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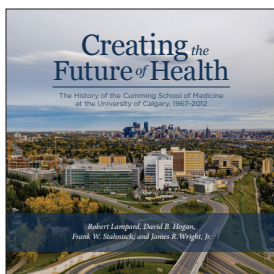
Lampard, Robert; Hogan, David B.; Stahnisch, Frank W.; Wright Jr., James R.

University of Calgary Press

Lampard, R., Hogan, D. B., Stahnisch, F. W., & Wright Jr, J. R. (2021). Creating the Future of Health: The History of the Cumming School of Medicine at the University of Calgary, 1967-2012. <http://hdl.handle.net/1880/113308>
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CREATING THE FUTURE OF HEALTH: The History of the Cumming School of Medicine at the University of Calgary, 1967-2012

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ISBN 978-1-77385-165-5

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*Thomas Erskine Feasby,
CM, MD, FRCPC, D.Sc (Hon)*

The Dean Feasby Years, 2007–2012

David B. Hogan

Introduction

In 2006 recruitment to replace Dean Gall commenced. Dr. Feasby applied for the position and underwent an initial interview in December of that year. Dr. Feasby recalled that the Search and Selection Committee, with approximately twenty members, was quite large. Reflecting on his earlier experience applying for the deanship at the U of A, Dr. Feasby came “prepared and eager.” After being informed that he was on the short list, Dr. Feasby returned to Calgary in January of 2007 for a second recruitment visit, and that February was offered the position effective 1 July 2007.¹

The faculty that Dean Feasby now oversaw had changed considerably since he left Calgary in 2002–3. Two major opportunities from his perspective when he assumed office were the new facilities (the HRIC and the TRW buildings) and the launch of the research institutes. Both were at a formative stage, and his goal was to capitalize on them. Space is always at a premium in a school of medicine; its lack can hamper the recruitment, retention, and efficient deployment of faculty and staff, the accomplishment of the faculty’s academic and clinical work, and the launching of new initiatives. Conversely, new space can help address these issues, and, depending on how that space is assigned, foster the development of cross-disciplinary and collaborative activities—a clear need with the research institutes early in their evolution.²

Adapting to Provincial Changes

The recession of 2008 led to major reductions in provincial funding of the U of C, as well as a decrease in funding from the AHFMR (in 2009 the foundation provided \$39 million in support compared to \$59 million in 2008)³ and revenue from endowments. Prudent management allowed the Faculty of Medicine to weather this financial belt-tightening without negative long-term consequences.

Alberta Health Services (AHS) formally came into being on 1 April 2009. It arose from the merger of twelve separate health-care delivery entities—the previous nine health regions and three provincial bodies responsible for alcohol and drug, mental health, and cancer services. This merger took place despite the belief that Alberta already had what André Picard of the *Globe and Mail* described as the “best, most innovative health system in Canada . . . [one that] allowed health authorities to shape services to local needs, created better continuity of care, made the health system more responsive, improved public health and led to strong alliances between university researchers and health regions.”⁴ With an estimated ninety thousand employees at the time of its formation, AHS became the largest health-care organization in Canada. It was hoped that the creation of a centralized body would eliminate wasteful competition between regions and allow for economies of scale.⁵ Not all, however, believed the reorganization would lead to significant financial savings.⁶

In the spring of 2009, Stephen J. Duckett became president and CEO of AHS. Born in Sydney, Australia, Duckett studied economics at the Australian National University and health administration at the University of New South Wales. In recognition of his academic contributions, Duckett was elected a fellow of the Academy of Social Sciences in Australia. When AHS hired him, he was CEO of the Centre for Healthcare Improvement of Queensland Health in Australia.⁷

Duckett started his tenure at AHS with high hopes, but shortly after his appointment the Province cut the organization’s budget by more than a billion dollars. Not surprisingly, as he was tasked with the implementation of these cuts, the government’s decision made Duckett personally unpopular. This was not helped by Duckett’s blunt, no-nonsense leadership style and perceived unwillingness to reach out to front-line workers and others with knowledge of health care in Alberta. For example, in June of 2009 he complained that Alberta’s faculties of medicine were lagging behind other Canadian schools in attracting research funds and producing significant results. Duckett said that he favoured funding only research that produced “measurable results.” He also characterized recruitment processes at the U of A as “sloppy.” He spoke of physicians primarily providing front-line clinical care—not a mix of administrative, research, teaching, and clinical services. Moreover, when Deans Feasby and Marrie (of the U of A) sent Duckett a joint letter expressing their concerns about AHS’s strategic plan and the lack of attention being paid to education

and research, Duckett described this as “just one of 7,700 responses” he had received, and that he had no plans to respond quickly.⁸

On 20 November 2010, televised remarks Duckett made (or more accurately did not make) to the media following a high-level meeting about the province’s emergency rooms brought things to a head. Duckett refused to answer reporters’ questions, saying instead that he was eating a cookie and that another person had been designated to make comments.⁹ Though he later issued an apology and emphasized that he had been instructed not to make any comments, on November 24 the chair of the AHS Board announced that, by mutual agreement, Duckett would vacate his position after just twenty months. Both parties, it was later reported, felt that Duckett’s ability to continue in his duties had been compromised.¹⁰ Dr. Chris Eagle was chosen as interim and then permanent president and CEO. Further upheaval and organizational shake-ups marked the early years of AHS. Chris Eagle stepped down midway through his five-year contract in October of 2013, four months after the AHS Board had been sacked by Minister of Health Fred Horne for failing to rescind executive pay bonuses.¹¹

