Dr. Robert Bens Kerr (1908-1997)

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Biographical Information: Dr. Kerr joined UBC in 1950 as Professor of Medicine and Head of the Department of Medicine.

Summary: *Tape 1:*
The early teaching years; the facilities at VGH; the first students; Dean Weaver; plans for a campus hospital; Dean Patterson; Dean McCreary's recruitment; the B.C. Medical Centre; clinical teaching at Shaughnessy and St. Paul's.
Tape 2:
The 'split' school; quality of the school; pathologist Dr. William Boyd; the B.C. Medical Research Institute and G.F. Strong Research Laboratory; Dr. Kenneth Evelyn; Dr. Stefan Graybowski (Respiratory Disease); Eric W Hamber; the medical thesis; social events; Sims traveling fellowship; the Dept of General Practice; School of Rehabilitation; Dept of Psychiatry.
Tape 3:
(Sub)Depts of Dermatology and Neurology; local cases of polio and typhoid; preceptor program; continuing medical education; renal dialysis program.

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Interview with Dr. Robert Kerr, Tuesday, February 19, 1985

Int.: *Dr. Kerr, to begin with, would you explain the circumstances of your recruitment to the Medical faculty at UBC?*

R.K.: I was first asked sometime in 1949 - in the fall - if I would be interested in being asked to be dean of the new faculty. I decided against that in view of the fact that I wanted to continue in clinical work and not be said to be in a full-time administrative position. At that time, I didn't want to become involved to that extent and I declined that. However, after Dean Weaver's appointment he came down to see me early in the spring of 1950 in Toronto. At that time I was in Toronto as I was Associate Professor of Medicine and head of the Department of Therapeutics in the Faculty of Medicine there. I was very interested in the suggestion that I come out to Vancouver to be interviewed concerning the position as head of the Department of Medicine. Mrs. Kerr and I came out to Vancouver in May of 1950 and spent four days here, meeting people and meeting the President of the University and various other individuals. I knew several physicians in Vancouver from my association with them during the war in the army and before I left the city Dean Weaver specifically asked me if I would become head of the Department of Medicine. I suggested that I would like to have a few days to think it over and I would let him know within ten days, which I did in June of 1950 and arranged to come out here at the end of August. We were to come out by train. However, there was a train strike and we had to delay our travel until early in September. We came out and arrived here about September 10th 1950.

Int.: *So that was just after classes…*

R.K.: They had just begun in the first year. At that time. Professor Friedman was head of Anatomy and Professor Copp was head of Physiology and Professor Darragh was head of Biochemistry. They had started their teaching in those basic sciences before I arrived. My first contact with the students was very interesting in that Professor Copp's equipment for his laboratories in physiology had not arrived as yet from the suppliers and he was unable as yet to provide the students with any laboratory experience so he asked me - I had known Dr. Copp previously - if I could arrange to have something on the clinical side to fill in the laboratory time for them for 2 or 3 sessions during those early weeks. I had known Dr. Murray Baird very well in the army, he was a consultant in the army and he was head of Medicine at Shaughnessy Hospital, the veterans' hospital. I approached Dr. Baird and we arranged to have a clinical presentation at Shaughnessy Hospital in I think it was three afternoons in September at which time patients were presented to the class with some interesting situation and we tried to point out the physiological background for the patient's symptoms. This started us on a program for first year students where we continued for many years with Professor Copp to bring the students down to the hospital to see patients and present them and their symptoms and signs and discuss with the students the physiological or anatomical background of the cause of their illness or physical symptoms. So this was the first clinical contact that we had and it was very interesting. Just to go back again, when we came out here in May and of course, when I first came here in September, I met several physicians in Vancouver, many of whom I had known before, however, many of them I had not met before and, of course, Dr. George F. Strong was one of the leading physicians in Vancouver. He was head of the Department of Medicine at Vancouver

