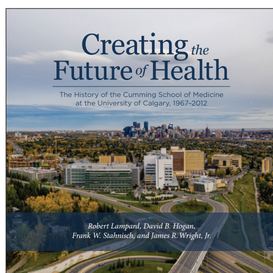

CREATING THE FUTURE OF HEALTH: The History of the Cumming School of Medicine at the University of Calgary, 1967–2012

Robert Lampard, David B. Hogan, Frank W. Stahnisch, and James R. Wright, Jr.

ISBN 978-1-77385-165-5

THIS BOOK IS AN OPEN ACCESS E-BOOK. It is an electronic version of a book that can be purchased in physical form through any bookseller or on-line retailer, or from our distributors. Please support this open access publication by requesting that your university purchase a print copy of this book, or by purchasing a copy yourself. If you have any questions, please contact us at ucpress@ucalgary.ca

Cover Art: The artwork on the cover of this book is not open access and falls under traditional copyright provisions; it cannot be reproduced in any way without written permission of the artists and their agents. The cover can be displayed as a complete cover image for the purposes of publicizing this work, but the artwork cannot be extracted from the context of the cover of this specific work without breaching the artist's copyright.

COPYRIGHT NOTICE: This open-access work is published under a Creative Commons licence. This means that you are free to copy, distribute, display or perform the work as long as you clearly attribute the work to its authors and publisher, that you do not use this work for any commercial gain in any form, and that you in no way alter, transform, or build on the work outside of its use in normal academic scholarship without our express permission. If you want to reuse or distribute the work, you must inform its new audience of the licence terms of this work. For more information, see details of the Creative Commons licence at: http://creativecommons.org/licenses/by-nc-nd/4.0/

UNDER THE CREATIVE COMMONS LICENCE YOU **MAY**:

- read and store this document free of charge;
- distribute it for personal use free of charge;
- print sections of the work for personal use;
- read or perform parts of the work in a context where no financial transactions take place.

UNDER THE CREATIVE COMMONS LICENCE YOU **MAY NOT**:

- gain financially from the work in any way;
- sell the work or seek monies in relation to the distribution of the work;
- use the work in any commercial activity of any kind;
- profit a third party indirectly via use or distribution of the work;
- distribute in or through a commercial body (with the exception of academic usage within educational institutions such as schools and universities);
- reproduce, distribute, or store the cover image outside of its function as a cover of this work;
- alter or build on the work outside of normal academic scholarship.

UNIVERSITY OF CALGARY
Press
press.ucalgary.ca

Acknowledgement: *We acknowledge the wording around open access used by Australian publisher,* **re.press**, *and thank them for giving us permission to adapt their wording to our policy* http://www.re-press.org

Lionel Everett McLeod
MD, FRCPC, FACP, FRCP(Edin) (Hon), LL.D (Hon)

Chapter 2

The Dean McLeod Years, 1973–1981

Robert Lampard

> *You can't just do your job as an individual physician. If you want to change what happens in medical school or at the bedside, you have to get involved in the way decisions are made.*
>
> —Dean L. E. McLeod[1]

Following his appointment as associate dean (professional affairs) in December 1972, Dr. Lionel McLeod became the likely successor to Dr. Cochrane. His new position made him responsible for all the faculty's clinical affairs and for managing the faculty-hospital affiliation agreements, including the one with the Foothills Hospital, while continuing as the professor and head of medicine until a successor to Dr. Cochrane could be found.[2]

Formally appointed dean in June 1973, Dr. McLeod brought an open-door policy and his approachable, imperturbable, and easygoing style to the position. As one former student remarked, Dr. McLeod was the Jean Béliveau (the hockey icon whose personal reputation for "class" and graciousness outshone his accomplishments on the ice) of Canadian medicine; as another colleague noted, "he affected every life he touched because he truly cared."[3]

Dr. McLeod loved hiking in the mountains, skiing, playing tennis, and spending time with his family and friends, but "his greatest achievement and source of satisfaction was helping young people get started toward a career in science and in the practice of medicine."[4] He would learn all the students' names, attend their get-togethers, and meet them at the TGIFs in the atrium. At one med show the class gave him the "smooth tongue award" and irreverently sang "God Save the Dean," much to his amusement.[5] As

his predecessor Dr. Cochrane would later remark, "the affection was mutual."[6]

Dr. McLeod's style was also marked by forethought. Commenting on this, McLeod said: "The less you say the more people think you know. I listen to the arguments, then make a decision in the best interest of the faculty, for I love conflict if it means vigorous debate. Nothing is more stifling than no conflict."[7] Another invaluable characteristic of a dean, he believed, was a strong sense of humour, especially in the face of stressful situations.[8] Case in point: Dr. McLeod once opened an important meeting by telling the participants, "Lets agree at the beginning that we will kick the shit out of each other over the contentious issues, but then leave as friends."[9]

Dr. McLeod didn't just bring personality and professional experience to the position of dean. Besides being a leading Canadian endocrinologist and nephrologist, he also had a long-standing interest in faculty management. This surfaced at the U of A when he was appointed the chairman of the Faculty of Medicine Research Committee in 1964. He was also appointed the first permanent secretary of the U of A Medical Curriculum Committee in 1966. Both experiences left him better prepared to apply for more senior faculty positions, "despite paperwork not being his favorite thing. People work was."[10]

The month before choosing the University of Calgary in April 1968, Dr. McLeod met with Dr. Cochrane and went over Dr. Cochrane's recently released "Philosophy and Program" article. In his initial assessment of the Calgary scene he noted that the city "lacks good general internists and a number of specialists. If young people are to come [and join the faculty], they must be prepared to support the school's objectives. Strong joint appointments would need to be made." Dr. McLeod also felt that the hospital structure in Calgary represented an interesting problem:

> An effective relationship with the Foothills Hospital Board will be necessary particularly as Family Practice was a critical part of the experiment. To develop and mold the medical staff into an effective educational unit will require a continuous evaluation and yet still necessitate flexibility. . . . I'm confident I can contribute and find the possibility most exciting and challenging. Although the role of the chairman [of the Division of Medicine] is heavy.[11]

In his reference letter for Dr. McLeod, professor and head of medicine at U of A Dr. Donald R. Wilson (1913–1991)[12] noted how knowledgeable and enthusiastic Dr. McLeod was: he "did good work, was great to work with and excelled at stimulating young people, but sometimes he took on more than he could reasonably achieve."[13]

A true Albertan, Dr. McLeod selected the U of C position at the top of a ski slope in the Rockies. Later he would add that he decided to join the U of C because he knew who he was joining: "In Adshead and Cochrane you have two who are

thinking of tomorrow, instead of thinking of the established practices of yesterday. In that setting you probably can do more than in any other place in North America."[14]

Dr. McLeod arrived on 1 July 1968 to serve as the first jointly appointed professor and head under the new affiliation agreement signed with the Foothills Hospital. He started two weeks after the first class of fourteen interns arrived at the Foothills Hospital. As there were no medical residents and Dr. McLeod was the only GFT in the department, the organizing and teaching load fell almost entirely on the voluntary contributions of the medical staff.

McLeod immediately applied himself to interpreting the Cochrane philosophy, helping design the undergraduate curriculum, and organizing the intern medical rotation. He would come to firmly believe in Dr. Cochrane's philosophy and was one of its strongest proponents. Clinically, he expanded the renal dialysis program by adding a home dialysis component (1970) while preparing for the first renal transplants (1971).[15] During the 1972–3 year, he chaired the Foothills Hospital MAC, becoming the most direct link between the hospital's administrator, Reg Adshead, and Dean Cochrane, after the latter retired as the Foothills Hospital's director of pediatrics on 30 June 1969.

As hospital department head, Dr. McLeod was responsible for recommending all appointments to medicine, as well as supporting all the family practitioner appointments to the medical staff. One of his first steps was to appoint a director (internist) and an assistant director (family practitioner) for each of the four medical units to foster integration in the management of them.

