FACULTY OF MEDICINE

JAMES HOGG RESEARCH CENTRE INTERNAL REVIEW
REPORT OF THE REVIEW COMMITTEE

November 15th, & 16th, 2022

Leonard Foster, Head, Biochemistry & Molecular Biology (Chair)

Pamela Hoodless, Professor, Medical Genetics and School of Biomedical Engineering (Internal reviewer)

Bruce Verchere, Professor, Pathology & Laboratory Medicine (Internal reviewer)

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OVERVIEW OF REVIEW REPORT

The major goal of a review is to provide the Research Unit with an opportunity to reflect on its research programs, operations and performance; monitor progress and productivity and obtain advice to guide continuing improvement of research performance and operational quality. The primary emphasis is on effective interdisciplinary research and environment for research trainees. Reviews also contribute to the public accountability of the university and the relevant health authorities. Reflective self-study documents prompt a process to appraise the scholarly, pedagogical, and professional activities of the unit, the success of its research programs and missions, as well as its other roles and responsibilities in health research and healthcare delivery. Internal reviews allow for assessment of the Research Institute's performance relative to peers, and enables effective planning and resource allocation. The process itself offers the unit an opportunity for periodic in-depth analysis of its research programs and goals and its achievement of objectives and priorities identified in the university, the Faculty of Medicine, the health authority and the unit's own strategic plan.

1. EXECUTIVE SUMMARY *(~1 page)*

The review panel met with various interested parties over the course of two days, November 15th and 16th, 2022. At the panel's request, a subsequent meeting was set up with JHRC trainees on Dec. 5th, 2022. The panel also reached out to a few specific people outside of these meetings, either to follow up on specific items that were brought up during the meetings or to obtain additional information from people who might not have already brought it forward.

At a high level, the key findings include:

- that all of the previous recommendations had been followed up on and, in most cases, completed.
- massive concern around the uncertainty of the move to the new building
- that the current Director, Dr. Sin, has strong and universal support among the whole community
- that a decision on the on-going leadership will be required soon, depending on Dr. Sin's decision about whether to stand for another term
- that efforts to refresh the faculty cohort have been largely successful but that they require continuous work
- that still more work is required in the EDI space
- that the core facilities are highly valued
- that there is some confusion around the name and that the branding of the Centre needs to be sorted out

We have elected to present our recommendations in a format that we have not seen before. However, it is quite clear that some of the biggest issues facing the JHRC must be dealt with by Providence Health Care and the Faculty of Medicine. Thus, we are separating here the recommendations into those that should be addressed by the Unit and those that need to be addressed by the Faculty of Medicine and/or Providence Health Care Research Institute. These review recommendations are typically only left up to the Unit to respond to and then there is no response from the other levels. By framing them this way, we now expect that the Faculty and Providence Health Care will provide to the Unit an update of their own progress towards meeting these recommendations. We list the FoM/PHCRI recommendations first because the 1st item in the list is, by far, the most critical item to deal with immediately.

Faculty of Medicine and/or Providence Health Care Research Institute recommendations:

1. That the Faculty of Medicine and Providence Health Care define a concrete plan for how the research activities of St. Paul's Hospital (including but not limited to JHRC) will be able to continue without interruption through the transition to the new building. We note that this is not just the responsibility of Providence Health Care: the Faculty of Medicine absolutely has an obligation to support their faculty members' scholarly activities. This plan should be in place by May, 2023 so that the JHRC community can move forward with all their other activities. In addition, nothing causes more stress than a lack of information. Thus, the leadership of the Faculty, Providence

Health and JHRC should hold regular Town Halls (or similar) to convey where the process is at and to get feedback/input.

2. That the Faculty of Medicine and UBC do more to convince the Health Authorities and the Ministry of Health that world-class health outcomes in the medical system can only be achieved through a full integration of world-class research with clinical care. This may require very high-level discussions that should be pursued (e.g., UBC VP Health to Minister of Health).
3. That the Faculty of Medicine and UBC change the processes around reviews such that recommendations are made to specific levels of administration, rather than just to the unit being reviewed (as we are doing here) and that each of those levels be required to respond to and provide updates on progress. This will give reviews more weight and make the investment in time that the reviewers and the unit membership make in them seem more worthwhile.
4. That the Faculty of Medicine, together with JHRC leadership, lobby the VPRI to solve capacity issues in the UILO. This could start with the argument that missed opportunities would have already nearly (or more?) funded such a position from increased overhead to UBC.