General Hospital. I met him for the first time in May of 1950. He had been head of the Department of Medicine at the General Hospital and very active in all aspects of medical affairs in Vancouver. He had initiated and really started the Rehabilitation Centre which has been named the G. F. Strong Rehabilitation Centre. He was instrumental in developing that centre because of the fact that his daughter had suffered a spinal injury, falling off the stairs in their home, and was paralyzed as a paraplegic, and he found that there were no facilities available in Western Canada to assist her in her rehabilitation. This prompted him to set up the rehabilitation centre which has become, of course, a very active centre in the community. Dr. Strong was really very helpful to me. I had to replace him as head of the Department of Medicine at the General Hospital because the agreement was that the head of the department at the university would be the head of the department at the hospital as well; it would be a joint appointment. This was a somewhat difficult situation in a way but he made it very easy for me. He was several years older than I was, and I think it was a very gentlemanly procedure in which he undertook to let me take over from him as head of the department. He was always very helpful during the ensuing years before his death at the relatively young age of 60. The only time in which we differed at all in our outlook. We sat together on the medical board at the hospital and, on one occasion, when there was a polio epidemic in 1954 I think it was or thereabouts, I proposed that a polio committee be formed - this was a rejuvenation of a former committee that had been in existence - with which Dr. Strong did not agree and he told me that he would not agree to it. However, I had proposed it at a medical board meeting and he was sitting next to me. He leaned over to me and said, "I am going to vote against this." And I said, "I know you will." And he did vote against this; however, the comnittee was formed and he cooperated very well, I think. My first undertaking, really, was to meet with all of the physicians in Vancouver who might potentially become members of the faculty or who were interested in teaching. The budget of the department was relatively very small - I can't remember exactly what it was but it was under $100,000, probably around $40 to $50,000 total - and therefore I had no funds to employ an individual fulltime by any means. So I had to rely on internists in the community who would be willing to give of their time to teaching - clinical instruction - and lecturing, practically without any remuneration. I was able to provide an honorarium of $50, $100 or $150 a year to those who participated in various ways but that was the limit of the financial remuneration they received.

Int.: *Did you have any trouble recruiting people?*

R.K.: No, none at all. There was tremendous cooperation with the B.C. Medical Association. I remember, shortly after I came in September, the B.C. Medical Association was holding its annual meeting in the Hotel Vancouver and they invited the whole of the first class and many members of the faculty to have lunch with them. And I remember they had the members of the first class stand up at the luncheon and be recognized. They were very helpful and cooperative. Clinical teaching didn't begin until the second year, until September of 1951, so I had almost a whole year to prepare a curriculum and prepare a faculty for teachers.

The same thing happened in the other clinical departments, of Surgery and Obstetrics. So that I interviewed all of the people in the city, all of the internists who either approached me or whom I thought would be interested and capable of conducting clinical teaching. And I recruited probably about twenty internists in the city in the first year to conduct bedside clinics.

And the second year lectures consisted of lectures concerning physical examination and physical diagnosis, some of which I gave myself but the majority of which were given by Dr. Donald S. Munro who was one of the outstanding clinicians in the city. He gave the lectures very well indeed. That was for the second year. The second year curriculum in Medicine began at Christmas - at the New Year's - in 1951, after the fall session. It consisted of lectures to the whole class and individual bedside clinics. I was able to keep the clinics down to four, or a maximum of five, students each, which was ideal, and I think most of them were four students. They were assigned to an internist who demonstrated to them and taught them to examine and take a history from patients.

Int.: *Was this all done at the Vancouver General Hospital?*

R.K.: Yes, all at the Vancouver General for the first year. They had two or three sessions a week with the clinician and I changed them halfway through the spring term - changed the teachers so that they would have two different clinicians in the spring term. That was our first year of clinical teaching, that would be in the second year for the students.

Int.: *Now, this is quite different from the clinical teaching you mentioned in the first year?*

R.K.: Yes, we continued through the first year, however, by asking the students to come down to the General Hospital and we held that in the old tuberculosis auditorium, the TB auditorium it was called in those days, in the Tuberculosis building and we demonstrated patients. For instance, when they were studying the respiratory system in physiology we had patients with respiratory diseases. I was able to demonstrate to them, to point out their shortness of breath or whatever symptoms they might have, and discuss the mechanism by which those symptoms were produced from a physiological and anatomical standpoint. And when they came to the cardiovascular system, I had patients with heart disease – who'd have angina, for instance - and we'd talk about how the pain developed in the heart from angina. Or with some cardiac irregularity – atrial fibrillation, or some other cardiac irregularity. Or we'd have patients with hypertension. Then we went on to the gastro-intestinal system and nervous system - patients with a stroke and so on to try and correlate the physiology and anatomy with the clinical presentation.

Int.: *Was it unusual to do that in the first year?*

R.K.: It was unusual in my experience. We were unable to do it in Toronto - we had never done it in Toronto. When I was teaching in Toronto, I always tried to correlate the basic science with the clinical but it wasn't done systematically in the first year. This has been enlarged now even more than it was at that time. I think it was more to stimulate the student.

Int.: *Did it work?*

R.K.: I think it did. I think they became very interested in this. I think it made their basic science a little more lively than just a dull, basic science subject.

