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# BEDSIDE AND COMMUNITY: 50 Years of Contributions to the Health of Albertans by the University of Calgary Edited by Diana Mansell, Frank W. Stahnisch, and Paula Larsson

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# A History of Aboriginal Health Research within the Faculty of Medicine, University of Calgary, 1966–2016

*Paula Larsson and Wilfreda E. Thurston*

Aboriginal health research and health-care provision has had a complex past within the University of Calgary Faculty of Medicine (now called the Cumming School of Medicine). The faculty made early strides in this area when it was first established by working with nearby First Nations with the goal of increasing accessibility. Yet these early efforts were influenced by a myriad of factors that halted their progress and led to a long hiatus in the faculty's focus on Aboriginal health. Historical legacies of biomedical power and colonial medicine[1] created tensions between the faculty and its partner First Nations tribes, and eventually the project was abandoned. Since then, any official faculty efforts have focused on internal policy issues with regards to the recruitment of Aboriginal students and faculty members. In the last twenty years, many individuals associated with the Cumming School of Medicine have initiated personal research and teaching programs with Aboriginal peoples. This rekindling of concerns about Aboriginal health from members of the university has come from the passion that individual professors, physicians, and researchers have shown for promoting Aboriginal health within the province of Alberta. Yet the individualized nature of this research shows that the school itself is poised

to create and implement a forward-looking and coherent mandate on the promotion of Aboriginal health.

## An Overview of Aboriginal Health in Alberta

In 2013, Alberta's Aboriginal population numbered about 220,000 individuals, or about 5.8 per cent of the provincial population.[2] Historically Aboriginal people have been the main inhabitants of Alberta's landscape, occupying its soil for at least eleven thousand years. The Aboriginal people of Canada are defined by section 35 of the Constitution Act of 1982 as "the Indian, Inuit and Métis peoples of Canada."[3] The term "Indian" has thus been legally cemented into the rhetoric of legislation regulating Aboriginal people within the country—and province—despite its social rejection as a historically racist term. The term is further augmented by several categories within policy: "Status Indian"; "Non-Status Indian"; and "Treaty Indian." Status Indians are defined by the Indian Act, originally passed in 1876, as "a person who pursuant to this Act is registered as an Indian or is entitled to be registered as an Indian."[4]

Despite the legal definitions, the terminology has changed to utilize a more inclusive and respectful term, that of "First Nations." The term is used to refer to both Status and Non-Status Indians, as defined under the Indian Act. To confuse the matter of terminology further, however, differences between federal and provincial definitions of First Nations exist. While the Alberta government lists forty-seven First Nations chiefs and councils, the federal government does not recognize leadership in three of these First Nations, thus providing only forty-four.[5] These complications signify how jurisdictional issues can work to convolute the systems that have been put in place to handle Aboriginal issues.

Three treaties were signed by the Crown with the Aboriginal peoples of Alberta: Treaty 6 (signed in 1876) includes sixteen of the First Nations; Treaty 7 (signed in 1877) includes five First Nations; and Treaty 8 (signed in 1899) includes twenty-four First Nations. Geographically, Treaty 8 is in the northern part of the province, Treaty 6 in the middle, and Treaty 7 in the south. The treaties eventually led to the creation of the reserve system by the federal government, which relocated the different First Nations to new lands and restricted their movement and settlement. There are 140 reserves in Alberta, scattered from the northern to southern borders.[6] The

Métis in Alberta were also provided with eight settlements or land bases, unlike in other provinces. First Nations' reserves range in population size, from zero to eight thousand, the former indicating that everyone has left that community and the latter—the population of the Blood Tribe, located in Southern Alberta—being one of the largest First Nations in Canada.[7] In addition, Aboriginal peoples from other provinces and the United States migrate to Alberta looking for educational and employment opportunities.[8]

There is a great deal of cultural diversity among Alberta's First Nations. Three language families have been identified (Algonquin, Athabaskan, Siouan), and within these three there are twelve differentiations.[9] Chief John Snow (1933–2006) of the Stoney Nation wrote of this cultural diversity with pride, stating:

> The word Sioux conjures up the whole of the rich history and culture of the Plains—Sitting Bull, the Custer Battle, great buffalo hunts, magnificent eagle-plume headdresses, and beautiful quill-decorated buckskin clothing. This is the heritage we share with the Dakota and the Assiniboine and the Oglala through our language-family connections. Our other neighbours were the Algonkian-speaking people—the Ojibway, the Cree, and the Blackfoot—with whom blood feuds were a continual fact. Nearby, too, were smaller groups, such as the Athapasascan-speaking Sarcee. To the west our contacts were with the people of the mountains, the Kootney, the Shuswap, and occasionally the Flathead; our relations with these were somewhat more cordial, but not always peaceful.[10]

First Nations' experiences with colonization and attempts at assimilation have also varied based on location and other aspects of geography.[11] Some have been impacted by oil and gas development, while others have had both opportunities and challenges posed by external economic development. At Morley, natural gas wells have been dug and the royalty payments have allowed capital expenditures on the reserve, especially on housing and administrative buildings.[12] Yet there is still much development to be done in order to counterbalance the legacy of colonialism on the plains.

The history of residential schools in Canada affected all Aboriginal communities. Alberta had twenty-five recognized residential schools, the highest number of any province in the country. These schools initially began in the 1870s, with the last school closing in 1996.[13] Residential schools were a combined assimilation project implemented by Christian churches in Canada and enforced by the federal government. Government officials, especially Indian agents who lived and worked on reserves, endeavoured to ensure that all Aboriginal children were placed within an institution and given a rigid education in Western beliefs, culture, and religion. Children were often forcibly removed from their homes and taken far away to schools, as colonial opinion held that the Aboriginal family posed a dangerous influence over the child's development. The separation from family, culture, and identity left deep scars on these students, many of whom were also subject to emotional, physical, or sexual abuse within the system. This legacy is still felt in Aboriginal communities, which have higher rates of addiction, violence, and disease than other populations in Canada.[14] In Alberta, it is still true that a disproportionate number—at least 64 per cent—of children in the child welfare systems are Aboriginal.[15]