James Hogg Research Centre recommendations:

5. That senior leadership, through extensive consultation with all faculty, decides on name branding that resonates not only internally but also with the Foundation and the external UBC community, and works to get that approved by all relevant groups, including UBC and Providence Health Care Research Institute. Of particular importance, we encourage them to ensure that this new (or maybe old) branding makes everyone feel included, especially those not doing research on heart and/or lung.
6. That the Director of the JHRC be included in meetings with the builders of the new building to represent UBC researchers. While Dr. Knight is involved in these meetings, he is technically an employee of Providence Health Care and thus has to represent potentially conflicting interests.
7. That senior leadership of JHRC makes an effort to evenly distribute administrative and service workloads across all faculty. This can be achieved by asking those from under-represented groups to only serve on committees where diversity is really important (e.g., a search committee but not the IT committee). Or, if needed, to protect time of or provide additional resources to those people who are needed in specific situations such that they are available to serve when truly needed but not at the detriment to their other activities.
8. That senior leadership works with the Foundation to ensure that principles of equity, diversity, and inclusiveness are factored into any support decisions. The expected outcome of this would be that Foundation support is fairly distributed across all demographic groups.
9. That the Director establishes an annual check-in with the Head of every department that has faculty in the JHRC.
10. That the JHRC has a mentorship policy for new faculty members, arranged jointly with the home academic department. This might include a mentoring committee involving other members of the department and the JHRC.
11. That the JHRC faculty make a concerted effort to bring about a culture change around the EDI environment in the Unit.
12. That senior leadership, together with the administrative team, formulates written policies describing transparency of processes, especially around financial arrangements that impact faculty and research programs.

2. RECOMMENDATION FROM THE PREVIOUS REVIEW AND UNIT'S PROGRESS (if applicable)

The last review of the JHRC was held in September, 2017. Several recommendations were made and we were provided with both the original report and the JHRC's responses at the time. Our evaluation of the JHRC's progress towards addressing these responses is here:

1. An internal Director of the JHRC …: implemented, with Dr. Sin having been selected and having led the Centre since 2018.
2. Sustainable financial plan and potential revoking of "Centre" status: the financial status of the JHRC appears to be stable, albeit not as generously supported as everyone would like. There seems to be no more concern that "Centre" status might be revoked.

3. Foundation support of JHRC: while there may be more meetings with the Foundation than before, the perception still exists that the JHRC is not at all a priority for the Foundation.
4. Integration of research cores with other UBC sites: there appears to be very little done towards this, aside from the animal facility which falls under UBC's broader animal care. It is not clear that attempting to integrate other cores with their contemporaries around UBC would be helpful any longer.
5. Recruit new faculty: this seems to be well underway, at least to the extent that it is possible within what the Faculty of Medicine allows. The impression that we heard from internal people seems to suggest that there is a slight imbalance towards more lung research and away from heart. Given the numbers we have seen, we are not sure that this is true. However, it is still the impression that several people expressed. In addition, some positions may be on soft money without a sustainability plan, which does not sit well with the broader faculty.
6. New hospital building: the JHRC is well-aware of the opportunities that the new building will create but right now the entire Centre is in limbo because of all the uncertainty around when the research enterprise will be able to move in.
7. Trainee environment: Dr. Scott Tebbutt has been Education Director for the past few years. The trainees very much appreciate his involvement. The trainees also appreciate the seminar series that they are deeply involved in organizing. Other aspects of the original recommendation did not appear to have been acted on (e.g., formal mentorship programs)
8. Cores
    a. Clinical trials infrastructure: the JHRC's internal clinical trials core was mentioned several times as a strength, so this seems to have come a long way. In addition, CHEOS provides another angle of support that is quite critical, although there seems to be very little communication between CHEOS and JHRC.
    b. IT support: IT support is still done at a Unit level, rather than at the Providence Research level, as was recommended.
    c. Biobanks: these seem stable, although there is still some work to do to make them widely accessible to the broader UBC community. How they will transition to the new building has not yet been considered.

3. OVERVIEW OF THE UNIT (STRATEGIC DIRECTION, LEADERSHIP, ADMINISTRATION) *(~2 pages)*

St. Paul's Hospital is in the process of building a new campus at a different location. There will be several new buildings, including a Clinical Support & Research Centre (CSRC). Construction has begun on the main hospital building but the developer and plans for the new Research Centre have not been finalized. It is hoped that a developer will be chosen early in 2023, which will allow a time frame for construction and moving to be established. Currently there is none.

