdisciplinary efforts at Duke University.

The motion was approved without dissent.

Nancy Allen: Thank you all for your many years of efforts. The next step is to take this resolution to the Board of Trustees, and December 3<sup>rd</sup> will be another happy day I hope.

## *Chancellor Dzau*

Nancy Allen: The next item on the agenda is a very happy occasion for me as well, having served on his search committee last year, and that is to welcome and introduce Chancellor Victor Dzau to you. Dr. Dzau became Chancellor for Health Affairs at Duke and President and CEO of the Duke University Health System on July 1, 2004. He most recently had served as the Hersey Professor of Theory and Practice of Physic (which is medicine), at Harvard Medical School, and Chairman of the Department of Medicine at Brigham Women's Hospital and Physician in Chief and Director of Research at Brigham Women's Hospital in one of the northern cities you know well.

His academic interests are in cardiovascular translational research and in mission-based education. He brought his laboratory here, where I am sure it will be very active over the coming years. If you read our local and other papers, you will know that he has already received a number of national awards, some since his arrival here (so, I think we get credit for those...). Victor has a very international background, and this will serve us well in some of the efforts in international health.

We've invited Victor here today to speak about his first hundred days, although if I count correctly it's probably closer to 145 or so.

Chancellor Victor Dzau: (Turning to the Nursing delegation) Well, first, congratulations! It sounds as if it's going to be a full day of congratulations for the Medical Center. It's a great pleasure for me to be here — but I think that the honeymoon is over. Someone asked whether it ever started, when I gave a version of this talk some months ago, and I said that this is what I did for my summer vacation. Actually it's really true, because I had thought that originally I would do a slow transition, start off by, you know, taking over, then do my usual Bostonian summer (a professor should take time off to Cape Cod), then I would learn about Duke, and then, ta-da! it'd be September 1, and I'm here.

Very shortly I realized that there's a lot more work to do, and I'm very happy to be here. It's been, is it 145 days? I have to say that I feel very, very welcomed, and people have been very open and receptive. Things are getting a little harder. I think last night I had dinner with clinical chairs and we did get into some honest discussion and that's really good — I think! And so we get from people getting to know me, getting comfortable, to maybe honest dialogue. So for the first 145 days, most of my time really was spent first to get to know this place. And as I expected from the day when I said I was going to come, I was very impressed. I think it is particularly impressive when you consider the kind of quality and pride and loyalty of people at this institution. Everybody wants to do the right thing. So that's a great starting point for me.

Before I talk about my experience and impressions, some personal comments. I am indeed a physician, and I think most people know me as a physician-scientist. If you google me, or look at what I am about, I think most of you know more about me than my research, but I actually had a very traditional academic pathway in thinking about the values and ambitions of academic medicine, which has to do clearly with patient care, research, and education. And in that context, I have certainly had experience getting involved in a number of initiatives. For example in education, I was one of the founders of the Academy at Harvard Medical School, which is an organization that tries to bring together educators throughout Harvard Medical School, because frequently educators feel non-connected, particularly within a clinical enterprise when there's so much work to be done, etc. This was very helpful in getting people to think about innovation, how to reward teaching, how to get new initiatives going. And we actually raised money so that was a very good experience.

In the clinical arena we did train as physicians, so I've certainly been very active in the that part of my life, a little less now, but still I make rounds, and teach and get connected. In

research I'm interested in the whole concept of *translation*. And I think you know that this is part of the emphasis of this institution. President Brodhead has certainly given great support to efforts to take basic knowledge and find how we can make it relevant in society. My work has to do with how do you take discoveries and make them applicable to man. One of the areas I work on — to do with an inhibitor of transcription called decoy, DNA decoy — is now ready to be tried. So I keep my fingers crossed. It's one of those instances when you have physician-scientists advance to the point that an idea can actually become a therapy. So we'll see whether it happens or not, but that certainly gives me the background in thinking a lot about some of the issues around the Medical Center which I will talk about.

I will keep to about 10-15 minutes so there will be some time for dialogue and discussion. In assessing Duke, what I think was very helpful to me, was to read the indenture of James B. Duke of the Duke Endowment, which absolutely as you know envisaged the creation of the Medical School and the hospital. In his indenture, it's very clear that he saw that discoveries and inventions are pivotal in advancing health care. And he also talked about the hospital as the place to deliver care. But interestingly he talked about a network of hospitals, because he recognized that there's a rural-urban maldistribution of care, and this is back in the 1920s, when he in fact recognized that we need a network of hospitals. And he talked about health disparities. And I think that these are still the values that we have. That view hasn't changed. Perhaps we've modified it, somehow or another altered it, but I think that the core value at Duke, as I see it, is that Duke is still centers on those areas.

The first month that I was here, Sandy (R. Sanders Williams, Vice-Chancellor for Health Affairs) and I and Peter Lange and Tallman (Trask) and others were having a retreat with President Brodhead, and some of the discussions raised questions such as, What are our core values? and, What is distinctive about Duke? What I'm going to tell you about is those aspects of this collective thought that are especially (in my opinion) germane to the Health System/Medical Center, in the form of what we call the five points of continuum, which are: value of discovery, translation, adoption, inquiry, and service. And they do form a continuum. I think that's what is wonderful about a place like this, in which when you are by the bedside as a physician, you can ask the question; then you can go back to discovery or knowledge acquisition, the inquisitive position. If you are also the person who is in the lab, you can think about how this can be relevant...

Now one of the things that I said very early about my observations at Duke is, it is large, it is complex, in the medical area. And as I try to put my arm around it, I've actually asked OK, there's a School of Medicine, there's a School of Nursing, there's a PDC (Private Diagnostic Clinic), there is the Health System, and what some of my staff gave me was organization charts — because, you know, somehow or other, all paths lead to the Chancellor being responsible for all this. One of the things that struck me is that we haven't articulated our common shared values sufficiently. So we've been doing a little of our own internal branding to say 'how do we describe all these pieces together?' because in order for us to move forward successfully, as a system, as a Medical center, as a team, we haven't seen all this as a whole. So we've been calling it "Duke Medicine," as people call it "Duke Law," and "Duke Engineering." *Duke Medicine* is that whole concept and enterprise, the whole that contains all the pieces, and how all these pieces are part of Duke Medicine, because it is what we are about, as an entity together, moving forward, in terms of trying to meet those missions and core values.

