REPORT OF THE AD HOC INVESTIGATORY COMMITTEE INTO THE SITUATION OF DR. LARRY REYNOLDS AT THE UNIVERSITY OF MANITOBA AND THE WINNIPEG REGIONAL HEALTH AUTHORITY

1. ESTABLISHMENT OF THE AD HOC INVESTIGATORY COMMITTEE

In November 2007, the Canadian Association of University Teachers (CAUT) established an ad hoc investigatory committee to examine the case of Dr. Larry Reynolds, former Head of the Department of Family Medicine at the University of Manitoba. The members of the committee are: Dr. Bob Miller, Chair of the Department of Family Medicine, Memorial University; Dr. Ernest Redekop, Professor Emeritus, Department of English, University of Western Ontario; and Dr. Colin Stuttard, retired Professor of Microbiology, Faculty of Medicine, Dalhousie University.

The Committee's original terms of reference (letter from James Turk to Dean Sandham, sent on November 19, 2007) were "to look into allegations that Dr. Reynolds' academic freedom and the University's policies on *Appointment of Heads of Departments* were violated in the recent head selection process" (when the Dean of Medicine rejected Dr. Reynolds' application for reappointment as Head of the Department of Family Medicine).

One year later, the terms of reference were expanded: "to investigate the termination of Dr. Reynolds in his position as a Professor of Family Medicine at the University of Manitoba and at the Winnipeg Regional Health Authority:

> To determine if the termination was consistent with the *CAUT Policy Statement on Tenure*; to determine if the termination was in accord with the University of Manitoba Policy on *Term of Appointment and Tenure*; and to make any recommendations you [the Committee] feel are appropriate."

(Turk fax to Dean Sandham on Dec. 12, 2008)

2. INITIAL FACTS

2.1 Dr. Reynolds' Original Appointment.

In 2001, Dr. Brian Hennen, then Dean of the Faculty of Medicine at the University of Manitoba, recruited Dr. Reynolds from the University of Western Ontario to take up a "Geographical Full-Time position" (joint appointment): 40% as Professor and Head of Family Medicine at UM (comprising 30% administration, 5% teaching, 5% research); and 60% as Medical Director of the Family Medicine Program of the Winnipeg Regional Health Authority (WRHA) with time commitments of 20% to patient care, 35% administration, and 5% for research. Included in the WRHA responsibilities was the position of Medical Site Manager for Family Medicine at St. Boniface General Hospital in Winnipeg.

2.1.1 Tenure

Section 3 of the formal offer, dated May 28, 2001, and signed by Dean Hennen and Dr. Brian Postl, CEO of the WRHA, is headed "Term of Appointment"; subsection 3.1 is headed "University of Manitoba" and includes the statement: "As a Faculty member, **your appointment will be tenured**. **Your tenured appointment will begin on October 1, 2001**. Your appointment as Head, Department of Family Medicine is effective from October 1, 2001 to September 30, 2006, and is **subject to renewal in accordance with the policy as approved by the Board of Governors, May 20, 1982** (copy enclosed)." In addition, there was a separate letter, same date and signatories, [serving] "as confirmation to additional understandings reached and not included within the formal letter of offer." These understandings included agreement that Dr. Reynolds would have time off to complete a Master of Health Science (Bioethics) degree at the University of Toronto during the first year of his appointment. (emphasis added)

We note that these documents contain no suggestion that Dr Reynolds' appointment as professor with tenure in the University of Manitoba's Department of Family Medicine was in any way contingent on funding from the WRHA (see below).

The UM Policy *Term of Appointment and Tenure* (effective October 22, 1991), at section 2.1 (Appointments with Tenure) states: "Such appointments continue until resignation or retirement, or until terminated earlier by the University for cause, or as a result of a declaration by the Board of an extraordinary financial exigency or redundancy."

2.1.2 Department Head

The UM Policy *Appointment of Heads of Departments* (effective May 20, 1982), under the heading "Scope" states: "… appointments are held at the pleasure of the Board." And under "Appointment Procedures" it states: "… the Dean shall strike a committee to advise on the appointment of a Head. In considering candidates for the position, the Committee shall automatically consider the incumbent as a candidate for renewal of appointment unless he or she declines to be considered."

The UM Policy *Term of Appointment and Tenure* (effective October 22, 1991), under "General Policy", Section 1 (Term of Appointment of Officers and Employees Other than as Full-Time Faculty Members) at subsection 1.2 states:

> "The term of appointment of … heads of departments … **shall be terminable at the discretion of the Board** …" At 1.4, the Policy states: "The termination of … appointment of … heads of departments … **shall not affect the … tenure** … of those persons as faculty members." (emphasis added)

According to the original May 28, 2001, formal letter of offer to Dr. Reynolds, his initial annual salary of $230,000 on appointment comprised remuneration from the University of Manitoba in the amount of $6,000 for GFT services, $35,924 Headship, and $2,442 Headship stipend (total $44,366), and remuneration from the WRHA of $20,808 for Site Director at St. Boniface General Hospital, and $19,000 for GFT, plus stipends of $20,808 for the position of Medical Director, Family Medicine, and $125,018 in Family Medicine block stipends (WRHA total $184,634). Neither UM nor WRHA had "any obligation whatsoever to continue, in whole or in part, that part of the salary attributable to the position in the other organization should such position expire or be discontinued." In addition, the accompanying letter confirming "additional understandings reached and not included within the formal letter of offer" seems to deal with WRHA commitments and clinical earnings. At item 8 it states: "As per University of Manitoba policies and procedures, six months written termination notice by either party is provided. In the case of misconduct … [or breach of contract]… the WRHA may immediate (sic) terminate the contract."

2.2 Non-reappointment of Dr. Reynolds as Department Head.

On July 11, 2005 (nearly 15 months before the end of his first term as Head of Family Medicine), Dr. Reynolds wrote to Dr. Brian Postl (CEO WRHA) thanking him for meeting on July 8 to discuss the process for Dr. Reynolds' "reapplication (sic) for my position as WRHA Medical Director and University Dept Head for Family Medicine. […] We agreed that I will review my options with Brock Wright, COO, Health Sciences Centre, and VP and Chief Medical Officer, WRHA, before making my decision about reapplication (sic)." Dr. Reynolds also complained that meetings he had been having during the past year with Dr. Sharon Macdonald (WRHA Vice-President and COO, Community Health Services) and Ms. Gloria O'Rourke, WRHA VP and Human Resources Officer, had been "experienced as harassing and intimidating."

The relationship between VP Macdonald and Dr. Reynolds had been fraught with difficulty almost from the beginning of his full-time headship. On Oct 1, 2003, at the start of the third year of his appointment, Dr. Reynolds had written to Dr. Macdonald with a litany of complaints about her management, ending with: "These conditions make my job impossible to do and unless they are rectified I am left with no choice but to resign from my position as Medical Director of the Family Medicine Program." Dr. Macdonald responded at length the same day, ending with: "I am prepared to accept your resignation." Dr. Reynolds did not resign.

Although Dr. Reynolds copied his July 11, 2005, letter to VP Macdonald, she did not refer to it until September 1, 2005, in a letter to Dr. Reynolds seeking to reschedule a meeting originally set for August 31 that Reynolds had cancelled. She listed Dr. Reynolds' Op-Ed article in that day's *Winnipeg Free Press* as another item for discussion. Dr. Reynolds went on vacation on September 6 and returned to meet with Dean Sandham (possibly together with Dr. Wright) on or about September 30, 2005, for his "Bi-Directional Annual Review." This seems to have been the first such "annual" review, although VP Macdonald had done a "performance appraisal" on May 4, 2004.

Either just before or directly after the Bi-Directional review on September 30 (the last day of Reynolds' penultimate year in his Headship), Reynolds emailed Drs. Sandham and Postl, with a copy to Dr. Wright, saying: "I am discussing options with Brock and at this point I will let my name stand for a second term as Medical Director and Head of the Dept of Family Medicine." On the same date, Dean Sandham wrote to Dr. Reynolds giving a summary of their Bi-Directional Review meeting, including these final comments:

> "We went on to discuss the issue of your relationship with Vice President of the Winnipeg Regional Health Authority and our view that this had proceeded beyond a remediation, that it was creating an unnecessary hardship for you and was preventing the full development of the program for your department. I stressed the need to have integrated academic and clinical department heads in the city."

On October 21, 2005, Dr. Wright wrote to Reynolds regarding his GFT position. Dr. Wright set out the terms of employment with WRHA that would be offered to Reynolds "if you decide to withdraw from the **current search process**, and you obtain an approved administrative leave through the University …" Specifics would be determined "through discussions between you and the new Head of Family Medicine and Medical Director of Family Medicine, WRHA." (emphasis added)

Provence Consulting advertised the positions in the January 2006 edition of *Canadian Family Physician*, and Reynolds "received calls from colleagues across the country expressing concern that they were being headhunted for my job" (see letter dated October 15, 2007 from Dr. Reynolds to Maggie Duncan, UM Office of Equity). The Dean's search committee (15 members, including the Dean, Dr. Postl, VP Macdonald, and two students) had been established, presumably in the last three months of 2005, but this was not communicated to Dr. Reynolds until Jan. 31, 2006.

On Feb 09, 2006, Dr. Reynolds was called to Dr. Sandham's office to meet the Dean and VP Macdonald. Later that day, in an email to Karen Grant (UM Vice-Provost, Academic Affairs) Dr. Reynolds reported that the Dean had asked him what his intentions were about reapplying for his job, and Dr. Reynolds had "told him that it was my intention to reapply." Dr. Reynolds added that the Dean told him he "must reapply thru (sic) the Headhunting firm that has been engaged. I was never informed about this. I have seen the ads and understood these were for others rather than the incumbent." (Reynolds email to Karen Grant) The next day, Dr. Reynolds emailed seach@providenceconsulting.com (sic), copied to Dean Sandham, Karen Grant, and VP Sharon Macdonald, to notify the consultants that he was working to clarify whether, as the incumbent who had **not** declined to be considered, he was automatically a candidate for

reappointment. Given the typographical errors in the email address (correct address: search@provenceconsulting.com), the consultants may not have received this message. However, the Dean did, because he responded about one hour later in an email saying:

> "Just a clarification. The last communication we had regarding you (sic) position was discussion around **how you would use your admin leave**, and our efforts to make that useful for you." (emphasis added).

(This prior discussion may have occurred in the first three weeks of October 2005, following the September 30 Bi-Directional review, when Dr. Reynolds notified Dean Sandham he would stand for a second term – see above.)

Ten days later, in a letter to Dr. Reynolds dated February 20, 2006, Mrs. Mary Hill, Administrative Secretary to the Departmental Headship Search Committee, noted that Dean Sandham had received Dr. Reynolds' email regarding his intention to apply for the position of Head. She asked Dr. Reynolds to send a copy of his CV and names of referees to Ms. Maureen Geldart at Provence Consulting. He responded on February 27, 2006, and received an emailed acknowledgement from Provence Consulting on March 6.

According to Dean Sandham (letter to Dr. C. Stuttard, dated October 29, 2009), the subsequent search process was delayed but not abandoned. "The delay in the search occurred as a result of a March 6, 2006 decision by the search committee to recommend that an external review of the Department be conducted to better understand the challenges faced by the unit, as well as the type of leader required. Subsequently, there was a 360 degree review of the Department and a performance review of Dr. Reynolds."

In fact, the Dean and Dr. Wright initiated "a 360° evaluation" of Dr. Reynolds in June 2006 (see May 2, 2006, draft document, *The Department Head Review Process*, and email to Dr. Reynolds from Marnie Donovan, Administrative Assistant to the Dean, June 16, 2006), and a later external review of the Department (see below). Dean Sandham and Dr. Wright conducted the evaluation based on a standard 360° form completed by Dr. Reynolds (no copy was available to this Committee) and an interview on June 23 with Dr. Reynolds. On June 26, Dr. Reynolds wrote notes of his view of the process, and characterized the meeting as "demeaning, threatening and demoralizing." He would await the Dean and Dr. Wright's written assessment before writing his response. We do not know whether, in fact, Dr. Reynolds did respond to the subsequent assessment; if he did, we were not provided with a copy.

