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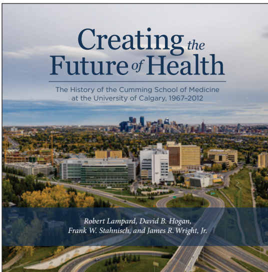

CREATING THE FUTURE OF HEALTH: The History of the Cumming School of Medicine at the University of Calgary, 1967–2012

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

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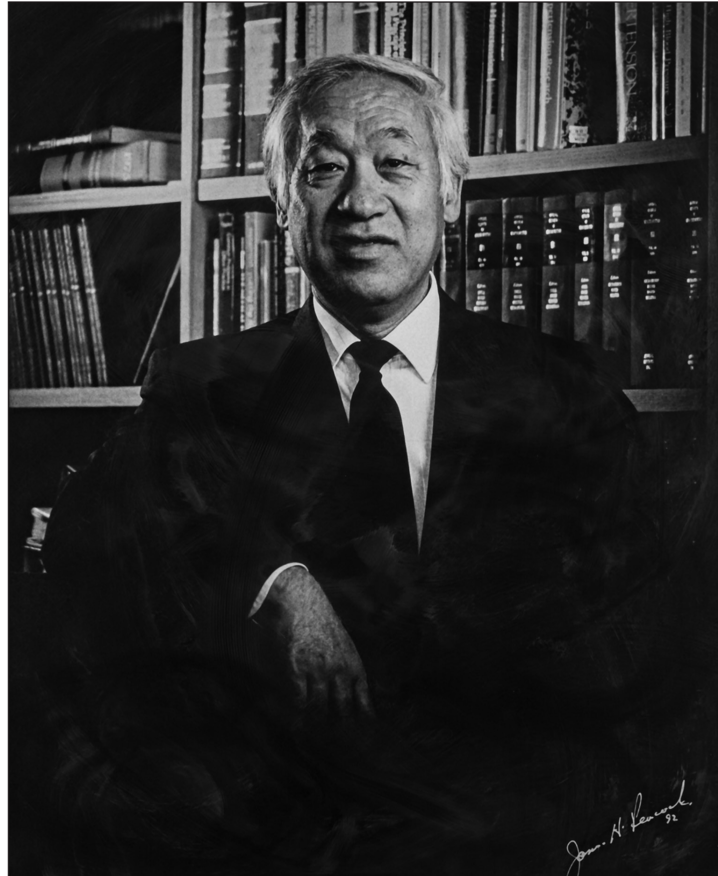

Moramu Watanabe
OC, MDCM, PhD, FRCPC, D.Sc (Hon)

Chapter 3

The Dean Watanabe Years, 1981–1992

James R. Wright, Jr.

After Dr. McLeod stepped down on short notice to become the first president of the AHFMR, it seemed clear to everyone—except perhaps the man himself—that Dr. Mamoru (Mo) Watanabe was destined to succeed Dr. McLeod as dean of medicine. Perhaps, this should have been obvious to Dr. Watanabe as well.

First, McLeod had known Watanabe for most of his professional career and had been cultivating a good relationship with him since they first met at McGill's Royal Victoria Hospital, where Watanabe was a third-year medical student and McLeod a clinical fellow in endocrinology and metabolism. While both eventually went their separate ways, McLeod was planning ahead and made certain that they kept in contact. McLeod next pursued research training in the United States and then accepted a position as a division head at the U of A. Watanabe, meanwhile, followed his postgraduate clinical training with a PhD at McGill before going to the Albert Einstein College of Medicine in New York for postdoctoral training in molecular biology. As Watanabe would later note:

> Lionel had noticed me in Montreal, wanted to recruit me to the U of A, so each year on his way to the nephrology meeting in Washington, DC, he would stop in New York, take me out for lunch or dinner and talk to me about the U of A. I had no interest in moving to Edmonton and McGill was expecting me to return. Also, Canada had created a teaching hospital research fund to support and encourage medical research, and every teaching hospital affiliated with a medical school was in the process of building a clinical research facility and every medical school was actively recruiting Canadians training in the United States to return to Canada. So I was juggling offers from a number of medical schools. During this time, the biochemistry department at the U of A was hosting an international conference

on virology and I was invited to make a presentation of my work at Einstein on RNA bacteriophages, so during this visit I allowed Lionel to show me around the med school and to talk to me about their research plans. The research activities in the clinical departments were still in the early stages of development, and I began to feel that joining the U of A would really test my abilities to succeed as an independent investigator, versus joining the established research environment at McGill or the University of Toronto, where, in my own mind, it would be more difficult to assess what I was contributing to the team effort. This naive thought, plus the concerted effort of Dean Walter MacKenzie, department head Don Wilson, and division head Lionel McLeod to recruit me, prompted me to accept the U of A offer.[1]

Watanabe was also developing a pattern of following in Lionel McLeod's footsteps. Asked, for example, how he originally moved to Calgary, Watanabe replied: "It's all related to Dr. Lionel McLeod." He elaborated:

> Lionel McLeod departed and moved to U of C as head of medicine and I inherited his vacated position as division head of endocrinology and metabolism (at U of A), reluctantly, since I was not interested in being an administrator and my overwhelming priority was to establish my credentials as a serious researcher. I had also been appointed an MRC associate, which mandated 75 per cent of my time in research. About seven years later, Lionel became the dean of the Faculty of Medicine (at U of C) and invited me to look at the headship of medicine. I was not interested in moving since . . . I was still not interested in becoming an administrator. I did, however, reflect on where I could continue to do my best research, liked the multidisciplinary research groups at the U of C, and thought that as head of medicine I would be in a better position to protect my research time. I also felt that the new young faculty members in medicine needed a lot of guidance to survive and succeed in their research careers, especially in balancing their heavy clinical responsibilities and education roles, and to become more competitive at the national level. I felt I could help them.[2]

Most importantly, at Calgary Watanabe had served sequentially as head of the Department of Medicine, associate dean (education), and associate dean (research) under Dr. McLeod, so he knew the faculty's issues; there was, therefore, no one

better prepared to take over as dean. But Watanabe still wanted to focus on a research career and did not apply. According to Watanabe, the transitions occurred as follows:

> Lionel was appointed as president of the AHFMR and he left the faculty on very short notice on 1 June 1981. Norman Wagner [1935–2004], president of the U of C, asked if I would take on the position of acting dean. I agreed to it because I felt it was an obligation having been in the position of associate dean (of both education and research) and since I was not going to be a candidate for the deanship, but I did warn Dr. Wagner that I would behave as the real dean, since marking time for a year would be disastrous for the medical school, especially at a time when AHFMR promised such tremendous opportunities. I did not apply for the dean's position, but near the end of the search process the secretary of the search committee asked for my CV so I complied, and the president offered me the position. Some important initiatives, most notably the building of the AHFMR building, had been put into place during my acting year and I was anxious to see them through to a successful completion, so I dropped the "acting" and slid into the deanship on 1 July 1982.[3]

Another major challenge facing Watanabe would be the "coordination of both the education and research activities of the faculty."[4]

The outcome of the search for a dean was not a surprise to most, as Watanabe's qualifications were exemplary and he had been succeeding in his role as the acting dean. Nonetheless, Dean Watanabe clearly had a different style than either of the previous deans. Bill Cochrane used to have coffee with students every day, either in the hallway or in the mall, and Lionel McLeod attended student parties and weekly TGIF celebrations. According to Watanabe,

> [this] was a bit too much—it took an awful lot of time. I used to have coffee and if a student wanted to talk to me—that would be fine, but I certainly didn't make it a point of trying to be too friendly with the students. There are times when you do have to discipline students and so you can't be too close to them. You can't cloud your objectivity, but this is true with everybody below you as well—you can't be too friendly with [a] small number of department heads or small number of faculty members ever, because when there is an issue you can't play favouritism and you need to be a little bit removed, which is why it's a bit lonely at the top.[5]

Watanabe decided the best way to maintain his interactions with students and faculty was through day-to-day “real world” contact:

> I continued my practice, I continued my research and I continued my teaching, and I said that it was important for me to do that because I wanted to interact with people in their normal activities—that is, you don’t want to be sitting in an office away from everyone and then having people come to you with their problems that become so huge that it couldn’t be solved. If you meet them in their own territory and they tell you about problems, you could nip the problem in the bud right then. . . . It’s a way of keeping in touch, not only with the activities of the faculty but also with the people.[6]

Having been able to observe the activities of the Dean’s Office while serving in back-to-back associate dean roles, Watanabe had considerable insight into its operations, and he felt that some areas needed attention. Therefore, he quickly implemented some changes:

> I just worked longer hours and I worked harder than I ever did in my life and. . . . I would come to work early in the morning, solve most of the issues, deal with the correspondence and by nine o’clock be free for department heads or faculty members wanting to see me for some urgent issues. I didn’t like the idea of people being upset or angry or having a problem fester while waiting for somebody to listen to you. The dean needs to be open and accessible. I also told my executive assistant that we have to change the culture of the office of the dean. Prior to my time, the Dean’s Office used to be known as a place you would go to if you wanted a “No” answer. We are going to start saying “yes” and if you can’t say “yes” right away, you ask them to leave it with you and we will get back to you as soon as we can with a “yes” answer. I used to ask department heads to tell me what they wanted—tell me what you’re working toward, what is your vision, what is your goal, because I may not have the resources or the funding to support you immediately, but it’s very important I know what it is you want to do because I do get people walking in and saying I want to donate some money—then I can connect you to them.
>
> You have to keep people dreaming a bit. When I said we were going to build the Heritage Medical Research Building, I asked faculty members to tell me what space they

> needed to build, what we don't have right now. Their response was hardly a response. I said to the department heads that after many years of saying "No" to people—you can't do this, you won't do this—people have stopped dreaming, they don't want to ask for anything, afraid that the answer will be "No." So we had to get people to start dreaming again about what they wanted to do.[7]

Clearly, Dean Watanabe's manner of solving problems was different from the other deans, and it was certainly not top-down:

> I would say the most important thing . . . for a leader . . . is you need to be able to listen to people and you need to have the time to listen to people. You need to make people feel very valued, you can't be inaccessible or not caring about what people think, and you need to help people solve their problems. A lot of the time people already have their own solutions. People would come and share their problems and at the end of the discussion I would ask them what they think they should do, and they would say, I think I should do this, and I would agree. They have the answer; they need to have someone validate it.[8]

Dean Watanabe was viewed as an excellent listener: "One of my strengths was that English was not my first language and so I am not very good at English, so I have to listen very, very carefully to what people are saying in case I miss the nuances, and so I think I come across as a good listener—it's because I am trying to understand what they are saying: that gives the impression that I am really listening."[9]

Dr. Watanabe understood that his department heads were experts in their fields and that he was not; they generally brought valuable input into most scenarios, and especially those involving their specialties. Therefore, he wanted to support their good ideas rather than try to change them to reflect his preconceived notions. This seemingly simple insight eludes many senior administrators, even seasoned ones, and was undoubtedly a key to his success as dean.