So, what is Duke Medicine? Well, it's got Duke University Hospital, it's got the VA — we frequently forget that — it's got the Durham Regional Hospital, it's got Duke Health Raleigh Hospital, it has the PDC, it has the School of Medicine, the School of Nursing, it has in fact a lot of community stuff, such as Duke University Affiliated Physicians. We have home services, and the service is pretty broad. If you look at the total in numbers, we're talking about, in the Clinical arena, we have about 1.5-1.6 million outpatient visits a year, somewhere around 65-70 thou-

sand (hospital) admissions a year. The total revenue is 2.3 and maybe this year, 2.5 billion dollars, and we have a large medical school ... that comprises about 2000 faculty members. We train about 400 medical students at one time. And I can send you all these numbers. I say, the only thing to emphasize is the size of this entity requires taking a step backwards to say, 'where are we? what do we want to be?' and I think one of the very pleasant duties for me of course is to see the School of Nursing emerging as an entity on its own, as a school which now is at a table with, in fact, all of the Health System. And we welcome Cathy Gilliss as our Vice-Chancellor.

Of course, it's been a great pleasure for me to work with Sandy, who has been a great partner. And also with Carl Ravin (Chair of Radiology) who chairs the PDC, and many others. Also for me, one of the great joys, because I was at Stanford for a number of years, is working closely with the university. At Harvard, where I spent most of my life (25 years) we are in Boston, somewhere on one side of the (Charles) River, and then the rest of it is on the other side of the river in Cambridge. Every visit to the President or Provost is a real trip, which meant that "connectivity" is just simply not the way it is here. But more importantly, it is the whole sense of collaboration and collegiality which is great here. As you think about where the sciences are going, where we are, the opportunity to cross all these schools and disciplines is clearly where the future lies. And already between Sandy's and Peter Lange's efforts, many bridges are being made. We certainly look forward to a lot more, and in areas that I would like to say a little bit towards the end of my talk

I could also tell you that we're very proud because of the fact that our Medical School is ranked #4 in *US News and Report*, and we are #5 in funding, and we are #6 in hospitals, and that's very nice. But, as I take a step back and do a little more self-examination, I think that there's more work to be done. I think most of the people I've spoken to agree to that... There's still a glass ceiling for Duke Medicine; we've never broken above 3 or 4: So, why not? is the issue. So that's part of this discussion. How do you get there? And who do we want to be?

One of the other issues that I've observed is the issue of *synergy*. I said earlier that we should make the whole more than the sum of the parts and now we want to bring planning across Duke Medicine, but also across all of Duke University. We need to learn to share a vision. Now in medicine we do face a huge amount of external competition. Aside from the academic competition that you can imagine... The challenges are retaining the very best, or getting the very best in different places. I can tell you that at Harvard the stakes are so high that people are just simply going after every single good individual, and so I do recognize that at Duke we have a lot of external competition. But in a healthcare environment, the competition is even more intense. It's really a complex environment when you talk about caring for the patient, caring for the population, trying to make sure that we have the highest quality in running a health-care business. And that's a very complex series, when you have to react to an environment rapidly, yet can't forget your fundamental core values.

This morning we had a retreat to talk about cancer. And we realized that in fact for-profit organizations are coming right into cancer care and growing rapidly... How fast can we decide to develop new technology, where elsewhere people look at it as a simple business... So we do have a lot of competition; the market competition is intense. And I think that to be able to meet that competition we have to run our institution effectively, efficiently, like a business — but we cannot forget our core values. And that's the message that I keep on telling people. There's nothing wrong in my opinion with thinking about what's justifiable, what's most cost effective, as long as we remember that we're here to take care of patients and we have a much higher calling and mission which is making sure that we continue great research and also educate and of course care for our population.

The other thing that I've observed around Duke is that we can be more visible both nationally and at the state level. Lots of legislative decisions are being made that affect us.; we are not as active in this area as we might be. Certainly when I make my rounds to (members of) the

legislature in Raleigh, they all point out to me that (they are all) Tarheel fans and don't like Duke very much. And all of the legislators are UNC graduates. But that's not the real message: the real message is that we're not very visible there, not visible enough. As the national debates on stem cells and many other issues are happening, the question is where is Duke on this front? I say that if you look at chancellors and presidents of universities in this country (with the exception of a few) most are relatively silent. That's because I think that the issues are so complex that if you really want to run the place, you don't want to go way out on a limb, speaking about some issue that may have great impact on an institution in a negative or in a positive way, and most of us don't feel, shall we say, knowledgeable enough to tackle very complex issues. But I think that for us to be breaking through the glass ceiling, being visible, we have to begin to think about those things, and we have to perhaps develop and recruit talents who are willing to work closely with Peter, myself, Dick, and Sandy and others to think about where do we want to go, what are our positions, which are really important to Academia, important to society, important to medicine.

So, this leads me to my final observation, which is the whole issue of diversity and health inequalities — many of you know that I've got a great interest in this area. But it stems from back in Boston, getting to know Paul Farmer, and really understanding what he's trying to do, to now being here and more energized... The issue of health inequalities, and all aspects of society, whether it's economics, business, policy, you name it, social aspects, and medicine of course ... In our own backyard, the health status of our citizens in Durham is really quite poor, and Rob Califf (Director of the Duke Clinical Research Institute) keeps reminding me that our numbers are worse than Cuba. And now here we're bragging about one of the best health care institutions in the country, so where's the disconnect here? I think disconnect is very clear, and therefore this is in fact our commitment and our obligation to do something about this. This leads to the larger concept of health inequalities and global health, which I will talk about for a few minutes.

Now, that I've made all these observations, what am I going to do with all of this? Recently the senior executives and deans at the Medical Center got together to talk about goal-setting. We asked ourselves to set goals for each other, for ourselves, both immediate and in terms of impact in the next few years. So these are my goals, which I will close by setting out for you:

First is building a team, building trust, and building processes. In order to think about that synergy that we talked about, I think the first issue is that people need to really work together as a team, and not work solo, and then try to pull together occasionally and say, 'what did we say we were going to do together again?' I think in building together as a team a lot has to do with expectation and understanding, how to communicate with each other, and so I've thought a lot about "well this decision on the health system went this way and the doctors feel 'we didn't participate' and the university said 'what did they do?' and someone said. 'what you put money into this?'" I think we're not going to do these things, I think it's great to have differences. It's great to have an honest debate. Yes, I understand that decisions need to be made, but I think everybody should be heard and I think that we should have an agreement, if not a consensus, about how to move forward together. But to do this you have to build trust, you have to build a team together, and you have to build decision-making processes that allow you to work with each other. So I would say that my first 145 days has involved putting a lot of time into this. There will be a lot of course out of this, new appointments, restructuring, stuff like that, and I would say that these appointments are very important, because it both sends the message about where your values are, and it also sends a message about what kind of person you can get and why, and how you want to get things forward.