The creation of AHS had an immediate and significant impact on the U of C Faculty of Medicine, as it meant that the faculty lost its main health-care partner, the Calgary Health Region. The site of decision-making henceforth became more remote, while the nearly continuous cycle of reorganization within AHS presented additional challenges. For one thing, it complicated

the building (or rebuilding) of relationships. Dean Feasby felt that one of a dean’s major responsibilities is to “get along” and develop good working relationships with key stakeholders. To this end, he cultivated constructive ties with the leaders of AHS (initially Dr. Stephen Duckett and then Dr. Chris Eagle), the provincial government (specifically the ministers of health and wellness and advanced education and technology), and the U of A’s Faculty of Medicine and Dentistry, which was led by Dr. Thomas Marrie, Dr. Philip Baker, and Dr. Verna Yiu (interim dean for ten months) during these years.¹² In 2011, AHS, in collaboration with the U of A and U of C Faculties of Medicine, established the Alberta Academic Health Network to develop a coordinated provincial strategy for academic medicine (including the areas of research, education, and patient care) and to help achieve the goals of the Alberta Health Research and Innovation Strategy. In his dealings with these and other organizations, Dean Feasby always strove to keep the “big picture” in mind and not let personal issues interfere. As important decisions were being frequently made in Edmonton, it was a priority to ensure the U of C faculty was at “the table,” notwithstanding the inconvenience of frequently travelling (often at short notice) to the capital.

Since its establishment thirty years previously, the AHFMR had been successful in maintaining and slowly growing its endowment while at the same time investing over a billion dollars in health research. Bill 27, the Alberta Research and Innovation Act, led to major changes in how the

provincial government would support health research in the future.¹³ It allowed for the dissolution of the AHFMR and the transfer of its endowment fund “to support a balanced long-term program of research and innovation related to health and directed to the discovery of new knowledge and the application of that knowledge to improve health and the quality of health services in Alberta.”¹⁴ On 1 January 2010, Alberta Innovates—Health Solutions (AI-HS) was established and the AHFMR wrapped up.

While the AHFMR had an arm’s-length relationship with the provincial government, the board of AI-HS reported initially to the minister of advanced education and technology. The intent was for AI-HS to use its allocated research funds to support short-term, project-based research aligned with government priorities that had commercialization potential, and to move away from providing salaries for researchers.¹⁵ Rob Seidel, the first chair of the AI-HS Board, was quoted in 2010 as saying that he would judge the success of this new funding strategy by determining whether the Province began doing better “on wealth creation, cost reduction and improving processes.”¹⁶ The minister of advanced education and technology, Doug Horner, along with Gene Zwozdesky, the minister of health and wellness, jointly sponsored the Alberta Health Research and Innovation Strategy that was released in 2010. This document provided a high-level framework for health research and innovation investments and decision-making in the province. The framework’s strategic focus was wellness at all ages for Albertans and

developing innovations in the delivery of health services. Attainment of these goals would be enabled by an investment in highly skilled people, innovative platforms, and knowledge translation.

These changes came as a surprise to many in the academic community. Opposition from researchers came late and was not particularly effective.¹⁷ Minister Horner nonetheless reacted angrily to these protestations, as he felt they were based on misunderstandings.¹⁸ From the perspective of the provincial government, it was felt that the prior arrangement was giving inadequate return on investment. Horner was quoted as saying, “The endowment was never meant to be a 25-year payroll plan for universities—it was meant for research.”¹⁹ He believed the changes being implemented would provide greater flexibility in recruiting new people and supporting research that would have a direct impact on the health of Albertans, while also providing opportunities for commercialization. Horner said it was “nonsense” to claim that politicians would be awarding research grants. The provosts and vice-presidents (academic) at both the U of A and the U of C supported him in his response.²⁰

At the time AI-HS was established, the U of C faculty had approximately 110 AHFMR-supported researchers who were now “at risk.” Compounding the natural anxiety brought on by a major change, the government failed to clearly communicate how the universities and their faculties would move from one system to the other. A transition fund of \$118 million, taken from the AHFMR endowment and spread over seven years, helped in covering

the salaries of researchers whose AHFMR support was coming to an end. This gave the Universities of Calgary, Alberta, and Lethbridge time to adjust. These three institutions worked together to collectively negotiate a satisfactory agreement with the provincial government. Considerable effort at the university level was necessary to work out a viable plan with the provost and reassure faculty that they would be looked after.

Opportunities, Initiatives, and Changes Closer to Home

Dr. Harvey Weingarten, an experimental psychologist, stepped down as president of the U of C in 2010, with engineer Dr. Elizabeth Cannon selected as his successor. Under her leadership the bold Eyes High strategy was created after wide consultation; it was released in 2011. Its uncompromising vision was aimed at ensuring that “the University of Calgary will be a global intellectual hub located in Canada’s most enterprising city. In this spirited, high-quality learning environment, students will thrive in programs made rich by research and hands-on experiences.”²¹

By 2016 the U of C wanted to be one of Canada’s top five research universities in terms of impact (in 2011 it ranked eighth based on direct research funding). The three foundational commitments outlined in Eyes High were to sharpen the school’s focus on research and scholarship, enrich the quality and breadth of learning, and fully integrate with the broader community. The university’s

Academic Plan and its Strategic Research Plan, both released in 2012, fleshed out these aspirational statements and provided more specifics on how this would take place.²²

Late in 2010, the faculty released its own strategic plan, which aligned with the U of C’s overarching priorities and goals.²³ Based on wide internal and external consultation, a vision (encapsulated in the slogan “creating the future of health”), mission statement, and core values were created. These, in turn, were used to define five broad strategies (raising the performance bar; excellence through broader accountability; sharpening research focus; sharpening education focus; and, exceptional patient care integrated with education and research) and twenty-one specific objectives to direct and measure the school’s collective efforts over the next five years.

The inaugural class of the U of C Faculty of Veterinary Medicine (UCVM)—Canada’s fifth veterinarian school and the first opened in two decades—began their studies in the fall of 2008. The faculty was established in the wake of an outbreak of bovine spongiform encephalopathy (BSE) in the province. On 20 May 2003, the Canadian Food Inspection Agency announced that a cow from a Northern Alberta farm was found to have BSE. The United States immediately banned Canadian beef and cattle and about forty countries followed suit. This single case was enough to jeopardize a national industry worth billions annually.²⁴ The main office, classrooms, library, and basic research laboratories of the UCVM were located on the Foothills campus site while much of its

clinical teaching and applied research takes place at the Spy Hill Campus in northwest Calgary. The co-location of UCVM and School of Medicine research labs brought animal and human health researchers together, fostering collaboration and interdisciplinary research.