Dean Watanabe also prioritized the improvement of communications between the faculty and the Foothills Hospital administration, which he believed to have been suboptimal. To this end, he concluded that these interactions needed to be face-to-face and involve him directly:

> And that brings me to what you cannot delegate. The one thing that I found you cannot substitute or delegate is that kind of interaction with people because it's very frustrating for people when they can't engage you in resolving an issue. Early in my deanship, in a meeting with Ralph

Coombs, the president of the Foothills Hospital, I said there were things that we really need to change. The [clinical] department head who goes to the president first would get shunted to the dean; and those who first approached the dean would be shunted to the president. I feared that department heads were shuffling back and forth between the dean and the president wondering what to do, never getting a satisfactory solution. I felt that the president and the dean needed to work it out together through frequent meetings. Even if there are no immediate issues there was a need for constant communication between the two organizations at the very senior level, to anticipate potential problems coming down the line. Later, on occasion the president tried sending one of his vice-presidents, which didn't work because the vice-president was not delegated to make decisions or commit to an action plan and the issue needed an urgent response.

During my time, I did not want to dilute the interactions between dean and department heads by delegating that function to someone else. When I first came to Calgary as head of internal medicine, I felt that department heads did not have any significant role or authority in the medical school and the allegiance of clinical heads was more closely aligned with the Foothills Hospital. My impression was that the activities and policies of the medical school were largely dictated by the associate deans and research group chairs. When I became the dean, I was determined to give department heads a stronger voice in the affairs of the medical school, to make them an integral and important part of the administration. I wanted them to be strong leaders for the department, but I also wanted them to be leaders at the faculty level.

My view was that to build a successful medical school, one had to have strong and successful units, not just research groups but strong and nationally and internationally respected departments. That meant working closely with and helping department heads, especially the younger ones, to be successful leaders. To do so requires defining what is expected. My advice to department heads was to extract the very best possible performance from the departmental members, whether it is in education, research, or clinical activity, which may require very different strategies for different members because individuals are at different stages of their careers with divergent

> skills and knowledge, with their own individual personalities. You have to be like the director of a movie—you need to know how an actor is going to respond to suggestions or commands to extract their best performance. And similarly, the dean's job is to extract the best possible performance from department heads. So with some, kindness and sympathy is required, while with others you may need more harshness. To do so, I don't know whether you can have people in between you and the people that you are trying to deal with.[10]

Dr. Watanabe, recognizing that the faculty's educational mandate had been well stewarded under the previous deans, wanted to increase its level of research intensiveness. He was concerned about the faculty's grant funding and research output. According to Watanabe:

> One of the things that struck me . . . was that the clinical members were not using national or international standards in appraising their research contributions. Some of the researchers in clinical departments were quite happy to get one or two thousand dollars here and there from different donors for research projects that they weren't ready or willing to submit as a grant proposal to a national funding agency to see if they meet national standards. I kept saying that we need to be doing research at the level of international and national standards. We need to be . . . proud of what we are doing because it can stand up to anybody's scrutiny. Now, it's very much more competitive, meeting international standards, but it wasn't then. . . . As a new medical school you do have to set priorities on what to develop first and . . . you have to develop your educational programs first.[11]

Watanabe was a big fan of the faculty's research groups. In fact, he was initially attracted to relocate to the U of C as a department head because he believed that his own research program would flourish within research groups, and as dean he believed that these were a key to the faculty's future research success:

> Research groups are fairly strong entities and you have to assess them in relation to individual departments. Some department heads had no concept or experience with research and so would have had difficulty recruiting or supporting research scientists. Research groups were very important in that scenario. Department heads with strong research credentials probably would have preferred a more traditional system but I think most of

> them, bathed in the overall faculty culture of democratic decision-making, could live with it. Research groups would identify candidates to recruit but would have to find agreement with one or another department head to finalize the recruitment. One advantage of this arrangement was that it assisted those departments that had little or no research activity to become more research-intensive. . . . Some department heads we were trying to recruit from outside didn't like our structure and would have preferred to have the control over all activities of departmental members. My advice to them was that the U of C was not the right place for them. Here you have to lead or manage by persuasion, convince people that what you want to do is the right thing.[12]

But Watanabe also recognized that department heads needed to work together to promote excellence within the faculty:

> I think it's important to have a culture of departments helping each other, versus a culture of competitiveness. So when I became the dean I started taking the department heads on six-monthly retreats where the department heads could interact with each other and become aware of some of the issues other department heads are facing, because in order to be a strong faculty we need to help each other—we need to understand whether psychiatry needs something or pathology needs something and why we should be supportive and that, I think, worked really well. Dr. Clarence Guenter said to me after one of the meetings in Banff, "You know, this is a very good thing to do because after our meeting it is very hard for me to go back and say that we need this in medicine when pediatrics needs it more. You can't be competitors—we have to work together to build something."[13]

As noted in the previous chapter, Watanabe inherited outstanding issues that needed to be addressed and was presented with new opportunities when he assumed the acting deanship. The most important of these was the new AHFMR, which had formed in 1980. Both McLeod and Watanabe were involved early in the foundation's history, as the latter explained:

> When Premier Peter Lougheed was interested in a legacy project, he consulted Lionel, who suggested the concept of medical research, which eventually became the Alberta Heritage Foundation for Medical Research. Lionel always was generous,

giving credit to Tim Cameron, who was dean of medicine at U of A, but I think Lionel was the person who sold the idea. At that time, I was associate dean of undergraduate medical education, Warren Veale was associate dean of research, and Bill Tatton was the chair of the research committee. Lionel, Warren, and I met during the initial stages to develop the concept and [we] produced a position paper documenting the proposal for a Heritage Foundation. Bill Tatton was involved. . . . In 1980 Warren Veale was finishing his term as associate dean of research and I was asked to take on the role starting 1 July 1980. The Heritage Foundation had been formed, a board was appointed, and Jack Bradley named as executive director. At the end of June, Lionel invited me to have lunch with Jack Bradley. Bradley wanted the AHFMR to start as soon as possible and decided to create an ad hoc scientific advisory committee to advise the board, and he asked if I would chair the ad hoc committee beginning July 7th. Although it was an incredibly short notice, I felt that it was such an important development I should do whatever it takes to make it successful. Members of the advisory committee were chosen, and we felt it was important to have an immediate competition for junior awards, studentships, and postdoctoral fellowships, to start in September of 1980. It was an almost impossible task, but we did meet the deadline.[14]

At the time of the turnover, the educational mandate appeared to be in very good shape. The Royal College of Physicians and Surgeons of Canada report, received in March of 1981, had indicated that, with the exception of general pathology, all residency programs were approved for the maximum of five years. The U of C's first-year internship program had just been inspected by the National Joint Committee on Physician Pre-Registration Programmes to ensure programs are of high quality, uniform, and portable across Canada. The Department of Hospitals and Medical Care had just approved twenty-five new residency positions for the U of C, and there was now a total of 244 funded residency positions.[15]

Chronology of the Watanabe Years

YEAR AS ACTING DEAN, 1981–2

Watanabe was appointed acting dean of medicine by President Norman Wagner (1935–2004) starting 1 July 1981. He almost immediately initiated discussions with Alvin Libin, the chair of the board of the Foothills Hospital, to look for common ground and areas for future co-operation. These discussions led to new visions around

excellence, establishing an academic Health Sciences Centre, and the Heritage Medical Research Building; Watanabe describes these interactions as follows:

> The relationship between the Foothills and the medical school had been complex, with the Foothills Hospital behaving as the dominant partner. My vision was that we needed to be equal partners, so I invited Al Libin for dinner to discuss our common vision, our future relationship and directions. His vision for the Foothills Hospital was to be the best in the world, which matched my hopes for our future. We agreed about becoming an academic health sciences centre that is an equal partnership between the two organizations, where both institutions are fully immersed in research, education, and clinical services. We agreed to visit some US academic health sciences centres to learn how they succeed.
>
> In order to succeed we needed new space on the site with three components that did not exist at the time—a wing for clinical research patient encounters, space for laboratories focused on clinical research, and space for advanced laboratory and diagnostic facilities. We agreed that a building jointly owned would be ideal.[16]

This precipitated discussions with both Premier Lougheed and the AHFMR. Watanabe was so excited about the prospects of this new building that it influenced his decision to stay on as dean after his acting year. As could easily be predicted, Watanabe continued to have important interactions with the AHFMR:

> Heritage was a very big part of my deanship. Even after Lionel [McLeod] became president of the AHFMR, he asked me to continue as chair of the ad hoc advisory committee, so we were the group that created the AHFMR scholarships, AHFMR medical scientists and AHFRM establishment grant terms of reference and ran their early competitions. At the faculty level it was all about raising awareness of Heritage competitions and recruiting to these opportunities. We needed to take full advantage of AHFMR opportunities—it was the only way for the faculty to grow.[17]

The Division of Educational Planning and Assessment (DEPA)was henceforth reorganized into the Office of Medical Education, which in turn became part of the Dean's Office. It was one of two divisions that did not become departments.[18] Dean

Watanabe considered DEPA a disappointment for the following reasons:

> Dr. Cochrane had created a Division of Educational Planning and Assessment but it failed to live up to its high hopes and expectations. It became a service arm, interested only in evaluation. It did very little, if any, research, which was an expectation in the original faculty plans—research was expected to guide the evolution and improvements in the curriculum. . . . Another shortcoming of DEPA was that, unlike McMaster, they did not want to or were afraid to play on the national or international stage. The result was that Calgary missed an opportunity to be viewed as an innovator in medical education.[19]

There were several notable donations later in the year. One of $250,000 from the Monroe-Litton Corporation, which was matched by the provincial government, permitted the purchase of forty-six microcomputers for educational purposes, while the Nat Christie Foundation of Calgary agreed to donate $100,000 per annum for three years to cover the tuition and fees of selected undergraduate students. Other important occurrences included the launch of a newly approved residency program in community medicine and the appointment of Dr. Church as associate dean (research) to replace Dr. Watanabe.[20] Seventy-two students were