So, I'm so pleased that Cathy Gilliss is here, as well, our new recruits. We recruited Molly O'Neill from Partners HealthCare who is our Chief Strategic Planning Officer. Pamela Sutton-Wallace from Duke who has background at Yale, who is my chief of Staff, and Karen

Frush (Pediatrics) who is now Chief Patient Safety Officer; I'm very proud of these four recruits. But we have a lot more work to do.

Step Two is what I call *system alignment* — if you read the *News and Observer* this Monday, they call it system realignment. Well, that's not a bad thing: I guess we're aligned without the need to realign. And the alignment to me, says the following: one is, if you want to work as a system, we have to think like a system, so fundamentally it's the tool by which we can use to organize the time we have... System realignment is about socialization and acculturation. Getting people to think that they are in the same culture, the same society, getting people to think according to the same system, so that when we have tough decisions to make, people are able to understand what it takes to move forward. So a lot of the work that we are doing now is in fact, getting people together, believe it or not. But getting people together in productive ways, because system alignment is about creating standard processes, quality, so forth.

Concerning patient care we need to talk about quality. How do we measure how good we are? We think we are good. And external forces are measuring us now, about how you care for a patient after a heart attack. There are special ways in which the data for evidence-based care is in fact generated by Rob Califf's shop in Duke Clinical Research Institute: but are we practicing it? This gives us a tremendous opportunity to take a translation/adoption to service and we need to measure that... Can we learn from Durham Regional? Can we learn from Duke Health Raleigh? Can they learn from us?

System integration is about safety. A big issue for us is: what's the best way to make sure that our patients are safe? There's a standard process going through this, and it's about electronic records, it's about information systems, it's about a patient being able to enter the system at any part of the Duke Health System and get the same quality of care. So that's the system we strive for.

The next piece, my number three, is the strategic plan, because we need to have a plan going forward, about we want to do what we're all about — what is a health system? And I think if we ask people, some people will say, 'well, three or four hospitals'. Health systems are about taking care of patients and about physicians and providers. So what do we want to look like in Wake County? What do we want to look like in Durham Regional? In this area? This strategic plan is an academic enterprise. In coordination with Peter Lange's effort for the University's Strategic Plan, which the deans of the School of Nursing and the School of Medicine also work with, we are doing a Duke Medicine Plan, and I think we are going to be coordinating, collaborating, planning ahead because there will be programs that cross the university in which the medical piece, engineering piece, and others will all work together, and I think those are real good opportunities.

My number four is the translational medicine initiative. President Brodhead has said that translational medicine is a very important part of Duke's mission. The issue for us is how do you take discovery to human application? That is one of our core missions, and as we look at this issue, I think we encounter nowadays many, many barriers, both cultural and academic, and tomorrow at the CIEMAS Panel Discussion I'll talk a little bit about those. The problem is that we also have many other issues, including an important issue of conflict of interest. I'm working towards thinking how to facilitate translation, so that at the end of the day we can really truly provide some value to society based on the discoveries that we make. I talk about science and technology, I'll try to include some critical people to make larger than incremental leaps, if we really want to be among the very best; and finally global health and health inequalities. This is a university initiative that I'm very pleased to co-lead with Peter Lange, and many of you in this room are very passionate about this. We are in fact sending out an invitation for a steering committee, and the Steering Committee will be asked for three goals. Peter is that alright? (Peter Lange said yes)

So the three goals that we ask of the Steering Committee are: one, how do we embrace all of this greatness of Duke to address the issue of global health? This is what we call a think-tank approach. I think if it's played all the way out you can think about it as an institute. It's a school. The idea would be, if you work in environment, that includes economics, business, policy, law and medicine all together focused on the global health issue, I think that we may be able to provide a lot of added value. It would be different from many other global health initiatives at other universities. It's about trying to think about how, as a university, we can contribute from the very highest level...

The second charge is to talk about how do we deliver care, the best systems of delivery, learn from very best, try models of care, and also intervention and research. This involves work both locally and internationally, in under-resourced countries.

And third is a curriculum. I think it is important to educate people about this, and particularly I think the greatest opportunity is at the undergraduate level, when people go, want to go into medicine, or economy, they ought to know about the issue of global health, and what does health mean to economy and vice versa? There are inevitably economic inequalities, but good health improves the economy, so I think that that's a great area for undergraduates to learn as they decide what to do with their career.

These steps are not all going to be done in one year. They will be initiated, but I think that we will have made clear steps forward I hope, by the end of my first year, in terms of these six goals. So, thank you very much.

Nancy Allen: I want to thank Chancellor Dzau for those wonderful reviews of what he has been doing in his spare time (not so spare anymore) and the exciting challenges that we have ahead, so we will certainly invite you back to report on what has happened. And everyone here will watch with interest. I'm sure that many of you will end up participating with the Chancellor in these projects. (Unfortunately, because of a long agenda, we do not have time for questions and answers.)

### *Graduate Program in Medical Physics*

Our next order of business is to hear a proposal to create a new Medical Physics Graduate Program. I now call on Professor James Dobbins who has chaired the steering committee to put forward this proposal. I will mention I think that Sandy Williams, Dean Williams, needs to leave for another meeting, unless he's plans to divide himself in two. And I might ask him to say just a couple of words, just before Jim gets started with the slides.

Sandy Williams (Vice-Chancellor for Health Affairs): Yes, thank you Nancy. I need to go to participate in a graduate-student award ceremony, so I hope I'll be forgiven for jumping the queue here. The process that is culminating today in the presentation to you about a new graduate program in Medical Physics began, as most good things do, with a few champions from our faculty. James Dobbins is here as the as the leader of that champion group. And as he will attest, I have made him jump over an increasingly high series of bars before this program convinced me that this was something that we wanted to move forward with. But he showed the drive and resolution, and commitment to the vision, and ultimately won my strong support for what you're going to hear about today. He had to convince me that this program was important to the core missions to the School of Medicine, that it was not redundant to other programs — complementary or additive, rather than redundant — to other similar programs that existed in other parts of the university; that it was not an effort to isolate, but an effort to reach out to other segments of the university and across multiple departments of the School of Medicine. At least two of our Chairs are here today to speak to that. So, I want you to know that James and his colleagues took me from being initially skeptical to being a strong advocate of what you're going to hear about, and I believe that this is a good thing that the School of Medicine can do for Duke.

Nancy Allen: Thank you Sandy.

James Dobbins (Radiology) then spoke, with a series of slides.