The main complication is that the current St. Paul's Hospital site has been sold and must be vacated by 2027. If it is not vacated on time, severe financial penalties will be incurred by Providence Health Care. While construction of the hospital is moving ahead to meet the deadline, currently the construction of the CSRC is predicted to be 1-2 years behind the hospital. Contingency plans if JHRC has to vacate the current site before the CSRC is completed have not yet been made since the timeframe for the completion of the CSRC is not clear. This timeframe may not be known until 2024.

Another key aspect is the uncertainty around branding. The unit has had several names over the years, including iCAPTURE, James Hogg Research Centre (JHRC) and the Centre for Heart Lung Innovation (HLI). JHRC is the UBC Senate-approved name and apparently the Senate made it clear when this was approved that they would not be keen to entertain another name-change request. However, virtually no one within the JHRC actually links themself with that name. The leadership, faculty, staff and trainees of the unit all view themselves as being part of the HLI. Some did not even know the name JHRC or that HLI was not Senate-approved. It is felt by many that the HLI name describes "what they do". Many in the Vancouver community and internationally know the unit as HLI. In fact, we, the reviewers, were quite confused going into this process as we also thought of them as HLI. Thus, officially changing the name to HLI by obtaining Senate approval is one option. However, some concern remains as to whether "HLI" limits their scope, while at the same time not being completely inclusive of the diverse research that is done at the Centre.

3.1 Strategic Direction

The strategic plan for the next few years is to continue building on the momentum they have generated to hire new faculty positions, to solidify support for core facilities, and to strengthen the structure around their substantial biobanks. However, it is very clear that everyone's focus for the next few years is going to be on the move to the new building. Every group with whom we met brought this up and it was clearly everyone's biggest worry. This looming, existential event with no real certainty around it will be a distraction until it is resolved, to the extent that we do not expect that they will be able to do much else at a strategic level until then. The next most-pressing issue is that research tends to be an after-thought for the Health Authorities, including Providence Health Care.

The strategic direction of the JHRC is led by Dr. Sin, with consultation coming from the VP Research and other members of the JHRC leadership team. It was not clear how much input the broader community (faculty, staff, trainees) of JHRC has into the strategic planning. Faculty, in particular, felt that some decisions around hiring directions were made without broad consultation, leading to some imbalances in topics areas studied.

With regards to the integration with other Medicine and UBC units, and the coherence of the mission with those other units, there are some good aspects and some not so good aspects. On the plus side, interactions with some departments (e.g., PATH) and some other centres/schools (e.g., SBME) seem well-developed and of broad benefit to both sides. On the other hand, channels of communication between JHRC leadership and some other home departments seem non-existent. And, as is mentioned elsewhere, "coherence" with other centres (e.g., Centre for Cardiovascular Innovation, Cardiovascular Centre of Excellence, The Lung Centre, Centre for Lung Health) is lacking in that the "heart" and "lung" space at UBC, in the Faculty of Medicine, and even at St. Paul's Hospital is very crowded.

See recommendation(s): 1, 2, 4, 5, 6,

3.2 Leadership

The current leadership is broadly and highly supported by the JHRC members, the Faculty of Medicine leadership, and the Providence Health Care Research Institute leadership. Dr. Sin is currently weighing his options around standing for another term. It was unclear who would step up to take on the role if he decides not to, although it would likely have to be another internal person given time and budget constraints. We noted that there are several strong ECRs who would be good candidates in a few years, such as after a second term by Dr. Sin. There is apparently a tradition within the Unit that the Director only serves a single term before passing it on to someone else. The key challenge for whomever the Director ends up being centers around the new building. The first order of business is to sort out when the move will happen and what that will look like. Only then will the Director have the time to think more strategically about what the Unit wants their space to look like. This will require some careful planning and capitalizing on opportunities, such as the next CFI Innovation Fund competition, to fill out and properly equip the space. The other strategic opportunity, again once the move to the new building is worked out, will be capitalizing on the excitement around a new space to continue recruiting new, young faculty.

Leadership is trying to promote diversity, equity, and inclusiveness. A Unit-level EDI Committee has been formed (notably from a grass-roots effort, rather than as top-down) but is in early days. They have been holding events but not fully engaging the whole community, particularly faculty. Recent hiring has increased diversity but there is still some way to go, particularly around gender, sex, Indigenous researchers, and disabled persons. The administration will need to work on ensuring equitable support for both career mentorship and financial aspects of support to new faculty. Another aspect of EDI, as it applies to this Centre particularly, is the representation of the cardiac aspects of research in the "heart and lung" portfolio. We heard several suggestions that there was a strong imbalance between the two subject areas among the research interests of faculty.