As noted previously, the commissioning of the HRIC and the TRW building offered further opportunities for growth of the school that should not to be missed. In 2007, they were essentially empty shells. It was estimated that about \$40 million would be required to “fit out” the buildings and fully occupy them.²⁵ Construction costs had escalated to such an extent that all the assigned funds had been spent. The provincial government was reluctant to provide additional money, as it felt that it had already paid for the buildings. Dealing with this issue was initially not a top priority for the U of C. Both the university and the provincial government had to be convinced that funds had to be found to allow for the buildings’ occupancy. At an opportune time, Dean Feasby was able to tour Minister Horner around the empty buildings. At a subsequent meeting they had later that day with Alan Harrison, the U of C provost, it was agreed that finishing, equipping, and occupying these two buildings would be a university priority and that the required \$40 million would be provided by the provincial government. If the meeting with Minister Horner and the provost had occurred two months later, when the recession began having a significant impact on the Province’s finances, it is unlikely these funds would have been

forthcoming.²⁶ The work on the two buildings was completed in 2010.

When Dr. Feasby became dean, the faculty had an accumulated debt of about \$2 million and was running an annual operating deficit. About thirty individuals reported directly to him. With the support of Paul Heinrich (who was the faculty’s executive director and chief financial officer for the first nine months after Dr. Feasby arrived) and Guy Levy (executive director of the faculty during the balance of Dean Feasby’s term) the accumulated debt and annual deficit were turned around in two years. When interviewed for this book, Dean Feasby specifically commended his senior leadership team for their contributions in addressing this and the other challenges encountered during his tenure.²⁷ He reorganized his dean’s office, delegated more, and created an Executive Committee consisting of himself, Mr. Levy, Dr. Richard Hawkes (senior associate dean, research), Dr. Benedikt Hallgrímsson (senior associate dean, education), Dr. Ron Bridges (associate dean, clinical affairs), and his vice-dean (initially Dr. Brent Scott then Dr. Jon Meddings and, at the end of his term, Dr. Glenda MacQueen). The Executive Committee met weekly. Dr. Feasby’s leadership style, as he later described it, was to bring together a diverse group of “smart people who work hard,” give them various responsibilities, and ensure that they got credit for their successes.²⁸ Dean Jon Meddings applauded this approach, feeling the accomplishments of his predecessor as dean arose from a culture of collaboration that he fostered.

Two faculty committees require special mention here. The Dean’s Advisory Board under the leadership of Gail O’Brien and Bill Sembo provided vital and much-appreciated advice to the dean and his leadership team on many issues, including business strategies, government relations, and the needs of the community and how best to respond to them. The second committee addressed the objective in the faculty’s strategic plan to promote (and recognize) the success of its academic members in internal and external awards.²⁹ To achieve this, an Awards and Recognition Committee chaired by Dr. V. Wee Yong was created in 2008. A database of awards and recognition opportunities linked to a system that identified eligible faculty members was created. Information on the nomination process and assistance (if requested) in putting together a competitive application package was provided. As can be seen in table 1, the committee was very effective in its work. Distinctions of particular note occurring during this period include four Orders of Canada, a Canada Gairdner International Award, Canadian Institutes of Health Research—Canada’s Health Researcher of the Year Award, and a Rhodes Scholarship.³⁰ An annual Celebration of Excellence event to honour faculty who received prestigious awards during the previous year and a Wall of Excellence in the HRIC atrium (unveiled on 18 January 2012) were both established during Dean Feasby’s time in office.

Table 1: Select Awards to Students, Staff, and Faculty (listed alphabetically)

- Dustin Anderson, Governor General’s Gold Medal Award (2011)
- Todd Anderson, Fellow of the Canadian Academy of Health Sciences (2012)
- John Baumber, Member of the Order of the University of Calgary (2009)
- J. Gregory Cairncross, Fellow of the Royal Society of Canada (2009)
- David Campbell, CMA 2011 Award for Young Leader (Student) (2011)
- William Cochrane, Alberta Order of Excellence (2007) and laureate of the Canadian Medical Hall of Fame (2010)
- Jay Cross, Fellow of the Canadian Academy of Health Sciences (2010)
- Marvin Fritzler, Fellow of the Canadian Academy of Health Sciences (2011)
- Donald G. Gall, Member of the Order of the University of Calgary (2008)
- William Ghali, Fellow of the Canadian Academy of Health Sciences (2010)
- Subrata Ghosh, Fellow of the Canadian Academy of Health Sciences (2012)
- Clarence Guenter, Member of the Order of Canada (2010)
- David Hart, Fellow of the Canadian Academy of Health Sciences (2008)
- Robert Haslam, Member of the Order of Canada (2007)

- Brenda Hemmelgarn, Fellow of the Canadian Academy of Health Sciences (2012)
- Morley Hollenberg, Royal Society of Canada McLaughlin Award (2011)
- Merrill L. Knudtson, Member of the Order of the University of Calgary (2010)
- Paul Kubes CIHR Canada's Health Researcher of Year (2011)
- Susan Lees-Miller, Fellow of the Royal Society of Canada (2010)
- Jocelyn Lockyer, Canadian Association for Medical Education Ian Hart Award for Distinguished Contribution to Medical Education (2009)
- Henry Mandin, RCPSC Duncan Graham Award (2011)
- John Manson Pelton, Member of the Order of the University of Calgary (2008)
- Renée Martin, Fellow of the Canadian Academy of Health Sciences (2007) and Fellow of the Royal Society of Canada (2008)
- Jonathon Meddings, Fellow of the Canadian Academy of Health Sciences (2010)
- Lois A. Milne, Member of the Order of the University of Calgary (2010)
- Christopher H. Mody, Fellow of the Canadian Academy of Health Sciences (2011)
- Braden O'Neill, Rhodes Scholarship (2010)
- Quentin Pittman, Fellow of the Royal Society of Canada (2010)
- David Proud, Fellow of the Royal Society of Canada (2012)
- Robert Sheldon, Fellow of the Canadian Academy of Health Sciences (2008)
- Garnette Sutherland, Member of the Order of Canada (2011)
- Hans Vogel, Fellow of the Royal Society of Canada (2012)
- Michael Walsh, Fellow of the Royal Society of Canada (2009)
- Samuel Weiss, Canada Gairdner International Award (2008) and Fellow of the Royal Society of Canada (2009)
- V. Wee Yong, Fellow of the Canadian Academy of Health Sciences (2010)
- Gerald Zamponi, Fellow of the Royal Society of Canada (2008) and Fellow of the Canadian Academy of Health Sciences (2010)