Dobbins: Good afternoon. I want to thank Dean Williams for those very kind comments. I am the Chair of the Medical Physics Graduate Program Steering Committee. I want to thank the Council Chair, Dr. Allen, and all the members of the Academic Council for allowing us the opportunity to come and present our proposal for a new graduate program in Medical Physics. I am here today on behalf of the Steering Committee and the more than 30 faculty members who have been involved over the past three years in the preparation of this proposal.

I also want to express our deep appreciation to the chairs of the five departments involved, and to Dean Siegel of the Graduate School, Dean Williams of the School of Medicine, and Senior Associate Dean Laursen of the Pratt School of Engineering, for their help and support in the process of putting this proposal together. I would also like to thank Associate Dean Leigh Deneef in the Graduate School and Vice Dean Jo Rae Wright in the School of Medicine for their tremendous help. The Medical Physics graduate program is at its heart an interdisciplinary endeavor, and the collegial support of these chairs and deans, across the boundaries of department and school, speaks well of the support that exists at Duke for these types of interdisciplinary programs.

Some of you are probably not familiar with the field of Medical Physics, and so I would like to give you some brief background information about it. I could say, somewhat in jest, that Medical Physics has more Nobel prizes than any discipline you have never heard of. And it's true that some of our colleagues in the physical sciences have not heard of this field. But there is a long history of important contributions of physics to the advancement of medicine, stretching back over a century to the work of Roentgen and Curie, whose discoveries of x-rays and radioactivity led to two of the first Nobel prizes in physics. In more recent years, two of the Nobel prizes in medicine or physiology, including the 2003 prize, have been awarded for work that was at its essence, medical physics. The application of physics to medicine has been responsible for the discoveries and technical innovations that gave rise to the medical disciplines of radiology, nuclear medicine, and radiation oncology.

So what exactly is medical physics? In a nutshell, it is the application of physics to the needs of medicine. Although it is built on the foundation of physics, it has grown to have its own body of knowledge and scholarship that encompasses elements from both physics and the medical sciences. Medical Physics is also distinct from its cousin, biophysics, which is concerned more with an understanding of the physics of biological processes than with the diagnosis and treatment of disease. Medical physics is inherently an applied discipline, incorporating theoretical, experimental, and clinical methods. Some contemporary examples of medical physics areas of scholarship include diagnostic imaging, external beam radiation therapy, diagnostic and therapeutic applications of nuclear medicine, small-animal imaging, and molecular imaging and therapy.

There are currently about 60 medical physics graduate programs in North America; of these, 11 are accredited by the Council on the Accreditation of Medical Physics Educational Programs, and about 50 are not accredited. Graduates of medical physics training programs can obtain jobs in academia, government, industry or clinical settings. There is a very strong job demand for graduates of these programs. Approximately 250-300 positions are open each year, but only about 50-60 graduates per year are produced by the existing medical physics programs. As we began considering the feasibility of a program at Duke, it became clear to us that there was a very strong need for additional graduate training programs in medical physics. It was also clear that Duke has the faculty expertise and resources to be one of the top programs in the country. However, the faculty members at Duke who are engaged in medical physics work are currently spread out over several departments. Creating an interdepartmental graduate program would enable us to expand the educational offerings currently available at Duke, and enhance interde-



partmental research collaborations and interactions. This program has received strong support from the faculty and departmental chairs.

I would now like to describe some of the key features of the proposed program. The interdisciplinary nature of the program is well suited to the new model of learning and discovery that is evolving at major universities. As problems in medicine and science become increasingly complex, the integration of disciplines across departmental boundaries is becoming more important. Our program would be a collaboration of five departments: radiology, radiation oncology, occupational and environmental safety, physics, and biomedical engineering. It would span three schools: the Graduate School, the School of Medicine, and the Pratt School of Engineering. We would offer both Ph.D. and Masters of Science degrees. Our academic offerings would be organized into four tracks: diagnostic imaging physics, radiation oncology physics, nuclear medicine physics, and health physics. Due to the collaborative nature of the program, we have adopted a team-oriented approach to leadership, with an administrative council comprised of representatives of the four academic tracks. We have developed a full curriculum that will provide excellent training to students for a variety of career paths. However, because we are an academic institution that values scholarship, we have carefully crafted our curriculum so that our graduates will be adequately prepared to play a significant role in advancing the field of medical physics after they leave Duke. We intend to make the program as affordable and competitive as possible by offering substantial scholarships for Masters students and fellowship support for Ph.D. students. We have developed the program with appropriate attention to financial viability, and have developed a financial plan that should enable the program to be self-supporting within five years.

Our faculty has discussed what we hope to achieve as a program, and these ideas are summarized in the following elements of our vision. We want to be in the top echelon of Medical Physics programs within a few years of launch. Based on the caliber of our current faculty, we should easily be among the top three or four programs in the U.S. We want to train our students at the highest level of proficiency. We want to provide excellent service to our community, through internship programs. We want to shape the future of medical physics as a discipline, and not just produce students to fill job slots. We want to provide a professional “home” for the many medical physicists at Duke, and by doing so, to enhance interdepartmental research collaboration and professional development. We also want to produce an educational program that will enhance the recognition of Duke and our constituent departments.

Now, a word about program structure. We expect participation from over 30 faculty members in five departments. As mentioned, we will organize the program academically around four tracks of study. The Ph.D. component will be the crown jewel of the program, but with minimal additional effort, we can support a very strong M.S. program as well. After the Ph.D. and Masters components of the program have started and are on a strong footing, we anticipate offering additional training opportunities including post-graduate training and medical physics residencies for individuals interested in clinical certification.

The leadership of the program will involve faculty members from the five constituent departments. At the center of the administrative structure will be the Administrative Council. The Administrative Council will handle most decision-making tasks of the program, and will be comprised of the Program Director, the Director of Graduate Studies, and the directors of each of the four academic tracks.

A full curriculum has been developed for both the Masters and Ph.D. components of the program. Here is a schematic of how the Ph.D. part of the curriculum will be structured. Each student will take 5 core courses, listed at the side (slide) for your reference. In addition, each student will take two core courses in a selected major track of study, and two courses in a minor track. One of the unique elements of our curriculum is that we will require each student to take a frontier course, which will be a course not traditionally associated with medical physics but re-

lated to the future of medicine. Such courses may be, for example, in bioinformatics, genomics, or other areas. Students will also be required to take several elective courses.