9

Heritage Medical Research Building

The Faculty of Medicine's second building opened its doors on 17 November 1987. It had several different names while it was being planned. The original concept for the building was conceived by Mo Watanabe and Foothills Hospital Board chair Al Libin when they met early in Watanabe's year as acting dean in 1981. They agreed that their two institutions should develop an academic health sciences centre focused on research, teaching, and clinical services, and that this should be an equal partnership. They further agreed that they needed a joint building to make this happen, and they hired an architect to develop the plan. Next, they approached Premier Peter Lougheed, who approved of the concept in principle but told them to come back when government oil revenues had recovered. At about the same time, the AHFMR Board became aware of these discussions and asked Dr. Watanabe to attend their next meeting and make a presentation on clinical research, as opposed to basic biomedical research, which they were accustomed to funding. Dr. Watanabe expected that his presentation was for information only, since the AHFMR legislation did not include

construction of new buildings. To Watanabe's and Libin's surprise, the board proposed $50 million in support of one-third of the clinical research building, but at the next meeting lowered this to $32 million so that they could offer U of A the same amount. Watanabe and Libin were left to find the remainder of the necessary funding.[1]

Although oil revenues had not recovered, they identified a new partner, the Tom Baker Cancer Centre (TBCC), and the building was to be called the Clinical Specialties Building; this would provide 250,000 net square feet of space and cost $120 million. However, this is not what happened. By 1983, it was decided that the building would be developed solely by the University of Calgary, that the AHFMR would provide $32 million, and that it would be called the Clinical Research Building. These changes were due to Premier Lougheed's decision not to fund the building from the Heritage Savings Trust Fund. Lougheed, instead suggested the development of a 50,000-net-square-foot building as a first phase that could be expanded when government revenues from non-renewable resources increased. It was further recognized that the boards of the Foothills Hospital and the TBCC could join in later if they could contribute financially to the project. Therefore, the board of the AHFMR was approached for its approval so that functional planning could begin. Early in 1984, the board approved the development of a clinical research building of 50,000 net square feet that would be finished internally in stages as new research programs proposed to the AHFMR were approved.[2] By the end of 1984, more details were available. The building would consist of a basement and five floors; two of those floors would be shelled in only and one of these might be purchased by the Alberta Cancer Board. Construction was to begin in December 1985 and was to be completed in 1987.[3]

Ex-premier Peter Lougheed spoke at the opening ceremonies of the new Heritage Medical Research Building on 17 November 1987. He described the facility as a "contribution, not just selfishly to ourselves, but to humanity. . . . It's going to be a place where brains and imagination, spirit, motivation, co-operation and teamwork are all going to be part of the decades ahead."[4] An article entitled "Lougheed Opens Research Building" duly followed in the *Calgary Herald* on November 18. It described "the facility at the edge of the Foothills Hospital site, [which] provides nearly 21,000 square meters of floor space on five floors for 40 new medical research scientists. Each scientist, in turn, will create at least five spin-off jobs, including research training opportunities for young people." The *Herald* also noted that a "sister building [was] due to be opened in Edmonton next month."[5] This was clearly seen as an answer to both deferred space needs and the expansion of the faculty's research enterprise. But it would require additional planning, and so several months before the opening, an Advisory Committee on Research Development was established to advise the Dean's Office on new research groups, primarily those to be located in the new Heritage Medical Building, but also in the Health Sciences Centre. In his interview for this book, Dr. Watanabe described his role in these

developments as follows: "I had a lot to do with getting the building built and keeping control of it all the way through to the end, but once it was built I asked Bob Church, who was the associate dean (research), to fill it with people and the programs, although we had programs suggested for the building, which we had to do in order to get approval for the building."[6]

accepted into the program in 1981 (the class of '84)—the same number that had entered the class of '83 the year before.

Early in 1982, it was announced that the U of C must find money to make up a $1.5 million deficit and that, as a result, the Faculty of Medicine expected to cut the equivalent of two full-time positions and make cuts in support staff. The faculty's operating budget, however, was expected to increase by just 12 per cent, which was barely enough to keep up with inflation. Watanabe reported that alternative sources of funding (e.g., from the Department of Hospitals and Medical Care, along with various endowments) needed to be found.[21] There was, however, some good news during this period—namely, the establishment of the Julia McFarlane Chair in Diabetes Research, which, as noted in the previous chapter, was based upon a privately donated endowment of $1.5 million. Also, early in 1982, a joint U of C–Institute of Medicine postgraduate training program in general medicine for Nepalese doctors was approved. Under the program, Nepalese doctors would receive one year of training in Calgary teaching hospitals and six months in a rural-practice setting.[22]

Drs. McLeod and Cochrane returned to Calgary to give the keynote presentations at the faculty's tenth-anniversary conference on 22 March 1982. Dr. McLeod noted "the delight I experience in visiting the medical school. It goes very well and remains one of the more exciting groups of people with which I find I can associate myself. Perhaps it is the youth, but I suspect it is more the ability and imagination of its staff that remains magnetic."[23]

In his presentation, Dr. McLeod discussed the potential impact of the AHFMR on medical education. He emphasized that recruitment must be done according to a plan. The challenge is to direct funds to the right program, not just to areas of either strength or weakness. Teaching experience must be addressed when recruiting researchers, if one is going to create a scholarly clinical service that is epidemiologically based. As a prod he added, "If we don't do well, we will roll over and die."[24]

John Baumber, discussing the faculty's future, pointed out that U of C graduates were returning to the faculty and that this was a sign of maturity. Dr. Baumber also emphasized that students must focus on problem-solving through hypothetical-deductive reasoning instead of just for examination preparation, something that will require practice and integration into the curriculum. Somewhat presciently, he added: "Students will become far more computer literate than most faculty. Computers will be used for evaluations and assessments, aids to memory in CME, and accelerating bench to bedside learning from target to research. Flexibility will remain a key note in a close faculty-student relationship."[25]

WATANABE BEGINS HIS FIRST TERM AS DEAN

Acting Dean Watanabe announced to the FC on 26 May that he was now dean with the following speech:

> As most of you know, the President's Office has officially announced my appointment as dean of this faculty for the next five years. Many of you have been kind enough to offer your congratulations and good wishes and I do want to thank you all for your encouragement and support. I certainly look forward to serving the faculty and to working closely with all of you to meet the challenges of the future. We are, I believe, sitting on a pivotal period in the life of this medical school. On the one hand, we are faced with budgetary restrictions that threaten our future growth and development. On the other hand, opportunities for growth are being made available through the Alberta Heritage Foundation for Medical Research, through donations from the private sector and through the Department of Hospitals and Medical Care. With careful and intelligent thought and consideration, I think it is possible for us to plan a continued and balanced growth that need not jeopardize any of the key elements of our current faculty endeavours.
>
> As most of you know, on June 4th we will be graduating our tenth class. . . . I think it is a reasonable time to reflect on the accomplishments of this medical school during its first ten

years. I'm afraid that we have sometimes had a rather negative view of our accomplishments, but I'd like to say that I think the school has done extremely well in a very short time. We are producing medical graduates who are considered by program directors across Canada to be knowledgeable, compassionate, and generally very good in clinical skills. Our research development has been impressive, and I think we have attracted some very good faculty here.

From this base, I think we have an optimistic future, an opportunity to develop into a first-class medical school. I would ask that we not dwell too much on the problems of the past but look forward and tackle our problems in a positive manner. I think that our greatest resource is our faculty and I believe we have the capacity and resource for greatness.

While we're dwelling on our past—let me publicly indicate my thanks to the many faculty who have given of their time and effort to assist me during this acting year. I have enjoyed the year immensely and as I said at the beginning, I look forward to working with all of you for a few more years.[26]

Immediately after assuming his deanship, Dr. Watanabe was forced to deal with a scandal. Copies of the end-of-course certifying evaluations had been found circulating through the student body; the confidential item bank and certifying evaluations would now need to be replaced. An investigation, carried out throughout the fall and concluded before the end of the year, determined that thirteen students from the class of '84 had some involvement, though the Student Promotions Committee determined that twelve of these students had not engaged in unethical behaviour and/or intellectual dishonesty. The Office of Medical Education's procedures for handling examination documents were immediately improved. And yet, to make things worse, it was announced at the same FC meeting that some investigators and faculty had been accused of stealing animals from the vivarium.[27]

In the wake of these events, Dean Watanabe's next speech to the FC, delivered via an extended diagnostic metaphor, dealt with both good news and bad news:

> As we start our fall session I would say that the patient—the faculty, that is—appears on inspection to be healthy and growing. On more detailed auscultation, however, I am not sure whether there aren't some signs and symptoms of an early disorder.
>
> First, the healthy exterior. Economic health is becoming to me a relative term. In the midst of an eco-

nomic recession and budget cutbacks, we are in the fortunate position of actively recruiting to our faculty and in a few moments, I will introduce our new faculty members. Since our last faculty meeting, we have twenty-seven new full-time and four new major part-time appointments, with several more expected to arrive in the next few months. Roughly a third of the new faculty members are funded by AHFMR and MRC support; a third from other agencies and a third from U of C funds resulting from previous vacancies and resignations. We have also had significant donations from the private sector—a Search Committee is actively searching for a member to occupy the Julia McFarlane Chair in Diabetes Research, funded by a $1.5-million donation. We have also received a $1 million commitment from the Nat Christie Foundation for the development of a Reproductive Biology Unit and a Search Committee has been established for the Clara Christie Professorship in Obstetrics and Gynaecology. In the past few days we have been notified of a $3-million grant from the Canadian Foundation for Ileitis and Colitis to set up a Digestive Diseases Research Unit. Also, as you walk through the building, you will notice the active renovation and constructive program funded largely through the Alberta Heritage Foundation for Medical Research. We have also recently finalized an agreement with the Department of Hospitals and Medical Care, which creates a significant number of positions for the clinical departments. We are, therefore, doing all right but let us not kid ourselves that this is going to continue. Universities across Canada are in difficulty and we, too, are in for a tight budget situation. It will take our collective wisdom to stretch our dollars and to reallocate our resources where required.

Now the unhealthy news. We, I think, have prided ourselves in recent years on our achievements in the undergraduate education program. We have insisted that we are here to teach our students knowledge, skills, and attitudes required to make a good physician. The results of the MCC exams suggest that our students are acquiring the necessary knowledge and skills. Recent events in our faculty suggest that we have not been uniformly successful in teaching our students the proper attitudes and ethics required for medical practice—I am talking of intellectual dishonesty. While it would be simple to write this incident off as a sign of the times, I

> think it would be important for the faculty to contemplate whether we have provided the appropriate environment and atmosphere that allows moral integrity to flourish. I do not wish to lay blame nor start a major debate. I think the time has come for all of us to contemplate our moral responsibilities.[28]

In the late fall of 1982, the *Calgary Herald* published an article entitled "Hospital chief raps provincial funding"; it described a growing rift between the Alberta Hospital Association and the Ministry of Hospitals and Medical Care. As Alberta Hospital Association president Bud Pals told the paper: "The province is attempting to control its expenditures by deliberately underfunding the hospitals, and that puts the (hospital) boards, who are supposed to provide service, in a very frustrating position." The story further explains that Premier Lougheed's minister of hospitals and medical care, Dave Russell, had indicated that the ministry would not cover hospital operating deficits at the end of the fiscal year.[29]

Other important occurrences in 1982 included the Department of Family Practice being renamed the Department of Family Medicine; the approval of two new research groups (immunological sciences and musculoskeletal); and a restructuring of the U of C Medical Clinic, in which the Ambulatory Care Centre Committee of the FC was disbanded and replaced by a management committee composed of representatives of clinical departments who were elected by "practising" members.[30] Seventy-two students were again accepted in the class of '85.