The Dean and Dr. Wright wrote a narrative summary of this "Annual Performance Review" and sent it to Dr. Reynolds on July 17, 2006. The summary explained that the evaluation was in the extended 360° category because Dr. Reynolds was one of "Those individuals **up for renewal**". At the end of the evaluation summary Dr. Wright's personal view "was that Dr. Reynolds should think long and hard about a second term due to the large number of concerns and overall unsatisfactory evaluation which had been delivered. **If he did apply** and was successful, there would need to be significant discussion regarding goals and objectives and if not, there needed to be significant discussion about a future role as a former head for Dr. Reynolds." (emphasis added)

Dr. Reynolds had already submitted his application before March 6 when, according to Dean Sandham, the search committee decided to delay the search (Dean Sandham chaired the search committee). Therefore, Dr. Wright's comment seems peculiar, unless he was referring to the possibility that Dr. Reynolds might apply in a second search process to be conducted in the coming months, after his first term had expired on September 30, 2006. Wording consistent with this interpretation (".. you will not submit your name as a candidate..") is found in the first (dated November 2, 2006) of two letters signed by Drs. Wright and Sandham and sent to Dr. Reynolds on November 7, 2006 (see Administrative Leave, below). However, Dr. Sandham (letter to Dr. Stuttard, op cit) notes that the November 7 letter "goes on to specifically state that he had 'withdrawn from the current search process'." Similar words: "if you decide to withdraw from the current search process, …" are in the October 21, 2005, letter to Dr. Reynolds from Dr. Wright. (see above). Thus, it is unclear whether, as Dr. Sandham contends, the original search process was continuing, or a new search was being contemplated. If the latter were the case, it would suggest that the Dean was not prepared to recommend Dr. Reynolds' reappointment; that is, the Dean had rejected Dr. Reynolds' "reapplication".

In his October 29, 2009, letter to Dr. Stuttard Dr. Sandham claims:

> "On November 15, 2006, Dr. Reynolds circulated an email to members of the Department of Family Medicine entitled 'Farewell', and indicated that he had withdrawn his application for re-appointment as Head."

And in his own letter to Dr. Stuttard Dr. Postl similarly states:

> "Dr. Reynolds himself, withdrew from the competition. Dr. Reynolds sent an email to the Family Medicine Program members and many others, including myself, dated November 15, 2006. Dr. Reynolds, himself, stated: 'I have informed the Dean of Medicine and the WRHA CEO, Dr. Brian Postl, that I have decided to withdraw my name as a candidate for a second term as Department Head and Medical Director for Family Medicine.' I trust that Dr. Reynolds provided you with a copy of that email."

In fact, no one has provided a copy to this Committee, but in his own, point-form account of his November 2006 departure from the Department, Dr. Reynolds (letter to Maggie Duncan, October 15, 2007) stated:

> "14. In November I was forced to negotiate an exit strategy and there was a public announcement of my departure 2 days before I left, without me having a chance to communicate with my Department members."

In addition, Dr. Sandham wrote:

> "We note that Dr. Reynolds had an internal grievance process available to him if he felt his treatment during the search process was unfair. He did not seek any remedy through this process, we suggest, because he had agreed not to stand as a candidate."

Since Dr. Sandham gives no reference for this putative grievance procedure, we assume he means the University of Manitoba's "Appeals by academic or support staff excluded from bargaining units" which applies to GFT staff and administrative academic staff, among others. If so, we can only observe that procedures under this policy do not cover any act or omission of the Board of Governors (Department Heads are appointed at the pleasure of the Board), or

failure to reappoint, among others. Thus, unless there is some other applicable grievance procedure, Dr. Sandham is again in error and, in fact, Dr. Reynolds did not have a University grievance procedure open to him. Therefore, his failure to appeal cannot be taken as evidence that he had agreed "not to stand as a candidate" – he was already standing as a candidate.

In any event, there seems to have been no second international search, nor continuation of the original search, despite a recommendation in the Moores-Woollard Report (Appendix). Instead, another member of the Department of Family Medicine, Dr. Jamie Boyd, was made Acting Head on November 17 (see below), and some time later was made Head.

While he and Dr. Wright were conducting their evaluation of Dr. Reynolds, Dean Sandham (with Dr. Postl) was also writing: "Draft terms of reference external review Department of Family Medicine Winnipeg Regional Health Authority and Faculty of Medicine University of Manitoba". The review process began in early June (see emails between Ms. Lynne Ducharme and Ms. Mary Hill, June 6, 2006, and Ms. Marnie Donovan, July 17 and 18, 2006, and August 29, 2006). The final terms of reference requested that the review be completed, and report provided, by July 15, 2006. However, the reviewers, Drs. Robert Woollard and David Moores, did not conduct their on-site interviews until September 24, 25 and 26, 2006 (see Appendix). Dr. Reynolds' term as Head of the Department of Family Medicine expired on September 30, 2006, but he apparently agreed to continue as the Acting Head and Medical Director until November 17, 2006 (see first letter dated November 7, 2006, to Dr. Reynolds from Dr. Wright and Dean Sandham).

3. ADMINISTRATIVE LEAVE (Nov 18, 2006 – Nov 17, 2007)

In their first November 7, 2006, letter (also dated November 2), Drs. Wright and Sandham set out the agreement they had reached with Dr. Reynolds regarding a "smooth transition" to a new Acting Head and Medical Director who would be appointed to replace Dr. Reynolds on November 17, 2006:

> "You have agreed that you will not submit your name as a candidate for this position for a second term as Head and Medical Director. Your request for an administrative leave has been approved by the University of Manitoba and WRHA and will commence on November 18, 2006. Your paid administrative leave is for one year, until November 17, 2007. During your administrative leave you will be entitled to your benefits as a Geographical Full Time member in accordance with the existing GFT Agreement with the University of Manitoba."

(Note: the Ad hoc Committee was unable to obtain a copy of this GFT Agreement.)

The letter set out details of the remuneration Dr. Reynolds would receive during his administrative leave, and continued, in part, as follows:

> "As you have withdrawn from the current search process and you have obtained an approved administrative leave through the University and the WRHA, when you return from your administrative leave, the WRHA and University are prepared to offer you a GFT

position in Seven Oaks Family Medicine Teaching Unit practice for a one year term, provided that a vacancy exists. …

"If there is no vacant position in the SOGH Teaching Unit upon your return from your administrative leave, then for a the portion of the one year period that there is no vacancy (up to a maximum of one year) WRHA is prepared to offer you a full-time term position within the WRHA Family Medicine Program and will top up your income, if necessary, to the level of a GFT Teaching Unit Family Medicine physician in accordance with the existing rates … If a vacant Teaching Unit position is not available upon your return, and you are employed within the WRHA Family Medicine Program, your specific clinical and other duties will be determined at that time through discussions and mutual agreement between you and the new Head of Family Medicine and Medical Director of Family Medicine, WRHA."

The same signatories sent a second letter to Dr. Reynolds dated November 7, 2006. The first three paragraphs read as follows:

"This will serve as a Letter of Understanding to be appended to your Original Letter of Offer dated May 28, 2001 and any addendums or letters of understanding attached thereto.

"All current terms and conditions of appointment remain the same except for the following:

"Your appointment as Head, Department of Family Medicine will be extended from October 1, 2006 to November 17, 2006."

This Letter of Understanding then sets out the components of Dr. Reynolds' salary, including $12,491.33 for "GFT (tenured)", and his Headship pay, which, the letter noted, "will cease during periods of administrative leaves." The letter ended with a request for Dr. Reynolds to sign his acceptance of "these terms and conditions" and return to the Dean, which Dr. Reynolds did on November 15, 2006. We note again that the terms and conditions of Dr. Reynolds' appointment included tenure in the Department of Family Medicine and GFT with tenure.

One year later, Dr. Reynolds received another Letter of Understanding, dated November 2, 2007, and signed by Dr. R.J Boyd, the new Head of Family Medicine and Medical Director; Dr. Milton Sussman, who had replaced Dr. Sharon Macdonald as VP responsible for the WRHA Family Medicine Program; and Dean Sandham. This Letter of Understanding gave Dr. Reynolds' rank and title as UM Professor and WRHA Clinician, and offered an "extension" to his GFT position in the UM Department of Family Medicine and in the WRHA Program at Seven Oaks General Hospital (SOGH Kildonan Medical Centre – Family Practice Residency Training Unit), effective November 17, 2007, and ending November 16, 2008. Dr. Reynolds signed his acceptance on December 10, 2007. We understand from Dr. Reynolds that, at the time, as a tenured Professor with a tenured GFT appointment, he attached no significance to the word "extension" other than indicating a change in his work site.

4. EXPULSION FROM DEPARTMENT

In early November 2008, Dr. Reynolds had the following email exchange with the new Head of Family Medicine, Dr. Jamie Boyd:

> >>> Jamie Boyd 11/4/2008 12:37 PM >>>
> Effective Nov.17 2008,Dr. Larry Reynold"s will be finishing his one year term GFT position at KMC. As all of you know Larry was our Dept. Head from 2001-2006 and followed this with a sabbatical year in 2006- 2007. Larry will continue his leadership role in Low- Risk Obstetrics that he started with the clinic at Women"s in Feb2008. He will likely continue his work in Emergency and move on to new endeavors and continue his role as a community teacher in many disciplines.Dr. Mark Boroditsky will take over Larry"s position officially Nov17 2008. This is what I was considering as an announcement.What do you think???
>
> Dr. R. Jamie Boyd
> Professor & Head, Department of Family Medicine University of Manitoba Regional Medical Director Winnipeg Regional Health Authority
> E6003 - 409 Tache Avenue
> Winnipeg MB R2H 2A6
>
> ph. - 204 - 235-3655
> f - 204 - 231-0302
> e - jaboyd@sbgh.mb.ca
>
> >>> Larry Reynolds 11/10/2008 10:06 >>>
> Jamie I hope Saskatoon was ok. Are you planning to announce today. If so later in the afternoon might be better.
>
> We need to talk about returning the laptop and about my palm pilot. I also have some holidays due. Jack W or B Cram will check that out.
>
> I guess that I should work with Tunje about the patient transfers, labs and messages for me. Do you have an understanding about what is going to be said to patients?
>
> Just to be clear from your meeting with me and Bobby. You said I can not apply for locum positions in the University Dept of FM and that I can not apply for the GFT position at FMC.
> Is that accurate.
>
> Larry

>>> Jamie Boyd 11/10/2008 12:53:52 PM >>>
As per our discussion, I will send out an E-mail this P.M. announcing that you are finishing your term position. I would appreciate that you return the laptop as soon as you are able to transfer your files, although I feel you should keep the palm pilot. I agree with checking out your holidays with Jack Wallace and Bobby Cram. I would appreciate you working out the patient transfers, labs , messages, and other paper work with Tunji , Bernie and the staff at KMC. The patients will be informed that Mark Boroditsky is taking over your position Nov17 and that you are moving on to new endeavors such as Low -Risk Obs. The answer is yes that as of now you cannot apply for any GFT or locum positions in the University Dept of Family Medicine. Thank you for your cooperation under very difficult circumstances.

Dr. R. Jamie Boyd
Professor & Head, Department of Family Medicine University of Manitoba Regional Medical Director Winnipeg Regional Health Authority
E6003 - 409 Tache Avenue,
Winnipeg MB R2H 2A6

Later on November 10, all members of the Department of Family Medicine received this announcement:

>>> "Jamie Boyd" <jaboyd@sbgh.mb.ca> 11/10/2008 2:38 PM >>>
Dear Colleagues,

Effective November 17th, 2008, Dr. Larry Reynolds will be finishing his one year term GFT position at KMC. As all of you know, Larry was our Department Head from 2001-2006 and followed this with a sabbatical year in 2006- 2007. Larry will continue his leadership role in Low- Risk Obstetrics that he started with the clinic at Women's in February of 2008. He will likely continue his work in Emergency, whilst moving on to new endeavors and continuing his role as a community teacher in many disciplines. Dr. Mark Boroditsky will take over Larry's position officially on November 17, 2008.