The program will need to offer a minimum of 11 courses on an ongoing basis, but we have identified a total of 33 courses we plan to offer after full curriculum development. Not every course will be offered every year. We will also cross-list elective courses from other departments such as biomedical engineering, physics, math, statistics, and computer science. At the beginning of a student's second year, he or she will declare both a major and minor track of study, and will take courses specific to those tracks. Practicum courses will be required, which will train students on the equipment and procedures associated with the clinical practice of medical physics. We plan a total of 33 and 39 credit hours for the Masters and Ph.D. programs, respectively. We also plan to offer an optional summer internship program through which the students can work with medical physicists in hospital or laboratory settings.

We have developed a financial plan that should enable the program to become financially self-supporting within five years. Training grants for the Ph.D. students and tuition from the Masters students will be the two key sources of revenue for the program. One of the key expenses of the program will be fellowship support for the Ph.D. students. We believe it is important that Ph.D. students have time to familiarize themselves with the four academic tracks before declaring a major and selecting an advisor. For that reason, the program will pay the fellowship costs of each Ph.D. student for their first year of study. After that, most Ph.D. students will be supported by research funds from their advisors. We also anticipate providing \$25,000 of seed money from the program for faculty research, particularly to support projects that cross departmental boundaries. And finally, we plan to provide partial scholarships to Masters students to make the program more attractive and affordable.

In summary, we feel that there is a strong rationale for the establishment of a graduate program in medical physics at Duke. The program will be an inherently interdisciplinary endeavor, and will enhance interdepartmental collaborations. We see this as one of its great strengths. The faculty of the program will be one of the strongest faculties of medical physics anywhere. The program will strive for a balance between Ph.D. and Masters students, and will have one of the most extensive curricula of any existing medical physics program. There is a significant job demand for the graduates of our program, and a variety of career paths available to them. In order to enhance our educational value to the students, we will seek accreditation at the earliest opportunity. And last, I am glad to point out that space for the program has already been identified by Dean Williams.

We believe that this program will fill a demonstrated need in the workplace, will provide a top-quality education for our students, will advance the field of medical physics, and will enhance the academic enterprise of our five departments. It is our goal to make this program an outstanding educational offering of which Duke can be proud.

Thank you for considering our request to approve this program, and I appreciate your attention.

Nancy Allen: Are there questions for Professor Dobbins? Or for any other members of the team?

### *Questions*

Catherine Gillis (Nursing): What's your thinking about the possibility of this program being a strong ally to the M.D./Ph.D programs?

Dobbins: Well, I think that we certainly want to entertain the idea as one of our structures in the program, to offer the M.D./Ph.D as an option. In fact, it's interesting to note we already had a student, unsolicited, email us and say that he would like to pursue an M.D./Ph.D. in Medical Physics. We would certainly be open to that. Our initial emphasis is going to be on the

Ph.D and Masters Degree Programs, but we would be delighted to entertain interaction with the School of Medicine to do that.

Ann Brown (Medicine): What qualifications would a student have to enroll in this program? Would you take nursing students? Would you take Bachelors-prepared students in the liberal arts? Or would someone have to be a major in a certain field?

Dobbins: Because there's a strong physics background required for this field, we really would be targeting students that had a strong background in the physical sciences. Specifically, we would most like to see students that have a bachelor's degree in Physics or something comparable, perhaps chemistry or math with strong science training. So, in order for the students to really launch in, from the very first semester, to be able to keep up with the classes, we really would need students with a strong physics background.

Question: The Masters and Ph.D. students coming out of that would presumably go different tracks for jobs, yet the program, the teaching courses look identical. Is there any thought into perhaps tailoring the masters program a bit more in terms of where the students would be going compared to the Ph.D.?

Dobbins: That's a very good observation. There is likely to be a different career path for the Masters and Ph.D. students. Let me just tell you a little bit about career options for Medical Physicists. Typically they follow several areas — academia, industry, government service, and clinical work. We would anticipate that perhaps half the students might go into the clinical profession, maybe a quarter into academia, and maybe a quarter into industry. Now this would be true for both the Masters and Ph.D. students, although we're much more likely to see the Ph.D. students go into academia. The masters students of course would not be properly qualified for that. But there is a clinical service component that would be available, a clinical career path that would be available to both the Masters or the Ph.D. students. And in view of the fact that a lot of the masters students are potentially taking a clinical job, we would want to make sure that they had adequate training and the clinical background to be practicing medical physicists. That is why we insist that all our students take a clinical practicum. And also why we want to make available to the students, primarily the masters students, a summer internship program where they can work with a medical physicist in a hospital. So we would like to train both the Ph.D. and the M.S. students to have some familiarity with clinical practice as well as academic training, but the Masters students will have more of an emphasis in the clinical area.

Steve Baldwin (Chemistry): Just curious, would your planned faculty come from Medical Physics programs, at least some of them?

Dobbins: Some do. A good number of our faculty members have Ph.D.s in Physics. Traditionally, medical physics programs in this country have been staffed largely by graduates of physics programs. There are, as I said, about 60 medical physics training programs in the country. So there are some very notable individuals in the field who actually have a Ph.D. in Medical Physics or Radiological Science or something to that effect. A good number of the faculty, though, have physics Ph.D.s. The majority of our faculty here will have Physics Ph.D.s.

Lori Setton (Biomedical Engineering): Can you give us a sense of the anticipated numbers of students and the ratio that would be Master students versus Ph.D.s?

Dobbins: Yes. We have looked at the finances of the program to help give us a little bit of an indication about what would be an optimum number of Masters and Ph.D. students. And we're targeting at the moment, about 8-10 Masters Students matriculating per year and about 2-4 Ph.D. students per year. The Masters program would last about 2 years, and the Ph.D. about five, so that by the time we've reached equilibrium, we would expect to have approximately 16-20 Masters students at a given time and about 10-20 Ph.D. students. So we really would like to see a balance between those two arms of the program at about equal numbers, somewhere in the 10-20 range.

Ann Brown (Medicine): You've done a beautiful job of detailing many aspects of the program. I'm wondering, you have a great opportunity, at the inception of a program, to think about generating a very diverse group of medical physicists. And physics is a very male-dominated field. And I just can't help but think that it would be important to try to take specific steps to think about how you're going to encourage women, and perhaps women and minorities to enroll in this program?

Dobbins: That's an excellent point. And it is unfortunate that Physics is a very predominately male-oriented profession. It has made some strides, I think, in diversity in the past decade or two but that is still something that's a concern to us as well. So we would like very much to encourage female applicants to our program. There are some notable female investigators in the field of medical physics. So we certainly want to — in fact, it might be a good idea to ask them for their input on how we might enhance that diversity in the program. In terms of diversity other than gender, I'm glad to report that medical physics is broadly diverse by geographic background. There are a number of international scholars in medical physics. So that type of diversity is not as much of an issue as the gender issue, but I take that point to heart.