The Reach! Campaign was an ambitious joint fundraising effort of the U of C, the Calgary Health Trust, and the health-care sector (initially the Calgary Health Region and then AHS). It was co-chaired by Brenda Mackie, Bill Sembo, and Ken King, and it raised over \$312 million by the time it concluded in 2009.³¹ This money was used to support more than a hundred initiatives, including the Centre for Emerging Infectious Diseases, the Centre for Excellence in Hypertension, the Enbridge Research Chair in Psychosocial Oncology, the Forzani and MacPhail Colon Cancer Screening Centre, and the Southern Alberta Institute of Urology.

In 2007–8, a comprehensive faculty mentorship policy was put in place for junior faculty members. Modelled on a similar policy used by the U of A's Department of Medicine, a mentorship director paired mentors (or on occasion a team of mentors) and *protégés* (also known as mentees). The junior member would then be mentored for five to ten years until promoted to associate professor. The twenty-page policy document outlined a formal process with regular documented meetings at least every six months. While the program did raise the profile of mentorship within the faculty it quickly became clear that mentorship was equally important for students and could be more effectively done at a departmental, institutional, or program level. Historically, academic mentorship (a process by which an experienced, respected, and empathetic person guides another, usually younger, individual in their personal and professional development) had taken place on an informal

basis within the person's "home" division, department, and/or institute.³² Mentorship programs were put in place for bachelor of health sciences, medical (through what was initially called the Faculty Advisor Program but was later referred to as the Faculty Mentorship Program), and leaders in medicine students. For medical students and postgraduate medical trainees, the nature of these mentoring relationships play an important role in raising interest in specific medical fields such as family medicine.³³ Mentoring (or remediation) is also offered to undergraduate medical students with repeated performance deficiencies and to help physicians from abroad assimilate into a rural Alberta practice.³⁴

Another objective of the faculty's strategic plan was to "create a socially responsible . . . global health program to ensure that the activities of the Faculty have a positive net impact on international development while also enhancing our international profile and benefiting our students and faculty."³⁵ Building on what had been done to date, the faculty sought to expand the opportunities available to students for global clinical and research electives. This naturally led to reflection on the need and nature of pre-departure training and post-return debriefing for these students.³⁶ As well, there was continued interest in building capacity within less-developed nations facing daunting health challenges. Examples of such capacity-building activities include the Sudanese Physician Reintegration Program and the Southern Sudan Healthcare Accessibility, Rehabilitation, and Education (SSHARE) Project.³⁷ The U of C's Chris

Brown produced an award-winning documentary titled *A Working Adventure in Laos* that vividly tells the story of the successful partnership forged with colleagues in Laos.³⁸ Reflecting this broad interest within the faculty, the inaugural Dr. Clarence Guenter Lecture on Global Health was held in Calgary on 11 April 2011. Fittingly, Dr. Guenter, whose contributions to international health are outlined in chapter 4 of this volume, gave a talk titled “Reflections of a Foreigner.”

Dean Feasby was an untiring advocate for these activities, and the establishment of the Tom Feasby Graduate Award in Global Health honoured this commitment. Designed to foster the development of health-care leaders in low- and middle-income nations, it provides support to candidates accepted into a PhD graduate program at the Cumming School of Medicine. Preference is given to those from countries where the faculty has an established relationship, such as Laos, Tanzania, Ethiopia, Sudan, Nepal, Uganda, and the Philippines.

Education

Under Dean Feasby the faculty was home to the following educational programs:

- Bachelor of health sciences
- Community rehabilitation and disability studies
- Graduate science education
- Doctor of medicine
- Postgraduate medical education
- Continuing medical education and professional development

The bachelor of health sciences (BHSc) is a four-year honours degree with three program options (bioinformatics, biomedical sciences, and health and society). Though several of its graduates enter medical school every year, it is not a pre-medical program. It focuses on building skills in research, critical thinking, writing for academic journals, and working in interdisciplinary teams. In the spring of 2007, the first class of forty-eight graduated. A reflection of the program’s success is the number of publications co-authored by BHSc students. Between 2007 and 2012 seven could be found on PubMed (a free search engine accessing primarily the MEDLINE database of references and abstracts on life sciences and biomedical topics).³⁹

Community rehabilitation and disability studies is a small interdisciplinary and inter-faculty university program offering several study options leading to bachelor of community rehabilitation, master of disability and community studies, master of science in community rehabilitation and disability studies, or doctor of philosophy in community rehabilitation and disability studies degrees.

During Dean Feasby’s tenure ten graduate science options were available in the school (biochemistry and molecular biology, biomedical technology, cardiovascular and respiratory sciences, community health sciences, gastrointestinal sciences, immunology, leaders in medicine, medical science, microbiology and infectious diseases, and neuroscience) through the faculty of graduate studies. (Table 2 provides summary information on the number of master’s and PhD

students enrolled in one of these programs between 2007 and 2012.)