Speaking on behalf of the Department of Family Medicine, I would like to thank Larry for all his hard work and dedication and wish him every success in the future.

Sincerely,

Thus, Dr. J. Larry Reynolds, a tenured Professor with a tenured GFT appointment, was dismissed from the University of Manitoba's Department of Family Medicine without formal notice and with no hearing regarding dismissal for cause, contrary to his contract and the policies of the University of Manitoba.

5. INTERVIEWS AND FURTHER COMMENT

The Committee made two trips to Winnipeg, the first in February 2008, and the second in December 2008. The first trip was devoted to a lengthy interview with Dr. Reynolds, after which the Committee reached the tentative conclusion that the Dean's apparent decision on March 6, 2006, not to recommend the reappointment of Dr. Reynolds as Department Head (and therefore WRHA Medical Director) of Family Medicine was a management right. It was not clear to the Committee that Dr. Reynolds' academic freedom was thereby violated, but the Committee did not preclude further investigation.

Between the first and second trips, however, and despite holding an appointment as a professor *with* tenure, Dr. Reynolds was dismissed from the Faculty of Medicine. The question for the Committee now changed from an evaluation of the administration's decision not to reappoint him as Head of the Department of Family Medicine to an evaluation of his dismissal as a tenured professor.

On Monday, December 15, 2008, the Committee interviewed Dr. Alan Jackson, a neurologist at the University of Manitoba and chair of the CAUT Clinical Faculty Committee, and Dr. Jack Wallace, the executive director of the University Medical Group – the business/accounting office for Geographical Full Time clinical teaching members of the Faculty of Medicine. Drs. Jackson and Wallace provided us with useful contextual information regarding proposals to abolish the employer-employee relationship for clinicians in the Faculty of Medicine and the WRHA – making all clinical faculty "independent contractors" with "nil" appointments at the University (no salary, apparently equivalent to adjunct appointments at other universities).

On Tuesday, December 16, 2008, the Committee met with Dr. Sandham, Dean of the University of Manitoba Faculty of Medicine; Dr. Postl, CEO of the WRHA; Dr. Wright, Vice-President of the WRHA; and Dr. James Boyd, who replaced Dr. Reynolds, first as Acting Head in 2006-07, and subsequently as Head of the Department of Family Medicine in the Faculty of Medicine and Medical Director of Family Medicine in the WRHA. Later that day, the Committee met with four members of the Department of Family Medicine: Drs. Brent Kvern, Gerald Konrad, Mark Kristjanson, Gerry Bristow; and finally with again with Dr. Larry Reynolds accompanied by Dr. Gary Beazley.

The Committee was able to hear the administrators' explanations of their treatment of Dr. Reynolds, and gave us an insight into the Dean's understanding of tenure. The Dean claimed that Dr. Reynolds was still permitted to teach, although he no longer held a GFT appointment in the University of Manitoba's Faculty of Medicine; in these respects, according to the Dean, he is like the other 250 people in Family Medicine. We believe that the Dean's claim was not accurate (see interviews with other members of the Department of Family Medicine, below). When we raised the question of the University's apparent breach of Dr. Reynolds' tenure contract, the Dean maintained that Dr. Reynolds' tenure was contingent on his remaining in the teaching unit, and that, since his appointment as Head had ended on November 17, 2006, his tenure had also ended. This also was clearly false (see November 2006 and 2007 letters of understanding attached to Dr. Reynolds' original employment offer, which Dr. Reynolds had accepted). In response to further questions about the definition of tenure in the Faculty of

Medicine, the Dean explained that tenure in his Faculty is defined differently from the definition in other Faculties and departments of the University. We pointed out we could find no documentation of any sort that would substantiate his position.

In a subsequent communication (letter to Dr. Stuttard, October 9, 2009), Dr. Sandham asserted that "tenure is not defined differently in the Faculty of Medicine," but then added that "There is a concept of 'contingent tenure' which could be applied within any Faculty at the University." He cited the UM policy: "We would draw your attention to 2.2.4 (sic) of the *Term of Appointment and Tenure Policy,* …" In fact, the particular sub-section 2.4 of the Policy document, headed *Contingent Appointments*, to which Dr. Sandham referred, is actually located in the second section of the *General Policy* (2. Term of Appointment or Tenure of Full-Time Faculty Members). It defines the last of four categories of possible appointment available to a full-time faculty member. Dr. Sandham totally ignored the first category, 2.1 *Appointments with Tenure*. Dr. Reynolds' was a category 2.1 appointment, not a 2.4 appointment. The word "contingent" does not appear anywhere in Dr. Reynolds' letters of appointment.

In the third section of the same document (*Policies and Procedures Governing Appointments of Full-Time Faculty Members Not Subject to a Collective Agreement*), sub-section 1 is *Appointments with Tenure*, and at paragraph 1.2 it reads: "Nothing in this policy shall prevent the Board of Governors, … , from giving an appointment with tenure to a faculty member **who has a contingent appointment …"** (emphasis added)

This would seem to indicate a separation of two different types of appointment, rather than a second type of tenure – the supposed "contingent tenure" proposed by Dr. Sandham. This interpretation is consistent with sub-section 4 of the same *Policies and Procedures Governing Appointments of Full-Time Faculty Members Not Subject to a Collective Agreement*: 4. *Contingent Appointments*, which is separate from sub-section 1. *Appointments with Tenure* (see above), and at 4.1 (the only paragraph) in its second sentence states: "**At the time of appointment** the University shall specify the funds upon which the appointment is contingent and, where possible, the term interval of the appointment." (emphasis added)

As we noted in section 2 above (Initial facts), Dr. Reynolds was originally given three University appointments: an academic appointment as Professor with tenure in the Department of Family medicine, and an administrative position as Head of that department; plus an academic, clinical joint appointment with the WRHA as a Geographic Full Time (GFT) faculty member, also with tenure, based in a WRHA facility. In addition, the WRHA appointed Dr. Reynolds as Medical Director for the WRHA Family Medicine Program, and Medical Site Manager for Family Medicine at St. Boniface General Hospital. The GFT appointment with tenure may be unique, but was a contract none the less.

Dr. Reynolds understood his original appointments as Professor and GFT faculty member, each with tenure, to be appointments only terminable by the employer for cause or financial exigency, conditions that both require due process, as specified in policies applicable to all Faculties in the University of Manitoba, including the Faculty of Medicine. He also understood that his administrative appointment had a five year term, renewable on recommendation of the Dean and the CEO of the WRHA.

Dr. Brian Postl asserted that *all* appointments, including tenured ones, were contingent on whether or not funds were available. He said that this underlined the difference between the Faculty of Medicine and other faculties and departments in the University in the understanding of the concept of tenure. In a subsequent communication (letter to Stuttard, October 29, 2009), Dr. Postl states: "Tenure is an academic University concept. The University can respond to you with respect to tenure."

Dr. Brock Wright claimed that Dr. Reynolds understood that his GFT position would end with the end of his appointment at the Kildonan Medical Centre following his year of administrative leave. "We would have considered allowing him to remain as a GFT in the KMC," said Dr. Wright, "but his performance was poor and clearly inadequate." He said Dr. Reynolds seemed to be surprised by the impending end of his appointment in November 2008, and wanted a lump sum or some other form of recompense. "Had we reappointed him," Wright concluded, "we would have been heavily criticized." He did not say by whom.

Dr. Wright subsequently addressed this question in a letter to Dr. Stuttard (dated October 29, 2009, and signed by Robin Carels for Dr. Wright) as follows:

> "The vast majority of the other physicians at the Kildonan Medical Centre would have criticized the WRHA if Dr. Reynolds had been permitted to remain as a clinician there. They were the ones who had to pick up extra work when Dr. Reynolds failed to show for scheduled clinics. On several occasions Dr. Reynolds failed to show up in clinic to supervise residents assigned to him. He showed a lack of respect for administrative expectations and routines, including failure to attend department meetings, failure to notify the Clinic Manager of some of his absences, including returning two days late from vacation despite having patients booked. He failed to respond to the Program Medical Director's requests to meet between June 2008 and September 2008 to discuss his performance and transition at the scheduled end of his term. During his time at the Clinic he was scheduled for 3.5 days per week in clinics and the remaining 1.5 days was for research and administration. It does not appear that Dr. Reynolds did any research during this time. For these and other reasons not detailed in this summary, the WRHA has no doubt it would have been criticized if it had agreed to give another term position there to Dr. Reynolds."

It is the view of this Committee that, in the absence of due process finding cause, any tenured professor would "seem surprised" to be told his appointment was about to end.

Dr. Postl, referring to events in September 2005, said that the whole administrative structure was built on having University Heads for the clinical teams, especially in Family Medicine; but that Dr. Reynolds' team came to him (Postl) and said that they would resign if Dr. Reynolds were reappointed. At the time of this interview the Committee had seen no evidence to corroborate this claim. To the contrary, it was remarkably at odds with the May 2005 anonymous, confidential survey of 80% of all 49 members of the Department of Family Medicine regarding the performance of the Department Head, in which 74% rated Dr. Reynolds' performance as "Excellent" or "Good" and 70% agreed that his appointment should be renewed unconditionally for a second term (Dr. Jack Wallace, UMG, "Department Head

Review", May 2005). Also, both Dr. Wright's and Dr. Postl's criticisms of Dr. Reynolds in this interview seemed inconsistent with Dr. Postl's September 13, 2006, letter to Dr. Reynolds expressing thanks for "your efforts in filling vacant shifts in Emergency Departments this past summer." "And so your decision to forego some of your well-deserved time-off to assist with the ongoing shortage is even more appreciated."

In his subsequent letter to Dr. Stuttard (op cit), Dr. Postl defined the WRHA Family Medicine Program (presumably in 2005) as comprising "a Medical Director (Dr. Reynolds), a Nursing Director, an Administrative Director and, in the early stages of Dr. Reynolds' time, an Allied Health Director." He listed negative comments received in emails from the Administrative Director and advice from the Nursing Director (who became Program Director after the Allied Health Director left). He questioned the survey respondents' perception of the confidentiality of the survey process. He dismissed his own letter of thanks to Dr. Reynolds as being "a form letter sent to all clinicians who assisted … in the summer of 2006 ..."

Dean Sandham allowed that Dr. Reynolds had satisfactory skills as a physician and some significant gifts as a contributor to the unit, able to form relationships with people of use to the unit; he added, however, that the same gifts were not evident in his relations with subordinates.

Regarding Dr. Reynolds' complaints about the way obstetrics were being delivered, Dr. Postl explained that Dr. Reynolds wanted a community site for obstetrics. However, obstetricians were leaving that site, so the hospital board decided that this was unsafe for patient care and made a decision to close the unit. Dr. Reynolds opposed this closure.

When asked whether Dr. Reynolds was only exercising his academic freedom by going to the media to plead the case for maintaining the obstetrical unit in opposition to the Board's decision to close the unit, Dr. Wright argued that he had written nothing to Dr. Reynolds that had a bearing on his academic freedom; to which the Dean added that "one of our most important jobs is to protect academic freedom."

Dr. James Boyd explained that the job of Head combines work for both the WHRA and the University, and that he had encountered no restrictions from either administration. He said that in his administrative work he tried to look at all sides and come to a consensus, asking whether he was doing the right thing for family medicine, the University and the WRHA. He also insisted that his own academic freedom had not been impeded in any way.

Dr. Postl remarked on the "jointness" of the relations between the University and the WRHA. Heads of departments, he explained, need to have a close connection with clinical programs in order exert leverage on teaching. He admitted that there are potential conflicts of interest, but claimed these were very few. The WRHA, he said, does not in any way wish to squash academic freedom; and there is room for debate on the full-time clinical/academic connection. On the one hand, there is academic freedom, on the other, accountability.