By far the biggest challenge the leadership will face for the next five years is the move to the new building. As discussed elsewhere, this is existential. It is also not something that the JHRC leadership can deal with on its own. The Faculty and Providence Health Care must step in to help solve this.

See recommendation(s): 1, 6, 7, 8, 9, 10, 11, 12

3.3 Administration

There is overwhelmingly strong support for the leadership and the administration at all levels. There was particular appreciation for the grants support team but all of the core facility management was praised. The general structure of the administration appears to be working reasonably well, with the caveats highlighted elsewhere in this

document. A need for increased transparency in how funding is allocated within JHRC, how grant tithing might be done, and how efforts with the Foundation are distributed among faculty would help alleviate some concerns.

There is a committee, appointed by Providence Research and led by Dr. McNagny, that has been formed to facilitate and plan the development of research spaces in the new building. It needs to continue to engage all staff at JHRC. There is also a committee which involves UBC but has not met for a long time. It is necessary to re-engage this committee. UBC is needed to become part of the process and solutions for the move to the new building.

One particular frustration we heard multiple times was with UBC's University-Industry Liaison Office. There was general support for what the UILO does but the problems lay with its capacity. It is perceived that there have been a very large number of missed opportunities because the UILO was too slow to put the necessary agreements in place. Perhaps the easier things, such as MTAs, MOIs, etc, could be simplified so that there is more time to deal with the more complex issues?

See recommendation(s): 4, 7, 8, 9, 10, 11, 12

3.4 Internal and External Relationships

For much of the UBC/Vancouver research community, the Centre for Heart Lung Innovation is the face of cardiac and lung research in Vancouver. This is what everyone within the unit feels they belong to, yet their official name does not reflect this. This branding needs to be sorted out. However, while the community associates itself with the HLI name, "HLI" exists in a complex, changing environment in Vancouver, including the Healthy Heart Program, Legacy for Airway Health and the new Centre for Cardiovascular Innovation (CCI). Thus, JHRC's/HLI's role is not always clear to the outside. However, it does have a defined role in research in the foundational and preclinical research space. JHRC is currently working together with CCI, to promote a good collaborative relationship. Extending this collaboration and possibly making the tent even bigger by merging some units might be helpful to all. Some members of HLI are also members of CCI.

Outside of the cardiac and pulmonary spaces, there also appears to be particularly good relationships with the School of Biomedical Engineering. Some of the entities that we might expect to see more interactions with include the BC Centre for Disease Control, VGH, etc.

Regarding relationships with Providence Health Care, the main conduit is through Darryl Knight. Dr. Knight seems very supportive of JHRC and the leadership.

See recommendation(s): 5, 6, 9, 10

4. RESEARCH *(~two pages)*

The James Hogg Research Centre is a jewel in the Faculty of Medicine's portfolio. It supports an outstanding array of research, from foundational to pre-clinical translational research in many areas. The most obvious are related to lung and heart biology/physiology but it extends beyond that to include sepsis, neurodegenerative disorders, and more. While their more common name, the Centre for Heart Lung Innovation, may be better known and more widely recognized, their formal UBC name (JHRC) more accurately captures the research done in the Centre. While HLI is a good name that everyone is proud of, many researchers do not associate themselves with those topics. This needs to be considered if the leadership moves forward with formally changing the name from JHRC to HLI. It is not enough to simply make the change without consultation on how to make everyone feel included.

The JHRC is internationally recognized and many of its faculty are among the most highly-cited researchers in their specific areas. While we encourage them to continue striving for excellence, they are already high-achievers. Hopefully some of the recommendations from this review help them go even further since we did hear of several bureaucratic and administrative hurdles that may be holding JHRC researchers back. One of the most significant seems to be that UBC's UILO is severely under-staffed (also discussed above), to the point where there are numerous opportunities every year that are not realized because the potential partner looked elsewhere or gave up entirely because the paperwork was taking too long. Presumably this could be fixed by hiring more staff at UILO. And it seems that the financial argument for this sells itself, too: more staff will enable more contract research agreements that bring more overhead to the University.

We heard from the people we interviewed that the scientific composition of the unit seems somewhat biased toward pulmonary research. We heard this from a number of people we spoke with. They felt that more effort could go

into securing funding for positions in the cardiac space, although this is somewhat opportunity-dependent. What could be done immediately is to have at least one member of the JHRC leadership be a cardiac biologist/clinician. The other incongruence is between the desired name (HLI), the mission statement ("Exceptional care through exceptional science in heart, lung and blood vessel diseases"), and the topic areas studied (all of the above, plus sepsis, neurodegenerative disorders, and more). There have been and are some outstanding researchers in the latter areas located in the JHRC but it is not clear that this is a good environment for them or if they have just landed there because there was no better place.