Administratively, he strongly supported the two emergency department enlargements, opened in 1969 and 1974, and expansion of the role of the Department of Family Practice in the hospital to include managing and staffing of the emergency department. The ER expansions created an ambulatory outpatient medical and surgical program and included full-sized operating rooms one of the first hospitals in Canada to do so. He viewed those decisions as far-sighted.[16]

On 20 June 1973, Dr. McLeod was confirmed as the second dean of the U of C Faculty of Medicine.[17] His appointment accompanied a changing of the guard at the Foothills Hospital with the retirement of Reg Adshead as the CEO in September. Mr. Adshead was succeeded by Ralph Coombs, whose career started at the U of A Hospital in Edmonton. Both came to Calgary on the same day, 1 July 1968. Coombs's and McLeod's amicable relationship would continue throughout the latter's tenure as dean.

Accreditation Progress

A year after his arrival in 1969, Dr. McLeod applied for a residency training program in internal medicine. It was provisionally approved following the RCPSC site visit in 1970 and granted full four-year approval in 1973. He also extended the medical CTUs to include one at the CGH under Dr. Howard McEwen, after McEwen's appointment as the CGH head of medicine.[18]

As the new dean, Dr. McLeod received the LCME and RCPSC accreditation reports in September 1973.[19] The LCME survey team noted that the faculty had been completely reorganized in 1972 into three components (service, education, research) but continued to utilize a divisional structure. The faculty consisted of 78 full-time instructors and 103 part-timers, and was supported by a $3 million budget with a further $1 million earned in research grants. There were 38 interns and 75 residents at the Foothills Hospital.

The LCME surveyors again recommended that the dean and the U of C president be placed on the boards of the three affiliated hospitals. Further, they indicated that the dean should be involved in the selection of all the hospitals' senior medical positions and CEOs. Conversely, the surveyors felt, the CEOs should be involved in any dean selection, and the U of C/Foothills Hospital Liaison Committee should be reactivated.[20]

The RCPSC did not make a site visit in 1973. Rather, the college reviewed the progress report submitted in January and noted that the faculty was still far short of its requirements. The ACC, with its 13,000 FP and 8,000 consultant visits, the surveyors felt was operating much below capacity and needed a major overhaul. They also recommended that the Foothills Hospital emergency physicians be jointly appointed and that residents be called in to see ER cases related to their specialties. The residency training programs in medicine, surgery, radiology, and pathology were fully approved for four years of training. Psychiatry, obstetrics, genecology, and pediatrics remained provisionally approved for training.[21]

Appointment to the Foothills Hospital Board

The long-sought appointment of the dean to the Foothills Hospital Board was finally implemented when Dr. McLeod, and Foothills CEO Ralph Coombs, attended their first board meeting on 16 April 1974.

Dr. McLeod's appointment to the board coincided with his enticement of Dr. Moramu (Mo) Watanabe from the U of A, who would come to Calgary as the professor and head of medicine.[22] Dr. Watanabe's first challenge was to reassess the two cardiovascular submissions to the Alberta Heritage Savings Trust Fund (AHTSF) from the Foothills and Holy Cross Hospitals, after both had been turned down by the government. Dr. Watanabe did so by supporting the HCH as the major service program, while expanding the cardiology teaching and research programs at the Foothills Hospital. The unanimity surprised government officials and the submission was approved.[23]

Educationally, the Association of Canadian Medical College (ACMC) released its clerkship requirements, which identified the core material to be learned, the skills that needed to be taught, and the evaluations that were necessary. There was also a requirement for portability. Based on these requirements, Calgary's "do-it-yourself" clerkship was restructured.[24] Clerkship blocks

were modified to include one twelve-week block in medicine, pediatrics, or FP to help clerks make career choices. An "in-house" multiple choice final examination raised questions when there was a 60 per cent failure rate. Dr. Watanabe, who had gained relevant experience at the R. S. McLaughlin Examination and Research Centre in Edmonton, found technical errors in the exam. Moreover, the questions did not discriminate between the more accomplished and below-average students.[25] Relief came when 90 per cent of the class passed the 1974 American National Board examination.

For faculty help, Dr. McLeod responded to the 1972–3 funding crisis by creating a new category of staff called major part-time; they would teach two days a week and do clinical work during the rest of their time. More reliance had already been placed on the part-timers for voluntary teaching by the Foothills Hospital medical staff because of the funding shortfall. At the time, Dr. McLeod felt the faculty was "60 percent funded based on the numbers we had anticipated at the outset."[26]

Organizational Progress

As five or more years had passed since some of the original clinical department/division heads had been jointly appointed in 1968–70, Dr. McLeod initiated a program of performance reviews. Although none of the incumbents were terminated, these performance reviews became an ongoing practice geared at improving faculty performance.

An internal organizational change came in 1974 with the creation of an associate dean position for administration and student affairs. It was initially filled by Dr. John Baumber (1939–2009).[27] Dr. McLeod had kept the associate dean professional affairs portfolio after becoming dean. He also appointed the first assistant dean, Dr. David Steinman, as the director of the Ambulatory Care Center. The Alberta Hospital Service Commission (AHSC) agreed to fund the medical director's position in the ACC, even though Dr. Steinman was already questioning whether the ACC was viable in its current form.[28]

In May 1974 the faculty received a request from the Alberta Dental Association and the Calgary and District Dental Society for a graduate program in dentistry. It was approved in principle by the faculty and the BOG, subject to the government's "firm assurance that continuing non-formula funding will be provided."[29] No funding guarantee was forthcoming, as had happened with the 1969 application for an undergraduate program in dentistry for forty students per year. Despite wanting more allied health programs, the faculty seriously considered but declined requests for schools of physiotherapy, chiropractic medicine, optometry, podiatry, and medical assistants. U of C did establish a BSc RN program for fifty students on the main campus in 1969. It started in 1970.[30]

Increased financial assistance for GFTs continued to come through the hospital budgets. One funded Dr. Ron Granger (1942–2001) as the jointly appointed director of the FP program at the HCH in 1974.

At the provincial level, the faculty's long-standing desire for a two-year FP residency requirement was implemented by the College of Physicians and Surgeons of Alberta (CPSA) in 1976.[31] It was a Canadian first, but it required one hundred and fifty more residency positions in the province. As part of the transition, the CPSA added the two Alberta deans to their board.

Research Progress—and a PhD Program

A 1973 review by the Committee on Research found that several research units were continuing to grow, particularly the growth and development, neurosciences, renal/immunology, and red blood cell units. CV-R and gastroenterology research unit staffs were closely linked to their teaching groups. All new researchers were encouraged to teach and have their appointment letter from the president so annotated. MRC grants were growing as well, albeit slowly, reaching $300,000 of the $1.9 million grants for Alberta researchers. The Medical Trust Fund was now generating up to $100,000 in excess earnings through patents seen in the ACC, providing another source of research grant funding.[32]

In 1974 Dr. Keith MacCannell completed his term as associate dean (research), noting the "modest but solid start that had been made."[33] By then there were nine research units based primarily on body systems.[34] Within each unit were research groups or teams that were usually formed to apply for MRC grants.

Dr. MacCannell had voiced his opposition to autonomous research groups; the establishment of institutes; or the creation of single-focus units like the McEachern cancer laboratory in Edmonton. Independent groups he thought might develop "sometime in the future, when the concept of interdisciplinary research was more secure than it is at the moment."[35] Research groups or teams, he said, didn't need to be fixed in composition but they did need a defined aim or direction. Research carried out purely for curiosity should not to be entirely ruled out either.