There was also the development of a new graduate program to train pathologists' assistants. The first students enrolled in July 2012. Those with this training assist anatomical pathologists. Training programs are two years in duration and accredited by the National Accrediting Agency for Clinical Laboratory Sciences. They lead to an MSc-level professional degree. Graduates of accredited programs are eligible to sit certification examinations. The U of C program is one of only two accredited training programs in Canada.⁴⁰

The size of the incoming MD class grew from 135 (2007) to 180 (2009) before falling back to 170 (2010).⁴¹ To deal with the greater number of medical students and changes in clinical practice, which made it more problematic to rely on volunteer faculty, in 2007 the faculty launched the Master Teacher Program. Master teachers were physicians with a demonstrated track record of providing excellence in education who received further training in educational techniques through the Teaching Scholars in Medicine Certificate Program, after which they would be integrated into teaching roles within the undergraduate medical curriculum. As of July 2012, forty-eight master teachers had been hired. Each appointee committed to approximately one day (8 hours) per week of educational activities. Over the course of one year, 340 hours must be provided.⁴² During this period the rural integrated community clerkship (now called the University of Calgary longitudinal integrated clerkship) was introduced. This allowed

for the placement of pairs of third-year medical students in established teaching sites outside Calgary for thirty-six weeks of their clerkship year.⁴³ Developing distributed learning models was one of the faculty's objectives in its strategic plan. Last, but by no means least, in 2008 the faculty underwent a successful CACMS-LCME accreditation visit and was approved for eight years.

Historically, the U of C's medical students have shown a strong sense of responsibility and concern for the problems of society. For several years, the Med Show and other student-led activities have raised funds for local organizations such as the Calgary Urban Project Society. The *Rich Man, Poor Man* dinners and silent auctions were introduced as a new way to raise funds for various good causes. Participating diners were seated in groups of eight. At each table a person at random received a three-course rich man's dinner, while the rest got a "poor man's meal" consisting of vegetarian fare.⁴⁴ This reflected the disparity in wealth seen in our world, where many people do not have access to stable food sources. In 2010, medical students from the U of C also opened a student-run clinic at the Calgary Drop-In and Rehabilitation Centre, Calgary's largest homeless shelter. During weekly evening clinics, two students see patients, who they review with a supervising physician. They collaborate with the physician to establish a treatment plan for individual patients and then assist them in following through with it.⁴⁵

Lindsay Kimmett, a second-year student, was tragically killed in a 2008 car accident. Her family established the Lindsay Leigh Kimmett Memorial

Foundation, which had raised nearly \$1.8 million by 2016 through events like the Kimmett Cup to help fund a variety of charitable endeavours, such as the U of C Lindsay Leigh Kimmett Prize in Emergency Medicine and a birthing centre in Tanzania.⁴⁶ The LINDSAY virtual human project, initiated in 2009, is named after her.⁴⁷ The project entailed the creation of a three-dimensional, interactive computer model of male and female anatomy and physiology to be used for medical education.⁴⁸ It arose as a collaboration of the Evolutionary and Swarm Design Laboratory of the Department of Computer Science, Faculty of Science, and the undergraduate medical education program in conjunction with the Virtual Medical Education Unit at the U of C's School of Medicine.

From 2007 to 2012 the postgraduate medical education office oversaw between 600 and 900 medical residents, clinical fellows, and international trainees per year, as well as approximately 300 visiting elective residents (see table 2). These trainees were enrolled in over sixty specialty and subspecialty programs accredited by the RCPSC and/or the CFPC. The faculty underwent successful accreditation of its postgraduate training programs in 2009.

Between 2007 and 2012 there was a growth in the number of faculty graduates who selected family medicine as their training choice. Twenty-four members (23.8 per cent) of the graduating class in 2007 selected family medicine. By 2012 this had increased to sixty-nine (40.8 per cent).⁴⁹ The increase occurred by design, as the low number of graduates choosing family medicine was

seen as a problem.⁵⁰ In fact, one of the objectives of the faculty's strategic plan was to encourage *generalism* in the undergraduate and postgraduate medical education program.⁵¹ Factors that positively influenced how students perceived family medicine were carefully considered. These included early exposure to family physicians and the provision of high-quality primary care experiences.⁵² An internal task force on promoting family medicine as a career choice, chaired by Dr. Keith Brownell, was struck and in 2009 it submitted its report. It contained thirty recommendations for faculty leadership to help redress the imbalance.⁵³ Several factors contributed to the success of this effort to increase interest in family medicine training, but only a few can be noted here. Associate Dean for Undergraduate Medical Education Dr. Bruce Wright was a highly regarded family physician and served as an effective role model. While the Master Teacher Program was open to all physicians, approximately half of participants were either family doctors or other generalists.⁵⁴ This provided students the opportunity of having greater contact with them. Finally, the exposure of students to clinical training in family medicine was increased by 50 per cent.⁵⁵

The Office of Continuing Medical Education and Professional Development offered a broad range of evidence-based learning opportunities to physicians, other health professionals, and the public in a variety of well-received formats. Course accreditation, professional course and event planning and management, venue arrangements, advertising and marketing help, registrant course

Table 2: Faculty by the Numbers

(Source: Canadian Medical Statistics)

	2007-8	2008-9	2009-10	2010-11	2011-12
MD (number)					
First-year class	150	148	175	168	174
Total	402	435	486	509	518
MD Tuition					
Canadian	\$13,210	\$13,818	\$14,385	\$14,600	\$14,864
International	\$45,000	\$65,000	\$65,000	\$45-\$65,000	\$68,000
Postgraduate clinical trainees (number)					
	611	647	702	803	879
Graduate science (number)					
Master	236	240	-	263	289
PhD	186	190	-	198	212
Faculty (number)					
Full-time	509	529	537	542	547
Part-time	1,281	1,399	1,488	1,660	1,824
Ratio (FT/PT)	0.40	0.38	0.36	0.32	0.30
Research					
Revenue	\$146M	\$133M	\$146M	\$142M	\$143M
Rank	7	8	7	7	7

materials, and course evaluation summaries were offered by the office. An important and highly cited paper published in 2007 that was co-authored by Jocelyn Lockyer, then serving as associate dean for this area, offered a meta-analysis of continuing medical education effectiveness.⁵⁶