We did not feel that there were obvious gaps in technical or intellectual expertise. Certainly, there are areas that are not covered but there are only so many people that can be accommodated and one Unit cannot hope to cover everything.

As far as maintaining and building the JHRC's reputation and impact, we feel that they are doing all the right things. Solving the UILO bottleneck described above would help, as would deciding on branding - decide what name you want to use, get it approved everywhere it needs to be, and start using it.

See recommendation(s): 4, 5, 12

5. PEOPLE AND WORK ENVIRONMENT *(~one page)*

Morale and cohesiveness within HLI is currently strong. The members enjoy working together and the integration of research with clinical problems was appreciated. The presence of strong role models for new faculty was a strength. The core facilities were considered a real strength of the unit, including the biobanks and an in-house clinical trial support team.

There was considerable angst around the timeline for the new CSRC building and the uncertainty of the timing of the move. The new CSRC is 1-2 years behind the hospital, yet the old hospital building needs to be vacated by approximately the time the new hospital building is ready, leaving a potentially large gap when the research endeavours may have no space. The significance of this uncertainty cannot be overstated. It is an existential threat to the JHRC. Just a single direct move from the old building to the new one would be disruptive to research activities but everyone buys into the advantages of moving to the new space and so could live with it. However, if people had to move to temporary space, then move again half a year, one year, or three years later, this would have an enormous impact on careers since most of that whole time could be unproductive. Trainees would be hugely delayed in their programs. Faculty would produce few to no research outputs, endangering their ability to fund future work, to support their trainees, or even to advance through the ranks. And everyone in the JHRC is aware of this. We expect that if faculty are not satisfied that they can continue to be as productive as possible during the transition then they will very quickly start to look elsewhere. They might make the first move, e.g., to another location within UBC, but then just never move to the CSRC. Or they might start looking for opportunities outside of UBC. Either way, we firmly believe this to be an existential threat to the JHRC.

The lack of in-person interactions through the pandemic and continuing today has impacted the social cohesion of the Centre. This is obviously not unique to the JHRC but is still something that requires extra effort to make everyone feel included and connected to one another again.

The faculty were particularly concerned about colleagues being on soft money. It was appreciated that some of these positions were created by the JHRC and/or Providence Health and that they might not otherwise have happened if they had to wait for hard funding. Nonetheless, soft money positions create an air of uncertainty in the faculty cohort (both in JHRC and elsewhere) that makes everyone feel a little less connected to the Centre since those positions are perceived as less supported by/important to the Centre. The added concern with soft-money positions is that it adds to the flight risk for faculty when they have to make the move, direct or indirect, to the CSRC.

There were mixed opinions on the JHRC environment as it relates to equity, diversity, and inclusiveness. While there was unanimous agreement that it is a collegial environment, that is not the same thing as what the EDI movement is aiming to address. As with most other Departments, Centres, and Institutes in the Faculty of Medicine and around UBC, there are some under-represented demographics in the JHRC. As is often the case, some of those people who fall into the under-represented groups tend to be "asked" to do much more than their colleagues, usually for the sake of appearances (e.g., having the right mix on committees). Also, while we were not able to see the details, we suspect that there may be an uneven (read: undiverse) distribution of other resources (e.g., Foundation funds). While we appreciate

that the Foundation does not control who is willing to donate money, they must also be held up to the same standards expected of everyone else around equity, diversity, and inclusion.

An important factor to the success of EDI lies in the acceptance of a change in the whole culture of a unit. While many felt that the Centre was doing a good job addressing EDI, this opinion was not shared by all. While the JHRC has an EDI Committee and that group is striving to provide programming and other efforts to improve EDI, it was brought up that only a very small number of faculty seem to attend any of the events, and it is the same faculty over and over again. While there are a lot of needs that demand faculty members' attention, this gives the perception to the rest of the Unit that EDI is not very important to the faculty.

See recommendation(s): 1, 2, 6, 7, 8, 9, 10, 11, 12

6. SUSTAINABILITY OF THE UNIT *(~two pages)*

The finances of the unit seem to indicate sustainability for the foreseeable future. There is some uncertainty around the long-term commitments of some of the sources of funding, but this is not any different than any other academic unit.