MacCannell's crowning achievement was finally securing government approval for a multidisciplinary PhD program after numerous attempts over several years.[36] Although he stepped down as associate dean (research), he continued to represent the faculty on the MRC Board. He asked MRC chair Dr. Malcolm Brown to visit Calgary again, which he did, bringing the whole MRC Board with him in 1975.[37]

One Step Back, More Steps Forward

Controversy was brewing within the renal program following the 1974 appointment of transplant surgeon Dr. George Abouna (1933–2016). It would lead to resignations, the temporary suspension of the renal transplant program, the revocation of Dr. Abouna's privileges in October 1975, four years of investigation, bylaw appeals, litigation, a severance settlement, and eventually a "blacklisting" of the U of C by CAUT, the Canadian Association of University Teachers. It

7

Dr. George Abouna, MBBS, FRCS, FACS

Dr. George Abouna was a Christian born in northern Iraq in 1933. He studied engineering in Britain before returning there for an MBBS and a FRCS in transplant surgery. While in the United Kingdom he performed the first pediatric renal transplant, the first living donor renal transplant, the first liver perfusion of a patient in hepatic coma, and the first liver transplant—all by 1968.[1] Impressed, Dr. Thomas Starzyl offered him a fellowship in Denver. After two years in Georgia, and two years back in England, Dr. Abouna followed his eighteen-year-old daughter to Canada, where he accepted Dr. N. T. McPhedran's standing offer to become the second transplant surgeon in Calgary in June 1974.[2]

Determined, forthright, focused, and with limitless drive, Dr. Abouna could work all night and operate all day. But by December 1974, personality differences among the transplant and dialysis teams were becoming apparent. Dr. McPhedran recommended that Dr. Abouna's promotion from the associate to the active medical staff of the Foothills Hospital be postponed for a year. With no improvement in the interaction among the team members, and with resignations pending, in June 1975 McPhedran recommended the life-improving renal transplantation program be suspended, which it was.[3] Notwithstanding that decision, a month later, on 30 July 1975, Dr. Abouna performed the first liver transplant in Western Canada using a sixteen-year-old donor. The patient's and donor's hepatic arteries didn't match; this created an anatomical challenge leading to massive blood loss, all-night blood donations by the staff, and a cardiac arrest on the OR table. Remarkably, the patient survived.[4]

The conflict at the U of C came to a head when two of the three nephrologists and the original transplant surgeon were offered positions in the United States. Both would accept the offers and leave for successful American careers.

To preserve the life-saving dialysis program, all of Dr. Abouna's transplantation privileges and his medical staff appointment were revoked by the Foothills Hospital Board in October 1975.[5] Dr. Abouna appealed this decision, but was ultimately unsuccessful. He also accused the program's two nephrologists of unethical behaviour.

An international task force studied the two programs and found that Dr. Abouna's kidney transplantation survival results were better because he always transplanted the first kidney.

The Faculty of Medicine's Executive Faculty Council concluded that it had no role in the

Foothills Hospital appointment process. An assessment of Dr. Abouna's research work reported it was sub-average, a conclusion he contested.[6] When his two-year university contract was not renewed in June 1976, his MRC and Kidney Foundation research was halted.[7]

With appeals exhausted, Dr. Abouna issued a statement of claim in 1976 for wrongful dismissal. Successful, the judge granted him a $100,000 settlement after concluding a medical staff appointment was a contract that had been broken.[8] The defamation suit against Dr. McPhedran was dropped when he apologized for his comments about Dr. Abouna's surgical competence. On appeal, the settlement was reduced to $10,000, after the Foothills Hospital confirmed that it would not have reappointed him on 1 January 1976.[9]

The fallout from this controversy was serious, particularly when one considers the negative patient testimonials, a petition, and criticism from future premier Ralph Klein and the Calgary mayor at the time, Rod Sykes.[10] The CPSA were forced to grant Dr. Abouna permanent specialist recognition, as they had not limited his licence as a "deemed specialist" to the time he held his U of C faculty appointment. The provincial model medical staff bylaws were changed to remove the associate category of appointment; this was replaced with a year of temporary privileges. The government established a Provincial Hospital Privileges Appeal Board in 1979. Dr. Abouna appealed to it, although he had already been appointed head of surgery at the Kuwait University Hospital a year before. His appeal request was denied.[11]

In 1980, the Canadian Association of University Teachers "censured and blacklisted" the University of Calgary because of its "flawed appeal process" and the "loss of academic freedom" that such a process implied.[12] The final blow came when the chair of the Foothills Hospital Board, Robert Black, was not reappointed by the premier in 1981. He was succeeded by Alvin Libin.

This experience underlined the importance of teamwork, and as such was an important reminder that the success of interrelated medical-surgical-academic-research programs depended on both the hospital and the faculty. While Abouna's appointments may have been easy to make, removing them were anything but.

Dr. Abouna would go on to perform 560 transplants by 1990, become the dean of the Bahrain Medical College, and receive the Albert Schweitzer Gold Medal from the Polish Academy. He died in 2016.[13]

was the most difficult issue to face Dr. McLeod during his deanship.

A month after the Abouna controversy began in June 1975, Premier Lougheed asked Dr. McLeod to consider becoming the chief deputy minister of community health and social services. Though Dr. McLeod declined the offer, the reasons he gave provided some useful insight into his career up to that point. He wanted further management experience in medical education and health care, he said, and the opportunity to address "patterns and systems of delivery of care."[38] He also felt that recent changes in the operation of the ACC "might emerge as reasonable community models especially [if] linked with the hospital structure."[39]

The intern and residency programs, which had been hospital based and run by Foothills House Staff Committee, were directed by the RCPSC to come under the management of the university. In preparation, Dr. McLeod activated the Graduate Clinical Education Committee (GCEC) in 1975 and appointed as chairman Dr. Fred Parney, who was also the chairman of the Foothills Hospital House Staff Committee. Helpfully, the Foothills Hospital Board continued to annually guarantee the number of house staff positions for the coming year in order to facilitate recruitment.

With the passing of the new Medical Examiners Act the new provincial chief medical examiner, Dr. John Butt, chose to locate his office in the U of C medical school.[40] His appointment to the faculty assisted in the development of forensic residency training in psychiatry and pathology.

Despite the temporary period of austerity, by 1975 the faculty's budget—totaling $4 million for the 1974–5 year, with a further $1 million coming from research grants and $378,000 from joint appointment funding through the Foothills Hospital—was large enough to fund 77 GFTs and 240 part-timers, adjunct appointees, and support staff.

The year ended on an optimistic note when the BOG sent the Sugars report on the cost of medical education at the U of C to the government.[41] E. G. Sugars, a U of C business school professor, found the cost per medical student was greater in Calgary than in Edmonton because the U of C faculty had fewer (three as opposed to four) classes of students; as well, library costs were higher at U of C, as there were fewer health-care faculties to apportion the cost. The Sugars study also concluded that Alberta medical faculties were underfunded compared to others in Canada. Dr. McLeod hoped this would accelerate the increase in the number of faculty positions, which it did over the next several years.[42]

For the undergraduate program, the faculty agreed to accept its original goal of 72 students in 1976, which represented an increase from 64 the previous year. On campus, more medical courses were being offered (24 full-year courses plus 11 half-year ones). PhD students now totalled 10, with 25 in the MSc program. Research grant awards exceeded $1.2 million. Five new faculty received grants, and publications increased. Sixty-five visitors came to tour the school and make presentations. Second-floor renovations in the HSC started at year's end, accounting for $1 million of the $1.7 million remaining surplus.[43]

Dr. Clarence Guenter was appointed professor and head of medicine in April 1976, after Dr. Watanabe accepted the associate dean (education) position in March of the same year. One of Dr. Guenter's initiatives was to create divisions within his hospital department, including rheumatology (at the CGH), gastroenterology, neurology, endocrinology, and respirology. Residency training programs were commenced in each one.

The 1975 LCME and RCPSC Survey

As planned, the LCME and RCPSC resurveyed the faculty from 14 to 17 April 1975.[44] In preparation, the faculty had made a determined effort to improve the documentation of its policies. Shortly before the 1975 site visit, an application to start a third surgical subspecialty residency training program in plastic surgery was prepared (the other two already approved were in neurosurgery [1971] and orthopedics [1972]). Calgary firefighters offered funding to renovate and equip an intensive care burn unit at the Foothills Hospital. The RCPSC surveyors approved the application in their report.[45]

The surveyors found that the jointly appointed professors/heads were satisfied with their working relationships and had few difficulties to share. Their primary responsibilities remained recruiting faculty. The Foothills Hospital was described as an excellent teaching hospital, although the faculty and students referred to some tension between the hospital and the medical faculty.