Today, the health of the First Nation communities in Alberta is of great concern to both Alberta Health Services (AHS) and to researchers in the University of Calgary's Cumming School of Medicine. Physicians, professors, and health-care workers are involved in many initiatives to identify health-care problems within these communities and to provide engaged, culturally informed, and safe health-care services. The creation and expansion of the Group for Research with Aboriginal People on Health (GRAPH) through the O'Brien Institute for Public Health, along with extensive faculty involvement in Aboriginal health research, demonstrate the determined contribution of members of the Cumming School to the betterment of Aboriginal health. Yet a more sustained focus on Aboriginal health has only picked up since 2009 within the school. The current initiatives resulted from the efforts of many individuals who pushed to bring Aboriginal health and First Nations people into the mandate of the faculty. This has been a long—and often frustrating—process for those involved.[16] It began in the 1970s with the building of the Stoney Health Clinic at Morley, and has culminated in the creation of the Aboriginal Health Program, the GRAPH research group, and many individual

research projects and clinic outreach programs initiated by Cumming School physicians and scholars.

## The Development of the University of Calgary Faculty of Medicine

The Faculty of Medicine at the University of Calgary was a late addition to the Canadian medical community. Other faculties were established much earlier in the West, with the University of Manitoba opening a medical college as early as 1883[17] and the University of Alberta founding its own medical faculty in 1913.[18] Alberta has been a major player in Canadian medicine since the 1920s. The province distinguished itself in public health through the building of new hospitals and mental-health facilities, the introduction of new clinics and sanatoria focused on the treatment of tuberculosis and polio, as well as a dramatic increase in resident physicians between 1900 and 1950.[19] The University of Alberta implemented its own MD training program as early as 1908, and in 1922 it became the first faculty of medicine in Canada to control its own hospital.[20] In contrast, the University of Calgary's medical faculty was not founded until 1967. The original intent of the faculty was to serve as a training program for family physicians rather than as a faculty with major biomedical research agendas and institutes. These physicians would help fill the shortage of family doctors throughout Alberta, especially in rural areas. Despite this fact, the faculty grew significantly into a leading research faculty.[21]

Dr. Bill Cochrane played a large role in the initial founding of the faculty. In 1966, he was invited by the university to visit Calgary and possibly take on the deanship of the new medical school. Yet as he described it when he arrived, "there was no school, no students, no program, and no faculty."[22] He nonetheless took on the challenge of starting the school and the faculty admitted its first class of students in 1970. The original program was only three years long (compared to the North American standard of four years) and it primarily focused on community health sciences and family medicine. In 1975 a new Health Sciences Centre was constructed adjacent to the Foothills Hospital and the Faculty of Medicine was moved away from the main campus to this new location.[23] The new location led to an improved integration of teaching and learning within

the program and enabled the development of a larger research community within the Faculty. Resident physicians developed expertise in psychiatry, rheumatology, and postpartum care.[24]

## Early Involvement in Aboriginal Health at Morley

The faculty undertook its earliest ventures into Aboriginal health research from the beginning of its clinical and educational programs. Even before the medicine program accepted its first class of students, the Faculty of Medicine was working closely with the Stoney people at Morley to improve on-reserve access to medical care.[25] Dr. Cochrane collaborated with both the Stoney Tribal Council and the Medical Services Branch of the Department of National Health and Welfare (MSB) to plan the building of a clinic on the Morley reserve.[26] The conceptual design for the clinic was partly based upon a research report undertaken by three university physicians and three medical students in 1970. The report was compiled through direct investigations of individuals on the Morley reserve. The researchers conducted interviews with Aboriginal residents, faculty members who had experience working on the reserve, nurses who worked with the Native population, representatives of the MSB, and even teachers who worked in the day school.[27] This research was undertaken to help the Faculty of Medicine, the Stoney Tribal Council, and the MSB alike to gain insight into the types of medical services most required in the community and the best way to provide a culturally engaged and community focused clinic. The medical situation at the time was dire and access to health care by reserve residents was minimal. There were only two traditional medicine men on the reserve that could be consulted. Otherwise, one Calgary general practitioner held two "office hours" at the nearby nursing station once a week. For emergency care, residents were required to go off reserve to an urban hospital. Many residents reported avoiding this, as they disliked "the impersonal, frightening and dehumanizing atmosphere" of large hospitals—especially of the Foothills Hospital, where they felt "strange, lost and almost unwelcome."[28] This feeling prevented individuals from receiving timely care, which in time led to further complications.

The study found that the medical needs of the community at Morley were largely influenced by the population's unique characteristics. The "Plains Peoples"—referring to the Blackfoot, Stoney, Blood, Sarcee

and Peigan tribes—had seen a significant population increase during the twentieth century, such that by 1970 they comprised 40 per cent of Canada's Aboriginal population.[29] Unfortunately federal neglect of health-care programs on reserves, and the devastating impact of the Indian residential school system led to significantly shorter lifespans among these people.[30] The negative health impact still continues today: while the life expectancy of the average Canadian female is about 82 years, for First Nations females it is about 75 years. Similarly, the life expectancy in other Canadian males is about 77 years, while among First Nations males it is at 70 years.[31]

At Morley, the researchers found a mixture of "a high birth rate; high infant mortality rates; extremely high fertility rates; a concentration [of population] on reserves with only a small exodus to the urban centres."[32] These factors combined to make Morley an extremely young population, with 59 per cent of the residents under the age of nineteen.[33] Unsurprisingly, researchers—identified as medical students David MacLean, Michael Davidson, and Warren Davidson, along with Drs. Donald Erik Larsen (1933–2017), Edgar ("Ed") J. Love (1931–2013) from the Department of Community Health Sciences, and external research associate Irving J. Rootman—found that the health care priorities reported by the individuals interviewed reflected this age distribution. Residents at Morley requested a focus on maternity care, with prenatal care integrated into on-reserve health services. A focus on family planning programs was also requested. Daycare services were deemed essential to enable single and ill parents, working mothers, and neglected children options for alternative child care. The need for better transportation was highlighted many times, so that trauma patients could receive timely treatment. Lastly, the people at Morley wanted a clinic with a large, welcoming, and comfortable waiting room. The researchers recognized that this aspect of a clinic "may be one of *the* most important in meeting their needs."[34]

