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Spark Podcast

Official Transcript

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Dr. Teresa Chan (00:02):

Welcome to the MacPFD spark podcast. This is a podcast that focuses on helping you develop your career as a faculty member. Our goal is to spark your enthusiasm and passion in one of our four main pillars of development, creativity, and humanism, scholarly practice leadership. And of course, teaching supervision throughout this podcast, we're aiming to bring you insightful and inspiring conversations that spark your interest and open up your mind to you. Ways to grow as a faculty. Okay. Have we sparked your interest yet? Let's get started with this one's episode. Welcome to episode two of the math PFD spark podcast. I am just as excited about this second episode as I was about the first. I hope I can keep up this love of excitement, but all our episodes, but it's not hard when you have guests like these. The first is Dr. Susan Reid. She's the department chair of the department of surgery, and she's going to be talking about how she's become the chair of the department of surgery. She's got a very unique leadership journey and it's going to be really cool to hear her tell that story in the second segment, we'll be talking to someone who's been around for a little while. Dr. Geoff Norman. He's one of my mentors and he still remembers what it was like to start up this medical school. So I thought we should hear from him some of the account that he has about being at the ground level. When the founders are a medical school began McMaster University's School of Medicine here in Hamilton, Ontario.

Dr. Teresa Chan (01:40):

Hello, everyone. Welcome to another edition of Mac PFD spark. Today I have a colleague and mentor and really just amazing person role model that I've known for a while. Now, Dr. Susan Reid is here with me. She's currently as we're recording this, the chair surgery, although she is looking for a successor. So that is something that's on the works right now, but she is definitely someone who is groundbreaker in many ways. And so welcome to the podcast, Susan.

Dr. Susan Reid (02:07):

Thank you very much Teresa and thank you for your kind words. I'm happy to have this opportunity too.

Dr. Teresa Chan (02:12):

Yeah. Great. So your journey to where you are right now, can you tell me a little bit about that? Because I think there are probably other listeners out there that might not see themselves becoming

a chair of a department someday, and you've had a, you know, everybody has their unique and special way they get to the place where they get to. But could you take me back a little bit and tell me the story of how you got to where you are?

Dr. Susan Reid (02:35):

Ah, thanks. I'm happy to do that. I guess I am a little bit of an anomaly, but thankfully the current situation is that we are having more and more women cert in surgery, particularly as well as, uh, other, uh, women in medicine, becoming leaders and taking on formal leadership positions. So for me, yes, it's not something that I initially really path started out as a clinician educator. And I had some opportunities to start to take on leadership positions. So like CTU director initially, and then I became a program director and that really opened up some opportunities for me. I became involved in the Canadian association of general surgeons, my national specialty organization. And through that as a program director, I was involved in committee work. That is when I really, for the first time felt that somebody was tapping me on the shoulder. And I wasn't very good at listening to that tap on the shoulder.

Dr. Susan Reid (03:39):

So I, um, had become the chair of the post-grad education committee for that organization and the then president a wonderful mentor to me, Dr. William Fitzgerald actually called me one day and said the executive would like to have you join us as the, what they called the vice-president succonded. So you're in line then to become the vice president. And then ultimately the president of the organization, I was just, I was taken aback. And I think that this is something that often I've heard from other women in Madison is that you have a bit of the imposter syndrome and when somebody taps you on your shoulder, the first thing you think is who me, I'm not, there's gotta be somebody that's better qualified than me to take on this position. And that's how I first reacted. I kind of flustered in my answer and I said, well, that's really nice, but I'm not sure that I'm qualified to do that.

Dr. Susan Reid (04:42):

And you know, I'll think about it. And I hung up the phone. I thought, well, that's just crazy. Like, oh, I, I could never do that. I could never become the president of the Canadian association, general surgeons. And so I actually, I didn't, I didn't do anything more about it and that maybe a few weeks went by and he phoned me back. He persisted. So what a great mentor and, uh, that's really important, right? So important because I think he recognized that, you know, that I was having these self doubts and he said, you are the one, you're the one we want you to come along and then join the executive and it's going to be great. And he, and he talked me into it and I tell you, it was really one of the best things that I ever did. I learned so much and grew so much and network a lot.

Dr. Susan Reid (05:28):

I just met so many more people across the country. It was really fantastic. And you really did the structure of being the vice-president of [inaudible] and then the vice president. And then finally the president, it really allowed you to see how to do things, how to run meetings, how to engage groups and the advocacy groups that we had, and just take on all these opportunities. So I think my skill set just grew tremendously. And at the same time, then I was able to have a bit more courage to look at the opportunities at home, which included the new position in the department of surgery as the associate chair of education, which was a combination of being the department education

coordinator, as well as heading up the, all of the post-graduate training programs in surgery. And that was a really, also a really fantastic opportunity. So when Dr.