The RCPSC surveyors noted there was a shortage of teaching space for residents on the Foothills Hospital nursing units. The overlap between the Foothills Hospital House Staff Committee and the faculty GCEC when it came to decision-making, they suggested, should be re-examined. The ACC also remained underdeveloped. So did the involvement of specialty residents in the Foothills Hospital emergency department.[46]

Compared to other medical schools, the percentage of the faculty's budget reserved for teaching salaries was higher than the average.[47] Many divisions remained short-staffed, especially in internal medicine. Some junior faculty members were inadequately protected from excessive administrative and teaching loads, but cohesion and enthusiasm abounded.[48]

Dr. F. J. Rounthwaite, the chief RCPSC surveyor, initially felt that every program should be placed on probation, but yielded to a group recommendation that left only the obstetrics and gynecology, pediatrics, and psychiatry programs on probation, primarily for their lack of office practice and ambulatory experience.[49] Both survey teams noted the absence of an updated affiliation agreement with the Foothills Hospitals, leading to a request for an update in three years.[50] The LCME team also underlined that "a clear decision about the future development of the ACH [needed to] be reached, soon."[51]

Dr. McLeod's awareness of the value of the accreditation process itself was evident. He accepted a 1975 appointment as the RCPSC representative on the board of the Canadian Council on Hospital

Accreditation (CCHA). The next year he became the CCHA's chairman.

The Alberta Children's Hospital, 1973–1980

The location of pediatric services in Calgary was partially settled by the Advisory Committee for the Multiply Handicapped (Burgess) Report to the Minister of Health in July 1972. The government confirmed the multiply handicapped facility location on the 17th Avenue site, and announced on 20 March 1974 it would include in the facility a diagnostic and treatment (DAT) centre, an expanded outpatient program, the Gordon Townsend school, and a Kinsmen-supported genetic, developmental, and laboratory research unit. [52]

Then a serious difference of opinion arose when Dr. Holman publicly contradicted the faculty's support for acute pediatric care on the Foothills site. Instead, he supported the location of both acute and multiply handicapped facilities on the ACH's 17th Avenue site, as recommended in the Burgess report. The dean accepted his resignation in January 1974.[53]

On 2 October 1974, Health Minister Neil Crawford (1931–1992) met with the Foothills Board and then confirmed that a major decision on the location of a combined (acute and multiply handicapped) Child Health Center (CHC) would be made, but did not indicate when.[54] Concerned, Dr. McLeod reaffirmed the faculty's position and then met with representatives of the Foothills and ACH Boards on 15 January 1975 to discuss it.[55] He emphasized how important it was that all acute care pediatric facilities be located at the Foothills Hospital site, regardless of what board managed them, and how the 17th Avenue location would negatively affect the faculty's teaching and research programs and divide pediatric health care in the city.[56] At the same time he accepted the appointment of Dr. Robert Haslam as the new director of pediatrics on 5 February 1975.

Dr. McLeod was deeply disappointed to learn in April that the government had decided the acute and multiply handicapped facilities would be integrated in the CHC and located on the ACH site.[57] The decision was formally announced on 20 June 1975 by Hospitals Minister Gordon Miniely. All new pediatric facilities would be located on the ACH's 17th Avenue site under the ACH Board. The government allocated $20 million for the expansion. There would be no additional pediatric beds built.[58]

The ACH was fully opened by 1981. The Foothills Hospital transferred its two acute pediatric care units, together with their staff, to the ACH in 1982, as was all pediatric resident training, by March 1982. The remaining specialized pediatric programs (emergency, neuro, cardiac, etc.) gradually moved to the ACH over the next fifteen years, except for the ICN, burn care, and radiotherapy, which remained at the Foothills Hospital. Dr. Haslam, the ACH professor and head of pediatrics would subsequently accept the position as pediatrician in chief at the Sick Kids Hospital (1986–96) before returning to Calgary again in 2000.[59]

The Concept of "Brain Industries"

As the austerity of 1972–3 deepened, Deans Cochrane and McLeod of the U of C and Mackenzie of the U of A began looking for additional government funding, preferably directly to their faculties.[60] The deans may not have been familiar with the principles that Premier Peter Lougheed had enunciated in 1966 in an effort to create investments with long-term horizons and the potential for accelerated growth.[61]

Fiscal relief came when the oil royalty and taxation issues were settled, and oil prices, together with provincial revenues, began rising. Immediately after his government's re-election on 26 March 1975, Premier Lougheed announced his economic diversification plan. The government proposed to set aside 30 per cent of its oil revenues into a Heritage Trust Fund.[62] The proposed fund would support health services and facilities, including what Lougheed termed "brain industries."[63]

The distant voice of MRC president Dr. Malcolm Brown was heard when Drs. Keith MacCannell and the U of A's Ernie McCoy, the provincial MRC representatives, returned from their annual meeting in 1975 relaying Dr. Brown's question, "Would the [Alberta] government be open to funding medical research?" The federal government was already curtailing its MRC contributions (at $58 million in 1975), while inflation was increasing at 7 to 10 per cent and research costs were increasing from 5.3 to 11.7 per cent per year.[64]

Following indirect overtures to the premier's office, the reply came back that the premier would consider medical research as a "brain industry" but that any brief to the government had to be a joint one from the two medical faculties.[65] Encouraged to pursue the premier's "brain industry" opportunity, Dean McLeod appointed Drs. Veale and Watanabe to prepare a report that recommended the establishment of an Alberta Heritage Health Research Fund.[66] (They were assisted by Drs. Neil Madsen and Ernie McCoy from the U of A.)

Eight days after the proclamation of the Alberta Heritage Savings Trust Fund, on 19 May 1976, Deans McLeod and Donald (Tim) Cameron (1920–2002) and AMA president Bryce Weir met with Premier Lougheed to present their request for a separate medical research fund. It was not rejected out of hand, but the premier did ask them to wait for the tabling of the cabinet's science and research policy report later that year. The report ultimately concluded that the government had the responsibility to support research for the two largest programs it funded—health and education.[67]

On 24 March 1977 the cabinet appointed a Health Research Task Force chaired by Dr. John. E. Bradley (1917–2004) to study the proposal. In their report of 2 June 1977, the authors recommended that 1 per cent (or $50 million) of the health and social services budget be used each year for research and that a foundation be created to manage this spending. Dr. Bradley had already asked Dr. McLeod to identify the direction of medical research at the U of C. In his reply, Dr. McLeod made three points: (1) future research at the

U of C would be based on current areas of strength, although these varied widely; (2) research would continue to be multidisciplinary, with the focus on certain current problems covering the full spectrum, from bench to bedside; and (3) where the research theme was more general, recruitment of high-quality research scientists would be necessary.[68] The dean added that research recruitment would greatly strengthen the undergraduate, graduate science, and graduate clinical programs, but not in those areas where there weren't many research scientists, like pediatrics, the surgical subspecialties, and psychiatry. Support for more part-time clinical teachers, he felt, would be more effective in those areas.[69]

On 2 August 1977 Premier Lougheed appointed Dr. Bradley as his special adviser on medical research. Three months later, the premier outlined the parameters for the foundation, including its new name—the Alberta Heritage Foundation for Medical Research (AHFMR).[70]

Dr. Bradley revised his proposal and recommend that there be a separate board, a scientific advisory committee, and an international review every eight years. The deans indicated that the cost of research was $150,000 per researcher and the space requirement was 1,500 square feet per research team.[71] They added that graduate students, postdoctoral students, and visiting fellows would need to be funded, and there should be a clinical component to it. With Dr. McLeod's assistance, the first legislative draft for a foundation was completed by December 1977.

The U of C Faculty of Medicine was structurally prepared to do more research. It had designed central service areas (including facilities for growing micro-organisms, cleaning up and sterilizing equipment, and hot and cold rooms) to support medical research. Common research services had likewise been centralized (the vivarium, electron microscopes, instrument and analytical laboratories, radioisotope services, medical gases) to support basic and clinical research. There was space as much of the second floor was still undeveloped.