The New Integrative Course Begins in 1983

On 15 March 1983 the new integrative course was implemented; this represented a major change to the curriculum. Henry Mandin had been asked to chair the Integrative Course Committee, which planned both its content and implementation. The course was four weeks long with sixteen hours of teaching per week.[31] In May and June of 1983, the Office of the Associate Dean (Clinical Services) reviewed the clinical facilities of the U of C Medical Centre (UCMC) and a UCMC Management Committee was formed, which reviewed allocated space, affiliation agreements with Calgary hospitals, and UCMC billing processes.[32] In June 1983, a four-day CME conference entitled Looking to the Future was held to celebrate the tenth anniversary of the first convocation of U of C medical students. Several students from the first class gave presentations. Honorary U of C LLDs were also given to Dr. Cochrane and Mervyn Graves, the retired chair of the ACH Board.[33]

The U of C Faculty of Medicine took a 2 per cent budget cut for 1983–4, most of which came from the departmental operating budget. Later in the year the university announced that it expected to be short $4 million for the 1984–5 fiscal year, and that the Faculty of Medicine would be

expected to cut 5 per cent in salaries (or $400,000). However, the projected budget reduction was soon decreased to 1 per cent, which could be managed without cutting positions.[34]

At the December FC meeting, Dean Watanabe provided an update on plans for the new research building. Other important occurrences that year included Dr. Arthur David Dickson's (1925–2018) appointment as chair of the Internal Assessment Steering Committee for the upcoming accreditation site visit in the spring of 1985; approval of the positions of assistant dean (medical bioethics) and assistant dean (continuing medical education); W. A. Cochrane's receipt of an honorary degree at convocation, at which he delivered the convocation address; and Calgary receiving twenty of twenty-five provincially funded new faculty positions for Alberta medical schools.[35] The incoming medical class remained at seventy-two students, while the quite familiar and congenial class atmosphere had not changed very much from the early beginnings, as one of the medical students from the inaugural cohort has recalled:

> We were taught in small group sessions on the twelfth floor of the Foothills Medical Centre. "Our floor" was stuffed with so many things: there were tables with textbooks on them, a corner that was used for chemical demonstrations, plastic torsos and models in another one, and opposite of the secretary's area there was the "anatomy department." . . . And, above all, the view from the windows on the hospital building's top floor was just spectacular![36]

PHYSICIAN WORKFORCE PROJECTIONS AND PLANNING

In the second half of 1983, a report on physician workforce "needs" suggested that the Western Canadian medical schools should cut their combined class sizes by 20 per cent. The administrations of these schools, believing that the study was flawed, countered with their own estimates. In early 1984, Dean Watanabe reported to the Government of Alberta that on a per capita basis only Newfoundland, New Brunswick, Prince Edward Island, and the Northwest Territories had fewer physicians than Alberta. Furthermore, if considering family doctors, only New Brunswick and the Northwest Territories had fewer. He also noted that new registrations in Alberta had decreased over the past three years, and that attrition had increased over the last year. Finally, if available first-year positions were compared to the population aged twenty to twenty-four, only British Columbia and Saskatchewan had fewer medical school positions than Alberta. The Alberta government responded by agreeing to provide more residency positions.[37] Dean Watanabe subsequently decided to develop a greater depth of expertise in this area. He soon became a nationally recognized expert on physician workforce planning and would be called upon to use this expertise again and again.

On April 1, the Canada Health Act was passed into law. It outlined the criteria provincial health-care systems must meet to receive federal transfer funding and precluded extra-billing by specialists. Immediately, Premier Lougheed "defended his government's stand on extra billing and hospital user fees in the legislature and said financial penalties assessed under the proposed Canada Health Act would be offset by keeping a tighter rein on costs." As the premier pointed out at the time, "if you don't have an opportunity for specialists to do some extra billing, such as plastic surgeons, we risk very significantly losing some of our key specialists to south of the border."[38] It was believed that the Province could face penalties of $14 to $20 million per year, but the government countered that these penalties would be offset by user fees, which would also keep everyone aware of the need for controlling costs. Eventually, the Province backed off from these defiant plans. As Dean Watanabe later reported, he believed that the Canada Health Act had no real effect on the U of C faculty.[39]

1984 also saw three important changes in the realm of postgraduate medical education (PGME). First, tripartite contracts for residents were implemented for the first time. Henceforth, residents signed contracts with both the university and the hospital (previously, it was only a contract with the hospital). Second, a pre-specialty rotating internship designed for those wishing to complete internships before entering a specific specialty was implemented. It consisted of eight-week rotations through obstetrics and gynaecology, pediatrics, surgery, and medicine. Finally, a program with the Saudi Arabian Education Mission in Canada was approved.[40]

Nationally, Canada saw two changes of prime minister in 1984. Pierre Trudeau (1919–2000) retired in February, and the Liberal Party selected John Turner as its leader. After he was sworn in as prime minister, Turner called an election and lost. On 17 September 1984, the Honourable Brian Mulroney (b. 1939), of the Progressive Conservative Party, became the eighteenth prime minister of Canada. Provincial health ministers across the country immediately wrote a letter to Mulroney to complain about outgoing Liberal health minister Monique Bégin (b. 1936) allowing federal contributions to provincial health care to drop to roughly 50 per cent for most provinces, and as little as one-third for some.[41] No resolution was forthcoming, and provincial health systems, including Alberta's, continued to be underfunded (from the perspective of the provinces) by the federal government. With the price of oil continuing to fall, this was not good news for Alberta's two medical schools.

At the December 12 FC meeting there was considerable discussion of the draft self-assessment document for the upcoming undergraduate medical education (UME) accreditation. It was noted that there were "some mistakes and errors in fact as well as in wording, and [that the document] has to be revised."[42] Many felt that "it generally has a negative tone, conveying the impression that the school is facing serious difficulties."[43] Others suggested that "it does not reflect the research

component of the school. . . . It emphasizes the negative consequences of increased research activities in the Faculty."[44] It was agreed that two members of the FC would help the Self-Assessment Committee to edit the report, and that there would be a special meeting of the FC in the new year to "obtain views of Council on the revised report."[45]

Other important occurrences included a new exchange program involving scientists at Alberta medical schools and Sapporo Medical College in Japan; the president of the Calgary Medical Students Association being made a voting member of the FC; and the CME program extending its teleconferencing to forty-two hospitals in Southern Alberta.[46] Ominously for the faculty's research enterprise, the federal government reduced the MRC funding by $27 million from the levels of the former government. To make things worse, the university budget for 1985–6 projected a deficit of $7.3 million to be made up for in cuts from the operating budget.[47] Seventy-four students were accepted into the class of '87.

THE 1985 ACCREDITATION

On February 13, a special meeting of the FC was held to discuss the self-assessment report. A. D. Dickson, chair of the Self-Assessment Committee, was asked to comment on the revised report and to lead the discussions. Drs. Clarence Guenter and Grant Gall had already met with the Self-Assessment Committee to suggest changes to the document—some of which were adopted. The document was reviewed in detail, with many motions approved and a few defeated. Finally, a motion was passed commending the committee "for its thorough revision of its original report and for taking into account the criticisms voiced at the last Faculty Council meeting."[48]

Later in February, accreditation site visits for the UME and PGME took place; both preliminary reports were highly positive. For its part, the UME recommended full accreditation for seven years (the maximum allowed in Canada). Of the twenty-three Royal College residency training programs that had been reviewed, only rheumatology and neurosurgery received provisional approval; the rest received full approval.

Both final written reports were received later that year. While the UME report was overall very positive, it pointed out the lack of academic growth in the pathology, radiology, surgery, and anesthesiology departments. The FC also noted that McMaster had been accredited for seven years and that "this indicated that three-year programs have been accepted." The Royal College's final written report accredited twenty-one of twenty-three residency programs for the maximum of six years.[49]

The report summary from the ad hoc survey team for the Committee on the Accreditation of Canadian Medical Schools and the LCME stated the following:

> The Faculty of Medicine of the University of Calgary has over a short period of some fifteen years, developed

> a strong and progressive programme leading to the M.D. degree. Although it is complex in its organization structure and execution, the programme is functioning effectively and affords an unusual opportunity for a wide segment of the faculty to participate in its management. Great credit for the over-all success of the operation is due to Dean Watanabe, who is widely admired and highly respected. He has earned faculty trust and support through wise leadership, administrative skill, and obvious commitment towards the goal of excellence in teaching and research. He has surrounded himself with a commendable team with similar attributes and aspirations. The team found much to commend and little to criticise. . . . Notwithstanding periodic debate, the three calendar year curriculum appears to be working well, and is not placing undue stress on students. In short, this school is well advanced towards fulfilling its promise of becoming a centre of excellence in medicine.[50]

The LCME's 1985 survey also had complementary things to say about the curriculum, noting that "another major achievement of the Calgary curriculum is the result and interaction of basic scientists with clinical scientists and clinicians. Everyone knows everyone and has some knowledge of their interests and fields of endeavor. This is an item of major importance not commonly found in medical schools."[51] When questioned about this, Dr. Watanabe would later explain that he agreed wholeheartedly with the LCME's observations:

> That culture is what enticed me to join the U of C. Credit goes to Bill Cochrane, the first dean. The idea of a critical mass, whether in research or education, is incredibly important if you want the best performance from your faculty members. Critical mass is difficult to create in a newer, smaller organization, so one needs innovative approaches. Bill Cochrane got it right—a brilliant move, which other institutions tried to emulate later.[52]

The report identified five areas requiring attention. These centred on the need to (1) complete research on the effectiveness of the novel curriculum (i.e., performance of graduates) and publish the findings; (2) be aware that some teaching faculty and students believe that the faculty was becoming too research intensive, though the survey team noted that it sees no inherent conflict in these activities; (3) make certain that department heads were better aware of all aspects of the curriculum; (4) improve the academic culture within the pathology department, which the survey team described as

disappointing; and (5) create a stronger academic department of surgery.[53]