Dr. Susan Reid (06:22):

Aura van was stepping down as the previous chair, I had much more confidence then in applying for that position. That's how I, how I got there. And that was in 2012. And the cool thing about that for women is that I, so I was the first female in Canada to become the chair of an academic department the first, wow. That's like I said, graphic at the time in north America, I was the fifth. So think of this in Canada, we have 17 medical schools right in the us, there's 193. Wow. They had at the time, this is 2012. It's really not that long ago in the combination between the us and Canada. So over 200 programs, only five chairs of surgery were women. Now we have, I think there's 26 of us and we have women who have then gone on to become deans. So it's been very inspiring for me then to see that in group grow and to have some of that peer to peer mentorship with that group as well, you know, people say, oh, you're a groundbreaker and that's sealing smash.

Dr. Susan Reid (07:37):

Right. I think a lot of it is timing, right? Because it's timing and a, and a little bit of persistence. And I think that you had mentioned earlier, we were talking about, um, in some health professions, they're predominantly women. And then maybe eventually we need programs for men for mentorship. And that I see some of the programs in medicine going that way, right? There's just, there's many more women in medicine, particularly in surgery. So many fewer women. And certainly there's more than what there were more now, more now than what there were for sure. It's still, there's still lots of improvement in terms of increasing our diversity, particularly related to gender and in leadership positions. Unfortunately, when you look at academic medicine across north America, the majority of leadership positions are occupied by older white males. Many of who are excellent at what they do and very qualified, but unfortunately many also who have been in their positions for a very long time. And I think that's a significant point when you look at why there's fewer women in leadership positions is just the access to those positions is sometimes being blocked. Not because they're not qualified or people don't think they're qualified,

Dr. Teresa Chan (08:55):

But because the person who's in the position is not getting out of the way. I usually like to take more of a health professions, education spin on things, but specifically within the academic medicine, there was a report that I thought would be worthwhile actually just bringing out some of the stats, right? So I think the double AMC, which is the big organization in the U S that studies kind of academic medicine and health centers that are associated with them. And they said, uh, in their like more recent report in January of 2020, that women are not promoted as quickly or to the same levels as men in leadership, like flat out. They said that the share of women, professors is 25%, even though there 46% of women are assistant professors, right? So there's a combination of probably a generational shift. As we have more women entering into academic medicine, stay in it.

Dr. Teresa Chan (09:43):

There's probably a leaking pipeline problem there as well. And there might be some domino Strickland's out there that are holding back their paperwork, cause they're busy running the rest of their lives and doing all these other things. Right. And so like, you know, it takes a Nobel prize to Nigeria to follow her paperwork for professors. So there's probably people that are putting this themselves in the back burner and promotion being on the back burner of the back-burner because

going to the gym and surviving from day to day, and maybe even going into the spa, it's probably going to be more enticing than filling out paperwork about yourself, not to mention the imposter syndrome and all that stuff. Right. So trying to figure out how we can do that, right? Because women often are in caregiver roles, unfortunately in our society, that seems to still be a cultural meme.

Dr. Teresa Chan (10:29):

Let's say that's out there. So part of it is of that, but then there's also those that discrepancy that you've said, and this is across all deans and department chairs is that there's only 20% of them. It's January 20, 20, and only 20%. And I think that there is definitely a lack of representation as well, right? Because only 12% of those chairs are from underrepresented minority groups of 12% of the 20%. So that's like even smaller group. And so it definitely is a conversation I think, worth having and representation might look different across the different schools, right? In rehab sciences and in nursing sciences clearly, uh, we have two very strong women at this present time leading both of those schools, Dr. Brooks and Dr. Carol are definitely women to aspire to be like for sure, for many of us. And so that's one of the pro tips, I think also is that your role model doesn't have to be in your discipline if there are other strong women, right.

Dr. Teresa Chan (11:25):

It doesn't even have to be in your profession. And I think that that's something that probably is worthwhile exploring as well. If you're because if you're one of those 2% of women at your shop that are in a leadership position and at every table, you know, there's not someone that looks like you at those tables, it might be quite alienating. So I think looking across disciplines to support each other across professions as well will be really powerful way, but I'd like to also call out that really interesting anecdote that you told about the way that your mentor, who really saw something in you didn't give up. And I would like to point that out as something that, for those of you who don't identify as women who are listing, that there might need to be a different strategy for recruiting equipment looks different for different groups.

Dr. Teresa Chan (12:13):

Some of it's cultural, some of it's imposter syndrome, some of us gender issues, some of it's representation. I didn't see myself that way. And so for all of us who are coaching women, I think about those needs for junior women as well, because they might be easy for us to overlook now that we've concrete arrived about what it meant to be when we were more junior as well. I would point all of those things out is that sometimes you need to do the soft ask and plant a seed years before years before. Yeah. Like I remember having a conversation with one of our senior leaders, Susan Denver, Dr. Denberg is as a woman in leadership, she probably knows this and I don't know if she even remembers it, but she kind of nudged me to think about, would I ever want a job, like the one Dr.