Meanwhile, the Committee on Research proceeded to develop guidelines for evaluating research work. Criteria included the number of publications and presentations, the impact of new techniques or hypotheses, the international reputation of the team, and its laboratory productivity, which would be measured by the grants received, the number of students on the team, the number of seminar presentations, etc. The committee was also restructured to increase the number of accredited research users and to decrease non-accredited users.[72]

Cancer Care Moves to the Foothills Hospital Site

Since 1968 the Alberta Cancer Board had been pressing for the relocation of the HCH's Calgary Cancer Centre to the Foothills site. To this end, Dr. McLeod offered 20,000 square feet of space on the second floor of the HSC. A structural assessment concluded that the floor below should be

finished at the same time. The renovations were initiated using capital surplus funds augmented by corporate donations totalling $700,000.[73]

In 1974 the faculty turned down a proposal to create a cancer institute, but it did agree to create a division of oncology. A year later the Alberta Cancer Board formally decided not to locate its forty-four-bed intermediate care unit within the medical school; it decided, rather, to move it to a 60,000-square-foot space in the proposed special services complex south of the Foothills Hospital, while leaving its oncology research unit on the second floor of the medical school. That way jointly appointed professors could participate in the undergraduate program, and students would be exposed to the clinical and scientific aspects of cancer care. An affiliation agreement to this end was signed by the faculty and the provincial cancer board on 21 October 1976.[74]

A Gerontology Opportunity

FP director Dr. Morris Gibson's long-standing desire to establish a division of gerontology finally saw some progress in 1977. This was just a year before he retired. The joint appointment by the faculty of Dr. Gilbert Rosenberg as the medical director of the new multi-level, three-hundred-bed Vernon Fanning Auxiliary Hospital brought the first trained geriatrician to Calgary. A pleased Dr. McLeod indicated that the appointment would "increase our emphasis both on the clinical problems of the elderly and on the aging process."[75]

The Fanning Centre opened on 1 January 1978, and immediately included rotations for FP and internal medicine residents. Aging research was expected to be limited, as there were few local investigators with an interest in the area. A multi-divisional review of the principles that should be used for expanding geriatric care was conducted by Drs. McQuitty, Rosenberg, and Guenter.[76] They concluded that the problems of aging require greater understanding and concern than they had been given and that, as a result, a broad effort was required; family practitioners and specialists should continue to care for those they already saw, rather than segregate care based on age. Support from both the U of A and U of C for an institute of gerontology in Alberta was approved in principle but not supported by the government.[77] The initiative did not progress and no more geriatricians or geriatric psychiatrists were hired. Disappointed and discouraged, Dr. Rosenberg left Calgary in 1980. It was only in the last years of the Watanabe deanship that geriatricians were again recruited to Calgary and both clinical and academic programs in aging were launched.[78]

More Progress

Under discussion for almost ten years, the Foothills Hospital special services building was formally approved for construction in October 1977. It contained programs and services that either lacked the requisite space or were non-existent. Eventually costing $92.5 million, the facility provided 200 auxiliary (long-term care) beds, 44 cancer beds

(operated by the hospital), a therapeutic oncology program, more radiological services, a dental unit, and increased warehouse space for more dialysis patients and psychiatric services.[79]

Despite ongoing faculty involvement since 1971, not everything was going well at the Morley Health Centre. The centre's latest director, Dr. A. J. Cunningham, summarized his observations: the two full-time and one half-time physicians at the centre were only serving 1,000 of the 2,000 residents; the other half used family practitioners in Banff, Cochrane, or Calgary. That was more than double the normal doctor-population ratio, and as such it was not sustainable. To the chagrin of the band, medical coverage and twenty-four-hour ambulance services were cut back, although the family medicine residency elective rotations continued. Idealism, expectations for a hospital, and cultural differences were straining the service.[80]

By 1977, the original clinical professors and heads were beginning to change. Dr. Parney, the director of anesthesia, stepped down to become the department's program director. Dr. Brody, the director of obstetrics and gynecology, unexpectedly passed away. Dr. Hugh F. Morrish (1931–2013), the long-standing deputy director, replaced Dr. Duggan, who retired as the director of diagnostic imaging.

When Dr. Parney became ill the next year, Dr. Gerald McDougall accepted the position of GCEC chair and program coordinator in 1978. Jocelyn Lockyer joined him. They were initially charged with revising the terms of reference for the postgraduate and CME programs. The GCEC also developed a five-year projection for postgraduate trainee numbers.

The first College of Family Physicians of Canada (CFPC) accreditation visit was held in 1977. The subsequent recommendations led to considerable correspondence between the CFPC and U of C division head Dr. Morris Gibson. The difference of opinion was smoothed over by Dr. McLeod, who had already become an experienced Royal College surveyor.[81]

The Faculty Prepares a Five-Year Development Plan in 1977

In response to the vice-president's request for a five-year development plan, Dr. McLeod tabled the faculty's plan in November 1977.[82] He acknowledged that the faculty was preparing for more growth (from the AHSTF and the AHFMR) with enthusiasm and impatience. He also made clear that the basic sciences would be emphasized in any plan, as the faculty was in the bottom half of Canadian medical schools when it came to its GFT staff-student ratio.

The study began by revisiting the faculty's original 1971 objectives. From the study came a set of twenty-four specific and achievable goals that focused on education, research, and service.[83] The McLeod plan aimed to add to the faculty's existing strengths on a multidisciplinary basis, pursue a full spectrum of bench-to-bedside research excellence, attract new young scientists, and upgrade

clinical teaching programs.[84] Long-term objectives focused on improving research linkages, adding to U of C's allied health programs, reducing dependence on the affiliated hospital funding, and improving the ACC setting, but not establishing institutes.

However ambitious the plan, Dr. Guenter pointed out that it failed to focus specifically on teaching students to self-learn; only then, he argued, would they become "the more exciting product we all dreamed about in the past, the student who defines his own objectives and pursues them throughout his career."[85]

On the negative side, U of C's MCC placings continued to slip, as they had since 1974. Seven students did not write the MCC exams, although they passed a later exam. In 1977, four passed on a deferred basis, with the 1977 graduating class ranging from second to twelfth (of sixteen Canadian schools). The best results were in psychiatry.[86] Deficits were especially noted in clinical skills, geriatric medicine, industrial and occupational health, computer applications in medical practice, basic medical science knowledge for future academics, and health-care-system knowledge and understanding. Disconcertingly, the graduating class averages slipped again the next year, to tenth and ninth place on parts A and B of the national exam.[87] A determined all-faculty approach led to everyone passing the MCC exams and white gloves for the dean in 1979.

Initiation of the 1978–80 Task Force on Self-Assessment

With the 1977 five-year development plan in place, Dr. McLeod directed his attention to the pending 1980 accreditation survey. He sought support for a major internal "self-assessment" at the 12 January 1978 meeting of the FC. It was supported by William A. Cochrane the U of C president, and Vice-President Peter J. Kruger.[88] His rationale was that the LCME recommended a periodic assessment be undertaken and the FC had asked for a five year follow-up to the organizational review in 1972.[89] Further, there were exciting opportunities at hand, like the formation of the AHFMR.

Upon receiving agreement for his proposal, a task force with sixteen faculty members and one student was appointed to examine the faculty's objectives and priorities, organization, administrative and divisional structure, and operation. The FC also asked that the faculty's priorities or weighted objectives be addressed.

The process began with every division being asked for a self-assessment of the strengths, weaknesses, and issues they faced. To validate the current curriculum, Dr. McLeod sent out a lengthy questionnaire to all members of the class of 1973. It was a follow-up to Dr. Cochrane's original expectation that feedback from students and graduates would be sought.[90]

On the Foothills Hospital side, Dr. Guenter declared the hospital's development stunted, and he challenged the Foothills Hospital MAC and Board to develop a long-range plan and review its

own performance. That led to a revisiting to the hospital's 1974 Roles and Goals report, which had identified "centres of excellence" for the hospital. In October 1979, the MAC tabled forty-eight documents that related to the hospital's future, along with a revised Present and Future Roles statement.[91] To help meet the goals laid out in the faculty and hospital documents, the hospital agreed to request twenty-six full-time and thirteen part-time GFTs from the government to staff the proposed programs.