Rich Burton (Fuqua): Can you help us understand a little bit about what a clinician actually does?

Dobbins: Yes, I am not actually a clinical medical physicist, so maybe I will ask one of my colleagues to do that. Dr. Yin is here, recently appointed as director of Radiation Oncology Physics. Dr. Yin? Would you like to answer that question?

Fang-Fang Yin (Radiology): I just joined Duke University two weeks ago. Regarding our clinical medical physics programs, Professor Dobbins already mentioned that there are two major components. One is clinical diagnostic radiology and the other is clinical radiation oncology. The majority of clinical physics activities are carried on in the radiation oncology department, and the Chairman, Dr. Willett, is here. Just to give you some idea, radiation oncology basically involves using radiation to treat cancers, so involves many technical and physical techniques for the cancer treatment. The clinical physicist basically has to make sure where the radiation is delivered, exactly where you're delivering it to, and whether the amount of radiation is delivered as you want it to be. For example, if you have a tumor in the prostate, and it's wrapped around by the rectum and the bladder, the challenge is how to deliver the prescribed radiation dosage to the prostate while not delivering too much radiation to the bladder and the rectum so as to avoid damaging these critical, normal organs. So you have to "modulate" passing radiation straight beams intelligently, and you have to turn them around to hit where you want to hit, spare where you want to spare. Such a "beam modulation" process involves the optimization of radiation planning and delivery methods, the effective design of delivery methods, and the use of imaging for image-guided target localization, as well as monitoring the radiation beams. That's what the clinical physicist is required to do. And our clinical researches are focused on how to improve the radiation therapy accuracy and outcome.

Carl Ravin (Radiology): I can do the diagnostic for you.

Dobbins: Our chair will field that question.

Carl Ravin: On the diagnostic side, all the modern equipment that we install, particularly for radiation, has to be certified by a diagnostic physicist as being what the manufacturer said it would be. It needs to be checked to be certain that it does that and the physics guys not only oversee the installation and the continued application of this, but devise new ways to use it more effectively. So there is a strong clinical need for medical physicists.

Dobbins: There are also certain regulatory requirements that are required to be met in hospitals, both in imaging and in radiation therapy, so the clinical physicists participate in the treatment. They are part of the treatment team as well as validating the functioning equipment and fulfilling regulatory purposes.

Nancy Allen: Thank you Professor Dobbins. As is customary, we hear a proposal for a

new Ph.D. program at one Council meeting and think about it. If anyone has additional questions for Professor Dobbins I'm sure he will accept your e-mails. If you have concerns that you wish to send to the Academic Council office please do that. We will be putting together a resolution to bring to you for the December 2 meeting, which is only in two weeks. So we will mail that out next week to get to you on Thanksgiving I think. So please send us any comments.

(To Dobbins) We are very appreciative of your work and that of all of your colleagues, and the support of many in this audience including Lew Siegel, Dean of the Graduate School, Provost Lange, Dean Williams who was here, and many others. So, thank you and congratulations on your work so far.

### *Harassment Policy*

We are hoping to conclude this session by 5:00. We have a very important topic to consider for the next 20 minutes or so and I know that this topic will come back to us at our next meeting and we will have substantial time reserved for further discussion and input. I now call on vice provost Judith Ruderman to present the work of the committee that has spent considerable time reviewing the Harassment Policy. And I understand that I have the Provost here to make a few comments to set us off the block.

Provost Lange: We are most pleased to be here today. This has been a very long process and a very thoughtful process so I thought it would be useful to give you a little context. The Harassment Policy was last exhaustively reviewed almost a decade ago. There were minor changes over the years since then but no thorough review. Over the first 4 years of my term as Provost it became clear to me — due to several incidents that came to my attention — that it was time for another hard look at the policy, a look that would determine both whether the policy itself was adequate and whether the procedures to implement the policy were appropriate to ensure that the policy was successful. If not, we need modifications. The committee that was appointed in the Fall of 2003 was asked initially to examine our procedures for handling harassment charges. They did so, and they were exceptionally thorough in scrutinizing everything about the policy. In fact, they exceeded their charge. I can only say, thank goodness for that, although I suspect they are not quite as happy as I, given the time they put in. In fact they did look at all aspects of the policy and as you know are presenting today a much revised policy. Judith Ruderman will certainly recognize her committee members in her own remarks, but I want to thank everyone on the committee, who all did enormous service for Duke.

Finally, I'd like to note that the policy went through multiple drafts and those drafts were, on a relatively continuous basis, revised through interactions with ECAC — I think at least three times, the Deans' Cabinet, the Chancellor for Health Affairs and his cabinets, Kate Hendricks in the Counsel's office, and other interested parties around the institution. The reach of the policy is extensive and thus we wanted to ensure that the revisions to it made sense across the various constituencies in the university, since it was important to have a single policy for the entire university. Now I'll pass the baton to Judith.

Judith Ruderman (Vice Provost, Academic & Administrative Services): I counted 28 drafts of this policy on my computer. I'm sure there are more that I deleted. When the Provost appointed the Harassment Review Committee more than a year ago, he undoubtedly thought that we would be finished with our work in a few weeks — a little tweak here, a little tweak there and the Harassment Policy would be ready to go. Wrong! Either because we took our job very seriously, or we enjoy each other's company, or we were gluttons for punishment and surely it was a little bit of each. The committee met frequently throughout the academic year. Charged with reviewing the process, we quickly determined that the overarching policy needed attention first. We took nothing for granted in either the current policy or the procedures, but instead evaluated every aspect anew. Perhaps you have heard of the Hebrew word *pilpul*, which refers to the close analysis of the Torah and the debating back and forth about interpretation. That's what it was

like. That's what it felt like for us as we discussed and sometimes argued our positions on the central text before us. I quote from an e-mail from March, 2004, "Dear colleagues on the Harassment Policy Review Committee. Whew. Two hours on one paragraph. We were so intense that one committee member said I can't take it any more and left. Others tried to follow, but I locked the door." The only thing I exaggerated there was the part about locking the door. The rest of it is true. I thought I had to inject a little humor to get the committee back for its next meeting. But enough for the prologue.

Let me recognize the committee members who are able to be in this room today to help respond to your questions or concerns. Steve Baldwin, Professor of Chemistry; Bobby Clapp, Associate Vice President of Duke University Health System; Cynthia Clinton, Director of Harassment Prevention in the Office of Institutional Equity; Trina Jones, Professor of Law; Ross McKinney, Associate Professor of Pediatrics, Infectious Diseases and Vice Dean for Research in the School of Medicine. They and the other committee members who couldn't be here today: Mindy Kornberg, Michele Longino, Ben Reese and John Perfect, they exemplify what good Duke teamwork is all about and I thank them. I could never thank them enough. Such wonderful colleagues in this interesting and certainly intricate endeavor.