The medical school had started out with an educational focus but was becoming more and more research oriented, especially with the advent of AHFMR-funded scientists. Some long-standing "teaching track" faculty members expressed concern that the balance was tipping too far toward research and that the quality of teaching would suffer. This was one of the notions that had been articulated in the earlier draft of the self-assessment document. When Dr. Watanabe was asked about this, he gave the following reply:

> When new medical schools are created, by necessity, the undergraduate education program has to take priority. As the student moves into the clinical years the clinical learning sites and clinical teachers need to be on site. The development of a research program, although it starts with recruitment of basic scientists, shifts into high gear only after the first two pieces are in place. To be a recognized medical school, there should be significant research activities, not only in basic biomedical and clinical research, but in other aspects of inquiry such as health services research, psychosocial and mental health, public and occupational health, health policy, international health—the full spectrum of health research. It was fortunate that the AHFMR came along when the medical school was moving toward the third phase of growth, namely, shifting research endeavours into high gear. My vision from the outset was to develop national- and international-calibre research units and programs.
>
> Unfortunately, there are faculty members who do not transition well in this scenario. They respond to the overwhelming educational needs in the early years by sacrificing their research and find it difficult or impossible to resurrect their research endeavours when the educational involvement decreases. It is not necessarily the shift in emphasis toward research that causes faculty members to feel threatened. Even if research grows, the educational activities remain core functions of the medical school and still continue to grow so "teaching track" faculty members still have a significant role to play in the faculty.
>
> In the early years of the medical school, academic advancement was largely on the basis of academic productivity, namely, publications and research funding. During my time, I changed the emphasis so that educational involvement was a consideration in merit increments and

> promotions. Faculty administration does need to find ways to assist faculty members in transition in finding a niche, a responsibility, a role, or a job that maintains their self-esteem, and allows them to contribute in meaningful ways. It can be a challenge.[54]

The physician workforce also remained an important issue in 1985. A study conducted for the federal and provincial health ministers projected a 10 to 17 per cent excess supply of physicians by the year 2000. The Alberta College of Physicians and Surgeons along with the AMA recommended a 10 per cent cut in enrolment at each school.[55]

Other important occurrences at this time included the federal government appointing Dr. W. A. Cochrane to the Canadian Biotechnology Advisory Committee; the faculty establishing the "Twenty Dollar Club" (a fund initiated by the Calgary Medical Students Association to support social outings between faculty and students); the replacement of retiring secretary Dr. Dickson by Dr. Lannigan; and a proposal for an intercalated year in laboratory medicine, which would allow a student to opt for one year of training between the second year and the clerkship, was approved. This year could be credited as one year toward a residency in laboratory medicine. Similar models exist in the United States and at one other Canadian medical school.[56] Finally, seventy-four students were accepted in the class of '88.

On June 14, the *Calgary Herald* published an article under the headline "U of C refuses to trim medical school." It stated that the U of C Faculty of Medicine "will again admit 72 first-year medical students in September, the same quota as in the past three years."[57] The explanation offered to the press was from Dr. John Baumber, associate dean of undergraduate medical education: "We are not taking our instructions from the government, but rather from the university Board of Governors. And they haven't instructed us to cut back. Besides, we are not entirely convinced there will be an over-supply of doctors in the western provinces. . . . Many of our senior students have told me they don't intend to work 60 hours a week like many doctors do nowadays."[58]

The number of full-time faculty had increased from 142 in 1980 to 241 in 1985. Space was therefore becoming an issue. The faculty compensated by converting library and conference rooms into laboratories that would be restored when the new AHFMR building was constructed.[59]

BUDGET WOES

In December of 1985, the U of C Faculty of Medicine had been told that a 4 per cent cut to its 1986–7 budget had been recommended. A total of $470,000 in savings needed to be found. Dean Watanabe subsequently told the FC "that if the cuts were taken in clinical faculty positions, a $470,000 cut would translate to a $940,000 cut, since the cost-shared portions of the salaries would be lost to the Faculty as well. He suggested that the Faculty of Medicine should agree to forego any salary adjustments or merit increments next year, and

that he should send a letter to the Board of Governors indicating this option."[60] Such a motion was carried at the FC meeting on 11 December 1985. The U of C BOG reported back in early 1986 that it would not consider the wage freeze as salary increases had already been negotiated.[61]

In May stories appeared in the *Calgary Herald* about a statement allegedly made by the minister of hospitals and medical care that the Calgary medical school might be closed. Dean Watanabe immediately contacted Dr. Alex McPherson in the Department of Health of the Province of Alberta, who stated that the minister had been misquoted. Dr. Watanabe received further assurances that there was no intention of closing the medical school in Calgary, and he passed this message on to his worried faculty.[62] At about the same time, David Russell's term as the responsible minister ended when Marvin Moore (b. 1938) replaced him in a cabinet shuffle. David Russell became the minister of advanced education, where he remained part of the discussions about the future of medical education in Alberta.

On a positive note, the provincial Department of Advanced Education announced that $80 million had been set aside to match donations for endowments from wealthy donors, with the details on how to apply for these funds to be announced soon. A few months later, the Dean's Office was told that the matching funds announcement may be delayed "in view of a tight budget" and that "more donations have been accumulated than the projected government allocation for matching this year."[63]

At the FC meeting on October 1, the dean stated: "Discussions are being held informally about an optimal location for the pediatric hospital. There have been no formal discussions, and no decisions have been made."[64] He also announced that the U of C Faculty of Medicine and the Foothills Hospital had reached a formal agreement with the Capital Institute of Medicine and Xuan-Wu Hospital in Beijing, to include an exchange of nursing, hospital administration, and other allied health professionals.[65]

Other important occurrences in 1985 included the Royal College's approval of a residency in medical oncology, the establishment of the drug testing laboratory at the Foothills Hospital in anticipation of the 1988 Olympics, which would enable monitoring of the use of banned drugs by athletes, and the FC's letter to Deputy Prime Minister Don Mazankowski (b. 1935) expressing concerns about MRC budget cuts. The Health Sciences Centre temporarily became a smoke-free building in October, though measures to make that permanent could not be implemented until the following year, as Edward Bryan Tinker (1932–2009), the U of C's vice-president of finance and services, wrote Dr. Watanabe on 1 April 1987 asking the faculty to delay implementation of its new non-smoking policy until a campus-wide survey had been completed in 1987.[66]

Meanwhile, the faculty was shocked to hear that California licensing authorities had decided that four years of undergraduate medical training would be required to practise in the state, which meant that U of C graduates would no longer be

able to acquire a licence to practise in California. The faculty also learned that an ACMC survey found that the U of C had the largest percentage of students choosing a career in pure research.[67]

In 1986, seventy-three students were accepted into the class of '89. The price of oil, which had been slowly decreasing during the 1980s, dropped another 50 per cent.

ALBERTA DOCTORS AND THE HEALTH-CARE SYSTEM AT WAR

The battle between the Department of Hospitals and Medical Care, on the one hand, and Alberta doctors on the other, continued to escalate throughout 1987. On February 13 of that year, a *Calgary Herald* article titled "Limit on doctors a step closer" stated that Minister Moore was planning to limit the number of doctors practising in Alberta since doctors' fees had escaped unscathed. He was also considering de-insuring some services and planned to cut the projected doctor fees for 1987–8 by $40 million. None of this sat well with the doctors.[68] In April, cancer specialists fought back through the press. For example, an article entitled "Clinics may drop cancer check-ups" appeared in the *Calgary Herald*. The province's oncologists indicated that provincial budget constraints may result in the offloading by the Tom Baker Cancer Centre in Calgary and the Cross Cancer Centre in Edmonton of cancer care follow-up to family doctors.[69]

The medical workforce debate continued. As recorded in the dean's report from the 13 May 1987 FC minutes:

> The Dean outlined the events following Hon. Dave Russell's statements suggesting that there may be duplication of and competition between programs of the two Alberta medical schools. The Dean had written an article published by the Calgary Herald which was sent to Mr. Russell and Mr. Moore. The Dean also spoke on the "Calgary Eyeopener" following Mr. Russell, and outlined evidence opposing the view that too many physicians for the future needs were being graduated in Alberta. The Dean reported that a representative of Advanced Education had come to see him before this exchange, requesting the impact of downsizing the undergraduate class in the medical school.[70]

Dean Watanabe Begins his Second Term in a Time of Uncertainty

On 1 July 1987, Dean Watanabe began his second term. He would later describe this period as follows:

> When I renewed my second term as dean I warned the president that it's

> going to be a very different term—I'm not going to be looking at it as a continuation of my first term—this term will bring a different kind of responsibility, a very different set of activities, and I need to sort of approach it like it is a new job, that's what gets you through your five years.[71]

Later that year, Dean Watanabe still believed that closing one of the two Alberta medical schools was not out of the realm of possibility:

> During my second term as dean, the Alberta government considered closing one of the medical schools as a solution to the perceived oversupply of physicians. Such rhetoric does make one reflect on the optimal balance between education and research. Many assumed that ending the undergraduate program would mean the end of the medical school; I suggested that we look at all of our activities and the benefits that accrue to Calgary as a result of our presence—postgraduate clinical training, CME, MSc/PhD graduate studies, research, external research funding that creates jobs, cash flows into Calgary, recruitment of world class clinicians who bring special expertise in health care, etc. I published an opinion piece in the *Calgary Herald* to inform the general public about what the medical school contributes to Calgary. Internally I suggested that the medical school review its options. One option was to become a medical school at the graduate level, focusing on PhD and postdoctoral students and postgraduate resident training in the clinical arena, continuing medical education for the practising community and maintenance of competence programs, coupled with intensive research activities in all spheres of medicine and health, including health policy, health management programs, etc.
>
> I also called the Hon. Marvin Moore, Alberta minister of health, to ask for a meeting to discuss his proposal to close one medical school in Alberta, which I suspected would not be at the U of A. I said that the government's concern was the escalating health-care costs, which some attributed to the increasing number of doctors, which I felt was erroneous, and I felt that cutting the number of medical students and doctors would not solve his problem and would create major problems in the future. I wanted to help him find the right solution. He agreed to a meeting and insisted on meeting me at the med school to get my thoughts. I suggested that he should resurrect the utiliza-

> tion committee that had been created when David Russell was the minister of health. The committee had made some important observations about unnecessary utilization of medical services, and I felt that an action plan should be developed to decrease utilization. I offered to help, meaning that some of our faculty members could provide useful insights. He called within a week and asked me to sit on the committee, and a week later the deputy minister phoned to say that Minister Moore wanted me to chair the committee. Having offered to help, I had no choice but to agree to serve. He announced publicly that the proposed closure of a medical school would be on hold pending receipt of the Watanabe report.[72]

This meeting between Minister Moore and Dean Watanabe resulted in the formation of the provincial Advisory Committee on Utilization of Medical Services, which was charged with monitoring and rationalization of health-care costs.[73] Dean Watanabe later described his time chairing this committee as a "fascinating exercise":

> Alberta Health had a huge database which stored all health-care encounters, but they had little or no analytical capability to mine this extensive information database. So, I took the raw numbers they generated for me and I researched the data. I also visited many communities to meet with physicians to discuss utilization issues and how to decrease utilization without jeopardizing the quality of health care. For the first time we were able to demonstrate that health-care costs and utilization could be flatlined even though the number of physicians continued to increase.
>
> Marvin Moore also toyed with the idea that other provinces were planning . . . to send the new graduates to rural areas. I advised him that it was not a good plan since more than 50 to 55 per cent of new graduates were women, and such an action could be viewed as discriminatory to women. He dropped the plan.[74]

Meanwhile, on November 17, the much-anticipated Heritage Medical Research Building opened its doors. Peter Lougheed spoke at the opening ceremony.[75] The opening was an answer to both deferred space needs and the expansion of the faculty's research enterprise (see sidebar 8).