The hospital also declared its intention to become more of a tertiary care and referral hospital, by increasing its specialist and intensive care facilities; constantly evaluating the role of family practitioners; giving primary consideration to the Faculty of Medicine in the development of future programs and facilities; and by participating in and facilitating research into new methods of patient care for the people of Southern Alberta.[92]

The quality and expertise of the Foothills Hospital's medical staff appointments was making an impact on its role as a referral centre. Admissions from non-Calgary addresses had increased from 17 per cent in 1970 to 31 per cent in 1978. Perinatal transports, which had previously been non-existent, climbed to 202. FP admissions had dropped from 37 per cent to 28 per cent in the same period, while the faculty members had increased to 113 full-time equivalents (FTEs), plus 6 major part-timers and 219 adjunct part-timers.[93]

Despite these changes, the deputy minister of health revoked Dr. McLeod's position on the Foothills Hospital Board, along with that of Mr. Coombs, "to avoid the Dean speaking to the Foothills Administrator through the Board."[94] In lieu of formal membership, the board asked Dr. McLeod to continue to attend its meetings as a guest, which he did until 1981.

The History of Medicine Course and the Hippocrates Statue

A program on the history of medicine, initiated by Dr. Cruse in 1972 as an elective course for surgical house staff, was extended to all interested students in 1978. It prospered and led to the creation, in 1991, of a two-day national medical student conference, known as History of Medicine Days.[95] Following another suggestion by Dr. Cruse, four statues of Hippocrates, Socrates, Krito, and Plato were commissioned and given to the university by the city's Greek community. This effort was led by ninety-two-year-old restaurateur Jimmy Condon (Demetrious Kouimgis), the owner of Nick's Steak House in Calgary.[96]

Located in the atrium, the Hippocrates statue was dedicated as "a symbol of the continuity of ancient wisdom and modern learning" on 20 November 1980.[97] The donation initiated the reintroduction of the Hippocratic Oath at the convocation ceremonies.[98] The other three statues were erected on the main U of C campus.

8

Dr. Peter J. E. Cruse, Infection Control Leader and Medical Historian

> *Seek out that which is noble in our past and make it a living ideal in our lives.*
>
> —Dr. Peter Cruse[1]

No faculty can ever have enough Dr. Cruses. Born in South Africa in 1927, trained as a surgeon in Britain, Dr. Peter Cruse worked briefly on Dr. Christaan Bernard's team. Although his father was a professor of history at Stellenbosch University, he chose to raise his family in Canada, completing his FRCSC at the Colonel Belcher/HCH hospitals under Dr. Smitty Gardner in 1966 at the age of thirty-nine.[2]

Asked to rejuvenate the HCH's Infection Control Committee in 1965, he discovered that the most common surgical complication, post-operative wound infections, was occurring at a rate of 0.2 per cent. He viewed this as a gross understatement. Uncovering a new National Institute of Health classification system (clean wound infection rate, or CWIR), broken into clean, clean contaminated, contaminated, and dirty wound infection rates,[3] he compared the HCH rates with the newly opened Foothills Hospital (1966), in two consecutive six-month study periods. The overall rate went from 8.4 to 3.7 per cent (CWIR 4.2 per cent at HCH) and from 5.7 to 2.2 per cent (CWIR 2.7 per cent at the FH). Both were well below the rates reported in the literature.[4]

By confidentially providing individual CWIR feedback to each surgeon, while encouraging meticulous hemostatic surgery, the rate continued to drop at the FH. Some months the rate was actually zero. The Centre for Disease Control followed his lead (initiating the CHIP and SENIC projects) and found hospital rates dropped 38 per cent in their monitored hospitals.[5]

Cruse's prospective study continued for twenty-two years.[6] By applying the TACT + FACT = low CWIR formula, the CWIR averaged 1.2 per cent.[7] Dr. Cruse gave over 120 visiting lectures in 18 countries and wrote 19 articles and 10 book chapters, which were translated into 4 languages. Unfortunately, the classification of wound infections was changed to surgical site infections by the NIH in 1992, relegating comparisons with his study to history.[8]

Wound infections were not Dr. Cruse's only interest. He promoted the integration of staff by initiating FH summer picnics, the annual medical staff ball, and later a medical-staff-sponsored

stampede-week breakfast. He also designed a crest and a tie for the hospital.[9]

To promote the FH as a trauma centre, he initiated twenty-four-hour coverage of the first intensive care unit, and organized trauma symposiums in 1967 and from 1971 to 1975.[10] His goal was highlighted when an oilfield worker was impaled on his truck seat on a bridge rail guard. It took ten hours to extract and transport him to the FH for life-saving surgery.[11]

Appointed an adjunct professor and then the second surgical GFT in 1975, he succeeded Dr. N. T. McPhedran as the professor and head of surgery from 1981 to 1988.[12] During his tenure he merged the HCH/FH open heart surgical units, began the Surgical Research days, and started a pre-operative clinic to reduce pre-operative stays—and in so doing, contributed again to decreasing CWIR rates.

Dr. Cruse also had an avocational interest in medical history, stemming from his father's career as a historian and evenings spent with neighbour and medical historian Dr. Earle Scarlett. He was surprised when the new U of C medical curriculum contained no instruction in the history of medicine.[13] And so he introduced his own solution, designating the Hunter and Lister surgical nursing units and initiating 7:00 a.m. presentations on various topics in the history of medicine.[14] The program ended the year with a banquet. Later he convinced a local restaurant owner, the Greek-born Jimmie Condon, to fund statues of Hippocrates (for the medical school) and Socrates (for the university). The life-sized Hippocrates statue still stands in the atrium and has become a faculty touchstone.[15]

The popularity of the history of medicine program increased after it was offered as an elective in 1978. Mentors were found for each student and topic. Up to 60 per cent of the class participated. An annual year-end conference was added, to which invitations were extended nationally in 1991.[16] Each year over 60 medical students attend the History of Medicine Days and are assessed on the content, research, and elocution of their presentations.

In 1992 the Alberta Medical Foundation initiated funding for an AMF/Hannah Chair in Medical History at the University of Calgary. Dr. Cruse was the initial occupant.[17] Locally, he began the Calgary History of Medicine Society (CHOMS) and their newsletter (CHERION). With his ophthalmological colleagues, he successfully recommended Dr. Harold Ridley for knighthood for the first cataract extraction and IOL implant in 1949.[18]

Dr. Cruse is remembered through awards given to students at Surgical Research days, the RCPSC historical presentations, and Calgary's History of Medicine days.

Medical Research Receives a Boost

Nationally, Health Minister Monique Bégin announced a turnaround in the level of federal support for the MRC. The federal MRC grant was increased to $63 million, and a five-year projected budget ensured more predictable funding.[99] Faculty research grant applications were becoming increasingly successful, with the faculty receiving $2.295 million in grants in 1978.[100] In spite of the effect of oil price cycles on the provincial economy, the university's now centralized development office was making progress in fundraising. It provided $750,000 worth of equipment requests to the faculty.[101] Dr. Morley Hollenberg's ocular research received a boost when the Lions Clubs of Southern Alberta raised over $250,000 in two telethons. These funds were matched by the government and used to purchase three ocular-specific electron microscopes to study individual normal and abnormal cells of the retina.[102] At the same time the Kinsmen Club gave a donation of $34,247 for geriatric care and research.

Dr. Keith Cooper, the division head in physiology—received his DSc from Oxford for his research into the mechanisms that determine and controlled body temperature—was appointed the U of C associate vice-president (research) at the university. A year later, he began a 5-year term as the vice-president (research).

Diabetic research received a huge boost with a $1.25 million gift ($250,000 per year over five years) from an anonymous donor—the largest single donation to the faculty to date. The donation, which began in September 1979, led to the creation of the Julia McFarlane Diabetes Research Centre.[103]

A visit by Premier Lougheed to several on-site research laboratories in 1979 gave him an indication of the research that was being done and how little space was still available for the proposed medical research foundation his government was planning. At the same time, Mr. Lougheed announced funding through the AHSTF for upgrades in the CVS units in Calgary. This led to Dr. Eldon Smith being recruited to head the Foothills Hospital cardiology program.[104] The approval of a residency training program in cardiology by the Royal College followed in 1981.