Dr. Teresa Chan (12:58):

Wong Walnut? And I had never thought about anything that high at that point, but she hinted at it. And then she knows me a little bit more. And then when the job was posted, like probably two years after the fact, you know, like that was the moment that I was like, huh, okay. I can see myself there because it took me two years to get there. Right. And so, especially when representation is there, I mean, in this case, the exception to that rule is that Dr. Wong is also an Asian woman. So it was easy for me to see that my predecessor was literally my phenotype and I could see it being accessible then, but she had a PhD and all this other stuff. So like there is stuff that had been managed from my

end as well. So I think that that's a really good take home point. Is that, what does that soft lob look like to plant the seed and then grow? Do you ever find yourself doing that with some of your more junior colleagues?

Dr. Susan Reid (13:48):

Oh, absolutely. So that's one of the great things about being the chair of a department is that you do get to connect with, you know, all of the new recruits and all of your faculty on a fairly regular basis, whether it's individually or even through the division head. So I'm always looking out for, you know, what is this person interested in? What are they going to be? You know, what do we think they're going to be capable of? And how can we start to set them up to be able to grow and develop the skills for other positions in the future? You know, when Dr. Fitzgerald tapped me on the shoulder a few years later, I did exactly the same thing to another female surgeon from a different university and tapped her on the shoulder to take up that vice presidents to Candace position. And I got the same reaction from her that I got, that I gave to [inaudible]. So it took me a little bit of time to connect with her.

Dr. Teresa Chan (14:47):

Yeah. So that's interesting, right. Because what goes around comes around. And I think being able to connect with the person that you were is really important, whether that's with your trainee, so it could be over other things, right. It could be, I think we always have to have some level of humility and empathy for our learners that allows us to really tap into what it meant to do something for the first time. So I'll run a resuscitation, take the lead on a surgery. These are things that we often try to ask ourselves to do as teachers, but as leaders sometimes, somehow that transformational leadership paradigm doesn't always translate over, even though you're well-rehearsed with the educator part is that you don't always see leadership as an educational platform, but I think that there are frameworks out there to really foster us to think about, okay, how can we take our education skills and use them in our leadership world?

Dr. Susan Reid (15:34):

I really liked those, the concepts that you're, you're alluding to, I, I, and the reference to how we are as educators, that really it hits home. And it, and it's so true is that, you know, it's, it gets to the question, are leaders born or are they made right? And I think it's a combination of both. And it's, it's really is part of no matter what you're doing in a leadership position to be looking to support those around you. You're not going to be in that position forever. And, you know, I think the other thing is that we need to continue to recognize that there's so many different types of leadership roles and many things that, that are being undertaken aren't necessarily named roles. And they can still be quite significant in terms of the development of those leadership capabilities and competencies. Sometimes people just need that pointed out to them as well. And they say, well, I don't have any experience. Well, actually you do.

Dr. Teresa Chan (16:31):

Yeah. That's true. I think in retrospect, you know, volunteering for nonprofits or helping fundraise for your school, like when you're a kid, right. Being part of clubs and things during medical school or nursing school, right. All of these places, you're actually leading all the way along. If you're stepping up, if you're doing this stuff. And so not everyone wants to be a great leader, but some of us who have always gravitated to some of those things, right. A student council, and then, you know, like being a residence advisors, some point or being president of your fraternity or sorority, if those were

still things that were available to you at the time, these are all opportunities for you to hone your leadership craft. And just because you haven't recently done anything doesn't necessarily mean you don't have some of those skills that's. And if you think back, most of us who are further along now, and our faculty have probably had a track record of some of those experiences, you just might not think of them as leadership because they didn't necessarily have some formal role title,

Dr. Susan Reid (17:33):

Right. Title. Yeah, absolutely.

Dr. Teresa Chan (17:35):

Very cool. Any final tips that you have for people who are mentoring young women to step up into leadership roles, whether you're a woman yourself or a man that's coaching a woman, what are some things that you think would be some of the take home points that,

Dr. Susan Reid (17:49):

Well, I think that's a great question to ask. And you just did mention that, you know, for men who are mentoring women as well, and I think that's a really important for everybody to remember that you can still be a mentor and an ally without necessarily being the same gender as the person that's, that's your mentee. And, you know, so for myself, starting in medical school and as a resident in surgery, there was really no female mentors for me to turn to at the time then. So a lot of my early mentors were male to be a good mentor means that you have to be open to have mentees who, who aren't aren't necessarily a physical reflection of what you are. I think that you had mentioned too previously when you to be a good mentor, it's not just mentoring a lot of times. It is that sponsorship, which I always see as a, as a more active form of mentorship, mentorship, I think is, you know, allowing sort of reflecting back to people and allowing them to come to some solutions and plans for things and just maybe gently guiding them.