Research

Much of the faculty's research activities during this period were organized within seven research institutes:

Alberta Children's Hospital Research
Institute for Child and Maternal Health

Southern Alberta Cancer Research
Institute (renamed the Arnie
Charbonneau Cancer Institute)

Calvin, Phoebe and Joan Snyder Institute
for Chronic Diseases

Hotchkiss Brain Institute

O'Brien Institute for Public Health

Libin Cardiovascular Institute of Alberta

McCaig Institute for Bone and Joint Health

The growth and strengthening of these research institutes was a highlight of Dean Feasby's tenure. A successful model used for six of the seven institutes was the creation of a synergistic partnership

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Continuing Medical Education at the U of C

Following the Osler dictum that medical education should be lifelong pursuit,¹ Canadian physicians have focused on making innovative and progressive changes in medical education. Medical knowledge has grown exponentially, necessitating the identification of what new medical knowledge and skills were needed to keep physicians current.² Thus, the need for an ongoing, effective, continuing medical education program (CME) in an increasingly electronic age.³

With no medical school, organized CME in Calgary was limited to the Calgary Associate Clinic's weekly case conferences at the Palliser Hotel, which began in the mid-1920s. The first full-time clinical department heads at the new Foothills Hospital were made responsible for medical education when it opened in 1966. The medical staff organization mandated a CME committee, which began an on-campus program.⁴ It was coupled with theme-based conferences in Banff on trauma and cancer.

To Dean Cochrane, CME was a priority for family practitioners. His first faculty appointment in 1968, Associate Dean Dr. John Dawson, was given that responsibility. Dawson quickly assumed responsibility for the

U of A's regional CME program in Southern Alberta and on-campus conferences.⁵ A decade later, Dean McLeod appointed Jocelyn Lockyer to manage the program, under the graduate clinical education coordinator, and later the associate dean for CME.⁶

From the outset the Calgary CME program offered six to thirteen courses per year and initiated some longitudinal programs by audio conference as well as starting an evening course. In 1982 a pilot CME program was initiated in Drumheller for physicians and allied health staff. In conjunction with the CPSA, it studied the use of online medical information and literature sources, consults, and referrals, to determine the impact of CME in a rural setting. The program was supplemented with audio and then audiovisual teleconferencing, followed by a hotline to answer clinical questions from consultants in Calgary. The study looked at how individual practices were changed and how new advances were integrated into them.⁷ Subsequent CME research programs focused on how physicians in practice learned and changed; effective teaching techniques; how practice guidelines became integrated; chart reviews; the impact of CME credits; and the role of the physician in patient education.

Recent research has been directed toward the delivery of health-care information to influence/change physician performance, and the links between clinical practice guidelines and actual practice. Specific questions have been addressed, including on the following topics: how small groups learn; the different professional development needs of rural and remote FPs

compared with urban ones; whether self-directed learning influence outcomes; whether face-to-face CME could be transitioned to web-based learning; and whether self-assessments affect clinical competence. The work of the program leaders also contributed to the initiation a national program to accredit CME programs in 2003.

The Professional Achievement Review (PAR):

To link actual practice performance with re-licensure, the College of Physicians and Surgeons of Alberta introduced the PAR program in 1996. To Lockyer, it was an opportunity to assess physician performance, based on feedback from all of the staff and patients with whom the physician worked. She completed her PhD on this subject by studying physician communication skills, collaboration with colleagues and specialists, the office environment, and clinical decision-making.⁸ Customized questionnaires were developed for family physicians and eight specialties, with “instruments” designed for each one. The multi-source feedback (MSF)—or “360 degree assessments,” as they became known—were the earliest and largest organized assessment in Canada, providing physicians with feedback about their communication, collaboration, and professional skills. The program was adopted by several regulatory authorities in Canada and has since become a key program of the Medical Council of Canada.

Rural Physician Action Plan (RPAP):

Formed in 1990 to address the recruitment and retention of physicians in rural Canada, the program was supported by a provincial grant. The CME component

focused on the Medical Information Service, in which physicians were originally provided with information from literature searches conducted on their behalf, as well as on expanded rural programming to support their learning.

Physician Learning Plan (PLP): In 2009 the Alberta Health/Alberta Medical Association negotiated an agreement that introduced the concept of “audited feedback” to physicians.⁹ Funded by the Province, the program worked with groups of physicians to determine areas of concern. Staff from the PLP program then worked with AH and AHS to determine whether data could be secured to provide individualized feedback to the group of physicians. Results and outcomes were shared with each consenting participant involved. Audits have covered such areas as the study of sedative and antipsychotic medication reductions in hospitalized seniors (35 per cent reduction), transfusion rates in ICUs, drugs covering joint replacement surgery, acute sepsis treatment in the ER, vitamin D serum monitoring (with a 92 per cent reduction), among many others.

To date the CME program and its associated faculty/staff have been prolific, publishing over 200 peer-reviewed articles, along with book chapters, monographs, and abstracts. It has 25 staff and a budget of over \$2.5 million, funded by physicians, Alberta Health/Alberta Medical Association, various research grants, industry and other sources. It currently offers 6 online courses and over 50 on-campus courses annually with over 5,000 registrants.

between a lead donor, the health-care system (initially the Calgary Health Region and then AHS), and the U of C. Dean Feasby was particularly proud of his role with the O’Brien Institute for Public Health. It had a longer gestation than the other institutes and had not been launched when he assumed office. Dr. Feasby saw the potential for an institute focused on public health and lobbied against indifference—if not overt opposition—to its establishment within the university. The founding of an institute organized around this theme was a noted objective of the faculty’s strategic plan.⁵⁷ Originally referred to as Institute Seven, it was established as the Calgary Institute for Population and Public Health in 2009. Its name was changed to the Institute for Public Health in 2011 and then to the O’Brien Institute for Public Health in 2014 to recognize the generous \$12 million donation of Gail and David O’Brien. (This was on top of their \$5 million donation to help create the O’Brien Centre for the Bachelor of Health Sciences Program.⁵⁸) Dean Feasby commended the hard work of Dr. Tom Noseworthy in launching the institute (then: Calgary Institute for Population and Public Health) and the leadership then provided to it (as the: Institute for Public health) by Dr. William Ghali.