However, we subsequently obtained a redacted copy of the Moores/Woollard External Review Report (see our Appendix) in which the authors explicitly stated:

> "The convention of combining the academic and clinical leadership roles to address both Faculty of Medicine and WRHA agendas likely will not work for Family Medicine and primary care."

The reviewers recommended "the appointment of an interim Acting Chair (Head) from within, pending a continuing national and international search." They also suggested that the Department should have an Associate Department Head as well as the Head, because "it is impossible for one person to [perform both roles as academic department head and service chief for the discipline]."

Dr. Wright pointed out that the vast majority of clinical professors are untenured, but are nevertheless considered to have academic freedom. GFTs do have tenure in their appointment, but very little of their total income derived from what the Faculty of Medicine regarded as the tenured portion of their appointment.

In fact, other interviewees told this Committee that very few UM GFT appointees have tenure; and Dr. Wright seemed to have essentially no understanding of the meaning of a university appointment with tenure.

Dr. Wright stressed that Dr. Reynolds agreed to step down as Head in return for a leave and then a salaried position. Dr. Postl supported this interpretation, adding that Dr. Reynolds had been fully aware of the agreement he had made in November 2006. It seemed to this Committee that in taking this position, these two senior WRHA administrators were either displaying woeful ignorance of the content of documents Dr. Postl had signed in May 2001, or were attempting to obfuscate the issues. Dr. Reynolds was "entitled to 12 months administrative leave after five years of continued (sic) service." (May 28, 2001 letter from Drs. Postl and Hennen to Dr. Reynolds confirming additional understandings not included in the formal letter of offer.)

In his subsequent letter to Dr. Stuttard (October 29, 2009), Dr. Wright concurred with the explanation given by Dr. Postl in his own October 29, 2009, letter to Dr. Stuttard:

> "Yes, it is without question that Dr. Reynolds' original contract offered him 12 months administrative leave after five years of continued service. However, the point is that after extensive negotiations with Dr. Reynolds' agent, the Manitoba Medical Association, Dr. Reynolds signed documents whereby he indicated that he would not be applying for the second term as Head of the University of Manitoba Department of Family Medicine or the WRHA Program Medical Director of Family Medicine. In exchange, the agreement that Dr. Reynolds signed on the advice of his professional advisors stated:
>
> > 'As you have withdrawn from the current search process and you have obtained an approved administrative leave through the University and the WRHA, when you return from your administrative leave, the WRHA and University are prepared to offer you a GFT position in Seven Oaks Family Medicine Teaching Unit practice <u>for a one year term</u>, provided that a vacancy exists. … If there is no vacant position in the SOGH Teaching Unit upon your return from your administrative leave, then for a the portion of the <u>one year period</u> that there is no vacancy (<u>up to a maximum of one year</u>), WRHA is

prepared to offer you a full-time term position within the WRHA Family Medicine Program and will top up your income, if necessary, to the level of a GFT Teaching Unit Family Medicine physician …'

"It has never been the WRHA's position that Dr. Reynolds would not have been entitled to a 12-month administrative leave. The fact is that he negotiated for and was given a substantially enriched arrangement whereby he received an additional 12-month term position at full salary."

In this report, at section 3 Administrative Leave (above), we have reproduced a slightly more complete version of the same section quoted above by Dr. Postl from the November 2/7, 2006, letter from Drs. Wright and Sandham to Dr. Reynolds. A copy of that letter, as provided to this Committee, is not countersigned by Dr. Reynolds. On the other hand, the second November 7, 2006, Letter of Understanding, from which we quote above (see section 3 Administrative Leave), was signed by Dr. Reynolds on November 15, signifying his acceptance of that Letter of Understanding, but saying nothing about the November 2/7 letter.

In the next session on Tuesday, December 16, 2008, the Committee interviewed Dr. Brent Kvern, a GFT associate professor in the Department of Family Medicine, on a contingent appointment renewed annually, and untenured for fifteen years at the University. He explained that tenure in his department is reserved for full professors, meaning that in his department only the head and a couple of other full professors have tenure. He added that he had a poor understanding of the concept of tenure in the Faculty of Medicine, even though he had held numerous administrative positions, including the associate deanship for continuing education (1999-2004) and program director (2004-2007), while Dr. Reynolds was Head.

He said that Dr. Reynolds allowed activities to move forward if they were well thought out; that he was a demanding personality, but that he strongly supported major curriculum changes. The Department lived through tense times near the end of his term, and it did not seem likely that he would be reappointed. Dr. Kvern said that they did not ask the Dean for more information, nor did they ask Dr. Reynolds about his reasons for his abrupt departure. He thought that underlying the turn of events were clashes of personalities; Dr. Reynolds did not get along well with the Dean. It seemed to Dr. Kvern that Dr. Reynolds could not win, no matter what. The administration of the Faculty of Medicine saw him as a problem, while the community doctors regarded him as a hero. Dr. Reynolds would spend one afternoon a week in clinical observation, and thought the academic department was really important. It is significant, Dr. Kvern said, that all "our positions were filled because of Larry as a leader." There was some turnover in the Department, but not because of Dr. Reynolds.

Dr. Kvern said that he saw no gross negligence or mismanagement or incompetence. Dr. Reynolds, he said, wanted to focus on the voice of family medicine within the larger context of health care in the Province, but he did not have skill in managing personal relations. Historically, there have been tensions between family medicine and internal medicine; and there is a general belief that Internal Medicine has a very strong influence on the Dean. He praised Dr. Reynolds' leadership in the development of a northern medical program, which was one of his priorities; and remarked on a general feeling of unfairness among Dr. Reynolds' colleagues

in relation to this case, that what happened might have been the right thing, but that it did not feel right. The perception was that there was simply a fiat.

The interview with Dr. Gerald Conrad followed. He is a GFT, hired by Dr. Reynolds about five years ago; he is the clinical director of the Family Medical Centre. He gave his personal perspective on Dr. Reynolds as Head of the Department and the possible reasons for his non-reappointment. As for Dr. Reynolds' one year contract at Kildonan, he assumed that this would be the first of a series of continuing contracts, like all the other GFT contracts. On the question of tenure, Dr. Conrad said his impression was that tenure guarantees a position, an office and a salary. Regarding the termination of Dr. Reynolds' tenure, he remarked that the administration, on the one hand, and he and his colleagues on the other, had differing points of view. Asked about the possibility of his hiring Dr. Reynolds as a "locum," Dr. Conrad said that he had been prohibited from doing so because this would have given Dr. Reynolds another University appointment. However, he was allowed to give any other professor a "nil" appointment.

The Committee met next with Dr. Mark Kristjanson, since 2003 a preceptor (student or resident supervisor) and a GFT untenured assistant professor, and Education Director at the Kildonan Medical Centre. He did not expect to apply for tenure. Except for department heads, there are very few tenured positions. He had no complaints about Dr. Reynolds' leadership, and considered him a strong advocate for family medicine. He knew that Dr. Reynolds had to deal with a move to have family physicians in community hospitals work under the supervision of internal medicine consultants. This situation has come about, he said, because a tiny minority of influential people believe that family medicine doctors need to be supervised. Dr. Reynolds wanted to retain the model of health care in which family physicians admit their own patients, rather than adopting the new model of using internists to supervise family physicians. When he was asked about his perception of his own academic freedom, Kristjanson replied that he would be concerned about keeping his job if he wrote to *The Winnipeg Free Press* advocating a view contrary to that of the administration of the Faculty of Medicine. The Dean, he said, is not particularly receptive to criticism. No one from the Dean's office, he added, has ever explained why the administration fired Dr. Reynolds. There appears to be a great deal of secrecy. Dr. Reynolds himself is under the impression that he has been fired because he has been a vocal opponent of some administrative decisions.

The Committee also met with Dr. Gerry Bristow, a former Associate Dean (Academic) of the Faculty of Medicine (1999-2002) and untenured professor, who retired in 2003. As Associate Dean, he had been in charge of all evaluations of members of the Faculty, including Dr. Reynolds. He met with faculty members and was active in recruitment and in interviewing candidates for departmental headships. He had known Dr. Reynolds for many years and always had a high regard for him; he saw him as a visionary, thoughtful in espousing his ideas, not only at the time of his original appointment, but throughout subsequent years. He was therefore surprised by the non-renewal of his headship.

Finally, the committee met with Dr. Larry Reynolds, accompanied by Dr. Gary Beazley, a former tenured Head of Family Medicine (1971-1990). Dr. Reynolds immediately brought up the topic of tenure, which meant something to him at the time of his initial appointment and throughout his work at the University. He said that he had never signed off on the termination

of his tenure, and had rejected the Dean's offer of a "nil" (adjunct) appointment. He did not see the offered contract of a one year GFT appointment as the end of his tenure; nor did Bob Cram, the negotiator for the Manitoba Medical Association (MMA) or James Boyd. He had considered his GFT appointment to be a continuation of his previous appointment and not one that might expire. He was unable to recall any GFT appointees who had not had their appointments renewed, nor could any of the other Departmental members we interviewed. All believed that annual renewal of GFT appointments was standard practice, at least in their department.

On the administrators' accusation that Dr. Reynolds' extra income had been fifteen times the average extra income for physicians at the Kildonan Medical Clinic, Dr. Reynolds explained that he had received that much because he was willing to do the emergency services and the many obstetrical procedures. There were times when he was the only GFT around the Clinic. In explaining why he worked in units other than the Kildonan Medical Clinic, he said that he would work in the Selkirk clinic because he was trying to save the unit from being closed, and because he believed that communities outside Winnipeg also deserved obstetrical services.

6. ANALYSIS

i. Dr. Reynolds' failed application for reappointment as Head of the Department of Family Medicine.

It seems clear that the search process for a University Head and WRHA Medical Director of Family Medicine, initiated in the fall of 2005, was severely flawed and ended in failure sometime after March 6, 2006. The incumbent Head, Dr. Larry Reynolds seems to have been subjected to coercion, initially to persuade him to agree not to stand for reappointment, then to withdraw his application, and finally to agree not to re-apply, presumably in any future search process. In the end, that pressure succeeded because time had run out for Dr. Reynolds. His five year term expired on September 30, 2006, but was extended only for about seven weeks, until another member of the Department, Dr. James Boyd, could be appointed as Acting Head – no search needed. Given that Headship appointments are held at the pleasure of the UM Board, the managers exercised their right to choose not to reappoint Dr. Reynolds to his administrative position. In doing so, they did not properly follow the University's Policy on Appointment of Heads of Departments.

ii. Dr. Reynolds' dismissal from his department in November 2008, and termination of his tenure without cause.

This was a clear breach of his contract with the University. No documentary evidence provided or accessible to this Committee substantiated Dean Sandham's claim that "tenure" in the Faculty of Medicine was not the same as tenure in the other Faculties.

Dean Sandham and Dr. Postl did not discuss the definition of a GFT appointment, nor the relationship to tenure. They considered tenure to be a question only of remuneration for a portion of the academic component of a tenured GFT position, and ignored all other aspects of

his job. GFT family physicians practice in academic units where they enjoy protected time to engage in academic activities, which also include clinical service to a defined population. And they have a component of their income protected from the demands of high volume, fee for service practice necessary to generate the overhead component of their activities.

iii. Conclusion

Dr. Reynolds was appointed to a position as a tenured professor. He was ultimately removed from this position without due process and without any acceptance on his part of the termination of his tenure. Thus, the University of Manitoba is in breach of its 2001 contract with Dr. Reynolds.