The report was well received, and the planning of the clinic was soon underway. The Tribal Council nominated a health council through the appointment of five Stoney members. The first health council was made up of Wallace Snow, Richard Amos, Tina Fox, Georgina Wilfred, and Wilfred Mark as chairman.[35] It was agreed that two physicians from the university would be present at all of the council's meetings, though they held no voting power on matters under discussion. In this way, the Health Council was able to exercise a significant amount of control over the clinic's development

Figure 2. Wilfred Mark accepting the keys from Dr. Otto Rath, marking the opening of the Stoney Health Centre, June 1972. Courtesy of the University of Calgary Archives, 84.005_13.05.

and early administration. The Faculty of Medicine was responsible for providing two physicians to staff the clinic—both family practitioners—while the minister of hospitals and medical care (hereafter referred to as "the minister") remunerated the university for the presence of the physicians in the clinic. The agreement stated that a physician would be present in the clinic for five half-day sessions of four hours each week.[36] Additionally, the clinic was to have a strong educational component, with a focus on community outreach programs. The Stoney Health Centre successfully opened on 6 June 1972. Its founding was highly celebrated as a success of the Stoney people and the University of Calgary Faculty of Medicine (see figure 2).

The partnership between the Stoney Nakoda and the Faculty of Medicine ran smoothly for the first few years. Indeed, the clinic itself was very successful: almost four thousand visits were made to the centre in 1973 alone.[37] Unfortunately, problems began to arise in the late 1970s. The health council expressed worry over how Stoney people were treated at the Foothills Hospital when they visited for referred medical services. There was also frustration with certain members of the staff at the Stoney Health Centre and a concern that there was not "a single doctor" that the Stoney people could identify with.[38] When the centre was first established, community opinion highlighted the desire for physicians that would actively engage with the community. In 1973, an evaluation report was put together by Dr. Joan Ryan, a researcher with the Department of Community Health Sciences. Stoney people who were interviewed for the report stated that "in order to become familiar with Stoney people, and therefore to treat them effectively, the doctors should become more involved with the people in the community and attend community events."[39] This requirement was felt to be unfulfilled, and this caused continued friction between the physicians and the Morley community.

The physicians employed by the university were also dissatisfied with the relationship.[40] There was a continued concern over the safety of caregivers while at the centre, since they often encountered verbal abuse and even physical assaults while on shift. The director of the Stoney Health Centre, Dr. John A. Cunningham (1925–2019), highlighted this concern in 1977 when he wrote to Dr. William M. Gibson (b. 1930), the head of the Division of Family Medicine at the university. Cunningham emphasised recent troubles he had encountered while treating patients.[41] In his letter responding to Dr. Cunningham, Dr. Gibson outlined the similar experiences reported by other staff at the centre:

> We have had threats of violence, indeed on one or two occasions violence directed at doctors or nurses working there, many instances when insulting remarks were made to our medical staff, some documented, others merely commented on, and altogether it has been an unsatisfactory state of affairs.[42]

In February of 1978 a special meeting was held to discuss these problems and the Tribal Council decided to "terminate its agreement with the University

due to their dissatisfaction with services being offered by university personnel at the Health Centre."[43] The university officials who were present at the meeting, medical educator Dr. Lawrence A. Fischer and pathologist Dr. Kenneth A. Buchan managed to talk the health council out of the termination, but the result was a renegotiation of the terms surrounding the partnership. The director of the health centre, Dr. Cunningham, was to be removed from his position that year and the university agreed to approach new, council-chosen physicians to be involved in the clinic. Previously, the university had often sent different physicians to work at the centre based on availability, and both the patients and the health council disliked the fact that this setup resulted in a lack of continuity in care. The new conditions were written up and a new agreement was signed between the Stoney Tribal Council, the minister, and the Faculty of Medicine that year.[44]

Although the dispute of 1978 was solved, problems persisted within the partnership. Later in the year, reports of physical and verbal assaults on the physicians at the centre led the faculty to stop scheduling overnight shifts for safety reasons.[45] Other problems were noted with staff neglecting their duties at the centre, especially in the case of reserve on-call ambulatory drivers.[46] The tensions reached their peak in 1984 when one of the university physicians was abruptly fired by the Stoney Council. This led to the subsequent resignation of the other two physicians who worked at Morley, and ultimately ended the U of C Faculty of Medicine's involvement with the Stoney Health Centre.[47]

## Aboriginal Health at the University of Calgary and in Canada, 1985 to 1995

In 1980, the provincial government provided the U of C Faculty of Medicine with new opportunities for growth by founding the Alberta Heritage Foundation for Medical Research (AHFMR). Financial contributions from the AHFMR allowed the faculty to begin recruiting physicians and health-care workers at an accelerated rate. In the 1980s, the faculty recruited more than one hundred new biomedical and health-care researchers.[48] The previous focus on family care and clinical practice was eclipsed by a new focus on innovative biomedical and health-care research. Yet the initial patient-focused character of the faculty still exerted a profound

impact on the development of the growing school. Indeed, these initial traditions led to a focus on what would come to be termed "translational medicine."[49] Faculty researchers proposed projects that utilized the faculty's ideal location—adjacent to the Foothills Hospital—to find ways of translating new advances in laboratory research into improvements in patient care and treatment. The sudden expansion of the faculty from its new hiring program provided the impetus to build a new building on site dedicated solely to research. Financial contributions from the AHFMR allowed for the construction of the Heritage Medical Research Building (HRMB) in November of 1987, and these enabled many basic research programs to flourish (e. g., in cardiovascular, inflammatory, and neuroscientific research).[50]