Dr. Susan Reid (18:58):

But sponsorship is a very active form of intervention where you are facilitating opportunities and bringing up people's names to have them put forward for positions or even membership on a committee so that other people aren't, aren't overlooking them. And that's even, you know, having an agreement when you're in meetings that you help make sure that those people who seem to sometimes maybe their comments aren't heard so well, or even frankly ignored that you can, you know, show a bit of sponsorship or even to be an ally to echo their comments or to acknowledge their comments. That sort of subtle thing. Yeah.

Dr. Teresa Chan (19:42):

Yes. I read a news article about how in Barack Obama's cabinet, that was something that women did was that they actually promised each other, that they would amplify and say, oh, that's a great idea. As Susan's idea is so good. And then they would repeat it again until it was hurt. And so when you have four or five people that are willing to be those collaborators and amplifiers in your committee, whether it's for women or people of people, of different ethnicities and this members of our community, that may not feel like they're up to snuff in terms of the terminology. Sometimes if you're coming from the outside, right. We have a lot of people who are stakeholders that are patient advocates or indigenous representatives on some of our committees. Like I think trying to figure out how we can partner with people around this would be really important.

Dr. Susan Reid (20:27):

Yeah. And it's still, I mean, it still happens and it happens fairly frequently. I've had it happen to me really, even within the last few months where my point and my idea was not acknowledged at all. And then somebody else made the same exactly the same point. And it was acknowledged. It was very frustrating. And we've talked about it at, uh, you know, at the faculty of health sciences when they sometimes have those leadership panels and, and D bents to support the growth of the leaders. And I remember talking with mark Crowder, the chair of medicine, who's, who's a fantastic ally. And he said, I, he says, I promise if I'm in a meeting, I'm going to be the one to amplify the message or to acknowledge it and make sure that everybody understands who, whose idea it was and to support it. It's, it's really sometimes worthwhile talking about these types of things so that then you can have those practical skills to, to rely on in the moment, because sometimes in the moment you're just, it gets so frustrating. It's hard to, to sort of initiate, uh, a different response as an indie as your own as yourself. But if you do have somebody who's an ally in the room and they recognize it and they've got that skill in their pocket, then it can really be very helpful.

Dr. Teresa Chan (21:49):

Yeah. I think part of what you're getting at is it's actually microaggression, right? When people kind of ignore you and then pick up on it, like when someone else says it, it's, it's valid suddenly. And so there are actually increasing kind of awareness of that as something that can happen. And the fact that it happens to you, who's a chair of surgery. Um, it's just, it floors me. Right. But it's the truth. It does still happen in these circles. And it's because we're socialized a certain way because bias works a certain way. And, and, and having allies that are sensitive to that so that they can amplify you and say it again, but attributed to you that those are, those are very key things that we can all do as a community to combat those implicit biases and the actions that sometimes people they don't mean to do it, right? Like most people are not doing it.

Dr. Susan Reid (22:35):

A lot of it is unconscious. It's absolutely unconscious. And, uh, and so I like, I don't personally take offense on it, even though it's frustrating. It's just that, you know, that women's voices are not heard as well as male voices physically.

Dr. Teresa Chan (22:52):

It's probably not a surprise to you, but my podcast voice sounds very different from my, my command and conquer resuscitation voice. Yes. If you were to actually, probably both of us speak in the lower part of our registers, not because of, well, maybe as meaningful voice training for some people, but like you, and I probably stumbled upon the fact that people seem to like, take me more seriously when I drop my register of my voice, rather than talking out here, I talk down here, right? Because people hear and, you know, you don't upturn your voice at the end. That's something that you learn on the main streets of people responding to you differently. And then, you know, these are all things that you learn over time, but it is something to be conscious of. And even when taking care of patients, I know that some of the elderly men, because a higher register voices are harder to hear.

Dr. Teresa Chan (23:44):

I will try to speak as low in my register as possible. And sometimes, you know, use assistive devices to actually combat that or write things out because it's really important that we are heard in our various ways. And again, this is just biology. I played less, less. So the actual, this is not even biased.

This is just literally our hearing changes over time. And it's harder to hear a certain registers, right? So you speak like Minnie mouse, it's frankly, a bit harder to hear that that is something that most of us eventually figure out along the way. But for those people who didn't know that fun fact, it is something like some of my elderly patients sometimes joke about how it's, it's just how they can adapt is that they have to, you know, ask us to speak up and things like that. But they, they, uh, they don't mean to do it, right. So like, I'm really well, thanks so much for a great conversation. There's a lot of great pearls here in our conversation that we've had. And hopefully we can have another conversation, another time to highlight some more points. That would be terrific. I've really enjoyed having a chat with you this afternoon. Thank you so much. Okay. All right. Let's check you guys later.

Dr. Teresa Chan (24:50):

Wow. That was a really awesome first segment of the Mac PFD spark podcast. And now onto our second segment.