The culture of the unit appears to be very collegial and generally all the faculty were positive about the future. There does not seem to be a standardized mentorship policy in place for supporting new faculty members. The general collegiality of the unit seems to be felt by the junior faculty, leading them to feel supported, but a more defined mentorship plan might be useful. The primary indication of succession planning is that several faculty serve senior leadership roles within the Unit (e.g., Associate Director, core directors), working with Dr. Sin, presumably setting them up for future moves into higher positions.

As with any Centre, Department, or other unit, operating on a tight budget is never easy. More money for operations would help enormously but we appreciate that every similar review ever conducted has probably recommended the same thing - more money. But with limited resources available to the University and to Providence Health, not much can be expected here. One major opportunity in this space that does seem like it could be addressed, however, is the involvement of the Foundation in JHRC. While we did not see any explicit statistics, we came away understanding that the activities of the JHRC are fairly low on the priority list of the Foundation. Whether this is true or not is hard to discern but, at the very least, some discussions with the Foundation may go a long way. For example, is there something the JHRC could do (e.g., rebranding) that might make the Foundation (and their donors) more interested in supporting activities there? As mentioned elsewhere in this review, however, any move to rebrand needs to be carefully thought through - there are several units around UBC that purport to focus on heart and/or lung health/disease. This complicated space likely makes it less attractive for philanthropy.

By far and away the most critical factor to the success of the JHRC is having a plan to sustain research activities through the move to the new CSRC building. And such a plan has to somehow minimize the disruption to research activities so that both faculty's and trainees' careers are not significantly undermined. This plan needs to be decided on fairly soon and communicated to all interested parties. Without having it addressed sooner rather than later, the JHRC risks having people (both faculty and trainees) looking elsewhere to continue their careers. This, more than anything else, is what the sustainability of the Centre hinges on.

See recommendation(s): 1, 2, 6, 8

a. TRAINING *(~two pages)*

Training and Education is one of three core areas in the JHRC 2022-2027 Strategic Plan, indicating its importance to the Centre. Currently, there are approximately 100 trainees associated with JHRC. Training and education fall under the mandate of the Education Director (Scott Tebbutt) and an Education and Safety Coordinator (Ivan Leversage). Their efforts are greatly appreciated by trainees. They work with the Trainee Association of HLI (TAHLI) to coordinate activities such as a research seminar series, which is open to all members of JHRC, EDI seminars and Career Path seminars. Of importance, TAHLI is provided with funds to organize activities, such as a Research Day, and hosting invited speakers. There are also small travel awards and grants ($200-$1000) that trainees can apply for. In addition, JHRC has a Knowledge Translation and Mobilization Training Program to help trainees with career progression. Overall, the JHRC is

highly supportive of trainees and provides an excellent environment for training due to the diversity of research areas encompassed at JHRC, and the emphasis on career development.

While all of the activities above are viewed as highly valuable, the bulk of the work falls on a few graduate students to organize. Broader input and participation from trainees and faculty at events would greatly improve the environment and collaborative opportunities between research groups. In particular, participation by faculty in EDI seminars would help promote a cultural change at all levels, including trainees.

Trainees from JHRC are associated with many different UBC departments, with PATH and Experimental Medicine being the most represented. While in person classes for two relevant graduate courses are held at JHRC, all formal training programs are through UBC rather than JHRC. Since minimum stipends are set by the UBC departments, some disparity between JHRC graduate students does exist. Minimizing these disparities could be facilitated by the Centre. One area of concern for both graduate students and PDFs was the lack of formal teaching opportunities. Several would like to be more engaged in teaching but opportunities are rare. This is likely due to the limited undergraduate teaching of PATH and EXMED, compared to other UBC departments. In addition, it is difficult to hold external funding awards and teach at UBC due to time constraints. While this does not fall under JHRC, a formal record of supervision in labs was suggested to validate the CV for future jobs.

Although most current trainees will be finished by the time the JHRC moves to the new site, investment in the current infrastructure was still considered important to trainees. Maintaining the training excellence will be a challenge as the moving date approaches. In addition, without a clear contingency plan, future trainees may lose valuable time in their education and career progression.

See recommendation(s): 1, 2, 6, 8, 9,

b. INDIGENOUS ENGAGEMENT *(~one page)*

An EDI committee has been formed but it is still early days. A survey was completed by the EDI committee in 2022 to gauge the EDI space. There is the will to incorporate Indigenous needs but no clear plan yet (as with all of these committees). Some in the HLI faculty are incorporating Indigenous samples into biobanks and research questions etc. Capturing indigenous samples is very important to ensure that all groups are represented in research. The desire to support these initiatives is there but more work is needed.

See recommendation(s): 8, 11

c. RESPONSE TO UNIT SPECIFIC QUESTIONS *(~one page)*

There were no Unit-specific questions raised.