Although this was a time of research growth and development for the faculty, Aboriginal health was not included within this new emphasis on research. The faculty took a step back from Aboriginal relations after the university ended its involvement at Morley. This retreat was seen in the lack of Aboriginal presence within either the faculty or the student body for the next two decades. Aboriginal students nonetheless continued to enroll in the university at large during the 1980s and early 1990s, often coming from far away reserves and knowing few members of the university community.[51] On the main campus, a student lounge called the "Red Lodge" was created by the Aboriginal students to decrease this isolation. The lounge was meant to provide Aboriginal students with a space of their own where they could celebrate their culture and socialize away from the atmosphere of the university (see figure 3).[52]

Yet the Aboriginal presence on campus did not spread to the Faculty of Medicine.[53] There were no special considerations in place for the admission of Aboriginal students to the medical undergraduate program, and the number of Aboriginal applicants to that program remained limited. The Faculty of Medicine's only real involvement with Aboriginal students was through infrequent visits from high school classes on reserve, who were sometimes brought in to tour the laboratories on the medical campus in hopes of increasing future recruitment.[54]

The faculty instead directed its attention to other research areas and would not turn back to Aboriginal health for at least a decade. This was possibly due to the inaccessibility of Aboriginal populations for researchers, as the faculty no longer had ties to local communities. More likely,


FIGURE 3. Image of students in the Native student lounge, December 1972. Courtesy of the University of Calgary Archives, 84.005_14.43.

however, it is a result of the widespread neglect in Aboriginal health research that was present across Canada at this time.[55] In 1986, Canada hosted an international conference on health promotion, which launched the Ottawa Charter for Health Promotion. The charter described the conference as "a response to growing expectations for a new public health movement around the world."[56] Health inequities—what came to be known as the social determinants of health status[57]—were found to be a neglected field. This new movement, along with the efforts of individuals in the field of health promotion, created a renewed interest in inequities in the field of public health. Part of this interest was focused on the inequality in health status and living conditions experienced by Aboriginal people in Canada. Aboriginal populations were extremely underrepresented within medical research initiatives.[58] Interest in Aboriginal health topics did not pick up again until the 1990s, once medical programs were well established among reserve populations and community health promotion was a common theme in public health departments across the country.

The renewed interest in Aboriginal health during the late 1990s was expressed in the creation of the Institute of Aboriginal Peoples' Health (IAPH) within the Canadian Institutes of Health Research (CIHR). The previous Medical Research Council of Canada had lacked such an explicit

focus on Aboriginal health.[59] To counteract this, the idea for an institute dedicated solely to Aboriginal health was generated in 1999, in the midst of discussions about the structure of the CIHR. During a workshop in Winnipeg, physicians Malcolm King, Jeff Reading, and John O'Neil debated the best ways to address Aboriginal health research. Drs. King and Reading were both of Aboriginal descent, and these deliberations led to significant changes in the structure of the CIHR.

It was concluded that rather than having Aboriginal health "embedded in an overarching theme," an institute of its own would be of the most benefit to the area of Aboriginal health in Canada.[60] In fact, when the CIHR was created the IAPH was one of the thirteen institutes created to manage all national health research funding. Dr. Jeff Reading became the inaugural scientific director, steering the focus of the IAPH toward increased capacity. It was noted that both research and researchers in the area of Aboriginal health were extremely limited.[61] Nonetheless the interest in expanding the field was present and the IAPH dedicated itself to "building capacity, both amongst researchers and within Aboriginal communities to participate in research."[62] Looking back on the impressive impact the IAPH has made on expanding the field, Dr. Malcolm King, the institute's second scientific director, commented:

> I felt comforted after this beginning that there was so much good will for the idea of an institute dedicated to research on Aboriginal health. It put our newly created discipline on equal footing, at least formally, with the heavyweights such as Neurosciences, Mental Health and Addictions.[63]

Expansion in the field of Aboriginal health was equally reflected among researchers within the University of Calgary. One major researcher in the area of clinical neuroscience was Dr. "Mo" Watanabe, dean of the Faculty of Medicine from 1982 to 1992. After his term as dean, he stayed on as a professor in the medical faculty and undertook research with First Nation's communities in the late 1990s. He became involved with information technology research among Aboriginal participants and pursued research on how the participatory-action format enabled medical researchers to connect with First Nations communities. Obtaining consent for the research was a difficult process and the project itself needed to be

undertaken with careful attention to its impact within the population. Dr. Watanabe outlines his feelings this type of research later on:

> I'm not sure how many people are aware with the depth of concern felt by Aboriginal communities when outside researchers come into their communities. They have to be involved and you must have approval. You must leave a benefit to the community.[64]

The benefit of his research was that it opened the door for other researchers to step into the field and undertake studies within First Nations communities. As dean, Dr. Watanabe led by example and legitimated working with Aboriginal communities as a career goal for Faculty of Medicine clinical and research members. Other faculty involvement with First Nations communities in the 1980s and '90s was, however, limited to individuals who worked in on-reserve clinics, but did so outside of their association with the U of C Faculty of Medicine. They chose to become involved in Aboriginal practice and research on a personal level, and the faculty at this time demonstrated no real interest in encouraging or building upon their activities. This apathy remained in the faculty for many years, even as individual researchers and instructors tried to advocate for official faculty engagement with Aboriginal health.[65]

## The Faculty's Slow Return to Aboriginal Health

In 1995, an accreditation survey pointed out the need for a greater focus on gender and equity within the Faculty of Medicine. The Office of Gender and Equity Issues was soon created in response. This new office established the Gender and Equity Issues Committee with the goal of promoting "equal participation in employment and education for women; Aboriginal peoples; persons with disabilities; and visible minorities."[66] The committee undertook many ventures between 1996 and 1999 aimed at achieving this mandate. It was most successful in the areas of gender and disability equity. The committee hosted many gender symposia and initiated the Positive Space Campaign on the Foothills campus.[67] It brought women's health into the undergraduate curriculum and proposed child-care programs on the faculty's campus to enable students with children greater

opportunities within the school. Through its outreach activities, the committee also created ties with important organizations such as Women in Science and Engineering and the Alberta/NWT Network of Immigrant Women.[68] The committee was also quite successful at implemented changes across the medical campus to improve accessibility within the building, thereby creating an equitable space for individuals with disabilities.