Dr. Teresa Chan (25:02):

Hello, everyone. Welcome to another edition of our podcast here. I am super excited to be recording an episode here with one of my personal mentors and heroes, Dr. Geoffrey Norman. It Geoff's been a fundamental force to be reckoned with here at McMaster university. And I'm so excited to be able to have a conversation with him on the record about some of the great stuff that he's been able to accomplish in his career here at McMaster. So, Geoff, I don't know that you need much of an introduction, but, uh, as, uh, Karolinska award-winner and professor of marriages here at McMaster, you've had such an influence on the way that we do medical education, not just here at McMaster, but really the whole world. First of all, thank you for that. And second of all, thanks for taking me under your wing or over these many years, I still think very fondly of those walks we had around main campus when you were helping me figure out what I wanted to do for my thesis. I really wanted to take a couple of minutes to thank you for that. But, uh, let's, let's get at it with the history of a little bit of the secret sauce that went into founding McMaster's medical school, because I think you definitely have a first person shooter experience there that a lot of us could only dream to have starting a medical school

Dr. Geoff Norman (26:15):

Again, with, to be honest, I'm, tranquilly a victim of circumstance. I never, when I, when I was 12 years old and the last thing I aspired to be was a medical educator. In fact, I was so anti anything that looked like soft arts or anything like that as an undergraduate, you had to take a liberal arts elective. And I waited until they classified astronomy as a liberal arts elective. And that's when I took my, my one piece of liberal arts. The rest of it was straight hard science, physics, and all that stuff. And many people know that I got a PhD in physics, which in hindsight was totally useless. It did open a lot of doors. And so the circumstances that I was a victim to was because I was, I came down here from what I paid to do graduate work in physics, in the reactor.

Dr. Geoff Norman (27:03):

And in due course on taking far longer than most people do to get a PhD. I found myself delightfully unemployed, and I had a file of about two inches of job application letters that were uniformly rejected. And then one day I was talking to one of the people on my committee who was a physicist, but at Wellstone computer center. And he said, oh, maybe we can get you a job. And I ended up for a year doing it, running a computerized medical record system in the family practice unit at the Henderson. Then my boss became a psychiatrist and I became unemployed again. And then I was

talking to a guy named Vic Neufeld, who some of you might've heard of who they'd been appointed very recently, the head of the office of medical education so-called program for education development. And I guess he took pity on me and says, oh, well, we can keep you off the Dole.

Dr. Geoff Norman (27:48):

Adam gave me a job investigating clinical problem solving skills. That's pretty weird because I don't know how he came to the conclusion that quantum mechanics would be a real leg up on understanding problem solving self and what he should have done as hard as psychologist. But thank goodness he did. And eventually over a period of decades, I'm morphed into one because that's really what all this stuff was all about. Anyway, September, 1971, I was the char founding research assistant in the program for educational development. And my task was to investigate technical problem solving skills. But along the way, you have to recognize to be very clear. I had nothing to do with the founding of the medical school. Unfortunately, the many people think I did, but I didn't. I was too late. The medical school class entered in 1969 and they regaled everybody. Each other was tales of the basement of his shadow cost.

Dr. Geoff Norman (28:44):

And what was the antidote cost model, which is where the first classes arose. So the first class entered in 69, but the Dean arrived in 65, which is the same day I arrived to do graduate work in physics. So self-evidently, I had neither the skills or the chronology to have anything fundamental to do with, with the curriculum. I did, however, get to know all of the founding fathers and to be very clear, those of us just because not too many people knew them because they're all gone. Now, the first Dean was John Evans, who was a cardiologist and ultimately became head of rural bank and became a politician and so on. And he was incredibly charismatic individual. He goes about six foot five. And he was one of those guys that when he walked in the room, everybody went quiet. He could wrap you around his little finger, but he was never authoritative.

Dr. Geoff Norman (29:32):

He was great at coaxing and controlling and showing real leadership. He was the first thing. The second person on board, I think was Fraser mustard, a pathologist. I have a good story about him that will come in a little in a little while. He was the second Dean bill Walsh, Alan Walsh's father, an internist in Hamilton was one of the other members of the founding fathers. And he was very critical because Hamilton had a very active postgraduate education, residency education programs and all the hospitals. And those had, those had to be brought into McMaster in order for McMaster medical school to work. And bill was the liaison between the town and the gown. And bill had all the right stuff to pull that one off and did likely the creative spark or the whole thing was Jim Anderson, who people have long forgotten. Jim died fairly young.