7. RECOMMENDATIONS

i. The Committee recommends that CAUT apply whatever pressure it can to cause the Board of Governors of the University of Manitoba to restore Dr. Reynolds to his tenured appointment as a full professor in the Department of Family Medicine in Faculty of Medicine;

ii. The Committee recommends that CAUT investigate in greater detail the structural relations between the Faculty of Medicine at the University of Manitoba and the Winnipeg Regional Health Authority, especially the implications of the proposal to create a Joint Operating Division that would make all clinical faculty "independent contractors" with only a "nil appointment" at the University of Manitoba;

iii. The Committee recommends that CAUT advise the University of Manitoba that external reviews of Departments and individual performance reviews of incumbent academic administrators ought to be clearly scheduled and completed before the end of the incumbent's penultimate year in their appointment, so that a timely decision can be made regarding the need for a subsequent external search for a new appointee. Searches should be conducted in accordance with University policy; failed searches should be transparent, and a new search should be initiated in due course.

Respectfully submitted.

Dr. Colin Stuttard
Dr. Ernest Redekop
Dr. Robert Miller

November 2009

CITATIONS

1982, University of Manitoba Policy *Appointment of Heads of Departments* (effective May 20)

1991, University of Manitoba Policy *Term of Appointment and Tenure* (effective October 22)

2001, May 28, Postl and Hennen formally offer of Headship, Medical Director and tenured professorship to Reynolds, effective October 1, 2001.

2001, May 28, Postl and Hennen to Reynolds confirming additional understandings.

2003, Oct 1, Reynolds letter to Macdonald expressing complaints; considering resignation.

2003, Oct 1, Macdonald letter to Reynolds – prepared to accept Reynolds' resignation.

2005, May, Jack Wallace, University Medical Group, "Department Head Review" (anonymous survey results).

2005, July 11, Reynolds letter to Brian Postl regarding "reapplication."

2005, September 1, Sharon Macdonald to Reynolds: issues including Winnipeg Free Press.

2005, September 30, Reynolds email to Drs. Sandham and Postl – will stand for a second term as Medical Director and Head of the Dept of Family Medicine.

2005, September 30, Dean Sandham letter to Dr. Reynolds summarizing their Bi-Directional Review meeting

2005, October 21, Brock Wright letter to Reynolds regarding his GFT position; refers to "current search process"

2006, Advertisement in January edition of *Canadian Family Physician*.

2006, Feb 09 Reynolds email to Karen Grant (UM VP Human Resources) about his 2 pm surprise meeting with the Dean and VP Macdonald: "I told him it was my intention to reapply."

2006, Feb 10, Reynolds email to seach@providenceconsulting.com (sic), copied to Dean Sandham, Karen Grant, and Sharon Macdonald

2006, Feb 10, Sandham email to Reynolds saying: "Just a clarification ..."

2006, February 20, Mrs. Mary Hill letter to Reynolds requesting he send CV to Provence Consulting

2006, February 27, Reynolds letter to Ms. Maureen Geldart at Provence Consulting.

2006, March 6, Provence Consulting email to Reynolds acknowledging receipt of documents.

2006, UM Faculty of Medicine Promotion and Tenure document (Approved at Faculty Executive Council: April 21).

2006, May 2, **draft** document, *The Department Head Review Process.*

2006, undated: Sandham and Postle, Draft terms of reference for an external review of the Department of Family Medicine [in] Winnipeg Regional Health Authority and the University of Manitoba Faculty of Medicine.

2006, June 6, July 17 and 18, August 29, emails between Ms. Lynne Ducharme and Ms. Mary Hill, and Ms. Marnie Donovan regarding preparations for the external Departmental review.

2006, June 16, email to Dr. Reynolds from Marnie Donovan, Administrative Assistant to the Dean.

2006, June 26, Reynolds notes of his 360° evaluation.

2006, July 17, Dean Sandham and Dr. Wright letter to Dr. Reynolds comprising a narrative summary of this "Annual Performance Review."

2006, September 13, Brian Postl letter to Reynolds expressing thanks.

2006, November 7, first letter from Brock Wright and Dean Sandham to Dr. Reynolds re Reynolds' administrative leave and subsequent GFT position at Seven Oaks Family Medicine Teaching Unit.

2006, November 7, second letter from Brock Wright and Dean Sandham to Dr. Reynolds to "serve as a Letter of Understanding to be appended to your Original Letter of Offer dated May 28, 2001 …" re Acting Head and Medical Director until November 17, 2006

2007, October 15, letter from Dr. Reynolds to Maggie Duncan, UM Office of Equity.

2007, November 2, another Letter of Understanding to Reynolds, signed by R.J. Boyd (new Head of Family Medicine), VP Milton Sussman (replaced Sharon Macdonald), and Dean Sandham, offering an "extension" to Reynolds' GFT position. Reynolds signed his acceptance on December 10.

2007, November 19, James Turk letter to Dean Sandham questioning Dr. Reynolds' dismissal as Head of Family Medicine.

2008, November 4-10, Dr. Reynolds' email exchange with the new Head of Family Medicine, Dr. Jamie Boyd.

2008, November 10, Colin Stuttard to Dean Sandham, requesting documents related to the case of Dr. Reynolds.

2008, November 24, Colin Stuttard to Dean Sandham, explaining the Ad Hoc Committee's mandate from CAUT.

2008, December 10, James Turk to David Barnard, on the disparities between the University's policy on tenure and the termination of Dr. Reynolds' appointment, stating that the committee will now be investigating this termination.

2009, October 29, Dean Sandham to Colin Stuttard.

2009, October 29, Brian Postl to Colin Stuttard.

2009, October 29, Brock Wright to Colin Stuttard.

APPENDIX: Redacted Copy of Moores-Woollard External Review Report.

Appendix

Report of the Review of the University of Manitoba
Department of Family Medicine
Conducted September 24, 25, and 26, 2006
By Dr. Robert Woollard and Dr. David Moores

Report of the Review of the University of Manitoba
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conducted September 24, 25, and 26, 2006
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Introduction:

The authors conducted a review of the Department of Family Medicine at the request of Dean Sandham and Dr. Brian Postl under the attached terms of reference (Appendix A). This broad overview of the Department's role and opportunities was to be in the context of the University of Manitoba and Winnipeg Regional Health Authority (WRHA) as organizations "...committed to work to refine our function as two institutions working in a continuum to provide an Academic Healthcare Centre." The mandating parties requested that the review include attention to both the regional and provincial expressions of Service Delivery, Educational Affairs and Research Affairs. To fulfill this mission we were fortunate in having a well organized opportunity to have frank and helpful discussions with a wide array of individuals and groups – as represented in the attached schedule (Appendix B).

We begin by expressing our deep gratitude to the large number of people who, under sometimes difficult conditions, expressed their loyalty and commitment to the missions of the Department, the Faculty and the Region by being both frank and thoughtful in their views of the accomplishments and challenges that all three parties are facing. We are particularly thankful to Marnie Donovan and the Dean's office for organizing the days and responding quickly and effectively in providing added information and contacts requested by the reviewers. While there is an inherent presumptuousness in feeling that three days, no matter how intensive, is sufficient to grasp the full nuance of complex institutions and relationships, we wish it known that we were in no way constrained in our requests. We feel that we have been able to develop an understanding of the broader elements of the context in which the Department must function, the challenges and gaps it has faced in fulfilling its mandate, and the opportunities that exist for the Department to thrive. The report is organized to reflect this.

While not naive about the challenges that remain to be addressed, both reviewers feel optimistic about the likelihood of success given the depth of human commitment we found at most levels of the organizations. The opportunities that the internal and external environments offer towards positive change are real and significant. The timing of the report is related to the routine task of reviewing an academic department as its leadership nears the end of its term. It is important to note that the precise timing of the review, so close to the end of the current incumbent's term, was dictated by the availability of the reviewers – who were initially approached by the Faculty and WRHA during the winter term but were unable to adjust prior commitments to accommodate an effective review before the dates on which it occurred.

Overview and Context:

The organizational expert Peter Drucker has said that academic health science centres are the most complex organizations yet devised by human ingenuity. This frequently sets the stage for misunderstanding, misperception, miscommunication and outright suspicion by the many people that are putatively dedicated to the complex and challenging task of providing care, researching needs and preparing practitioners with the requisite knowledge, skills and attitudes to serve patients – "those who suffer." While Manitobans in general have a proud history of collaborative accomplishment and innovation (first jurisdiction in the British Empire to have women's suffrage, a premiere cultural scene, the development of agricultural practices and marketing, etc) and the medical school shares this tradition (the origins of the practices and programs that have essentially removed Rh disease in most parts of the developed world, seminal understandings of pulmonary disease and its management, etc), it is clear that academic health system and its Department of Family Medicine has been buffeted by the forces that have affected most centres in Canada.

These realities are:

- Rapid expansion of technological and organizational innovation of variable health impact but unquestioned increase in costs
- A dramatic and broad shortage of appropriate practitioners to fulfill the increasing demands of the healthcare system

- A particular contraction of the availability of primary care physicians brought about by changes in numbers, patterns of practice and system changes that reward episodic over continuity of care, and higher volume lower intensity limited scope practices
- Intergenerational shifts in work load demonstrated clearly by Watson et al in Winnipeg but undoubtedly occurring elsewhere as a general trend
- The paradoxical devolution of health system decision making to regional authorities with dramatic centralization (from the point of view of community hospitals and community practitioners) WITHIN those regions
- Ever enlarging and alienating hospital consolidation of services with outflow of previously engaged family physicians into exclusively office/clinic services – often in a restricted or limited area of practice
- An intermittent and sometimes clumsy series of federal and provincial attempts to promote collaborative and inter-professional practices without recognizing or honoring the successful models that have already evolved
- The often consensual but uncritical love affair with information technology (IT) and electronic medical records (EMR) as the answer to communication and relationship problems, whose solution is rarely technical
- Shifts in the boundaries of primary and consultative care as complex patients move in and out of the system and cohorts of physicians age and change (eg, fewer pediatricians providing primary care, fewer family docs providing obstetrical care, etc)
- The frequently unexamined relationship between community practices and hospital emergency departments – *from the patients' point of view*
- The broader social phenomenon of a sense of entitlement across many segments of a society already wealthy in global terms

These factors are not enunciated as implacable forces that militate against any hope for success in advancing the inter-institutional mission in the realm of primary care. They are certainly not offered as excuses for enduring dysfunction. However, it would be most unwise to not recognize the effect they have had in pushing current relationships to their present, sometimes unhelpful state.

As Donald Berwick points out – "*each system is exquisitely designed to get the results that it does.*" Therefore, if the Faculty, the Department and the WRHA wish to have a different result i.e. a more effective mutual engagement in creating and applying primary health care resources in service to Manitobans, then mutually agreed upon change is going to have to take place. As with most complex systems, such change will only occur when there is a coordinated and mutually respectful top down and bottom-up effort towards positive change.
This brief and general context runs the risk of being oversimplified and a stating of the obvious. However, it is apparent to the reviewers that unacknowledged external strains can become unhelpfully personalized. This can lead to a toxic downward spiral involving loss of institutional self and mutual confidence which in turn leads to a mutual sense of hopelessness in the face of undoubted opportunities to not only do things differently but to *make a difference* across a host of fronts.

Positive change requires both grass roots and leadership commitment. In the complex environment where an academic health science centre and its community (where primary practitioners practice their craft) meet, timing and attention to detail is everything.
This report seeks to make some respectful and positive suggestions. The authors are well aware of their limitations and the presumption of a three-day visit, even when supplemented by reflections of a number of follow-up contributions kindly sent by those we interviewed. We see our task as weaving the many perspectives and ideas presented into a cogent and respectful picture, a snapshot if you like, of a Department, Faculty and Region at the point of change. The report's utility will have to be judged by those who must effect the desired change. What we are unambiguous about is the confidence we have that many of the remarkably skilled and committed people we met are capable of achieving great things. This is especially true if their efforts are aligned rather than working at cross purposes.

Background

The Department of Family Medicine is housed in several sites peripheral to the Faculty of Medicine and its adjacent Health Sciences Centre (University Hospital). This is unique in that it appears its sister academic departments are all in closer proximity and functionality to the Faculty of Medicine.