Yet this progress was not reflected in greater Aboriginal equity. The committee focused primarily on gender issues and had little success in implementing changes on campus for Aboriginal students, primarily due to a lack of interest in allocating resources to this area.[69] In 1997, a working group was created within the committee to look at strategies for increasing Aboriginal student recruitment. Titled the Working Group on Recruiting First Nations Students to the Faculty, its mandate was "to review the success of past efforts and to recommend additional initiatives."[70]

The group was run by Dr. Gordon Fick, a professor in community health sciences with a specialization in biostatistics. It worked closely with the Native Centre on main campus and with the Nechi Institute in Edmonton. Unfortunately, Dr. Fick reported problems with initially finding members to even participate on the committee and the working group's progress was slow. He commented many times that "it has been most difficult to get any action moving on this project."[71] After reviewing the number of issues involved with Aboriginal student admissions, Dr. Fick proposed a joint initiative of the faculties in the Health and Education Cluster—clusters were created at the university during this period[72]—aimed at creating outreach programs within high schools. This initiative would present Aboriginal high school students with information about how to apply to the Faculty of Medicine so as to generate interest in future careers within medicine. Sadly, the proposal never went far, as resources were required and funding was not forthcoming.[73]

The working group also found that faculty-defined research strategies lacked any real interest in Aboriginal health. It was only involved in a few minor activities on reserves, including a "Summer Science Project with Tribal 7."[74] Aside from small projects, there arose some debate within the faculty over whether two spots in the undergraduate program should be reserved for Aboriginal students. Unfortunately, nothing seemed to come of this debate either and no changes were made to the faculty's official policy. This issue was highlighted in the working group's final report. One

of the key recommendations was for the U of C Faculty of Medicine to develop an official Aboriginal recruitment policy to enable an equitable application process.[75] The lack of such a policy throughout the 1990s, and even into the early 2000s, demonstrates little concern within the faculty for Aboriginal admissions during this period.

A subsequent accreditation survey in 2000 once again highlighted the absence of concern with Aboriginal admissions or recruitment. Although the university calendar claimed that "the University of Calgary is committed to providing equitable access and participation of Aboriginal people in all its Faculties, programs and services," the lack of any official policy was a glaring omission in this effort to foster equity.[76] After a review of the U of C Faculty of Medicine's policies and philosophy, the Committee on Accreditation of Canadian Medical Schools (CACMS) requested that the faculty develop "an institutional policy regarding the diversity of the student body."[77] A similar request was made in the same year by the Liaison Committee on Medical Education (LCME), which in a report to the Faculty of Medicine they requested that an "institutional policy regarding gender, racial, cultural and economic diversity of the student body" be implemented.[78] Although these recommendations were made, the medical faculty's admissions policies remained unchanged and these requests by the CACMS and LCME were disregarded. The issue would be put aside until the next accreditation period.

This is not to state that the Faculty of Medicine completely ignored the issue of Aboriginal health and equity. In December 2004, the faculty created the Aboriginal Health Task Force. This task force was led by Dr. Lindsay Crowshoe, an Aboriginal physician and member of the Treaty 7 Piikani Nation recently hired into the faculty. The goal of the task force was to "provide recommendations to the deans of medicine that address the health needs of Aboriginal people."[79] Other participants in the study included a number of individuals of Aboriginal backgrounds and a selection of faculty members and students from the Faculty of Medicine. The task force recognized that individual access to higher education and professional training is directly correlated with the health of a community. Therefore, it focused on outlining how the faculty could develop strategies and allocate resources to increase the number of Aboriginal medical graduates. In addition, the group sought to "enhance the cultural competence of non-Aboriginal and Aboriginal medical graduates," in order to enable

physicians and researchers to address the health needs of Aboriginal communities.[80]

Under Dr. Crowshoe's guidance, the task force was well organized and highly productive. It held regular teleconferences and worked hard to meet in person. This commitment allowed for the timely completion of a May 2005 report, within five months of the task force's creation. The report proposed that Aboriginal health concerns would be best met with the creation of an Aboriginal Careers in Medicine Program. The program would regulate and oversee the admissions of Aboriginal students through the creation of five over-quota seats for Aboriginal applicants. Because they were over-quota, the spots available for Aboriginal students would not detract from the total spots available for other applicants for the Undergraduate Medical Education (UME) program, and would be separately funded by the Aboriginal Careers Program. These seats would be competitive and require a second interview with an Aboriginal interview panel and an essay demonstrating the applicant's connection to the Aboriginal community.[81] The program would have full-time professional and support staff, an Aboriginal admissions committee, and would be in charge of supporting the students admitted to the positions throughout their course. The report outlined a detailed budget for the proposed office, totalling $613,000 a year.[82]

The Admissions Committee officially approved the proposal in December of 2005 for the following year.[83] With these promising steps, it seemed as though the Faculty of Medicine was finally willing to recommit itself to the area of Aboriginal health and recruitment. It was therefore a great disappointment the next year when the funds promised to the task force for the Aboriginal Careers Program were not forthcoming and the assured over-quota positions were not made available for the 2006–07 academic year.[84] The following year saw a similar disappointment as the faculty continued to neglect its promised funding and commitment to over-quota positions. The envisaged steps toward a commitment to Aboriginal health were therefore abandoned, and the idea for the Aboriginal Careers in Medicine Program fell to the wayside by the end of 2006.[85]

In its place came the Aboriginal Health Program. The creation of the Aboriginal Health Program (AHP) was another important milestone in the U of C Faculty of Medicine. Once again led by Dr. Lindsay Crowshoe, the program was developed out of the Building Aboriginal Health

Teaching and Learning Capacity project, which had begun in 2004. The AHP began as an initiative "to improve Aboriginal health outcomes by building capacity and cultural competence among medical providers and, ultimately, to bridge the voices of Aboriginal patients and physicians through dialogue, mutual respect, and a shared understanding of health practices, needs and concern."[86] The AHP officially opened its office on the Foothills Campus in 2008. The program's goals have been three-fold: 1) to recruit excellent Aboriginal students into the faculty and provide support; 2) to educate non-Aboriginal students and practitioners to be culturally competent; and 3) to encourage research in the area of Aboriginal health.[87] The program has since reached out to local junior high and high schools, both on and off reserves, to encourage young Aboriginal students to "recognize medicine as a potential career."[88] The program's recruitment activities are now quite diverse, involving such things as presentations given at schools and conferences, hands-on demonstrations, school visits to the university campus, medical simulation programs, and a medical student mentorship program. These activities are all free of charge and supported through the funding of the program itself, to address Aboriginal issues within the Calgary UME program.[89] This is an important faculty initiative as it works to bring new Aboriginal students into the medical community and encourages Aboriginal youth to strive for higher education. The creation of the AHP marked a turning point for the school, as it was finally committing to initiatives in Aboriginal health.