Dr. Geoff Norman (30:19):

He was an anatomist. He was also an anthropologist and he did some amazing studies of kids growing up in the sixties. And, uh, it was people think we don't have good evidence, but people think that it was Anderson who invented problem-based learning. And I said, I say, invented deliberate. It wasn't deliberate. Yeah, it kind of was copied from somewhere else, but we'll get to that in due course to those folks started getting together. They brought on other renegades, like Barden Miller chair of surgery. And that was the first feature pediatrics and Nate Epstein sheriffs, a cadre. These were all people who had already made their mark elsewhere, either in Canada, the UK or the U S but

all, all of them were unusual. Individuals who had a real creative spark and that was the initial team. And so they put together this problem-based learning curriculum.

Dr. Geoff Norman (31:07):

There's a couple of reasons, a couple of anecdotes about a fly. It turned out the way it did. One is that bill Walsh at one point said, all we really want is for the medical students to get a degree and have fun doing it. And seeing patient problems is one way to achieve that. And it was as simple as that, the other thing that, the question that always gets raised is so, yeah, but did they, did they read about Dewey and did they read about Plato and Aristotle and Socrates and all these casts? I mean, somebody who was Greek said, well, this is just, this is just Socratic dialogue, isn't it. And I had to admit that there was, I could tell from the little, I knew about Socratic dialogue yeah. As it was. But when the dust settled and particular a thesis done just a few years ago by a woman in the Netherlands, Jenny Servon poetry reports through the archives and interviewed all the people.

Dr. Geoff Norman (31:57):

She could get her hands on. And it was very clear when the dust settled that these guys essentially invented the thing almost out of whole cloth. It was not a logical or rational evolution for people who had come before. There are other things like Jerome, Bruner, and John Dewey, who can be seen as predecessors to PBL, but the founding fathers themselves didn't know anything about those guys. They just put this thing together, out of the whole cloth. It's not just PBL. If you, if you listen closely to the rhetoric, it is problem-based, self-directed small group learning. And pretty soon those three became glued into a single package. And so you can't have one without other. So to this day, all the students spend a lot of time in tutorials and small groups. So this day they're encouraged to do their own learning. Although are your students in every curriculum?

Dr. Geoff Norman (32:49):

Most of their learning is their own, but it became one of the three steps, three legs of the stool called problem-based learning. One of the questions would be where did those things come from? And it's not as if there's a direct descendant from one person to another, although as I'll point out in one case, there is. But rather you have to also recognize the culture of the times. Very simply the first class at McMaster in September of 1969 and Woodstock occurred in August of 1969. And those two events are not just coincidentally very clearly. I think the whole idea of small groups really was a product of the times. There was lots of, there were encounter groups. There was dope smoking groups. There was sexual groups. It was just natural to have educational groups as well on, in subtle ways. I think they weren't influenced by that.

Dr. Geoff Norman (33:44):

What would he explicitly said? Let's do what the hippies do, but it came out that way as, like I said, the time, right? Precisely for years when they are entering class came in, homie me up in front of the stage. And I start talking in a dry academic monotone voice about the early days as I talking and taking off my tie, flying it around my forehead or the granny glasses out of my pocket and popping them on Ken's out of that, remember one of the things that around my master for many, many decades, wasn't you didn't do any objective evaluation. You didn't have any examinations. It was all done in the small group. Why did that happen? Because we can have the small group ethos that I can be straight with you with man, and you can be straight with me. And if I tell you what's wrong with you, you'll take it in and change.

Dr. Geoff Norman (34:40):

It took a long time before that particular bit of Axiom vanished because time and again, we did many, many studies that showed that in fact, tutors can distinguish good from bad. They can't predict how students are going to do on licensing exams. And so on. As, as Howard Darnel was one of the second generation of the faculty said, it's a student, doesn't pick his nose or drink his bath water. He's above average. And that's kind of the way it was. Ultimately, some other things came in that some people view as regressive there's times in the eighties, I would go to meetings and somebody would see me coming in and they would put a pallor, you know, a death mask on. And they'd say, how are things of McMaster that point? Yes, but you've gone back to lectures.

Dr. Geoff Norman (35:29):

No, we've always had lectures. Actually. It's just a, you didn't read the fine print, but it was, you know, when is McMaster going to fall off the wagon was of the long, the ongoing thing for years and years. One thing I have to tell you about though, is where a problem-based learning conference came from, right. Relates to an episode. I just remember the fifth person. How could I forget bill Spaulding, diabetologist, endocrinologist, Hamilton, dark internist as well. And bill Spalding and I were driving down with queen Elizabeth way at a boat Bronte road from a meeting in Toronto, in his metallic blue, 1978 Honda accord. And I talked to him, I said, bill, where did this idea of using problems comes from, I would pop into a Spalding accent, which is very nice. Thanks. I mean, you talk like this, but nobody remembers what he talked like.

Dr. Geoff Norman (36:17):

So was no point what happened was this? He said, well, when I was a medical student at Western, I had a fraternity brother who was in the business school. And a couple of years ago, I went and visited him because he was now at Harvard business school. And he was telling me about this here case study method. I thought, Hey, we could use that in medical school. And so even though there's been debates back and forth about whether McMaster just plagiarized the case study method, or didn't plagiarize a case study method, the fact of the matter is that there's a direct lineage between Harvard business school case study method and McMaster PBL through bill Spalding. Ironically, some years later, Harvard adopted problem-based learning, but they called it something else and they took credit for inventing it. So what goes around, comes around. What else? Oh, yes.