The Department consists of three primary teaching sites (family medicine centres), where the GFT faculty engage in full service family practice. In addition, all faculty members offer a variety of comprehensive in-hospital services (obstetrics, general medicine, emergency medicine etc).

Funding for the GFT positions is dependant primarily on a block funding grant stemming from negotiations in the 80's and 90s. There is no financial distinction across academic rank nor one based on experience or years of service. The comparability of GFT funding and support across other disciplines is not known but likely would be significantly different.
The funding of clinical services appears to suffer from the same mechanisms and relative value problems as in other provinces.

Funding support staff for the academic mission in the undergraduate, postgraduate and research portfolios is through another block grant which was initially part of the overall package. Other than COLAs, this grant has not changed since the mid 90s with predictable impact problems on the staff so funded.

The WRHA provides significant funding and support for the academic teaching units in addition to taking responsibility for primary care within the region.

The extensive and effective experience of partnering Faculty of Medicine resources with that of the Regional Health Authority has not had the impact on the service mission of the Health Authority to the extent expected. Fully 85% of the FPs/GPs practising within the region's boundaries have no formal, informal or other relationship with the region or the Faculty of

Medicine. The family practice workhorses are contained within the other 15%. Sixteen of this 15% group are the GFT members of the academic department.

Issues for Discussion

Leadership

Dr. Larry Reynolds is the current Head of Department. His first five year term ends Sept. 30, 2006. s.17(3)(h)

The reviewers heard from a variety of sources about the key leadership skills, styles and features for an academic lead. The convention of combining the academic and clinical leadership roles to address both Faculty of Medicine and WRHA agendas likely will not work for Family Medicine and primary care. Notwithstanding the support from the WRHA for family medicine clinical issues there remains the 85% of the primary care workforce disengaged from the region. The reviewers recommend the appointment of an interim Acting Chair (Head) from within, pending a continuing national and international search.

Region Service Delivery Gaps

There are significant challenges for the WRHA related to the provision of comprehensive primary care. The dominant lens from which the region is able to view these gaps is through conventional institutionally based services (emergency room, inpatient services). There appears to be some recognition that approximately 100,000 or more citizens within the region go without primary care services except for those provided out of WRHA's institutional settings.
An Associate Chair (Head), with appropriate support, should develop and nurture an engagement plan involving the unattached or aligned FPs/GPs within the region. Such activity would provide an action research focus for health service delivery and close this gap.

Primary Care Reform/Renewal

It is difficult to determine who is leading the academic, clinical and research initiatives in this important domain. Educating and training people to provide comprehensive primary care

services requires influencing and changing the system within which they are expected to work. Not influencing and changing the system will be the undoing of the academic enterprise of family medicine. Models that aid, abet and support conventional specialty disciplines generally do not address the critical factors influencing the size of the primary care workforce and the comprehensiveness primary care service provision. If anything such models adversely affect it.

Primary Care Workforce Initiatives (IMGs, NPs and PAs)

In addition to Family Medicine are several parallel primary care education and training initiatives occurring in Winnipeg. The Department has little or no involvement in these initiatives. However, an unhelpful competitive atmosphere has been created which puts at risk the conventional reliance on community based teachers and preceptors for tried and true initiatives. Payment differentials for work of similar intensity are creating recruitment problems for the more established programs of the Faculty of Medicine.

Educational Issues (Undergraduate and Postgraduate)

Undergraduate students in the Faculty of Medicine (as represented by 3 individuals) provide a predictable perspective as to the very limited role Family Medicine has in their curriculum. Additionally, being assigned to preceptors who are desperately unhappy in their circumstance within the system, only adds to the dilemma of career choice. Choosing Family Medicine was seen as an "act of courage" and only an option for students with self confidence. It was described as "having the self confidence of going out with a less than sexy partner on a date". The attitudes and pronouncements of specialty and sub-specialty faculty are not helpful.
Students would like more 'mentorship' with a family physician in 1st year to learn about the 'cool things' in family medicine. Their overall suggestion was to "maximize every opportunity for exposure to family docs". More lectures and more paired teaching with specialists were seen as ways to accomplish this.

Some thirty family medicine residents provided the reviewers with a spirited critique of their educational program and faculty. Some 1st year residents were at a stage in their postgraduate program where anything other than clinical medicine experience was seen as taking away from what they really needed or what was important. Some felt the program lacked a standard of

academia and cited lack of enthusiasm and support from faculty for teaching rounds and their academic half day. Some preceptors were characterized as practising anecdotal medicine not evidence based medicine. One third of residents had experience in using an electronic medical record, and saw that as important to their future practice

Support Staff and Health Professional Staff Issues

There is a remarkable mix of unbridled enthusiasm and 'stick-to-it-ness' on the part of support staff and health professional staff. At the same time there are major morale problems and evidence of despair in not meeting internally set standards of performance nor being able to change the system within which family medicine operates clinically and academically. Engagement of staff and maximizing their contribution is essential.

Observations and Opportunities

The reviewers were impressed with meeting remarkable people doing interesting things across the full range of institutions and running from senior leadership and management through faculty, front line teachers and caregivers, to support staff working in difficult situations. We also saw frustrations, unrealized opportunities, and serious resource and personnel challenges. Such challenges make it difficult for some to realize the full potential if the available talent were aligned and focused on a common mission and vision. While much is being accomplished under sometimes trying circumstances; a broad range of constituencies that were interviewed stated a concern that the Department was characterized by a culture of broad demoralization and missed opportunities. Perhaps most poignantly stated by one of the medical students, "The department has a defeatist attitude, it feels like the underdog and acts like it ..." The roots of this are undoubtedly multifactoral and go back a decade or more. As one senior Faculty leader (not a family physician) observed "... the mid nineties were very cruel to family medicine in Manitoba."

The forces and issues that represented these blows to family medicine are certainly not confined to *academic* Family Medicine, did not cease at the turn of the century, nor are they unique to Manitoba. Many of these issues persist until today and undoubtedly contribute to the fact that 85% of Winnipeg primary care physicians have very limited or no contact with either the Faculty of Medicine or the Winnipeg Regional Health Authority. These institutions have described

themselves as "...committed to work to refine our function as two institutions working in a continuum to provide an Academic Healthcare Centre". There are serious and obvious challenges in the provision of the primary health care aspects of that mutual commitment. Respecting the magnitude of the task and the very modest human resources that the academic department possesses, one can certainly empathize with the statement,... "there are limits to what you can expect people to do in stepping up to the plate, when your plate is full."

However, as it seems that a remarkable constellation of actors, opportunities and inherent strengths within the Department are aligning to create possibilities for initiatives to change the current state of affairs. The challenging but worthwhile task of reacquiring a culture of *determined* optimism needs to begin.

While the concept of "departmental culture" may seem vague, we use the term deliberately for two purposes. One must move away from individual, personal and interpersonal attributions as causes of the current state of affairs to recognition of the systematic nature of the challenges faced by a beleaguered department. Just as quality improvement and patient safety, in the broader healthcare system, are best approached as systems issues, so too is positive cultural change best served by addressing root causes rather than targeting individuals.

Cultural change requires a broad commitment to sustain efforts over a long period of time, on the part of both top down leadership and an engaged grassroots faculty and staff.

This is the context in which the following observations and recommendations are made. While there may be some misperceptions and oversimplifications, they are intended to provide a focus for reflection and strategic planning.

Issue 1: Lack of a clear and broadly embraced mission and vision

The Department, the Faculty and WRHA have been buffeted by a series of organizational, economic and social changes in the way in which health services are delivered, the nature of

those delivering those services, and the mechanisms and relative values of service remuneration. These forces have had a profound impact on not only the self confidence but the mutual confidences of the Department, the Faculty and the WRHA. Mutual frustrations about unintended consequences, unrealized expectations, and missed opportunities, while not unique to Winnipeg, have led to an unhelpful crisis of confidence in the ability of the Department to participate in and positively influence necessary change. Given the potential for common purpose, establishment of good will, and mutual understanding, it will be important to have a clearer articulation of mutual expectations in the very near future.

Opportunities: The material submitted by the Department states that 90% of the 2001-2002 strategic plan has been achieved. This is a remarkable accomplishment and calls for the Department to revisit its mission and strategic priorities. Given the evolving context of service delivery and the opportunities for partnerships that have arisen since 2002, it is vitally important to engage the broader Faculty, the WRHA, other professions and the community in which family medicine is practiced.

The current mission statement has an exclusively educational focus. Though that may be appropriate and may account in part for what appear to be some successes in attracting students to the discipline, it is insufficient. Educating and training individuals for comprehensive primary care practice, in the context of a system that will not support it, requires additional energies and strategies to change the system. Given the relationship with the WRHA and the challenges facing primary care practitioners and the healthcare institutions with whom they are increasingly disengaged, it would seem appropriate to embrace a broader mission and vision. Even if all that is achieved is clarity of expectations, it would be an improvement on the current state of significant mismatch between the external expectations of the Faculty of Medicine, Winnipeg Regional Health Authority and Manitoba Health and internal/external resources.
Moreover, experience elsewhere has demonstrated that a clear mission and vision grounded in serving the broader society in educational, primary and translational research, and clinical engagement terms can actually attract the funding and resources necessary to accomplish the mission. Embedded in this activity is the opportunity to entirely rethink the relationship with the Department as a whole, the WRHA and the large community of un-engaged physicians both

within the WRHA and in the province for which the Department has a mandate. It is the reviewers' sense that there is significant receptivity on the part of the above named institutions to engage in such reflection and planning.

Suggestion: The Department and Faculty undertake a mutually engaged strategic planning process in order to:

- Re-define the mission and vision of the Department
- Clarify the mutual expectations of the Department and the Faculty of Medicine
- Establish priorities for early successful accomplishment in the areas noted above.

Issue 2: Dual academic and service role of Department Head and Department

In the relationship between the Faculty of Medicine and the WRHA, the general pattern of administrative responsibility is that the academic department head is also the service chief for the relevant discipline. While there is some variability across departments, it appears to be a functional relationship in many instances. For Family Medicine, it presents some particular if not unique challenges. This is especially true for an academic department with very limited resources (size and financial) relative to the magnitude of the service task. It is also problematic that the conventional hierarchies used in the other specialty disciplines to teach and do research are not available to family medicine. This situation is further aggravated by the significant disengagement of community family physicians from the institutional care burden which is reported to have been more equitably shared across a larger cohort prior to the last decade or so. A number of the broader trends outlined previously have had particular impact in this area. They have undoubtedly contributed to the state of mutual frustrations between the WRHA and the Department, articulated to the reviewers by those on both sides of this divide. In common with confreres across the country, family physicians/general practitioners in Winnipeg have found themselves gradually but consistently less welcomed in tertiary and academic teaching hospitals. While the acuity of people in the community has increased, the remuneration and relative value systems continue to be more supportive of episodic and lower acuity care. The infrastructure support for primary care does not exist. There is no reason to suppose the trends in Winnipeg are

dramatically different than those found in other large and enlarging hospitals and university communities. The importance of coordinated, comprehensive and continuing care of complex patients in the community is only just being realized. Increasingly specialized hospitals with increasingly specialized wards try to grapple with the issues of comorbidity that attends the vast majority of ill patients requiring hospital admission. Reactive attempts to establish "hospitalist" programs are variable, and we understand an intense attempt to maintain engagement of community physicians by the WRHA several years ago eventually foundered. It is obvious that during periods of major change in the acute care and institutional delivery systems, all of the participants (decision makers, managers, professional care givers and support staff) will frequently be in a reactive mode in dealing with critical areas (unassigned patients, emergency room saturation, patient safety concerns, etc.). Such reactive decisions together with their cumulative impact and unintended consequences have obviously had a corrosive effect on working relationships. This has occurred at a number of levels both within a community of care and the Faculty of Medicine itself. The reviewers were acquainted with several examples including the shifting of obstetrical services, challenges to effective care for unassigned patients, major difficulty with timely specialist consultation within some institutions and intrusive requirements for consultation in others. It is not within the scope of this review to reflect in detail on any of these events, but to underscore the fact they have contributed to the unhelpful downward spiral of participation of community physicians in hospital care. It is a major cause of the increasing sense of beleaguerment of those who remain. Providing comprehensive care in what seems like such a thankless or barren environment is problematic. A further structural challenge in the relationship between the WRHA and the Department is the asymmetry in geographical mandate between the Health Authority and the Department's provincial mandate for education, research and service.