Yet one item that was still absent from the Faculty of Medicine was an official Aboriginal recruitment policy. In the LCME's 2007 mock accreditation survey, the reviewers expressed surprise that no official policy had yet been implemented, despite numerous recommendations to that end. It was noted that

> the reviewers were concerned that we have been addressing the student diversity standard and Aboriginal issue for the past 8 years but have not clearly articulated our goals, objectives and plans for obtaining them with regards to increasing Aboriginal students in our student population and supporting them while they are here.[90]

The LCME concluded in an interim report that "the Faculty had progressed towards but had not achieved full compliance with the expectation that there be institutional policies and plans for the recruitment and retention of applicants of Aboriginal heritage."[91] The mock survey pointed out that the lack of an official recruitment policy was preventing the faculty from reaching its long-professed goal of diversity on campus.

In response to this criticism, the Faculty Admissions Committee put together a planning subcommittee to outline important guidelines for a potential recruitment policy. The subcommittee studied the policies of other faculties of medicine at different Western Canadian universities and found that, on average, other faculties had five reserved spots for Aboriginal students.[92] No such policy was present in Calgary, but research into the number of Aboriginal students admitted to the faculty each year found that the admission of Aboriginal students often accounted for around 1.7 per cent of the student population, or four to five Aboriginal students a year.[93] However, the Calgary faculty was against the idea of "minimum quotas" and instead sought "to attract and accept appropriate numbers of Aboriginal medical students each year" through a non-quota strategy.[94] To this end, the planning subcommittee created a report in 2007 recommending that a recruitment policy be guided by the following four principles:

a. Ensure that all students meet the necessary cognitive and non-cognitive attributes required to succeed in the Faculty of Medicine and in medical practice.

b. Not segregate the selection of Aboriginal students from other students to such an extent as to create an exclusive group of students.

c. Recognize the challenges of Aboriginal students while remaining fair to all applicants.

d. Allow for the recruitment of sufficient numbers of Aboriginal students to address the under representation of Aboriginal people in the University and in the profession of medicine.[95]

After taking these guidelines into consideration, the Faculty of Medicine released its long-awaited policy on Aboriginal recruitment in 2008.[96]

The faculty did not stop at merely formulating such a recruitment policy. It went on to commit funding to support the creation of a new position dedicated to facilitating the recruitment of Aboriginal students. This position was titled Aboriginal program officer and was fully funded by the end of 2008.[97] The officer was in charge of establishing links with local Aboriginal and Métis communities and organizations to promote the program and recruit applicants. They also provided ongoing program support and acted as a guidance officer to Aboriginal students within the faculty. With the creation of this position, the faculty declared its intention to "promote appropriate class diversity and . . . achieve the Faculty's goals on an appropriate number of excellent students of Aboriginal heritage each year."[98] After a prolonged delay, the faculty had finally taken meaningful steps towards an official policy promoting Aboriginal health and education. It would continue down this path the following year (2009) as well, with the creation of the Calgary Institute for Population and Public Health.[99]

## Aboriginal Health Care and the Program Activities in the Institute for Public Health at the University of Calgary

The Calgary Institute for Public Health was officially formed in April of 2009 as a partnership between the University of Calgary Faculty of Medicine and the AHS, yet the relocation and further staffing had to await the refurbishing of the basement area and first floor of the Teaching, Research and Wellness (TRW) Building on the Foothills campus the next year.[100] The perceived need for such an institute was based on the fact that while the Faculty of Medicine had organized its research into formalized institutes, the community and public health portfolio was not well represented in this structure. Originally named the Calgary Institute for Population and Public Health, the new name—the Institute for Public Health (IPH)—was adopted in 2011 and, after receiving a sizable donation from the Calgary-based O'Brien family, it was renamed the O'Brien Institute for Public Health in 2014. The institute began to operate in 2010.[101] Its 2009 strategic plan outlined the institute's priorities as follows:

> Importantly, the Institute will aim to improve health care delivery and population health through a shared research agenda and knowledge exchange between providers, AHS-CZ [Calgary Zone] researchers, and academic researchers, to promote the implementation of new approaches resulting from joint research and knowledge transfer and exchange. The research itself will have a positive impact on the health and well-being of the people of Calgary, Alberta, and Canada and may also have a global or international scope, depending on the nature of the research conducted under the auspices of the Institute and its membership.[102]

The creation of this seventh institute for research—which soon attracted membership from a number of other university faculties as well as AHS—gave a new prominence to health services and public health research. A review by an international scientific advisory group in October 2013 recognized the institute's rapid ascension within the province, and emphasized in particular the leadership of the scientific director and assistant director:

> The Institute for Public Health has demonstrated commendable accomplishments in the academic realm since its creation, has attracted a cadre of talented and enthusiastic researchers and has clearly benefited from exceptional scientific leadership from Bill Ghali and more recently Lynn McIntyre. The Institute has earned considerable respect from both researchers and knowledge users in the health system in Alberta. It is clearly a major asset to the University of Calgary and to the Province and is poised to make much greater contributions.[103]

In June 2011, the IPH formed research groups to advance its mission. One of the seven groups that applied and was accepted was the GRAPH research group. GRAPH's mandate was to encourage research that aided Aboriginal communities in achieving well-being. GRAPH, in alignment with the CIHR, embraced research in any of the four pillars commonly identified by the CIHR (biomedical, clinical, health systems and services, and population health). Research that incorporated interdisciplinary perspectives, collaborated with Aboriginal communities, respected cultural

safety, and resulted in advocacy for health equity was to receive particular emphasis.[104]