Dr. Geoff Norman (37:06):

One of the other things, this is, I really, I like this one. One of the other hallmarks of McMaster was the idea of the non-expert tutor and a whole rhetorical speech around Ron expert tutors grew up because the idea was that expert tutors would just swamp you with all their expert knowledge, and you'd never be allowed to learn on your own own. And so non-expert tutors were much to be preferred because they would ask questions. And then the corollary to that was to be a good tutor. You don't have to know anything about the subject matter. As long as you can ask the right questions. Well, gee, people, it's really hard to ask the right questions on you until you know what the right answers are. And this came to me firsthand, like a bullet between the eyes. When I got sucked into being a tutor in the cardio rest renal unit.

Dr. Geoff Norman (37:59):

Now there's well documented evidence that the whole thing to learn in medicine isn't for all. And I can vouch for that. I couldn't run a thing about nephrology. It was all completely over my head. You have to recognize I've never had a high school biology course. Thank God. There was a backup plan

and that the nephrology unit planner was a guy named Kenzie Smith. It was a nephrologist and he would attend every second tutorial and get them back on course, but I'd be asking questions and the alternative tutorials. So Johnny, what do you think about the role of Soviet and it was another forest. So the question is the real question is, so why did we get onto this on the non-expert tutor anyway? Well, here in lies the story cross my heart and hope to die. If you knew Fraser mustard, this is a guy who could stop railway trains.

Dr. Geoff Norman (38:50):

He was about six foot five. He was about 250 pounds. He paid his way through. You have to medical school as a football tackle. What he walked into the room, everybody went silent and unlike Evans, he was not a nurturing personality. He was a dominating personality. He was also a cardiovascular physiologist and his expertise was in platelets. So what they found over the first two or three years of running the curriculum, was it in the cardio unit when Fraser was tutoring, whatever the problem began as whether it was myocardial ischemia or pericarditis, whatever it might be within 10 minutes, it was a plaintiff's problem. So in order to shut Fraser up, they put them in the neurology unit. And that's where the idea of non-expert tutor came from. I'm not kidding,

Dr. Teresa Chan (39:36):

A practical solution to a practical problem, I guess,

Dr. Geoff Norman (39:40):

But in a sense that epitomizes the McMaster approach, which was very much grassroots and very much try and see what happens. Kind of a spirit of discovery, a spirit of let's give it a go and see what happens, guys.

Dr. Teresa Chan (39:54):

Yeah. It's a truly innovative kind of spirit, right? Like it sounds like it was, uh, an adventurous time

Dr. Geoff Norman (40:00):

And you have, would read adventurous time and terrifying too terrifying to, okay. There is another story you want some stories don't use.

Dr. Teresa Chan (40:09):

Yeah. That's, that's the point. I think having this conversation, so really

Dr. Geoff Norman (40:15):

Cast your eyes back 50 years when I was just a newbie, I was the new kid on the block. I was trying to do this research in cognitive psychology, having never taken any course in psychology. I shouldn't have nothing at all about cognitive psychology. I was scared from morning till night. Cause I didn't know what the hell I was doing. I had to teach myself a T test cause I had never taken a statistics course. And I actually, I was a lot like the first generation of medical education researchers that we all sort of stumbled into this. They were being was a theology person. Christine Macquire was an economist or a third Holstein was a clinical psychologist. You can go down the list and all of us were odd. Boston couldn't find decent employment anywhere else. The other thing was that McMaster was scary. It was scary too, because they were trying this massive experiment with no examinations, no lectures.

Dr. Geoff Norman (41:09):

And yet the LMCC loom large at the end of the three, three years. So she are we going to be okay, well of course conference I went to was at Michigan state university and they were one of the really solid people in medical education research back then. And um, I went to the reception and because I was poor as a church mouse, when there was free booze, I had a little difficulty restraining myself. I love scotch, but couldn't afford it. So I had had several scotches and I ended up talking to a guy named Lee Shulman, who everybody recognizes as being one of the most complex, brilliant medical, not medical educators there ever was and went on to being the president of the Carnegie foundation. Lee had a delightful sense of humor, but anyway, at the reception here, I was getting four sheets to the wind and I sort of said, Jesus lady, I know this whole problem based learning thing. I mean, probably by the time our kids graduated within about five years, they're going to look like everybody else. And all we're going to be able to say is they had more fun getting their MD and Lee with us to England, as I said, so what do you prefer? Sexual artificial insemination.

Dr. Teresa Chan (42:22):

That's a good story.