10. CHALLENGES FACING THE UNIT *(~one page)*

While we have mentioned it several times, it bears repeating here: <u>without a believable, realistic plan for the move to the CSRC that considers and minimizes disruptions to peoples' careers, the JHRC may cease to exist as a viable entity in five years, with a massive loss in human capital from both UBC and Providence Health</u>. This is a problem for both Providence Health and the Faculty of Medicine, and both groups need to work together to find a solution. The importance of this is absolutely recognized within the Unit, including by the Director. We impress upon the leadership of the Research Institute and the Faculty of Medicine just how urgent this is and that it is a problem that must be solved at their levels. And it is critical that faculty be convinced of a viable plan much sooner than seems to be the current plan.

Apart from this issue, we believe that we have captured all the other issues that were raised in other sections.

See recommendation(s): 1, 2, 6

11. RECOMMENDATIONS *(~two pages)*

We are separating here the recommendations into those that should be addressed by the Unit and those that need to be addressed by the Faculty of Medicine and/or Providence Health Care Research Institute. These review recommendations are typically only left up to the Unit to respond to and then there is no response from the other levels. By framing them this way, we now expect that the Faculty and Providence Health will provide to the Unit an update of their own progress towards these recommendations. We list the FoM/PHCRI recommendations first because the 1st item in the list is, by far, the most critical item to deal with immediately.

Faculty of Medicine and/or Providence Health Care Research Institute recommendations

1. That the Faculty of Medicine and Providence Health Care define a concrete plan for how the research activities of St. Paul's Hospital (including but not limited to JHRC) will be able to continue without interruption through the transition to the new building. We note that this is not just the responsibility of Providence Health Care: the Faculty of Medicine absolutely has an obligation to support their faculty members' scholarly activities. This plan should be in place by May, 2023 so that the JHRC community can move forward with all their other activities. In addition, nothing causes more stress than a lack of information. Thus, the leadership of the Faculty, Providence Health and JHRC should hold regular Town Halls (or similar) to convey where the process is at and to get feedback/input.
2. That the Faculty of Medicine and UBC do more to convince the Health Authorities and the Ministry of Health that world-class health outcomes in the medical system can only be achieved through a full integration of world-class research with clinical care. This may require very high-level discussions that should be pursued (e.g., UBC VP Health to Minister of Health).
3. That the Faculty of Medicine and UBC change the processes around reviews such that recommendations are made to specific levels of administration, rather than just to the unit being reviewed (as we are doing here) and that each of those levels be required to respond to and provide updates on progress. This will give reviews more weight and make the investment in time that the reviewers and the unit membership make in them seem more worthwhile.
4. That the Faculty of Medicine, together with JHRC leadership, lobby the VPRI to solve capacity issues in the UILO. This could start with the argument that missed opportunities would have already nearly (or more?) funded such a position from increased overhead to UBC.

James Hogg Research Centre recommendations:

5. That senior leadership, through extensive consultation with all faculty, decides on name branding that resonates not only internally but also with the Foundation and the external UBC community, and works to get that approved by all relevant groups, including UBC and Providence Health Care Research Institute. Of particular importance, we encourage them to ensure that this new (or maybe old) branding makes everyone feel included, especially those not doing research on heart and/or lung.
6. That the Director of the JHRC be included in meetings with the builders of the new building to represent UBC researchers. While Dr. Knight is involved in these meetings, he is technically an employee of Providence Health Care and thus has to represent potentially conflicting interests.
7. That senior leadership of JHRC makes an effort to evenly distribute administrative and service workloads across all faculty. This can be achieved by asking those from under-represented groups to only serve on committees where diversity is really important (e.g., a search committee but not the IT committee). Or, if needed, to protect time of or provide additional resources to those people who are needed in specific situations such that they are available to serve when truly needed but not at the detriment to their other activities.
8. That senior leadership works with the Foundation to ensure that principles of equity, diversity, and inclusiveness are factored into any support decisions. The expected outcome of this would be that Foundation support is fairly distributed across all demographic groups.
9. That the Director establishes an annual check-in with the Head of every department that has faculty in the JHRC.
10. That the JHRC has a mentorship policy for new faculty members, arranged jointly with the home academic department. This might include a mentoring committee involving other members of the department and the JHRC.

11. That the JHRC faculty make a concerted effort to bring about a culture change around the EDI environment in the Unit.
12. That senior leadership, together with the administrative team, formulate written policies describing transparency of processes, especially around financial arrangements that impact faculty and research programs.