As part of the faculty's Task Force on Self-Assessment, Dr. Guenter, now the chair of the Committee on Research, met with every research group and division head to review their research progress, aims, and needs. His recommendations were that the renal group split from immunology, the blood group disband, the behaviour group join with psychiatry, and CVS-R be divided. GI was felt to need basic scientist help. Oncology and infectious diseases needed better funding. Surgical research was underdeveloped while the Division of Education, Planning and Assessment needed to do more research. The basic science groups Dr. Guenter found were doing well.[105]

Organizationally, the faculty reached 154 GFTs and 29 major part-timers, with 294 adjunct appointments. The faculty's budget in 1978–9 totalled $7,789,000, increasing to $9,115,000 the following year. Research grants added up to $2,737,000 out of a total of $8.3 million for the

university as a whole in 1979. Two-thirds of the faculty's funding was coming through the university and 35 per cent from the hospitals.[106] Reflecting back on the faculty's circumstances during this period, Dr. McLeod noted that

> we were unable to mobilize adequately a thrust beyond solid patient care and teaching programs and a few islands of research strength. Research strength was sufficiently limited that teaching and particularly clinical teaching could not be built upon a solid scientific base.[107]

Forming the AHFMR and "Doing it Right"

Having confirmed the government was "open" to creating a separate medical research fund distinct from the AHSTF, the premier set about "doing it right." He appointed Dr. John Bradley as his special adviser on medical research on 2 August 1977. Dr. Bradley would take almost three years to contact or visit 250 medical research institutions in North America and Europe to determine the best framework for the foundation and its relationship with the government.[108]

To validate the AHFMR proposal, Premier Lougheed organized the first government house dinner on 19 March 1978 for a small group of medical and academic leaders. When asked how much money should be made available, the audience provided a range of sums, from $6 million to $20 million. The premier then announced that he was prepared to set aside $300 million, which would earn $30 million per year from interest.[109]

On 5 March 1979, the premier publicly announced the impending AHFMR proposal, shortly before his second government house dinner on 28 June 1979. In October the premier visited Harvard University and met with Albertan and the future Harvard dean of medicine Dr. Joseph Martin. Martin was impressed with Premier Lougheed's understanding of the issues and challenges facing the proposed AHFMR, particularly his desire to keep it at arms-length from the government.[110]

On 26 October 1979, Bill 62 was introduced to the provincial legislature. All three parties supported it. Four months later, on 19 March 1980, the AHFMR Act was proclaimed and its board, including chair Eric Geddes (1926–2002), was appointed. The premier met with them to discuss their mission. He concluded the meeting by saying, "I'll see you after the next International Board of Review visits [in 7 years], but my door is open."[111]

The fear that MRC funding would be diminished or replaced by AHFMR funding proved unfounded. The Quebec formula was applied to Alberta funding requests, as Rene Simard indicated. That is, "if the grant application was accepted by both the provincial and MRC bodies, then MRC funding was accepted."[112] It also helped the U of C that Dr. Watanabe was appointed the chair of the ad hoc Scientific Advisory Committee (SAC) in 1980. In time, it was found that some grant applications were declined by the AHFMR SAC but

accepted by the MRC, as their quality improved so significantly.[113]

The 1977 Five-Year Development Plan Is Updated

As the task force's report was being completed, Dr. McLeod was asked by the vice-president to update the faculty's five-year development plan. Completing it on 3 December 1979, he predicted that, "if thoughtfully exploited, the medical school should evolve into one of the finest academic medical centres in Canada."[114] There was a unique opportunity, he said, to create new programs in basic and clinical research through careful planning and recruitment, thereby fostering an environment conducive to productive scientific enquiry. While the AHFMR might contribute to improve staff-student ratios, he felt it would not address the GFT shortage in divisions that did little research.

Seven research programs were already showing strength.[115] Further, the criteria and guidelines to identify some of them as "institutes of research" were under consideration, given the substantial growth that was expected.[116]

Dr. McLeod felt there were four priorities the faculty should follow: (1) develop and secure grants and strengthen the current "full-spectrum" research groups; (2) recruit new research groups identified by the Committee on Research; (3) develop plans to upgrade other academic groups that didn't provide a full spectrum of cell-to-bedside research; and (4) recruit new young scientists who had an ability to teach.[117]

Educationally, Dr. McLeod felt the faculty remained unduly dependent on non-university funding sources (e.g., the Foothills Hospital, ACH, and the provincial cancer board). More university funding would be needed to upgrade and expand the clinical teaching programs.[118] Dr. McLeod predicted that the number of approved residency programs would reach between 27 and 30. Resident numbers would likely increase from 215 to 260, and more hospital funding of joint appointments would occur. The need for up to 50 more teaching staff, Dr. McLeod felt, might be reduced if medical researchers contributed up to 50 per cent of their time to clinical and academic work.[119]

Other issues identified by Dr. McLeod included the need for more effective linkages with the affiliated hospitals, especially the Foothills; growth of the allied health education programs; the development of institutes whose role and nature would have to be determined; decreased dependency on affiliated hospital funding; and an improved ambulatory care setting for clinical education.

As the Foothills Hospital developed into an academic health sciences centre, Dr. McLeod felt that areas of excellence were needed in the other hospitals such as musculoskeletal diseases at the CGH and pediatrics at the ACH. The maturation of the Foothills Hospital, he wrote, was complicated by its underfunding and its role as both an academic and community general hospital.[120]

The 1979–80 Task Force on Self-Assessment Report

The task force that Dr. McLeod had appointed in 1978 tabled its report at the EFC meeting held 19 March 1980. It amounted to a comprehensive analysis of the status of the faculty.[121] The report began with the objectives of the faculty, which were described as follows:

1. to produce doctors specializing in family medicine;
2. to produce well-trained doctors for the clinical specialties;
3. to provide an environment conducive to research;
4. to improve medical education through ongoing evaluation;
5. to produce doctors qualified in the approved specialty programs;
6. to produce medical scientists;
7. to provide CME for family physicians and clinical specialists;
8. to provide high-quality health services;
9. to foster the delivery of health services to the community;
10. to provide learning experiences for allied health professionals; and
11. to support and contribute to public health education.[122]

The objectives were then prioritized in the following order:

1. to produce doctors in family medicine and the traditional medical specialties;
2. to provide an environment conducive to research, education, and the delivery of healthcare services;
3. to produce doctors qualified in those specialties, and medical scientists;
4. to provide high-quality health services through the ACC and other institutions;
5. to provide continuing education learning experiences for the allied health professions; and
6. to contribute to public health education.[123]

The committee concluded that 50 to 60 per cent of graduates from the U of C Faculty of Medicine had chosen FP.[124] Research, it was felt, needed to be given the same priority as graduate education,

with the expectation that more students would choose research as a career path.[125]

Organizationally, the senior structure of the faculty now had four associate deans (for undergraduate education, research, graduate clinical and continuing medical education, and professional services), three assistant dean positions (education, research, and the ACC), and administrative assistants for finance and administration.[126] The report recommended that the EFC, which the dean chaired, remain the senior executive body with four more members added. It was to have the associate deans and twelve standing committees periodically report to it and was to remain responsible to the FC. The separation of policy formulation and implementation was viewed as artificial and impractical, too often leading to an unclear designation of who was responsible for the solving a particular problem.[127]

The task force found the clinical division heads received demands from multiple origins and were often forced to deal with two or three institutions, especially when it came to recruitment. The faculty's reputation for recruitment was poor. There was no identifiable geographic focus for the basic medical sciences. Middle management was underdeveloped. The divisional structure needed to be strengthened and research groups demonstrate more effective leadership. Further, divisions should be called departments, as they were in the hospital.[128]

Standing committees were found to be adequate, but some tidying up in their terms of reference was needed. The Admissions Committee needed to establish admitting criteria and computerize its data bank. Student Affairs needed to promote more contact between medical students and the faculty as well as medical students and graduate (MSc, PhD) students. More counselling and social interactions were recommended. The Space Committee needed to be reactivated and provide plans to increase staff densities, find more seminar space, and seek better use of the secretarial spaces. The Committee on Research was encouraged to be more vigorous and to better monitor what was occurring among faculty members. The variable quality of graduate students needed to be addressed. The Curriculum Committee itself made forty-four statements and recommendations. Greater involvement of part-time faculty together with additional funds for teaching were needed, along with more CTUs, more community-based clerkship rotations, and an expansion in the number of continuity-of-care patients assigned to undergraduates. Curriculum evaluation needed improvement. A database indicating the teaching duties of each faculty member would help to better distribute the load.[129]

A broader postgraduate self-assessment committee, composed of program, hospital, and resident representatives, was needed. Resident evaluations were weak and, in some cases, not given to the resident. Self-assessments of the strength and weakness of the sixteen approved programs was valuable and was later extended to FP. A standing committee on CME had been appointed and had drafted a two-year plan to address the lack of research into the program's effectiveness, the lack of

a regional nucleus of interested doctors, the variable quality in the presentations, and how many staff had responsibilities in another department. CME for specialists was also needed.[130]

The divisional review found a lack of community health teaching in the clerkship, a lack of community agencies in the ACC, an absence of community teaching beyond the ACC, the Cochrane clinic, and the Morley Centre, and an unclear set of objectives. The DEPA workload was heavy, with the director spending a quarter of his time assisting the Faculty of Law (which had been formed in 1975). FP needed more resources, especially at the HCH. The medical biochemistry division had seen its involvement in undergraduate education diminish, with its members' teaching "taken over" by the clinical scientists. In medical biophysics, there was no clear role for the division or a critical mass of staff—only two full-time faculty with divergent interests. The internal medicine division needed a recruitment plan for developing future subspecialty programs and an expansion of its section in the clerkship.