Dr. Geoff Norman (42:24):

20 years later, I was doing a session of the ARA meeting. And unbeknownst to me, Lee was in the back of the room and I related this anecdote and one, the session broke up. Lee came hustling up to the frozen ironic that remains the single best of the, of problem-based learning as a program evaluation. You can't pull any real difference between any curriculum than any other curriculum. There is some evidence that curriculum accounts for 3% of the various teachers, 6% and students, 94% Curriculums curricular kind of a way to keep you people like me off the streets, I guess.

Dr. Teresa Chan (43:08):

Well, I think there they're more than that. I think they, they, they laid down a foundation for people to grow from. And obviously because medical school is not the terminal end point for most of our practitioners now, right? There's usually especially, uh, with advent of residency and then multiple fellowships for some specialties. It's, there's a lot of, uh, those, a lot of development that happens afterwards. But I think that having fun, making those connections, having that support when you're first getting started, it's a replaceable. So I think having a good model to kick that off, regardless of how you do it can set down some really good precedent for the students. So I think it can still be important,

Dr. Geoff Norman (43:49):

Much more pragmatic way of saying it is, you know, if they come up the same and they had more fun getting there, why not

Dr. Teresa Chan (43:56):

Exactly. I mean, I think that at the core of it, most of the time as educators, we do aspire to make sure that our students are having a good time while they're learning. Um, so if you can crystallize that, why not? Right?

Dr. Geoff Norman (44:12):

It was Glen McGarry. One of my proteges who at one point said learning, isn't fun, learning fun. Things is fun. Learning, boring things is boring and learning hard things is hard and no apologies necessary. That's the way it is. Physics is a great, great leveler. It doesn't teach you. And there was no fun to be adding physics. Admittedly, it had other things going for it. I mean, I was, and to this day I still champion pure science for the sake of pure science. And it totally hooked me in terms of the wonderment of books, figuring out how the cosmos works and all that Jesus, it was hard, psychology up psychology was a breeze by comparison, honestly, nothing to it. So the step kind of thing, you know, I many, many times I say to us also, what did the physics by two things? One is I couldn't be dismissed easily by people. You know, the, the standard way to dismiss us educators as PhDs is, well, you're not a clinician. You wouldn't understand doesn't work when you're six foot five and have a PhD in sociologically very useful. The second thing is it gives me a bit of a grounding, a better grounding than most people in mathematics. So easy. I became a successful statistics teacher and I wrote some books in that anyway, that's that was McMaster in the early days. Yeah,

Dr. Teresa Chan (45:38):

Well it sounds like it was quite an adventure.

Dr. Geoff Norman (45:41):

It was quite an adventure. Now I admit, I think I was a bystander to the adventure, but by and large, I didn't, I certainly made very little in the way of active contributions to the evolution curriculum. I just think,

Dr. Teresa Chan (45:53):

But you were there to ask the questions and then be part of, uh, the witnessing of, of, of all of these great people putting together a very, very unique program. So thank you so much for sharing your account of it because I think it's definitely. Oh, okay. That's okay.

Dr. Geoff Norman (46:14):

But I think the one enduring thing out of McMaster's, hopefully we're always injured as the cast of characters change and as the curriculum perhaps changes or doesn't change. And as the healthcare environment changes, hopefully not as rapidly as it did this year, but the one thing that continues to make McMaster unique goes back to the right back to the beginning. When I could see bill spalling and say, hi bill, and he'd say, hi Jack or John Evans, or any of those guys were head and shoulders above me. They're 20 years old. And we were always on a first name basis and people have come to McMaster from other institutions and within hours, they sense that there's a camaraderie that exists in this place that is truly unique in any kind of hierarchical, stuffiness, I won't name names, but the Western town, that kind of stuff. I can't say that it's totally absent from McMaster. Of course we have some pompous stools on too, but by and large, there's always been a much more open and sharing and collegial environment here than anywhere else. And Theresa May be in part two, which may not happen today. I don't, I like to talk more about the beginning of educational research, which if I was also a spectator. Yeah, well maybe this is enough for one session.

Dr. Teresa Chan (47:45):

Thank you so much for sharing all of that. I'll be cutting that into its first part of it there, but that's great. Stay tuned for more from Geoff and I, as we archive some other stories.

Dr. Teresa Chan (47:57):
Thank you so much for tuning in to the MacPFD Spark Podcast. Just so you know, this podcast has been brought to you by the McMaster Faculty of Health Sciences and specifically the Office of Continuing Professional Development and the Program for Faculty Development. If you're interested in finding out more about what we can offer for faculty development check out our website at www.macpfd.ca that's www.M-A-C-P-F-D.ca. Many of our events are actually web events that are free. Finally, I'd like to thank our sound engineer Mr. Nick Hoskin who has been an amazing asset to our team, thanks so much Nick for all that you do. And also thank you to Scott Holmes for supplying us the music that you've been listening to. All right. So until next time this is MacPFD Spark signing off.