In December, the faculty was asked to plan around a 6 to 7 per cent budget cut. Earlier in the year the provincial matching fund had met its obligations with all endowments made prior to March 31, but donations made after that date had not been dealt with. These included two new research chairs and two new professorships. It was

also announced that the U of C would receive $4 million from the provincial matching fund and that $750,000 of this would come to the faculty.[76]

In 1987, sixty-eight students were accepted into the class of ’90. The Admissions Committee also implemented a policy change and did away with the formal quota of a maximum of thirteen non-Albertan students per year, as it was noted that on occasion they had admitted more than the quota.

One final event spilled over well into the next year. In December of 1987, there were widespread public protests after Medicare cutbacks were implemented by Minister Moore, and Premier Don Getty (1933–2016) initiated a two-year-long Commission on the Future of Health Care. Alex McPherson was appointed the commission’s executive director and Louis (“Lou”) D. Hyndman (1935–2013), an Alberta legislator and future chancellor of the U of A, served as chair. The commission started meeting in 1988. Initially, some of the hearings were held in Calgary to facilitate input from residents, but later it was decided that all remaining sessions would be held in Edmonton. It was assumed that this would not disenfranchise Calgarians since all sessions were being videotaped, but Calgarians did not see it that way and many became upset.[77]

10

XV Olympic Winter Games, 1988

In 1981 Calgary was selected as the host city for the 1988 Winter Olympics. A year later Dr. E. Bruce Challis, then head of the U of C Department of Family Medicine, was appointed chief medical officer for the Games. In early 1984 Dr. Geoffrey Haigh (athlete medical services), Dr. Greg Powell (general emergency medical services), Dr. Robert Baynton (medial laboratory services, which in addition to drug testing was responsible for gender verification and provision of general diagnostic services), and Scott Rowand (auxiliary medical services) joined Dr. Challis’s leadership team as voluntary chairs for their assigned areas. Lane Casement was the overall manager.

Seven full-time staff supported the nearly 800 volunteers who provided medical services across 27 venues during the Games. Most participating countries also brought their own medical teams with them, with the Alberta College of Physicians and Surgeons granting temporary licences to their physician members. Local consultants agreed to be on call for athletes and other team members over the duration of the Games. If hospitalization was required, the Foothills Provincial General Hospital took care of athletes and team

members while the Calgary General Hospital was responsible for International Olympic Committee delegates, members of international sports federations, and other important visitors. The Holy Cross and Rockyview Hospitals would deal with media. The Canmore facility would serve the Nordic Centre. An accredited Medical Control Laboratory costing nearly $2 million was established at the Foothills site for drug testing.[1]

An unusual research project conducted in preparation for the Games dealt with the mascots Hidy and Howdy. The high school students wearing the costumes frequently became ill, with some even fainting. Treadmill testing at Foothills found that the temperature inside the suits increased rapidly to 34 degrees Celsius, while the inspired air became hypoxic and hypercapnic. This was solved by placing a small battery-powered fan in the headpiece, which pushed a stream of air across the face of the occupant and out through the mouth of the mask.[2]

On 25 January 1988 a province-wide illegal nurses strike began; this of course affected the city's hospitals. Threats that the striking nurses would refuse to provide services to visitors during the Olympics led to anxious moments.[3] Fortunately a settlement was reached on February 12, the day before the Games opened.

During the Games there were 3,395 medical encounters (athletes accounted for 500, spectators 796, and 2,099 were with volunteers and staff).[4] Tragically, a fatality took place. Dr. Joerg Oberhammer, a forty-seven-year-old orthopedic surgeon with the Austrian team, collided with another skier at Nakiska, was knocked into the path of a snow-grooming machine, and died instantaneously. Another serious injury occurred on the same hill. A seventeen-year-old working as a photographer's assistant suffered a severe head injury, also while skiing, and required resuscitation.[5] Long after the Games concluded he remained in a local hospital.[6]

The Medical Control Laboratory tested 428 urine samples (this total included 5 quality-control samples). On selected athletes, testing was done for five classes of banned drugs (i.e., stimulants, narcotics, anabolic steroids, ß-blockers, diuretics), probenecid (which can be used as a masking agent), local anesthetics, corticosteroids, human choriogonadotropin (which stimulates the production of testosterone) in men, and cannabinoids. There were sixteen positive analyses and one athlete, a Polish hockey player, was suspended.[7] His coach felt he was deliberately drugged, possibly for "political reasons."[8]

Typically, when the legacy of an Olympic Game is considered, the focus is on either the infrastructure built or the local economic impact. Less thought is given to the health and wellness effects. An obvious boon for the local medical community was the creation of the Medical Control Laboratory. The Games also played a key role in the transformation of the small Faculty of Physical Education into one of the most highly regarded kinesiology faculties in Canada and the establishment of the Sport Medicine Centre. While some young Canadians were inspired to pursue their Olympic dream by the Calgary event, there is no convincing evidence that being the site of an Olympic Games leads to a population-level increase in physical activity.[9]

1988 BEGINS WITH AN ILLEGAL NURSES' STRIKE AND THE CALGARY WINTER OLYMPICS

The year opened with an illegal nineteen-day nurses' strike at most provincial hospitals that greatly hampered the provision of health care. The underlying problems that precipitated the strike were not addressed or resolved. In June the Commission on the Future of Health Care released a controversial interim report suggesting a pilot study with hospitals contracting-out nursing work to private companies to avoid strikes and other union problems. This was not well-received by nurses, their union, or other health-care workers.[78] The 1988 Winter Olympics were held in Calgary from February 13 to 28. The event was preceded by major construction projects on the main campus of the U of C, such as the speed skating oval. The Faculty of Medicine had no official role in the games, but many faculty members participated. According to Dr. Watanabe, "Our head of family medicine was the medical director for the Olympics and he was a volunteer, I believe, not necessarily involved on behalf of the medical school. Similarly, a lot of faculty members were there as volunteers."[79] A summary of the medical services program for the 1988 Winter Olympics is available elsewhere.[80]

DUPRÉ REPORT

In March, it was announced that cuts to the faculty's budget for the upcoming fiscal year would be a miniscule 0.4 per cent, and not the 6 to 7 per cent that had been expected. This change was a result of the Dupré Report, which had been struck by the minister of advanced education in late 1987 to determine if there was any merit to the complaints that the U of C was underfunded relative to U of A. Stefan Dupré (1936–2012), chair of the committee, concluded that the funding disparity between the U of C and other Alberta universities, at $1 million, was relatively minimal. It was the result of increased administrative costs to support research because of the unanticipated rapid development of research programs at U of C.[81] Although the U of C expected the differential to be much higher than $1 million, the influx of funding came at a good time. Three new associate deans were announced: Henry Mandin (education), Keith Brownell (graduate clinical and CME), and Eldon Shaffer (clinical affairs).[82]

During this time, the Saudi Arabian PGME training program was withdrawn. However, current residents were able to complete their program. U of T, McMaster, and the University of Western Ontario also declined to renew their contracts for Saudi Arabian residents.[83] On September 8, Nancy Betkowski (b. 1948) replaced Marvin Moore as minister of health. On this development, Dr. Watanabe offered the following observations:

> Before the Utilization Committee finished its term, the minister of health changed hands and Nancy Betkowski (now Macbeth) became the new minister. I asked for a meeting to bring her up to date on the committee's work and asked her how we

> could help her, which I subsequently learned impressed her and I gained her trust. At that time the relationship between the minister, Alberta Health, and the Foothills Hospital was tense over issues of computers and hospital information systems, so at the request of the chair of the board of Foothills Hospital, I arranged a dinner meeting with him and the minister and later also assisted the deputy minister in interactions with the senior administration of Foothills Hospital, which eased the tension. This . . . improved the dynamics between the medical school and the Foothills Hospital.[84]

Other important occurrences during this time included the GCEC decision to limit the number of international medical graduate residents to 10 per cent in its PGME programs (on account of concerns regarding the number of physicians in Canada); AHFMR funding of a Biomedical Technical Support Centre, which consisted of a machine shop and an electronics shop in the basement of the Health Sciences Centre; the decision to make a four-week clerkship rotation in family medicine mandatory; and increased enrolment in the Medical Sciences Graduate Program. This meant that the overall number of graduate students had increased to 173, up 30 from 1987 and the largest enrolment in the program to date.[85]

Seventy-two students were accepted into the class of '91 in 1988. Only sixty-two graduates received their degrees that year.[86]

WATANABE BEGINS 1989 BY TAKING ON HEALTH-CARE COST-EFFECTIVENESS

In January, Liberal MLA Sheldon Chumir (1940–1992) organized a health-care forum and asked Dean Watanabe to speak. On January 15, the *Calgary Herald* published an article summarizing Watanabe's frank comments that "Politicians and doctors must do some soul searching to determine how best to deliver quality care as economically as possible."[87] The article continued:

> Doctors must begin eliminating those services which don't improve health or quality of life. . . . Watanabe said one example might be for doctors to measure how treatments prolong quality of years rather than just extending life itself. He didn't give examples of treatments that could be cut. . . . Watanabe said despite advice to the contrary politicians have been unable to avoid duplicating expensive, high-tech facilities such as cardiac surgery. . . . Politicians don't want to fund preventive medicine because its effects are only felt after many years, while politicians are re-elected every four years.[88]

The article contained several direct quotes from Dr. Watanabe:

> Physicians must evaluate quality of care, cost-effectiveness, outcome and performance against an acceptable set of standards. . . . It's time that we confronted politically motivated expenditure and acknowledged it for what it is and stop blaming physicians and patients who have no part in the decision-making that incurs these costs.[89]

One of the recommendations of the 1985 accreditation review was that the elective program in years one and two of the UME curriculum be reviewed, as electives were a "loose arrangement" with supervisors providing oversight of the student's activities with variable levels of rigor. The results of this review, including recommendations on how to formalize electives, were presented at the March 8 FC meeting. The motion to accept the report and its recommendations carried with five students opposing. Because of strong student opposition, the report and recommendations were referred to the Curriculum Committee, with resolution of the outstanding issues ultimately coming through compromise.[90]

The term "Foothills Medical Centre" was introduced to the FC in March. The dean said this referred to the "site" that included the Foothills Hospital, the Health Sciences Centre, the Tom Baker Cancer Centre, and the Heritage Medical Research Building.[91] In the spring, the FC approved the allocation of the third floor of the Heritage Medical Research Building for the Cancer Research Centre, with a projected completion date of June 1989. The centre's director would be the new Terry Fox Foundation Professor.[92]

By mid-year, the Faculty of Medicine had 286.4 FTE positions, of which 183.3 (or 64 per cent) were fully recovered from non-university funds. Since 1985, there had been a 23 per cent increase in assistant professors at the U of C, with small changes in other professorial ranks.[93] Other important occurrences included former dean William Cochrane being awarded the Order of Canada; inaugural associate dean (graduate clinical and continuing medical education) Gerald McDougall stepping down after ten years in the position; a successful five-year on-site review of the U of C program by the CFPC; the formation of a Medical Education Research Group; and the approval of four-week mandatory family medicine rotations in both the UME (to begin in 1992–3) and PGME curricula.[94] Seventy-five students were accepted into the class of '92.

Lionel McLeod resigned as president of the AHFMR in October and the board began a search for his replacement. When McLeod started, the foundation had few budget constraints. According to Robynne R. Healey, Carolee Pollock, and Julian Martin, "in 1988, declining returns on the endowment's investments, the expenditure of $60 million on buildings, and the failure of the Alberta government to supplement the endowment as promised combined to make reconsideration of

budget priorities imperative."[95] Dealing with these budget realities on an ongoing basis likely made continuing in the position of president less desirable for McLeod.

THE BUDGET AND CHANGES AT THE AHFMR CREATE UNCERTAINTY IN 1990

Another budget cut was announced for the 1990–1 fiscal year. The dean told the FC that, although the overall budget had increased by 3 per cent, due to inflation this translated to a 2 per cent cut. Therefore, the faculty would incur a loss of $250,000.[96]

Early in the year, the MCC issued a position paper supporting a change in format for its qualifying exam with a view to increasing the compatibility and portability of licensure requirements. This involved ongoing deliberations between national licensing agencies, the medical schools, and the MCC. Some of the proposed changes would create problems for the U of C and its three-year curriculum. Therefore, the EFC responded with its "Response to the Medical Council of Canada Proposal for the Updated LMCC: February 7, 1990." It was made clear that the U of C did not support the current proposal. Further, the EFC recommended the following: part 1 of the exam be held at the end of the medical school curriculum; assessment of clinical competency take place during the post-MD training period; one examination be developed that would be acceptable for medical licensure and certification by the College of Family Physicians; those pursuing Royal College programs be given the option of limited licensure and not participating in the general licensure program or taking the examination for general medical licensure; the knowledge and competencies to be assessed be defined and communicated; the validity of the proposed examination format administered nationally for assessment of clinical competency be guaranteed; broad discussions take place with post-graduate trainees and deans prior to implementation; and broad general agreement be attained prior to implementation.[97]

On a more positive note, the Alberta-Pacific Rim Sister Province Medical Exchange Program was expanded during this period to include links with the Sapporo Medical College in Japan, Hallym University in South Korea, and Harbin Medical University in China. The announcement that the Foothills Hospital would be building a parkade in the area currently occupied by the tennis courts and adjacent to the nurse's residence was well-received by clinical faculty.[98]

On May 9 a new associate deanship was established for the Office of Continuing Medical Education with the approval of the FC. This role was previously linked to graduate clinical education. Keith Brownell remained associate dean (graduate clinical education) and John Parboosingh became the associate dean (CME) later in the year.[99] Also in May, Matthew Warren Spence (b. 1934) attended his first meeting of the Board of Trustees as president-elect of the AHFMR. Spence, an Alberta native, was a pediatric specialist/biochemist who had been the MD/PhD director of the Atlantic Centre for Mental Retardation and the director of research at the Izaak Walton

Killam Children's Hospital in Halifax, as well as a former vice-president of the Medical Research Council of Canada. As such, his qualifications were impeccable. At the May meeting, the budget projections for 1990–1 were grim. They were "based upon two criteria: the endowment should last into perpetuity and that inflation be included in budget calculations."[100] In mid-year, the Getty Commission released its "Rainbow Report." It argued in favour of a "phased-in budgetary shift to prevention,"[101] regionalization that focused on local needs, greater attention to human resources planning, better health data collection (potentially through electronic "smart cards"), and "some private financing to increase choice and competition and redefinition of insured services."[102]

The AHFMR's Board of Directors, aware that the foundation needed to plan strategically for the future, noted that the Rainbow Report suggested that the foundation broaden its existing biomedical research mandate to include "research into health care systems, health status, intervention outcomes and promotion and prevention." As the AHFMR's new president, Matt Spence was expected to lead the foundation through these changes.[103] Late in the year, it was announced that the Joint Injury and Diseases Unit would occupy the fourth floor of the Heritage Medical Research Building, with construction finishing around June 1991. Mark Adams had been appointed to the Arthritis Society Chair in Rheumatic Diseases/Rheumatology.[104]

At the December 19 FC meeting, Grant Gall, associate dean (research), spoke extensively about the upcoming AHFMR competition. Matt Spence's installation as president in July, combined with the considerable turnover in the AHFMR's board, added elements of uncertainty to this important competition, which would provide insight into whether the AHFMR's soft funding could be considered to provide a secure and safe future for senior biomedical investigators. Gall reported to the FC on his meetings with President Spence. The December 19 FC minutes summarized this as follows:

> Dr. Spence had given assurance that submissions to the Scientific Advisory Committee of AHFMR would receive appropriate review by carefully-selected external reviewers, as well as through ad hoc additions to SAC [the AHFMR's Scientific Advisory Council], by an added body of internal reviewers as deemed appropriate. The issue of a terminal policy for scholars and scientists is currently under review, and after consideration by Trustees, will be widely disseminated in the new year. Dr. Spence had advised Dr. Gall that, in future, applicants to various AHFMR competitions will receive verbatim accounts from external referees as well as the traditional executive summary when adjudications have been completed. Finally, Dr. Gall indicated his desire to correct the faculty perception of "zero growth." Data were presented

> indicating that Heritage funding allocated to The University of Calgary had plateaued by 1984 and had since decreased to some extent. This was contrasted with data showing that, despite this, there had been a total growth in research funding. Dr. [Kenneth D.] Lukowiak inquired if these figures reflected a growth in faculty numbers or merely an increase in operational funding. Dr. Gall responded that data in that regard had not been accumulated but that his expectation was that these would reflect continued faculty growth. In response to questions from Dr. Marvin Fritzler, Dr. Gall indicated that Dr. Spence had assured him that there was no intent to "cap" numbers of Heritage scientist and the selection process for reviewers for Heritage grant applications rests with Dr. Spence. Dr. Gall had suggested to Dr. Spence that a scientific committee be established for this latter purpose as is the practice of the Medical Research Council. Dr Watanabe advised the Council of Dr. Spence's intent to meet with scholars and scientists sometime in January, 1991.[105]

To understand the sense of urgency in Calgary about this renewal competition, some context is required. According to Healey, Pollock, and Martin, when the AHFMR was first founded, "the University of Calgary was better prepared to take advantage of the new source of funding and, as a result, experienced greater success in the early award competitions at all levels."[106] In general, applications from the U of C, a relatively new medical school needing to build its research programs (as opposed to U of A, which was more established) had been more carefully prepared. Again, quoting Healey, Pollock, and Martin: "Watanabe [who at the time had been the associate dean of research] was keen to have a commitment to a research philosophy pervade all aspects of the institution as it did at the more established University of Alberta. To this end, Watanabe ensured that any applications leaving Calgary were vetted locally and were of as high quality as possible. . . . This paid off in many successful applications."[107] At this time, AHFMR scholars who had been recruited to Alberta at the beginning of the scholars program were coming to the end of their second and final term; these scholars either needed to be promoted to the status of AHFMR scientists or else risked having no continuing salary funding (unless the U of C could provide it). Therefore, the future of biomedical research at the U of C was highly dependent upon renewal of these soft-funded research salary awards.[108]

Other important occurrences during this period included an open house from October 17 to 19 to recognize the university's twenty-fifth birthday; approval of the guidelines on outside professional activity, a document describing when faculty members should report outside activates to their department head (and in some instances fill out

the relevant form); approval of a detailed "Policies and Procedures: Clinical Clerkship Undergraduate Medical Education Faculty of Medicine University of Calgary" document; and the election of members from the Faculty of Medicine to serve on the selection committee for the U of C's next dean of medicine.[109]

In other news, seventy-two students were accepted into the class of '93. On December 19, the FC passed a set of new rules that would apply to the class of '94. Accordingly, the minimum grade point average requirements for formal applications to medical school for Alberta residents were set at 3.0, and at 3.5 for Canadian residents; for applicants from abroad this was 3.75.[110]

BLACK FRIDAY (1991)

There had been huge anticipation related to second-term renewals and the first round of AHFMR promotions. While considerable consultation had occurred between the two Alberta medical schools and Dr. Spence prior to and during the renewal competition, in retrospect, all parties failed to reach a consensus on the expectations for promotion from the scholar level to the scientist level, and, to make things much worse, the parties did not fully recognize this. To further complicate matters, because of the large number of applications in this competition, the SAC had approved a new ranking system based upon the MRC scale, with possible scores ranging from zero (unacceptable) to >4 (excellent), as opposed to the yes/no system that had been used in all previous competitions, in which applicants either met the bar or did not; the new system meant that each applicant had a numerical score that could be ranked.[111]