As my cover memo to you has already indicated, and the Provost just repeated, this document once it left the committee room in June has been brought to a number of other individuals and groups including ECAC and it continued to evolve over the summer months and into this Fall. The latest changes were made after your draft was already in the mail and I did want to mention them. The phrase "Duke University" is now always followed by "and Duke Health System." And patients, as in hospital patients, have been added as a category under section of "all others" who may make a claim of harassment. A sentence has been added to the definitions of the terms *allegation* and *complaint* on page 2, noting the handling process to be used and hence making the distinction between an allegation and complaint clear early on in the document. Otherwise the proposal is basically the same as the one you have before you.

The major differences between the proposed policy and procedures and the current policy and procedures are documented in the table that was included in your packet. I would just mention two of these major changes. First the Harassment Policy and Procedures encourage informal processes for handling even a written complaint. In the past a written complaint would almost automatically result in a formal hearing. Second, if a case does go to a hearing panel there is a consistent method for constituting a panel and all members of that panel have a vote. With the current policy, faculty cases are treated differently than all others in that these hearing panels contain either a majority of faculty or are totally composed of faculty. And not everybody has a vote.

That brings up the point with which I want to conclude these remarks. It's important that I mention the principles or values to which the review committee continually referred as it went about its work. The principles of rightness, fairness, and practicability. In the gray areas, especially where those principles might come into conflict, like our debates, we ultimately developed a proposal we were satisfied to let loose and input afterwards from many others has been invaluable, not surprisingly, in improving the proposal. I should mention that at 3:25 this afternoon your chair handed me a 2 page e-mail from a member of the faculty who I don't see in the room. And I want to tell you that of the 6 points I agree right away with 3 of them and I think some clarifying language should be added on those three points and with 3 other points I don't think any modifications are necessary. But I mention that just to emphasize that it's your turn now to have a go at this document and at the committee. We hope you agree that the changes we're recommending make sense on account of those values I mentioned, those principles that they know to be right, fair and practicable. But in any case, we are ready now for your feedback and I thank you in advance for that feedback.

Sally Kornbluth (Pharmacology and Cancer Biology): I'm curious about the thinking on

the change on filing on malicious complaints from the 2002 to the 2004. So is that not considered harassment then to file gratuitous or malicious complaints?

Ruderman: Yes, we determined that it's not that that is acceptable behavior, but we felt that that should not be considered a form on harassment in and of itself and should be dealt with under other workplace policies — it's not that we approve of malicious complaints. If anybody on the committee wants to add to, or correct, anything I have said, please go ahead. Cynthia, you look like you want to.

Cynthia Clinton (Director of Harassment Prevention). I just want to add a few comments to what Judith said. In looking at those cases where people feel there have been intentional malicious complaints filed, we've found it's very difficult, if not impossible, to go to the mental intent of someone filing a complaint. And we'd much rather err on the side of leaving open the possibility of people coming forward with concerns and complaints so we can quickly, if feasible, determine whether or not action is merited. In the old policy, in order to find that someone had intentionally filed a malicious complaint, you really did at a practical level have to get inside that person's head. And I can tell you there were people who came to my office with allegations that, even when they turned out to be untrue and far-fetched, I had little doubt that the person genuinely believed him or herself to have been harassed.

Josh Socolar (Physics/ECAC): Since you mentioned Dr. Plesser's e-mail this morning, there were two points in it that I think it might be helpful for you to speak to right away. One is that in the old policy there was at least some mention in the introduction of the fact that certain kinds of cases could be criminal cases and some external process to Duke might be initiated. And in the current version there is simply no mention of it at all. And I was wondering what the reasoning about that.

Ruderman: Frankly, I had forgotten that there's something in the current policy about that. But this is one of the 3 points that I agree with. I think that should be at least mentioned. I would want to talk with the committee and others about this, of the fact that filing a complaint at Duke University does not preclude filing a complaint at an external judicial system, or some language of that sort. I want to check what it says now. Ronen didn't mention what it says now. So that's one of the 3 points I agree with. So you are welcome to bring up only the points that I agree with!

Socolar: The second one had to do with footnote 4 on page 6.

Nancy Allen: And I will just say that I literally received his e-mail at close to 3:00 when Linda had already packed up to come over here so we couldn't copy that for that entire Council. If it is helpful we can send it by e-mail to Council members.

Judith Ruderman: I think we are addressing the points. My guess is that we can do that.

Socolar: So footnote 4 in the document says that in some cases OIE or the supervisor may have an obligation to investigate the complaint whether or not the complainant's signature is obtained when the complaint is reduced to writing. And the question is: what kind of cases would those be and how does the supervisor or OIE determine that?

Ruderman: This is a very good point that Ronen brings up. That footnote is referring only to the filing of a complaint. It doesn't deal with allegations. And Ronen really is asking, you know, there could be allegations of harassment, then what is the supervisor's responsibility? So that footnote refers not only to the filing of a complaint, but the fact that we must proceed on the complaint even if it has not yet been reduced to writing or doesn't have a signature. So I think that Ronen's question is correct. Does the supervisor ever have a responsibility to act on behaviors even if the complainant is loath to do so? Cynthia has told me that the answer is "yes" to that so we need to insert some language.

Here's the problem. A lot of people when they read these kinds of policies, they want everything spelled out. Ronen uses the word "nebulous" in his e-mail and I understand the thinking that prompted the word nebulous, but you really can't spell everything out. We could

provide some general guidance about the kind of allegation or complaint that needs to have action taken, whether or not the complainant wishes it. For instance, if I went to my supervisor and said Josh has said something to me that I don't like. That might be different from Josh is doing another form of behavior that is quite egregious, is dangerous, so it must be stopped immediately. I didn't use a good example. But there is sometimes a gray area.

Provost Lange: Isn't this also the point where we discovered that there are situations in which we could incur institutional liability by not investigating a charge, even if the charge is never signed and brought. So there are certain situations where Duke could become institutionally liable for failure to investigate something even though the complainant chose never to file formally. So I don't think it's nebulous, it just leaves a window to protect our institutional status, under conditions in which you could well understand that the complainant might not wish to file, but where we nevertheless have a responsibility...

Ruderman: The bottom line is: we will address that issue too. That point is well taken. Do you want to bring up any of the others?

Socolar: No...