More anatomy teaching in the form of horizontal themes was suggested. A shortage of histopathologists was noted. Pediatrics had strengthened considerably, but the ACH's location and the paucity of research were clear disadvantages. Psychiatrists were in short supply to face a heavy service load and residents were hard to recruit. Surgery needed a recruitment plan beyond the five existing programs. No physiatry program existed.[131]

The task force also studied the benefits and pitfalls of three- and four-year undergraduate programs.[132] The integrated three-year course had proven workable and successful for most students. The opportunity to request a one-year extension for slower students, or students who wanted to explore a research program or enter an MSc or PhD program, was supported. The recommendation for a more in-depth orientation for new faculty led to a wider dissemination of the Guide to the Educational Program brochure. Re-sequencing the teaching order of body systems in the undergraduate program was approved with growth and development becoming the first; this avoided having the same faculty teach every summer. It was also found that starting the curriculum a few weeks earlier gave more time for course assignments.

The most important recommendation was that divisions should become departments. The task force also recommended that microbiology and infectious diseases and the clinical neurosciences group become departments, bringing the total to seventeen.

The task force's draft report was presented and discussed at length before being tabled at the FC meeting of 23 May 1979.[133] The final report with specific motions, together with the dean's five-year plan and the 1980 accreditation preparation report, were all tabled at the FC meeting of 19 March 1980. Nine motions were approved. Four were internal to the faculty, including the list of priorities and the terms of reference for the division heads. Four required consideration by the BOG before they could be passed: to change divisions

to departments, add microbiology and infectious diseases as a department, drop DEPA and medical biophysics as divisions, and change the names of two departments to anatomy and radiology.[134]

Board Approval of the Task Force Recommendations

At its meeting on 20 November 1980, the board approved the recommendations sent to it, including the renaming of divisions as departments.[135] The responsibility for DEPA was turned over to the faculty's curriculum committee, and eventually the Dean's Office. Medical biophysics was dropped as a division.

While lengthy, the whole process of creating a special committee to review the work of the faculty before an accreditation would become the norm. Performance by the faculty at every accreditation since 1970 has led to the granting of the maximum approval period possible, a record not exceeded by any Canadian faculty of medicine. The president, already impressed, initiated similar reviews of all the U of C faculties in the summer of 1979.[136]

The 1980 Accreditation Surveys

The LCME and RCPSC made their scheduled surveys from 14 to 17 April 1980,[137] leaving Calgary the day before a strike by the province's registered nurses dramatically curtailed acute care in the city, with only the Foothills Hospital remaining open.

The LCME survey team complimented the work of the task force and the changes, improvements, and documentation that had followed its review. They included significant portions of it in their report but were left with two major concerns: the need to consolidate pediatric services, and the "veritable fantasizing" about the impact of the AHFMR.[138]

The LCME recommended a full five-year accreditation but required the submission of a progress report in two years to address staffing and other resources available for education; the results of the current curriculum evaluation; the resolution of certain organizational issues surrounding the roles of the division and departments; and the resolution of the difficulties in specific divisions (pediatrics, psychiatry).

The RCPSC surveyors complimented the GCE committee on their many useful criticisms and conclusions in their 1979–80 residency program reviews. The survey chairman described as remarkable "the relationship between family physicians and specialists that exists on the wards in all the hospitals, which enable residents to learn how to be consultants to primary care physicians."[139]

The Impact of the AHSTF and AHFMR

By the end of 1980, faculty medical research grants had reached $4.9 million, with $1.76 million coming from the AHFMR and $1.9 million from the MRC. In the first six months of 1981, the AHFMR

made grants to the faculty totalling $4.1 million to cover medical research studentships, fellowships, scholarships, establishment grants, capital equipment, and renovations. By late 1981, the faculty had received a total of $8.8 million from the AHFMR. Not surprisingly, the need for more research space was becoming evident in both Calgary and Edmonton, as all the U of C research space available had been allocated and renovated by 1978.

As the U of C faculty's growth continued almost unabated, the balance in faculty members between education and research began tipping toward research. In the seven priorities listed in the task force report and approved by the EFC, research had been raised to the same level as graduate education.[140] The 1981 budget reached $12.5 million. There were 165 FTE positions. In the postgraduate programs, there were 55 MSc and PhD students. While the undergraduate intake remained steady at 70 students, the postgraduate resident total reached 244.

Using AHSTF funds, the $4-million, 7,400-square-foot CVS unit expansion was opened on the ninth floor of the Foothills Hospital by Premier Lougheed in February 1981.[141] This was followed by the Foothills Special Services facility, which opened in October 1981, providing more auxiliary, cancer, and dialysis beds, as well as expanded x-ray, dental, and psychiatric services, space for the provincial lab, and an internal shopping mall.

To Nepal

For a month during the winter of 1981, Dean McLeod and Dr. Melville Kerr, the head of the OB/GYN department, visited the Faculty of Medicine at Tribhuvan University in Kathmandu, Nepal. Dr. Kerr had been working, visiting, and advising the new faculty on how to improve medical education since it opened in 1977. Invited to attend the tenth All Nepal Medical Conference, held from 19 to 22 February 1981, the two faculty members were met by former Foothills Hospital surgeon Dr. Gerald Hankins, who had been working in Nepal for over ten years.[142] The scientific program began with Drs. McLeod and Kerr giving the Mrigendra Medical Trust Oration on "Trends in Undergraduate/Postgraduate Medical Education."[143]

Encouraged by the visit, Dr. Kerr prepared a proposal for a postgraduate training program in general medicine for Nepalese doctors. He asked that some of the twenty-two Nepalese medical graduates of Tribhuvan University come to Canada for postgraduate training and that faculty members from the U of C volunteer to go to Nepal to teach and train faculty there. The proposal was accepted, providing the staff member found someone to cover their commitments while they were away. Thus began the faculty's first international medical training program. In the years that followed, several Nepalese MDs came to Calgary and reciprocally, many faculty volunteered to go to Kathmandu.[144]

Becoming the First President of the AHFMR

Shortly after his return from Nepal, Dr. McLeod resigned his position as dean. "A job," he would later say, "should be for five years. By then you have done what you can. You have to do the work no matter how bright you are. Once you've been a dean, you can't go back." Or more succinctly, "you should leave before you have to leave."[145]

Dr. McLeod was offered the appointment as the first president of the AHFMR from among seventy applicants. In praising the selection, board chair Eric Geddes emphasized Dr. McLeod's leadership at the U of C.[146]

Advantageously, the price of oil was at a peak. Monies from the Heritage Trust Fund amounting to $300 million were diverted to establish the AHFMR in March 1980. The incubation period had been prolonged, but the premier was satisfied that it was the most thoroughly researched policy legislation his government ever tabled. With the birth of the AHFMR, the second "golden age" for academic medicine in Alberta began.[147]

The AHFMR would have a greater impact on the U of C than on the U of A, as it was younger, had earned fewer research grants, and its basic medical science divisions were less well developed.

Dr. McLeod would leave the deanship with a significant list of accomplishments together with a blueprint for the future, in June 1981.