Opportunities: Despite this situation's apparent bleakness, the reviewers found that the particular circumstances in Winnipeg provide some seeds for optimism. We found a broad consensus about the depth, urgency and interrelated nature of the above challenges. We found interest and commitment from the perspectives of leadership to frontline care. We found teachers prepared to contribute to a more positive problem solving environment.

Given the complexity of the task, this may seem a naïve expectation, however it is worth keeping

in mind the long standing and broadly held "Manitoba approach" to collaborative problem solving in times of duress.

We believe that the Region and Faculty have insightful and committed leadership, prepared to work towards a rekindling of family medicine within the region. We are much less convinced that there is sufficient understanding and attendant respect for the potential capacities and complexities of the education and training for a modern family physician. The labour intensive, preceptor based, one-on-one and small group problem based teaching characterizing family medicine is distinct from the conventional lecture, hierarchical team and 4-5 year time frame representative of traditional Royal College specialties. However, with appropriate engagement and sustained commitment to a new leadership team in the department, significant strides can be made. Some interviewees outside the Department noted that the senior leadership of Faculty and WRHA need to realize that family physicians are more than a collection of inadequate specialists. Modern education and training involves more than a series of specialist supervised rotations. However, with appropriate engagement and sustained commitment to a new leadership team in the department, we believe significant strides can be made.

Both the Department (through the development of its aboriginal training program) and the Region (through the development of access centres) and the Northern Medical Unit (through its long standing needs based approach) have to fulfill the social accountability mandate of the healthcare system. Unfortunately, these have been poorly coordinated. They do provide the substrate for concerted action, should there be mutual commitment to do so. Our interviews with the various players did indicate some willingness to undertake joint commitment to address the health needs of the more vulnerable populations in urban and rural settings in Manitoba. Such an undertaking might draw the various actors from a stance of mutual suspicion to aligned commitment. Properly led and resourced, such an undertaking could move the academic enterprise in Manitoba to the forefront of socially accountable medical schools in Canada.

Suggestions: The following are seen as *enabling* objectives to address the above challenges and seize the above opportunities:

- A new and fully funded leadership team should be urgently recruited and provided with a clear mandate
- This team at minimum should include a Department Head and Associate Department Head who can between themselves develop a close working relationship and division of labour such that both parts of the dual role can be achieved – it is impossible for one person to do
- The Department and its planning partners should identify and support constructive initiatives consistent with shared values. These could include:
  - teaching units within the evolving access centres
  - a teaching unit in conjunction with the tertiary Bannatyne site
  - a reevaluation and reshaping of the relationship with the Northern Medical Unit
  - mutual engagement in a graded series of evaluated initiatives in addressing the unassigned patient problem
- A commitment of the Department, the Faculty, and the WRHA to develop and provide resources for initiatives in the realm of primary care renewal that demonstrate:
  - an undertaking of responsibility
  - a clear plan with agreed upon interval and outcome goals
  - a mutual preparation to accept the risk of failure in some realms while committing to articulating the "lessons learned" from any such initiatives

Issue 3: Interdepartmental relationships in education, research and service

As with most departments of family medicine across the country, there is an asymmetry of resources between academic departments in terms of academic positions, hospital support and roles, and concentration of practitioners. This is further compounded by the large and sometimes rather diffuse obligations ascribed to the Department of Family Medicine and the discipline it represents. The evolving role of primary care in the healthcare system generally and its acute care institutions is a compounding or confounding factor as the Department seeks to redefine its relationships. One might fairly characterize many of the specialty disciplines in any medical school as having a footprint primarily in its institutions with a toehold in the community.

Obversely, primary care can be seen as having its footprint in the community with an occasional toehold in larger institutions. While this asymmetry can be seen as a strength, it is often unarticulated. The intense interface between the institutions and the community represented by the emergency room and the unassigned patient issues can lead to distancing and unhelpful conflicts. This is obviously the case in the interrelationship between the Department of Family Medicine and the Department of Internal Medicine.

Opportunities: The department heads that the reviewers met were consistently positive about both the importance of the discipline and the opportunities for shared approaches to mutual problems. This ranged from the Department of Pediatrics' concern about enhancing distributed childcare throughout the province and an aging cohort of primary care pediatricians who are not being replaced; interest on the part of Surgery and Orthopedics to participate in enhanced skills training for practitioners in isolated communities beyond the ring road; commitment of Psychiatry to ongoing and expansion of shared care initiatives in the realm of mental health; screening and early management of patients with back problems in conjunction with orthopedics. Even the challenged relationship with Internal medicine has resulted in four different models for care of unassigned patients. This creates possibilities for experimentation and assessment.

Suggestions:

- While some of the suggested interest in support for Family Medicine is clearly utilitarian in nature, the reviewers were impressed and even envious of the consistently expressed attitude of support and understanding we found among the academic department heads we met. The other academic departments in the Faculty should be seen as potential constructive partners in the planning exercise outlined in #1 above and the evolving relationships outlined in #2.

- The relationship with the Department of Internal Medicine deserves particular and urgent attention. The reviewers suggest that the Dean initiate a mediation and planning exercise engaging the interim leadership and extending into support for the new Family Medicine leadership team.

- The Interim (and subsequently new) Department Head and Associate Department Head should urgently sit down with senior executive team of Winnipeg Regional Health Authority to begin to clarify mutual roles and expectations with reference to both institutional and community care. These clarifications should be respectfully intricated into the planning process outlined in #1 above.

Issue 4: Intradepartmental relationships, priorities and morale

The complex external environmental issues noted above have a direct impact on the relationships *within* the Department itself. There is an overall mixture of pride in the undeniable accomplishments of the Department; frustration at the relative dearth of resources to deal with ongoing responsibility; and a sense of being misunderstood and thwarted in some areas (electronic medical record, community based faculty development, development of IMG program, etc). Despite areas of spirit and a number of units and teams having positive and effective working relationships, we might fairly describe the departmental culture as being one of beleaguerment. There appear to be pockets of rather low morale, particularly among some support and health professional staff. This will require attention as outlined below. There is a lack of clarity as to how fiscal decisions are made. This had lead to frustration and embarrassment for those managing recruitment and relationships with community preceptors. The situation is compounded by the fact that the IMG program, perceived as being presented as a fait accompli, has a higher schedule of payment for preceptors than that accorded regular preceptors. While understandable in intent, it has had a very frustrating impact on those attempting to manage relationships with longstanding community preceptors. Fiscal flows and arrangements in this department elude precise definition. It will be extraordinarily important to have a more effective, transparent and predictable funding flow within the department for both practical and symbolic reasons. One thing is clear: most members of the Department feel that they have barely adequate or less than adequate resources for the existing tasks. They view with suspicion proposals for added initiatives without incremental resources. On the other hand, we are aware that some available funding has not yet been utilized. Whatever the historical and current justification for this stance, and whatever the reality of available but unaccessed funding

is, any planning processes for change will have to deal with this reality.

In our brief visits, we did not see any major rifts between groups and units within the department. There exists a broad sense of common purpose, and a feeling that the current leadership had sought to engage staff in the processes and committees of the Department. While it is fair to say that the Department is at a place where their common external challenges have not been translated into internal fissuring, they have led to some inward looking defensiveness. This is not a particularly creative stance given the threats and opportunities in the immediate environment.

Opportunities: People and institutions external to the Department appear prepared to participate in a renewal and redefinition process on the part of the Department. There appears to be a broad appreciation for the discipline of family medicine. Major players appear to support the discipline in becoming reengaged with the healthcare system across a range of service and academic issues. Watson et al[1] have demonstrated that while the absolute numbers of primary care physicians relative to population and services has not changed dramatically, the *availability* of practitioners has. This change has had a disproportionate impact on the academic Department of Family Medicine, whose practitioners continue to engage in hospital and obstetrical care as dwindling minorities of practitioners are so doing. Newer graduates are not swelling the ranks either. In a perverse way, this enlarging gap in care and commitment may represent an opportunity to concentrate the will of the discipline on a constructive response. Strategically, the above planning process may want to concentrate on areas where the Department and discipline can address the most urgent of unmet needs. Under the rubric of "social accountability" this approach has proven successful in obtaining substantial resources in other jurisdictions.[2] The hazard is of continued burnout and beleaguerment.

Clearly, practice patterns will need to evolve to account for these changes and/or policy changes will have to be enacted in order to reverse the perverse incentives that make it more economically viable to stay in your office on Portage Avenue than engage in full service practice. Such changes in both training and practice have proven elusive in many jurisdictions but some particular opportunities exist within Manitoba. If the Department and Faculty review

the WHO initiative on social accountability of medical schools, its expression under the AFMC and recent publications in the area; they will note the importance of a five way partnership (policymakers, health managers, professional organizations, the academy and the committees themselves). Engaging these partners at this time in Manitoba may be very fruitful. Ample experience from elsewhere can be drawn upon for this purpose. Working towards a common purpose and with the communities mutually served is one of the most powerful forces for simultaneously enhancing morale and achieving the resources required to express the best opportunities for family medicine.

Within the Department we found a remarkably committed and thoughtful group of nurses who are increasingly defining their role and developing functioning relationships in the teaching units. These appear to be increasingly robust examples of collaborative practice. In addition they are connecting this to national efforts in interdisciplinary collaborative practice and network development, and should be encouraged to do so. In addition to this, the Province has embarked upon Nurse Practitioner training and Physician Assistant training. The reviewers were not privy to details of numbers and nature of training, but are concerned that these training programs' relationship with the Department appears to be distant and the primary care nurses *within* the Department are wistful that new resources are pumped into new programs while their clearly functional development is not being similarly recognized and resourced. This represents an opportunity for coordination around primary care within the region and the Province. Even within the region, there appears to be an unrealized potential for educational collaboration with the evolving access centres. We believe that this would be a very fruitful area for exploration as the Department redefines its mission. Clearly there will have to be additional leadership, GFT and non GFT resources if these opportunities are to be grasped.

Brief conversations with representatives of Manitoba Health indicate a receptivity to the Department's participation in planning and coordination of primary care initiatives. This may be of particular import in looking at evolution of payment systems and relative values of payments to incent new styles of practice. The current block funding model has been adjusted for physician payment but has been static for over a decade for non-physician components. An openness to address this in a coordinated fashion would provide a major opportunity for change.

Suggestions: The following suggestions vary in their specificity and are not ranked by priority.

- Recruitment and/or promotion of fully funded Department Head and Associate Department Head as indicated above.

- Redefine the roles of the leadership both of the Department as a whole and its educational, research and service subunits.

- Recognize, support, and enhance the development of the cadre of primary care nurses as they redefine their roles and capacities both locally and at the national level.

- With the Dean, embrace Manitoba Health in negotiations around the block funding with the intent to develop better payment systems to incent new styles of collaborative practice. This strategy need not be confined to block funding negotiations, but it may give a venue for joint faculty/departmental efforts to rebuild confidence.

- In the context of the above activity, engage with the Nurse Practitioner and the Physician Assistant programs to explore redefinitions of collaborative practice (c.f. Ontario models)

- Clarify the dissonance that currently exists between primary care nursing responsibility for teaching and WRHA focus only on clinical services measures.

- Support and encourage primary care nurses with faculty appointments to publish the considerable innovation and experience they represent.

- Ensure available expansion funding is accessed and deployed in service to the increased workload represented by the expanded class.

- Clarify and establish the budget distribution for preceptor payments to avoid future embarrassment.