APPENDIX 1: MATERIALS REVIEWED

1. JHRC Self Report 2022
2. Previous Review and responses 2017
3. Survey
4. Faculty of Medicine Strategic Plan
5. EDI Survey results

APPENDIX 2: ITINERARY OF REVIEW

Internal Reviewers:	**Dr. Leonard Foster (Chair),** Professor and Head, Department of Biochemistry and Molecular Biology, University of British Columbia
	Dr. Pamela Hoodless, Professor, Department of Medical Genetics and the School of Biomedical Engineering, Director & Distinguished Scientist, Terry Fox Laboratory, BC Cancer
	Dr. Bruce Verchere, Professor in the Departments of Pathology & Laboratory Medicine and Surgery, Director, Centre for Molecular Medicine and Therapeutics, University of British Columbia

Tuesday, November 15th, 2022

All times are in PT

8:00 am – 8:45 am	**Research Leadership** Dr. Robert McMaster, Vice-Dean, Research, Faculty of Medicine Dr. Michelle Wong, Senior Director, Research, Faculty of Medicine Dr. Darryl Knight, President, Providence Health Care Research Institute
8:45 am – 9:30 am	Dr. Donald Sin, Director, James Hogg Research Centre
9:30 am – 10:00 am	***BREAK***
10:00 am – 10:45 am	**Program Directors** Dr. Aslam Anis, Director, Centre for Health Evaluation & Outcome Sciences
10:45 am – 11:30 am	**Decanal, Research & Education** Dr. David Granville, Associate Dean, Research, VCHRI
11:30 am – 2:00 pm	***BREAK***
2:00 pm – 2:45 pm	Dr. Dermot Kelleher, Dean, Faculty of Medicine and Vice-President, Health
2:45 pm – 3:30 pm	**Staff Members** Arianne Brown, Assistant to the Director Kasia Celler, Science and Grant Writer Kelly Ceron, Human Resources Manager Chung Cheung, Research Lab Manager Joe Comeau, Information Systems Manager Ivan Leversage, Education and Safety Coordinator Gurpreet Singhera, Biobank Manager Claire Smits, Operations Director Beth Whalen, Molecular Phenotyping Core Manager Tracy Yang, Finance Administrator

Wednesday, November 16th, 2022

All times are in PT

7:15 am – 8:00 am	Dr. Don Sin, Director, James Hogg Research Centre
8:00 am – 1:00 pm	***BREAK***

1:00 pm – 1:45 pm	**Faculty and Principle Investigators** Dr. Jamil Bashir, Clinical Professor (Joined with one other person) Dr. Liam Brunham, Associate Professor Dr. Jordan Guenette, Associate Director & Associate Professor Dr. Illker Hacihaliloglu, Assistant Professor Dr. Tillie Hackett, Professor Dr. Graeme Koelwyn, Assistant Professor Dr. Zachary Laksman, Assistant Professor Dr. Kelly McNagny, Professor Dr. Chris Ryerson, Associate Professor Dr. Amrit Singh, Assistant Professor Dr. Scott Tebbutt, Professor
1:45 pm – 2:30 pm	**Department Heads, School & Centre Directors** Dr. Peter Cripton, Director pro tem, School of Biomedical Engineering Dr. Zu-Hua Gao, Head, Department of Pathology & Laboratory Medicine Dr. Roanne Preston, Head, Department of Anesthesiology, Pharmacology & Therapeutics Dr. David Wood, Director, Centre for Cardiovascular Innovation (CCI-CIC)
2:30 pm – 3:00 pm	***BREAK***
3:00 pm – 3:45 pm	**Research Leadership** Dr. Robert McMaster, Vice-Dean, Research, Faculty of Medicine Dr. Michelle Wong, Senior Director, Research, Faculty of Medicine Dr. Darryl Knight, President, PHCRI
3:45 pm – 5:00 pm	Optional time for reviewers' discussion

Monday, December 5th, 2022

All times are in PT

11:00 am – 11:45 am	**Graduate Students and Post-Doctoral Fellows** Cyril Helbling, Graduate Student Elizabeth Guinto, Graduate Student Firoozeh Gerayeli, Graduate Student Katrina Besler, Graduate Student Khushbu Patel, Graduate Student Jordan Hamden, Post-Doctoral Fellow Lauren Forgrave, Graduate Student Linda Lapp, Post-Doctoral Fellow Meng Wang, Post-Doctoral Fellow Rachel Eddy, Post-Doctoral Fellow Stephen Milne, Post-Doctoral Fellow
11:45 am – 1:00 pm	Optional time for reviewers' discussion