The founding lead for the GRAPH research group was Dr. Wilfreda E. Thurston, a population health researcher in the Department of Community Health Sciences, jointly appointed to Ecosystem and Public Health in the Faculty of Veterinary Medicine. She was greatly assisted by Dr. David Turner, who at the time was the Aboriginal research coordinator in her program of research. Dr. Turner has been affiliated with the Saulteaux Nation of Saskatchewan and has since transferred in to the aboriginal health portfolio of the AHS. Dr. Thurston was a co-investigator on the Alberta Networked Environments for Aboriginal Health (NEAHR) grant. The principle investigators were Dr. Cora Voyageur, a member of the Athabasca Chipewyan First Nation and Dr. Lindsay Crowshoe. Dr. Voyageur was in the Department of Sociology and Dr. Crowshoe in the Department of Family Medicine. Dr. Turner was a staff person for NEAHR, building relationships between non-academic community members and academics. He also assisted in organizing the first workshop to be run at the university on Aboriginal research for the Faculties of Medicine and Veterinary Medicine, entitled Conducting Research *With* (Not On) Aboriginal Peoples, held on 3 December 2010 at Blackfoot Crossing in Siksika.[105] The workshop was jointly sponsored by the Department of Ecosystems and Public Health in the Faculty of Veterinary Medicine; the Department of Community Health Sciences in the Faculty of Medicine;[106] the Calgary Institute for Population and Public Health;[107] and NEAHR. Drs. Thurston and Turner also recruited Ms. Sharon Goulet, a Métis woman working in the Aboriginal portfolio of the City of Calgary Family and Community Support Services, to the GRAPH Executive Committee.[108]

The founders of GRAPH developed a Community Advisory Committee in 2012 to ensure that Aboriginal health research at the University of Calgary was informed by community stakeholders. This committee included representation from the Alberta First Nations Information Governance Centre (AFNIGC), the City of Calgary, corporations with Aboriginal-relations leaders, and non-governmental organizations. The research group received $2,000 each year from the IPH between 2012 and 2014.[109] GRAPH used this funding to sponsor external speakers, support an annual research forum (the first was held on 20 September 2013), and increase local and national exposure. GRAPH was responsible for arranging

speakers for two seminars in the academic year for the weekly joint IPH and Department of Community Health Sciences rounds.[110] Terms of reference for GRAPH and the Community Advisory Committee were developed and fundraising began through the Cumming School of Medicine Fund Development Office. These efforts originally focused on the creation of a research chair in Aboriginal health research.[111]

At the beginning of the second year, Dr. Cheryl Barnabe, a Métis rheumatologist and health researcher in the Departments of Medicine and Community Health Sciences, agreed to take on the leadership role. Dr. Barnabe is a clinician researcher who received the Canadian Rheumatology Association Young Investigator Award for 2014 in recognition of her significant contributions in epidemiology and health services research in rheumatic diseases, particularly in addressing disparities in access to care for the Aboriginal population. Under her leadership, a strategic work plan was developed for the 2014–17 period, an information brochure produced, a monthly research seminar organized, and regular meetings of the executive held.[112]

In the meantime, Wilfreda E. Thurston and David Turner continued to work with the medical school's Fund Development Office. The focus for fundraising shifted from a chair in Aboriginal research to support of GRAPH research infrastructure and a chair or professorship in Aboriginal wellness. Linkages were also made with the emerging Cumming School of Medicine pipeline program, developed for the bachelor of health sciences (BHSc) in which

> Students within the program would complete their undergraduate BHSc program at the U of C, while also benefitting from a supportive educational program to supplement their education and to maximize their chances of success. Applicants will be guaranteed admission to the MD program following successful completion of the undergraduate degree, assuming that pre-defined criteria are met. The goal of the program will be to ensure that sufficient supports are put in place to maximize the chances of success.[113]

As of January 2015, ongoing fundraising efforts were increased with the agreement of Charles Weaselhead, the grand chief of Treaty 7 Management

Corporation and chief of the Blood Tribe, who, along with Andrea McLandress from the Tervita Corporation, agreed to act as an advisor. Health is one of five core areas identified by the Treaty 7 Management Corporation, and a health secretariat provides advice to the health directorates in each Treaty 7 community. Chief Weaselhead was also a member of the board of the First Nations Information Governance Centre and its Alberta arm, the AFNIGC. Ms. McLandress, a Métis woman born in Manitoba, was an Aboriginal liaison working with communities around Alberta, where Tervita was partnering with oil and gas companies.

## Towards a Mutual Understanding of Research-Ethics Concerns Regarding Health-Care Research with Aboriginal People

One of the outcomes of GRAPH was the linkage of the AFNIGC with the Conjoint Health Research Ethics Board in 2013. The AFNIGC is governed by a board and is responsible for administration of the First Nations Regional Longitudinal Health Survey and the First Nations Education, Employment and Early Childhood Education Survey in Alberta. It is part of the national First Nations Information Governance Centre (FNIGC). The members of the AFNIGC board are the elected chiefs of Alberta in territories covered by Treaties 6, 7, and 8; thus, the AFNIGC is accountable to the chiefs.[114]

The FNIGC trademarked OCAP™ (Ownership, Control, Access and Possession)[115] as its guiding principles for research with Aboriginal peoples and the protection of data, traditional knowledge,[116] and all information collected from First Nations by researchers. The AFNIGC educates First Nations community members and leadership about OCAP™. University researchers are also required to uphold principles covered in the Canadian Tri-Council Policy Statement on research Involving the First Nations, Inuit, and Métis Peoples of Canada, which are consistent with OCAP™. Both OCAP™ and the Tri-Council policy represent growing recognition in the broad Canadian context that research done in the past with Aboriginal peoples was not always respectful, helpful, or even shared with them at any time. In some cases, past research was actually harmful.[117]