Ruderman: Well, I'll just mention to you, the other point I agree with is that Ronen says, in the issue of informal resolutions, that when we talk about these being considered binding and he says, "are such resolutions required to be in writing, to be signed by both parties? This is not specified." I agree it should be. That's simple.

Rich Schmalbeck (Law): I'm not sure if Sally was satisfied with the answer to the question, but it left some other questions in my mind at least. So, let me follow up on that a little bit. I understood you to say that filing of malicious complaints might be subject to disciplinary action, but not under these rules, under some other rules. I guess I'd like to hear a little more about what those other rules might be. But then I understood Ms. Clinton's response to sound like you didn't think maliciousness could ever be proven. So it sounds as though those violations are deemed not to exist, in which case they wouldn't be subject to any kind of remedy under any other rule. So could you address a little bit the disjuncture that I heard between the two responses and also, if they are subject to any kind of sanction under any other rules, could we hear a little more about that?

Ruderman: We're two different people who gave two different perspectives. Cynthia is talking from her experience as the person who deals with such claims.

Cynthia Clinton: From the perspective of someone who deals with harassment discrimination complaints, it's much too difficult to prove the intent of the person. We're looking at a cause of action as it is laid out in the current policy. I will respond to that from a departmental or unit perspective. You can look at behavior objectively, and if there is behavior that is causing disruption to the workplace, see whether the person is making unfounded or malicious statements about another's behavior as disruptive. If so, then the allegation should be addressed from the perspective of the manager or supervisor and people address this as they would other disruptive behavior. But to have it as a cause of action under the harassment policy is problematic, at least from my perspective. I think that trying to prove someone intentionally brought a malicious complaint would be very difficult in any situation... From the workplace perspective, the manager or supervisor can certainly lay the groundwork by saying you have an avenue, you have a resource to deal with your complaint of harassment or discrimination. But the way in which you are communicating about it in the workplace is disruptive. An extreme example might be an employee who says he or she is being harassed and does nothing about it: doesn't provide any specifics, won't go to OIE, won't pursue the complaint and is not making allegations that rise to the level of requiring institutional response to it. That behavior might be viewed as disruptive and should be handled at the workplace as opposed to the cause of action that follows.

Ruderman: I don't think that satisfies you (Rich) right?

Rich Schmalbeck: Proving intent is always difficult, but it's the kind of problem that dis-



ciplinary rules and criminal law grapple with all time. You do the best you can to infer subject intent on whatever objective grounds you can. And I don't see that as particularly unique. I think it might be that as a matter of fact, malicious intent would not (always) be difficult to prove, to prove that a malicious complaint had been filed. But it would still reassure me to know that there was prohibition on making malicious complaints and of course there is a procedure...

Ruderman: Well again, maybe my answer is too simplistic. There are a lot of behaviors that are not appropriate behaviors. I don't know that we always spell out all these behaviors in policy, do you know what I mean? So, I think the committee simply felt that if a person was making a malicious complaint, that it should not be adjudicated under the harassment policy unless to some degree that was considered harassment.

Schmalbeck: I would just like to know under what other policy that would...

Ruderman: That's an excellent question. There may be workplace policies that I wish Mindy were here to address.

Bobby Clapp (Associate Vice President): I can say that I'm not sure this will be to your point of students, but along the lines of what was being said earlier an employee is behaving a certain way, there are work rules and violations of those work rules that would come into play essentially in this kind of circumstance. They are pretty clear. There are 10 or 13 of them. And if you violate a work rule then you are subject to discipline by your supervisor. So, in this case, if someone was making a claim about someone, spreading it around the work unit or the institution, they would be violating several work rules and subject to discipline under that. That's one option. Now Judith would be better to speak to a student who was filing harassment claims.

Julie Edell (Fuqua/ECAC): The Honor Committee would treat it like any other case where a student brought an allegation against a faculty member that was unfounded.

Ruderman: Well, I'm more concerned here, I think you may be more concerned with what faculty policy is in existence, you know. Again, there isn't one. I wouldn't want this to be a sticking point personally... Cynthia has told us that she doesn't find it practicable. If you believe as a Council you want to recommend that that go back into the policy, I think that is your prerogative. We just have to mull that one over — maybe it's up to us to come up with better arguments, to be more convincing. But right now I think we've heard your good point.

Laurie Shannon (English/ECAC): I just have a quick question about the balance in-between informal and formal resolution. And I noticed that once a decision is made by OIE and the complainant to go for a formal process, a hearing panel is impaneled — but that that panel could make a determination to send it back to an informal process. And I wonder if you could talk a little bit about what the criteria would be for such an override?

Ruderman: I'm going to ask Trina to respond to that, since Trina has sat on hearing panels.

Trina Jones (Law): There are some cases in which you may actually get a complaint that looks valid, but the complaint may turn out to lack merit or proof even though OIE has allowed the case to go to a hearing panel. At some point, someone has to make a determination about whether or not the case should proceed through the full formal process. The Committee decided that this decision should rest with the hearing panel. In this sense, the hearing panel performs a role similar to that of judges in our civil court system. After a complaint has been filed in court, and after the parties have had sufficient time for discovery, that is, to investigate their respective claims, a judge may decide that the case lacks merit or sufficient proof and that there is no reason for a trial. The judge will thus dismiss the case for efficiency and fairness reasons. We have sought to build a similar procedural mechanism into the harassment policy. The policy contemplates that OIE will be lenient or generous in allowing cases to go forward to a hearing panel. But, the hearing panel has discretion to dismiss cases that turn out to be merit-less without holding a full hearing.

Shannon: But that wouldn't determine the case by summary judgment, but it would send

it back to another level.

Jones: In some cases the hearing panel might terminate the case and in some cases it may just send the case back to OIE for resolution through the informal process.

Bobby Clapp: OIE err on the side of thoroughness...

Ruderman: I believe this is in the current policy, is that correct?

Nancy Allen: Do we have perhaps a couple more questions or comments.

Provost Lange: Now I just want to add one thing. Judith did not point out that one thing that led to this entire review was the lack of flexibility in the previous policy: there were unfortunate outcomes where lack of flexibility led to cases generally not being handled well because there were no intermediate structures. I think this last point, about being able to send a case back, introduces a level of flexibility in the form of a properly constructed panel...administrators felt they didn't want to be put in a position of seeming to squelch cases. So they are going to lean toward having the case handled by this system...

Nancy Allen: Are there additional questions or comments for Judith? If not please send any thoughts and clarifications. We will bring it back next month. I thank the committee for their hard work.

Respectfully submitted



John Staddon  
Faculty Secretary

December 29, 2004