The Hotchkiss Brain Institute (HBI) profited from an advantageous starting position with a strong director (Dr. Weiss) and a generous benefactor (Harley Hotchkiss and his family). The institute was further strengthened by the announcement in March of 2012 of the Mathison Centre for Mental Health Research and Education, made

possible by a generous \$10 million “investment” (his term) by Ronald Mathison.⁵⁹ Nonetheless, the HBI experienced a deeply felt loss with the passing of Harley Hotchkiss in 2011.⁶⁰ The faculty had already suffered a loss with the death of another generous benefactor, Daryl (Doc) Seaman, in 2009.⁶¹

The Calvin, Phoebe and Joan Snyder Institute for Chronic Diseases had also done very well with a “star” leader (Dr. Kubes) and a supportive donor. The Libin Cardiovascular Institute of Alberta has benefited from the strong leadership of Drs. Brent Mitchell and Todd Anderson and the support of the Alvin and Mona Libin Foundation, as well as other donors. Its accomplishments are detailed in *Hearts, Minds, and Vision: Roots of the Libin Cardiovascular Institute of Alberta, 1930–2010*.⁶² Dean Feasby was proud of the accomplishments and optimistic about the future of the Alberta Children’s Hospital Research Institute for Child and Maternal Health (which has received important support from the Alberta Children’s Hospital Foundation), the Arnie Charbonneau Cancer Research Institute, and the McCaig Institute for Bone and Joint Health.

Several of the faculty’s fifty-two endowed chairs and professorships were filled during this period as well. This included Frank W. Stahnisch’s appointment as the Alberta Medical Foundation/Hannah Professor in the History of Medicine and Health Care at the U of C (2008).⁶³ Neurologist Andrew Demchuk became the first holder of the Heart and Stroke Foundation of Alberta, Northwest Territories & Nunavut Chair in Stroke Research in 2010, while Brenda Hemmelgarn was

named the inaugural Roy and Vi Baay Chair in Kidney Research in 2011.⁶⁴

Two faculty teams were responsible for major advances in health technology. In May of 2008, a surgical team led by Garnette Sutherland successfully used the neuroArm in an operation. They created the first image-guided, magnetic resonance-compatible surgical robot capable of both microsurgery and stereotactic surgery.⁶⁵ Building on this and other successes, their research program has expanded to include an advanced engineering and prototyping laboratory, a surgical performance-haptics laboratory, a telementoring and debriefing room, and an experimental operating room for the development of the neuro-Arm II.⁶⁶ In 2010, a group led by neuroscientist Dr. Naweed Sayed was able to cultivate a network of brain cells that reconnected on a silicon chip and allowed them to monitor their activity at a high resolution.⁶⁷ Referred to as the “neurochip,” this research tool can be used to study how the brain works and has the potential to determine which drugs are likely to work for specific brain disorders by looking at their effects on the activity of brain cells on the neurochip.⁶⁸

Two members of the faculty received national recognition for their research contributions during these years. In 2008, Dr. Sam Weiss received a Canada Gairdner International Award for “his seminal discovery of adult neural stem cells in the mammalian brain and its importance in nerve cell regeneration.”⁶⁹ The CIHR recognized Paul Kubes as Canada’s Health Researcher of the Year.⁷⁰ The award was in recognition for his contributions to

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Calgary Stroke Program

“Creating the Future of Stroke Care” is the vision of the Calgary Stroke Program (CSP). A collaboration of the U of C (Department of Clinical Neurosciences [DCNS] and Hotchkiss Brain Institute) and Alberta Health Services, it provides cutting-edge stroke-related clinical services, rich educational opportunities, and research leadership. The program’s origins date back to 1993, when Drs. Tom Feasby (then head of DCNS), Roland Auer, and Garnette Sutherland persuaded the Heart and Stroke Foundation of Alberta to create the first stroke research professorship in Canada.¹ In late 1995 Dr. Alastair Buchan accepted the position. Concurrently adult DCNS in-patient services were being consolidated at the Foothills Medical Centre (FMC). The Stroke Prevention Clinic, the first component of the CSP, opened in the spring of 1995. Much of the evidence on which it was based came from the work of Dr. Henry J. M. Barnett² of Western University, where both Feasby and Buchan trained. Buchan, with Sutherland and Auer, opened a laboratory in the Heritage Medical Research Building to study the process of cell death following a stroke.³ Buchan hoped to find effective neuroprotective therapies,⁴ but it was the emergence of thrombolysis that revolutionized stroke care.

In December of 1995, results of the National Institute of Neurological Disorders and Stroke (NINDS) tissue plasminogen activator (tPA, a protein involved in the breakdown of clots) trial for acute ischemic stroke were published showing that patients who received tPA were at least 30 per cent more likely to have minimal or no disability three months post-event.⁵ This watershed study showed something could be offered to patients presenting with an acute stroke, though tPA had to be provided quickly and could lead to intracranial bleeding. To be used effectively a major retooling of how stroke care was provided and neurologists practised was required.⁶ Dean Smith suggested to Buchan that a stroke thrombolytic program could be established in Calgary,⁷ and the Calgary Health Region (CHR) agreed to both the use of tPA and keeping a bed permanently blocked on the Neuroscience Critical Care Unit for acute strokes.⁸ A “brain attack” team was rapidly mobilized, with the first local patient treated on 2 April 1996. The results obtained were comparable to those seen in the published trials. Initially all DCNS neurologists were engaged in delivering thrombolytic care, with Buchan providing 24/7 backup support,⁹ but over the years CSP evolved into a separate service. The Canadian licensing

of tPA for acute ischemic stroke in February 1999 was conditional on monitoring outcomes,¹⁰ which led to the Canadian Alteplase for Stroke Effectiveness Study, which looked at all patients treated between 17 February 1999 and 30 June 2001 that was coordinated at the University of Calgary.¹¹ The adoption of thrombolytic therapy for strokes in Canada represented a striking example of rapidly moving from efficacy to effectiveness studies and on to routine care.¹²