In continued collaboration with stakeholders, including Treaty 7 Management Corporation, the AFNIGC, and Aboriginal Friendship Centres, GRAPH have set out to promote training and research in the social determinants of health for Aboriginal people while recognizing diversity between populations and groups, and to advocate for the expansion of the cadre of informed and culturally competent scholars. In 2014, for example, GRAPH was developing a proposal for a summer school on Indigenous research methods for community members as well as academic researchers.[118] GRAPH has also proposed to seek solutions to institutional barriers that impede Aboriginal research. Such barriers include granting agencies' lack of recognition of the extra time it takes for researchers to build relationships with Aboriginal communities or to obtain the participation of members in proposal development. GRAPH, through the BHSc pipeline, hopes to identify Aboriginal students who would like to go on to graduate training, thus adding to the number of Aboriginal health researchers in Canada. Through ongoing relationships with the AHS Aboriginal Health Program, GRAPH hopes to build a knowledge-exchange process that will influence health programs and policies provincially. This will include promoting multi-sectorial and multi-level research that helps create culturally appropriate services that address all of the determinants of health.

With a focus on the determinants of health, GRAPH has promoted research that addresses issues not generally considered in the health sector, such as the disproportionate number of Aboriginal children in foster care and among the homeless.[119] Thus, proposals have been developed with the participation of members of the U of C Faculty of Social Work and with colleagues from the University of Alberta and the University of Lethbridge. Homelessness research has been done in partnership with the Calgary Friendship Centre, Calgary Homeless Foundation, Alpha House Society, Awo Taan Healing Lodge, and Elbow River Healing Lodge, and thus has reached into the local communities. Leadership has been provided in proposed development of a national network on Aboriginal homelessness research. As funding becomes available, GRAPH can be expected to provide increased leadership in Southern Alberta and the Campus Alberta Health Outcomes and Public Health initiative.[120]

## Conclusion

When the University of Calgary Faculty of Medicine was founded it had promising connections to Aboriginal communities and was engaged with researching the medical needs of Aboriginals. Dean Bill Cochrane instigated this program in 1970 when he partnered with the Stoney Tribal Council and the Medical Services Branch of the Department of National Health and Welfare to plan the construction of a health clinic on the Morley reserve. Unfortunately, this relationship became tense at the end of the decade, and growing tensions between doctors and patients at the centre led the university to end its relations with the clinic.[121] Thus began a long hiatus for the faculty's official involvement with First Nation's communities, as the faculty focused on expanding elsewhere, particularly into biomedical research and translational medicine. The 1980s and '90s were a time of accelerated growth within the faculty, but this growth did not include an interest in Aboriginal health.

This began to change in the late 1990s, when an accreditation survey indicated the need for an office of gender and equity within the faculty. The resulting Gender and Equity Issues Committee began in 1996, and it worked to bring Aboriginal health back into the faculty's mandate. Although the committee's suggestions for action varied over time, the idea of revisiting Aboriginal issues within the faculty was continuously brought forward. In 2000, another accreditation report again stressed the need for clearly defined policies regarding diversity in the faculty. The formation of the Aboriginal Health Task Force in 2004, and the development of an Aboriginal Health Program in 2007, were the first real breakthroughs in the struggle to make Aboriginal health a priority in the faculty. By 2008, the faculty had developed an official policy regarding Aboriginal student admissions to undergraduate medical education. It also created the position of an Aboriginal recruitment officer, to support recruitment for the Aboriginal program.

From 2009 on, these efforts to increase attention to Aboriginal health issues were aided by a number of factors. These included the creation of, and recruitment of faculty to, the Faculty of Veterinary Medicine, as well as the efforts of Dr. Susan Kutz, who had long-term relationships with Indigenous communities in northern Canada. This increased the profile of research in Aboriginal communities and aided the faculty's refocusing

on Aboriginal health. The University of Calgary 2012 Academic Plan also supported the work of GRAPH, as it called for the creation of a recruitment strategy for Aboriginal students.[122] The creation of the IPH was, however, the greatest opportunity for increasing research with Aboriginal peoples. The institute could make Aboriginal research a priority by supporting GRAPH even though the medical faculty's strategic plan for that period did not. Mr. Turner's ongoing relationship with GRAPH insured that his extensive positive working relationships, both provincially and nationally, could be called upon to support GRAPH. The close relationship between the IPH and the Department of Community Health Sciences provided the strength in population health research and community engaged scholarship that are congruent with growing Aboriginal requirements for meeting local and community needs. The role played by the members of the Department of Community Health Sciences in the promotion of an Aboriginal health agenda may be attributed to individual representatives and their powerful focus on inequities.[123]

The drive for change within the faculty was led by a number of individuals who strove to bring the idea of Aboriginal health to the fore. Physicians associated with the faculty have reached out to First Nations communities on a personal level, dedicating their time and effort to clinical work, patient care, and Aboriginal-focused research projects. Official faculty support for such efforts is a more recent development, seen most prominently in the creation of the AHP. Yet there are still many areas for growth. Further steps toward community engagement would create essential links between the faculty and local First Nations and other Aboriginal communities. The connections with Chief Weaselhead represent an important step toward official faculty engagement, but more work is needed to solidify the position of Aboriginal health research at the university. To do so would enhance the university's access to the networks that were developed across Canada by the CIHR Institute of Aboriginal Peoples' Health, as well as to research funding. More importantly in the long term, further engagement with Aboriginal communities can help contribute to reconciliation and health equity among Indigenous populations.

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121 Dr. John A. Cunningham, director, "Annual Report of the Director of Stoney Health Centre" (1977) University of Calgary Archives – UARC 2000.042 file 11.04.

122 This was the only mention of the term "Aboriginal" in the 2012 Academic Plan and a search of the 2012 Strategic Research Plan for the University of Calgary located no mention of the terms "Aboriginal" or "Indigenous."

123 See for comparison Geneviève Jessiman-Perreault and Lynn McIntyre, "The Household Food Insecurity Gradient and Potential Reductions in Adverse Population Mental Health Outcomes in Canadian Adults," *Social Science and Medicine—Population Health* 31, no. 3 (2017): 464–72.