- Clarify and redefine relationship with the IMG program such that competition for preceptors is minimized.

- Carefully consider any increase in clinical service load on the Department (eg Emergency shifts, etc) unless there are substantial benefits to the *academic* mission of the Department.

Issue 5: Research

The Department of Family Medicine has not yet established a tradition of research development and excellence. While there may be many reasons for this, (including competing clinical and educational duties, limited focused external support for research development, etc) these factors are not unique to the University of Manitoba. It is not clear that there has been a sustained and broad commitment to develop research skills and productivity among the admittedly limited number of GFT faculty. These challenges take place against a background where a decreasing proportion of general faculty are supported by university salary and fee for service duties mitigate against research even among GFTs in other departments.

Opportunities: Notwithstanding these realities, Dr. Katz has proven himself to be a very accomplished researcher and has achieved salaried support. He should be seen as a resource as the Department redefines its mission with specific reference to research.
In addition, the Department has in its Associate Dean Dr. Choy a thoughtful and potential advocate. He is quite clear on the steps required to establish robust collaborative research development in residents, and the development of collaborative networks. He is supportive of educational research case reports and special community (Mennonite, aboriginal, etc) based research. The evolving relationship with Shantou University in China could foster research spin-

offs in several domains.

Suggestions:

- The Department should establish a focused strategic and developmental plan in the area of research that should engage faculty and community partner research collaborators.

- As part of its general planning and redefinition it should establish specific targets for research output at the faculty and staff level.

- The Faculty of Medicine should consider establishing "seed funding" to kick start primary care research initiatives.

Issue 6: Finances

The reviewers had neither the mandate nor the expertise to undertake a detailed Departmental budget review. At our request, both the Faculty and the Department produced summary accounts, records and funding flowcharts outlining University and extra-University financial sources and applications. While helpful, these materials served to underscore the adage ascribed to Peter Drucker that academic health science centres are the most complex organizational and financial entities yet devised by the ingenuity of humans. Complexity has some advantages in terms of diversifying funding sources and providing for a measure of resiliency. It can also be a source of confusion and misunderstanding and frustration. This appears to be the case in the present circumstance. Various funding streams have been augmented in relation to expansion of the educational program of the medical school and Department. While the Department has a fiscal committee, it was not clear where precisely decisions referable to augmented funding sources have been made over the last couple of years. We did not delve into the provenance of the various accounts. Neither did we examine the flexibility that did or did not exist for a movement of various funds towards particular departmental priorities. However, it is clear that the Dean's office felt that funds for expansion and recruitment were available and that they were not accessed in a timely fashion. Consequently desperately needed recruitments were not

achieved. It does not appear that there was any capacity to provide infrastructure and secretarial support for these new faculty. An equally strongly held belief within the Department was that they had secured designated funding for the implementation of an electronic medical record for their clinical practices. It appears that the Dean was concerned that there was inadequate preparation for full implementation and running costs of the conversion and felt it inappropriate to expend the money at this time. While the reviewers had neither the mandate nor the expertise to delve into the funding streams, and the functional planning and implementation strategies of an electronic medical record, the $300,000 allocated seems rather modest sum. Secure downstream sources for full deployment and maintenance did not seem to have been addressed

We cite these two examples because of the parlous state of relationships between the Department and the Dean's offices. They have contributed to a heightened sense of aggrievement and misunderstanding at a time when this can be ill-afforded. While the concept of "enough" rarely enters into the academic funding discourse, it appears that expansion funds together with other interests of the Winnipeg Regional Health Authority and Manitoba Health may provide opportunities for increased funding. This opportunity, jointly managed with mutual respect, might help to support the enhanced development of academic family practice at the University of Manitoba.

Opportunities: There is an interest in renewing and advancing the delivery of primary care services in the Province of Manitoba and in the WRHA in particular. There is an opportunity to link these developments with the development of academic family practice, an essential element in any sustained renewal. One should have optimism that with clear strategic planning and collaborative financial accountability, it is likely that opportunities for mutually beneficial investments could be found. This will require a degree of collegial and coherent financial management that has not yet been achieved between the Department, the Faculty, and the WRHA. The development of this relationship should be a high priority.

Suggestions:

- As part of the review and prioritization exercise the Dean, the interim (and subsequently new) Department Head and Associate Department Head should

establish a series of joint meetings of their senior financial officers and advisers to clarify the current state of accounts and financial flows. They should identify the opportunities for full deployment of existing available funds, prioritization of expenditures towards strategic goals and identification of opportunities for additional funding sources.

- The bylaw review and implementation for the Department of Family Practice should proceed forthwith.

- The roles and responsibilities of the fiscal committee should be clearly outlined

- The non-physician portion of the "Block Funding" should be a high priority for renegotiation with Manitoba Health. There has been no increase in this fund in over a decade while the intensity of need for the people represented by this fund has increased.

Issue 7: Education

The reviewers were privy to the most recent summary accreditation reports for both the CCFP and the CCFP-EM programs. In addition, one reviewer was aware of the broadly commendable developments in the Faculty's undergraduate program. Consequently, it would be redundant to review the current fully accredited status of the educational programs for which the Department is responsible. However, given the centrality of educational programs to the Department's mission, and the passionate commitment across interdisciplinary faculty and staff, we would make the following additional observations.

We had lunch with a small number of medical students on the first day and they proved remarkably insightful and positive about the discipline and the role that they felt family practitioners could play within a curriculum currently overloaded with specialists. While they made the previously noted concern about the attitude of the local department, they had trenchant insights into ways in which things might be different.

- "Family is the hardest thing to do well."
- "The curriculum should emphasize the positive aspects of being a generalist involved in a range of activities."
- "Family is the fallback position in the culture here, but increasing examples of students *choosing* Family Practice may mean things are shifting."
- "We need to have increased confidence in ourselves in order to choose Family Practice."
- "Interaction with the Department is almost nil."
- "The Northern Unit Experience is the best week of first year but it's seen as something extra rather than part of the curriculum."
- Much more could be achieved with team teaching approaches to health issues where "the specialist talks about what they did with patients in hospital while the family doc could demonstrate "the reason people *don't come into the hospital* is because I did my job well."
- They were aware of the Welcome Back Manitoba program.

These observations are provided in detail because it would appear that there is a positive substrate for Family Practice among thoughtful medical students. The recent marketing study and some of the CARMS data may represent a positive direction upon which to build.

On the other hand, our lunch with some two dozen residents together with subsequent correspondence might best be characterized as a series of complaints (with a few very welcomed kudos). We are cautious to not read too much into such a brief snapshot and many of the complaints seemed trivial (timing of holidays), and predictable (too much "touchy feely" emphasis on roles and relationships rather than high tech procedures, etc.) but some were more substantial concerns about the experiences being heavily preceptor dependent and insufficiently evidence based. It is difficult to make much comment on this other than perhaps it often takes satisfied faculty to create satisfied residents.

Faculty development appears (under quite constrained circumstances) to have developed a commendable vision and have partnered with the research director to deal with basic "information mastery" in response to the evidence based medicine concerns of the residents. On the limited budget, they outlined their tasks as enhancing skills, reward and recognition, faculty evaluation and staff development. It would appear that Dr. Martin has provided effective leadership in a situation where the community based faculty development at the faculty level has been vacant for approximately 15 months after being shifted to the Department of Medical Education. Dr. Martin's planned departure in January, with no obvious succession planning, should be a source of concern notwithstanding the dedicated and thoughtful staff we met. The rate of change envisioned in both the environment and the Department itself underscores the importance of a robust and responsive faculty development. It would appear that the evolving urban based aboriginal training stream is not particularly well connected to the Northern Medical Unit and their rural programs. This may be an opportunity to shift the ethos of the Department to more clearly focus on marginalized populations and to develop closer ties with rural components necessary to fulfill the provincial mandate. Experience elsewhere (British Columbia, Quebec, New Brunswick, Newfoundland, etc) indicate that an unambiguous focus on acquitting social accountabilities through assessing priority health needs can, properly coordinated, attract significant external funding and partnerships.

There appears to be limited input from the Department at the Undergraduate Medical Education Curriculum Committee and other places of potential influence for increased presence in the undergraduate curriculum. At a time when expansion funds are flowing, this relative absence may be unwise.

Issue 8: Promotions and recognition

Although bylaws have been present since the 1980's, they had not been consistently followed and are currently being rewritten. There does not appear to be a very tangible expression of

promotion, accomplishment, and career development in working in the Department. As the non-physician portion of the block funding has not been renegotiated there appears to be an unfunded functional liability in terms of the increased workload without a commensurate enhancement of personnel.

Suggestions: As part of the review and planning process a formalized system of recognition and reward would be helpful in promoting positive change.

Summative Comment

Unmet expectations from within and the usual external expectations from the Faculty of Medicine and Health Authority have been a feature of this department for several years. With such a limited GFT workforce, expectations need to be reconciled. Although the faculty and staff of this department were often accused of seeing themselves as the poor second cousins of the Region and Faculty, this is their reality. At the risk of offending all the players involved, the social accountability of Manitoba Health, the University of Manitoba, the Winnipeg Regional Health Authority, and the Department must be reviewed. The aim surely must be to provide opportunities by which ideas and plans may be generated. The future of health service delivery is at stake.

Woollard and Moores

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[1] Diane E.Watson, Alan Katz, Robert J. Reid, Bogdan Bogdanovic, Noralou Roos, and Petra Heppner
Family physician workloads and access to care in Winnipeg: 1991 to 2001
Can. Med. Assoc. J., Aug 2004; 171: 339 - 342 ; doi:10.1503/cmaj.1031047

[2] Woollard R.W., **Caring for a Common Future**, Medical Education 2006; 40: 301-313

DRAFT OF TERMS OF REFERENCE EXTERNAL REVIEW DEPARTMENT OF FAMILY MEDICINE WINNIPEG REGIONAL HEALTH AUTHORITY AND FACULTY OF MEDICINE UNIVERSITY OF MANITOBA

1. Purpose: This external review is a standard part of university practice at the time of department head appointment or reappointment. It is a very useful process for the department, the faculty, and the region in the ongoing development off our academic and service delivery programs.

2. Scope: The Winnipeg Regional Health Authority and the Faculty of Medicine, University of Manitoba are committed to work to refine our function as two institutions working in a continuum to provide an Academic Healthcare Center. Our department heads fill both clinical and academic department head positions to integrate our functions more efficiently. For this reason the scope of this review is broad and comprehensive.

2.1 Service Delivery

This external review should review and comment on service delivery for primary healthcare in the broad sense in the Winnipeg Regional Health Authority and selected areas in Manitoba. As such the reviewers will be asked to meet with members of the academic department regarding clinical service issues, primary care providers in the Winnipeg Regional Health Authority to include independent family doctors, separately organized multidisciplinary primary care centers such as the Access centers and other providers of primary care including nurse practitioners, midwives and social services. We will request attendance by members from outlying regional health authorities regarding clinical service as well.

Because of the interface between the Departments of Family Medicine, Internal Medicine, Pediatrics, Surgery And Obstetrics and Gynecology interviews will be arranged with members of these departments as well.

Representation in interview will be provided also from both major teaching hospitals to include the Health Sciences Center and St. Boniface hospital.

2.2 Education Affairs

This external review will include interviews with the Associate Dean and members of the Undergraduate Medical Education Committee, the associate Dean and members of the members of the postgraduate medical education training committee, and the Associate Dean Continuing Medical Education to allow assessment of the involvement and performance of the Department of Family Medicine in these areas. Interviews with students in these areas will be made available.

2.3 Research Affairs

Opportunities to review research activity within the department will include a variety of faculty within the department and in the University research structure.

This review is an important part of our joint academic and clinical activities. We very much value the willingness of individuals to take part in the process. We will make available appropriate support space, support staff, travel locally, and arrange for meetings of individuals identified as important who may not have been on the original agenda.

We would ask that the review be completed and a report provided by July 15, 2006