Early recruits to the CSP were Drs. Philip Barber (1998),¹³ Andrew Demchuk (who returned to Calgary in 1999 after a two-year stroke fellowship in Houston with Jim Grotta, one of the NINDS investigators),¹⁴ and Michael Hill (1999).¹⁵ By 2018 physician membership in the program had grown to 13 neurologists, 4 physical medicine and rehabilitation specialists, 3 vascular neurosurgeons, and 3 interventional neuroradiologists.¹⁶ A stroke fellowship program funded by CHR was launched in 2000. Drs. James Kennedy, Jessica Simon, Shelagh Coutts, and Anna Tomanek were the initial fellows.¹⁷ As of 2018 75 clinicians from 18 countries have been trained.²³ When Buchan left Calgary in 2005, Demchuk (director of the stroke program), Hill (director of the stroke unit) and Barber (director of the Calgary Stroke Prevention Clinic) assumed medical leadership roles in the CSP.

Stroke was designated as one of six priority clinical areas of the Partners in Health fundraising campaign, with a monetary target of \$14 million.¹⁸ Most of this was to purchase and house an MRI machine. A substantial donation from the Seaman brothers of Calgary jump-started the campaign,¹⁹

and in 1999 the Seaman Family Magnetic Resonance Research Centre was officially opened.²⁰ In 2001 a second imaging centre was opened with support from the National Research Council of Canada and AHFMR for animal work.²¹

Early publications of the CSP dealt with tPA for stroke,²² stroke services,²³ the Alberta Stroke Program Early CT Score (ASPECTS) for strokes,²⁴ and transient ischemic attacks (TIAs).²⁵ The first randomized controlled trial coordinated by the CSP was designed to determine whether early treatment reduced stroke risk after a TIA or minor stroke. Research remains an important component of the work of the CSP. Its members have led important studies, such as the Endovascular Treatment for Small Core and Anterior Circulation Proximal Occlusion with Emphasis on Minimizing CT to Recanalization Times (ESCAPE) trial,²⁶ that have changed stroke care in Canada and around the world.

In 2001 a new multidisciplinary stroke and TIA²⁷ unit opened at the FMC. Over the years the services offered by the CSP have continued to improve and expand. In 2010 it was the only comprehensive stroke program to obtain from Accreditation Canada a Stroke Services Distinction designation, which was awarded to health organizations that meet or exceed national standards for stroke care.²⁸ CSP achieved 99 per cent of all targets for the delivery of optimal care. Complementing this clinical recognition, in 2011 the CSP received a CIHR/CMAJ Top Achievement in Health Research Award.²⁹

research on the immune system, and specifically on how the brain can affect immunity.⁷¹

From a Royal Visit to Fist Bumping

Several other noteworthy activities took place in the faculty between 2007 and 2012 that merit comment:

- Royal Visit: On the 7 July 2011, the Duke and Duchess of Cambridge visited the W21C Research and Innovation Centre on their first official tour of Canada. Premier and Mrs. Stelmach, Chancellor Jim Dinning, and chair of the U of C BOG Douglas Black accompanied them.⁷²
 - Canadian Medical Hall of Fame: The 2010 induction ceremonies of the Canadian Medical Hall of Fame were held at the Bank of Montreal Centre in Calgary on 13 April 2010. One of those honoured was the U of C Faculty of Medicine's founding dean, Dr. William Cochrane.⁷³ On 29 October 2010, Dr. Cochrane and the other living deans (Drs. Mo Watanabe, Eldon Smith, and Feasby), along with Dr. Warren Veale on behalf of Dean Lionel McLeod and Dr. Pam Sokol on behalf of Dean Grant Gall, provided their thoughts on the evolution of the
- faculty as part of celebration of the fortieth anniversary of the first class.
- The Mackie Family History of Neuroscience Collection: The collection was purchased from the Texas-based neurologist Dr. Robert M. Gordon and is made up of over 2,400 books.⁷⁴ It includes an original copy of Watson and Crick's *Nature* paper, in which the double helix structure of deoxyribonucleic acid (DNA) was first described, *Cerebri Anatome* by Thomas Willis, and Camillo Golgi's *Sulla fina anatomia degli organi centrali del sistema nervosa*, which was the only book he ever wrote.⁷⁵ At the opening ceremony in late 2010, President Cannon noted that the collection would be "an invaluable resource for neuroscience research and education."⁷⁶
 - Fist Bumping: In the fall of 2009, during the H1N1 pandemic, Dr. Feasby advocated using a fist bump rather than a handshake as a greeting to prevent the spread of the virus. A paper on the advantage of a fist bump in reducing pathogen transmission was published in 2013, and it was also discussed favourably in an article published in the *Atlantic Monthly* titled "The Fist Bump Manifesto."⁷⁷

Concluding Comments

In May of 2011, Dean Feasby announced that he would not be seeking a second term. Dr. Jon Meddings, who was chosen as Dr. Feasby's successor, assumed office on 1 July 2012.

Dean Feasby's goals were to capitalize on the completion of two new buildings and successfully implement the recently inaugurated faculty-based research institutes. Successfully attaining these goals entailed dealing with the recession of 2008, the creation of Alberta Health Services in 2009, and the changes in provincial health research support brought on by the establishment of Alberta Innovates—Health Solutions. The growth of the faculty required corresponding changes in its administrative structure and style. Under Dean Feasby the faculty had its BHSc first graduates, while the faculty's strong undergraduate MD, graduate, postgraduate medical education, and continuing medical education and professional development programs showed continued success. Important transformative research work was done. All this positioned the school well for whatever the future might hold.