On Friday, February 22, the results were announced. In the competition for promotion from scholar to scientist, there were 17 applicants, of whom only 4 were funded (4 of 9 from the U of A; zero of 8 U of C). For scholarship renewal, 2 of 4 U of C applicants and 1 of 2 U of A applicants were funded. In the new scholars competition, there were 7 of 8 successful applicants from the U of C and 1 from the U of A. Among clinical investigators, 1 of 2 new applicants were funded and 1 of 2 were renewed. In one fell swoop, the future of the U of C Faculty of Medicine research program seemed uncertain. This competition was dubbed "Black Friday" in Calgary. Even the more junior faculty members who were successful naturally worried about their long-term future in Calgary.[112]

To make matters worse, an SAC member leaked some of the confidential internal discussions to researchers in Calgary and indicated that there had been strong support for promotion of eleven of the applicants (rather than just the four highest-ranked applicants). This precipitated a letter-writing campaign. According to Healey, Pollock, and Martin:

> The letters, which fill a four-inch binder to overflowing, are instructive for their polarized nature. Letters from researchers at the University of Calgary were generally vicious in their attacks on Spence's leadership, accus-

ing him of misrepresenting results of the SAC review to trustees. Letters from researchers at the University of Alberta were more supportive of the new president. Certainly, one can argue that the success of four applicants from the University of Alberta might have led to the greater sense of support expressed by those researchers. However, there is more to it than this. Clearly, the two universities held completely different understandings of the mandate of the Foundation, the role of the SAC and the trustees, and the state of the endowment.[113]

There was an attempted appeal to the AHFMR Board of Directors by members of the U of C faculty, which was not successful. However, according to Gall:

> it was agreed, after many years of submissions to this effect from both Universities, to develop a Heritage Advisory Committee consisting of Alberta Scientists. This Committee is to assume the policy role of the previous Scientific Advisory Committee and is to be involved in long-term planning, day-to-day issues and monitoring programs. The Committee is to deal directly with the Board of Trustees. Gall considered that this represented a positive step that would, for the first time, enable a true partnership between the Universities and Heritage.[114]

The Calgary members were Quentin Pittman, Marvin Fritzler, Jim McGhee, Hans Van de Sande, and Grant Gall; the committee was chaired by Matt Spence.[115] Clearly, the U of C, the U of A, and the AHFMR had not agreed on whether the AHFMR was meant to have a pyramidal structure or not. AHFMR's expectations, at least as the province's finances increasingly worsened, was that the universities would pick up many of the salaries for faculty members recruited with junior salary awards. But the universities were not in a financial position to do this.[116] To Watanabe, the outcome of this competition was a total surprise; he was, as he later indicated, very angry: "I spoke with the chair of the board, Al Libin, [and] made an appearance at the AHFMR board meeting, but they were unyielding and the decisions stood. . . . I don't know if our faculty knows how much I fought for them at Heritage since I didn't want to display my anger publicly."[117]

The fallout was considerable. According to Grant Gall, "an initial reaction of outrage was followed by one of profound disappointment with the impression of 10 or 12 years of Faculty-building having been destroyed in such a short time."[118] He further indicated that "his office did not consider that the adverse decisions made properly reflected the real worth of the candidates involved and that they were, in fact, first class scientists."[119] When recently interviewed for this book, U of C faculty member Quentin Pittman, a vocal member

of the Calgary committee of AHFMR scholars and scientists that was then seeking Spence's resignation,[120] concluded that

> in retrospect, first of all, they [the AHFMR] were getting to the maximum carrying capacity. So, if you want more people coming in it means that somebody has to go out the door. And to be honest, all of the people recruited . . . did not turn out great. The thing about hiring scientists is [that] so often as a trainee your career is inextricably linked up with your supervisor because you're working on their projects, doing their things, working on their ideas—it's a synergistic relationship, but it's very difficult to know how you're going to do once you get away. . . . So some people, when they get on their own, just don't do that well. In retrospect [the outcome of this competition] . . . cut off some of the people who weren't really stellar performers, and a few other people who didn't really have the stomach for the risk bailed out and left. It was an upsetting time, but in retrospect I don't know if it was all so bad . . . and we continued to recruit all through the '90s on Heritage and did recruit intermittently on Heritage until they closed the program recently.[121]

A detailed and less emotion-laden analysis of these events, which became known within the AHFMR as "the crisis," comes from Healey, Pollock, and Martin, who note that the crisis was "not the result of a single event—in this case one round of competition for a particular award. Rather, it was the result of a number of simmering dilemmas that happened to boil over at a particular moment."[122] These additional issues included the U of C's dependency on AHFMR soft funding to run its medical school; the crashing price of oil and its effect on the provincial economy; the implementation of Premier Getty's austerity programs and related university budget cuts; the AHFMR's overcommitment of its funding (both in terms of its research awards and its commitment to construct research buildings in Calgary and Edmonton); the government's decision not to supplement the foundation's endowment, as earlier promised; and differing philosophies related to the AHFMR's mandate and decision-making processes.[123] Fortunately, U of C applicants to the MRC were more successful than the national average, providing some immediate vindication for the quality of the faculty's research. But, ominously, the overall national funding rate had decreased significantly. Later in the year, Henry Friesen of the University of Manitoba accepted the position of president of the MRC, and rumours of major changes that could decrease federal funding for biomedical research were rampant.[124]

Basic scientists at the U of C were also worried about the upcoming AHFMR external review and strategic planning exercise. They were concerned

that plans were under development to expand the foundation's research mandate from biomedical research, which it had been supporting since its inception, to include clinical and health research.[125] According to Watanabe,

> the AHFMR's original legislated mandate was to support biomedical research, and support for public health research was explicitly excluded. Scientists feared that the AHFMR's hidden agenda was to shift research focus away from basic biomedical research to applied research. This was ironic since I was pushing MRC, who at that time was undergoing a strategic direction review and consultation, to broaden their research base to include health services research, population health, and psychosocial research.[126]

Physician workforce concerns also persisted throughout this period, and Dean Watanabe's involvement continued. As he later explained:

> It was my research background that allowed me to participate in the dialogue. I always wanted evidence to not only backup but also inform policy decisions. When governments across the country started to take drastic measures to cut medical school enrolment, I started to develop what I call the science of physician workforce planning and became one of the national spokesperson predicting that not only were we not looking at physician oversupply, but in fact would be facing a physician shortage in Canada. Our own minister of health, Nancy Betkowski, hosted a meeting of the federal and provincial ministers of health in Banff. I attended and made a presentation as an intervener on behalf of the Association of Canadian Medical Colleges but armed with the Barer-Stoddard Report, the ministers marched ahead with their plans to cut enrolment by 10 per cent. Politics trumped science that day.[127]

The Barer-Stoddart Report, "Toward Integrated Medical Resource Policies for Canada," commissioned by the Canadian deputy ministers of health and discussed by the health ministers in Banff, was eventually published in February 1992.[128] On 25 September 1991, Watanabe told the FC that "the press reports indicate that early implementation of the recommendations might be anticipated. Many recommendations have major implications for medical schools so that a response is imperative and is being developed for this school. Issues raised relate to the admissions process to medical schools, the undergraduate curriculum, residency programs, the funding of academic health sciences centres and many other issues having an impact on our activities. One particular recommendation would have medical school enrolment in Canada

reduced to 1,600 positions (a reduction of 150–160 positions)."[129] At the following FC meeting, on December 11, Dean Watanabe reported that the faculty had developed a response to the Barer-Stoddard Report and that copies were available from his secretary.[130]

Other important occurrences during this period include the establishment of a new Department of Oncology; Alberta Health's announcement that it would gradually shift the ratio of residency allotments for specialists and family physicians from 50:50 to 60:40 due to the former group's retirement rate; and the first History of Medicine Days, an annual gathering of medical students from Canada in Calgary to present abstracts related to the history of medicine.[131] Seventy-three students were accepted into the class of '94.

Transition to the Smith Deanship in 1992

By early 1992, the provincial Ministry of Health was pushing for decreased enrolment in both the undergraduate and postgraduate programs at both medical schools in Alberta. It was unclear if there would be any budgetary implications associated with this development. According to the minutes of the FC's meeting of March 11, Dean Watanabe indicated

> that this decision would finally be made by the Department of Advanced Education and that the Ministry of Health recommendation had been forwarded to this department, and the matter will be discussed at a meeting in late March 1992. Alberta Health has assured the deans that there would be no cuts in enrolment without consultation with the two medical schools. Furthermore, the Department of Advanced Education has indicated that they will not take a unilateral decision regarding decreased enrolment. He pointed out that the fact remains that the Alberta government made a commitment to the other (provincial) ministers of health to make some cut in enrolment. A meeting involving faculty from five western universities will be held in April to discuss matters arising from the Barer-Stoddard Report and this will include cuts in medical school enrolments. The provinces of British Columbia and Saskatchewan have already indicated that they will not accept any cuts in their enrolment so there will be pressure on the universities in Alberta and Manitoba to decrease enrolment. . . . With respect to postgraduate programs, Dr. Watanabe indicated that Alberta Health may decide on a reduction, but at this time there is a committee reviewing postgraduate training positions and the recommendation of the committee has been for an increase in post-

> graduate programs at both universities.[132]

Biomedical basic scientists suffered a second shock only a year after Black Friday. Rumours were rampant that the MRC was planning to restructure and broaden its funding mandate. From 2 to 3 April 1992, the MRC, Henry Friesen, and representatives of the firm of Coopers-Lybrand visited the U of C to consult with stakeholders. On April 2, there was an open forum on the directions of the MRC, and on April 3 there were all-day workshops with thirty working groups to engage stakeholders. This was part of a national process to review all aspects of the MRC's activities and to develop plans for the 1990s. Biomedical scientists across Canada were concerned that money formerly earmarked for basic biomedical research would soon have to be shared with population health and other non-basic-science researchers, and that this was not going to be associated with an influx of new funding.[133]

As the minutes of the FC's 13 May 1992 meeting indicate, bad economic news continued during this period:

> Dr. Watanabe commented on recent newspaper articles with regard to budget cuts. He advised Faculty Council of the position of the Minister of Health in that regard. Over the next four years the total health care expenditure, currently about 3.5 billion dollars, will remain at that level. No additional dollars will be allocated for new programs. Most of the cuts will occur at acute care institutions and thus will impact heavily on the faculty of Medicine.[134]

This would represent a challenge for the new incoming dean, Eldon R. Smith, who was appointed the U of C's fourth dean of medicine on 1 July 1992. The inflation-adjusted price of oil had plummeted roughly two-thirds during the eleven years of Dean Watanabe's tenure. It seemed clear, then, that Dean Smith was in for hard times unless the price of oil skyrocketed again.

However, before he accepted the position of dean, Smith obtained a commitment from U of C president Murray Fraser (1937–1997) to guarantee six salaries for faculty members coming off AHFMR salary awards.[135] That year, seventy-four students were accepted into the class of '95.