Int.: *It is interesting that it seems that that method basically came about because of lack of equipment.*

R.K.: Well, no. I had it in mind to do it anyway. Yes, that was one of the things I was going to do when I came out here anyway. No, I don't think that was just fortuitous that it happened that way. No, I think we would have done it anyway. I found Dr. Copp very cooperative. He had to give up the time, in his laboratory at the time, to do these because what we called (I've forgotten what we called them now - clinical sessions?) clinical sessions, he had to give up part of his laboratory time in the curriculum to provide these and we had five or six of them a year. As second year went on we had to develop the curriculum for the third year and we had long sessions with the heads of the departments concerned to devise timetables and curricula and so on.

The curriculum in the Department of Medicine for the third year consisted of a series of didactic lectures covering all of the common disease entities, system by system, a systematic coverage of that. These were accompanied by two bedside clinics a week, again with a clinician, and one afternoon a week in which a patient would be assigned to a student. A student would have a new patient every week to take a history and make a physical examination and then would report on those patients to the clinician the following day. In that way, they would have had about 36 new patients over the year in medical conditions and they cover a great many of the common medical conditions. They would have to write up the history, and those histories would be evaluated by a Fellow in the department. By this time I had sufficient funding to provide a teaching Fellow in the department who was a junior member, either a man who had just qualified as internist or ones who were studying for their internal medicine examinations. Among these people was Dr. Hal Robinson, who became director of CARS and he has just retired from that position; and Dr. Orm Murphy who practiced internal medicine and then became director of Shaughnessy Hospital.

I should have the other names to hand, but I can't recall many of them. But I had a teaching Fellow whose function during that year, in addition to doing some research, was to be with those students on those afternoons on the wards. That was the third year. In addition to that, in third year we had lectures in therapeutics which were conducted by Dr. Arthur W. Bagnall – he's very ill now - he conducted those lectures, the treatment of common diseases, the therapeutics. In addition to that, in second year we had a course called clinical micoscopy at first, then it was called clinical pathology, in which the students became familiar with the laboratory aspect of diagnosis. These were lectures and laboratory demonstrations taught by Dr. Eden and Dr. Cockcroft from the Department of Pathology (they came under Medicine, actually). All this time we were devising our curriculum for fourth year. At that time we had a vacation between each year. We didn't have a continuum as there is now but we had a vacation between, and I decided that fourth year should concentrate on outpatient clinics particularly being one of the major ambulatory medicines. At that time we had a very good outpatient department. It was before medicare and we had a large clientele in the outpatient department. The outpatient department at the General Hospital really functioned as the family doctor for maybe 10,000 people. It was a large clinic. I was able to set up an afternoon a week for the time the student was on medicine. The medicine in fourth year took a quarter of the year, ten weeks and we decided that the concentration should be largely on outpatient work and I was able to set up a situation where, for the ten-week period that the student was on medicine, he was on full-time, all day long and he or she would see one new patient in the outpatient clinic every day.

Int.: *Would this be one of the only areas where they would get that much concentrated…?*

R.K.: I don't know. Well, certainly in this school there were not enough clinical patients to do this. But they would be in the outpatient department three afternoons a week for the full afternoon and, in order to provide the best possible teaching I was able to recruit Dr. D.M. Whitelaw (Dr. 'Mac' Whitelaw he was familiarly called; Dr. Donald Whitelaw) as the head of the outpatient department. He was one of the very outstanding physicians in the city. He had been in practice downtown in the Medical-Dental Building but he came up to us and became Associate Professor in the department and his function, as far as teaching was concerned, was to organize the teaching at the outpatient clinic. I assigned our best clinicians, in my opinion our best teachers, to these students. For practical purposes, one clinician would have maybe one or two students a day over there. I did this myself, this was part of my teaching. I was over there at least one day a week, and men like Dr. Kenneth Evelyn and Dr. Munro (I've forgotten all the other people who were involved in the teaching). The student would see a new patient every day he was there, three days a week. He would be the first contact with the patient. The patients were very appreciative of this because they felt they got better attention, because the physicians who were there ordinarily in the mornings would be very rushed and they might not be able to spend as much time with an individual. But the student spent three hours, and the patients thought it was wonderful, on a new patient or a patient who had to have his history reviewed. For instance, during the morning, if a patient came in with a new complaint or something like that and the clinician saw him and felt he didn't have the time to go into it he would say, come back, and make an afternoon appointment with a student, and this student would go into it in very great detail. We had the students see the patient for an hour or 1½ hours. Then we would go in and the student would report to us what he had found and we would check it up and talk to the patient and examine the patient with the student. By 4:30 or 5 p.m. we would come to a definitive end-point. Either the diagnosis would be apparent or we would have to have some more investigation, laboratory or X-ray or some other form of investigation to clarify the situation or we would initiate some treatment. We would come to some definitive end-point, the same as a doctor would in his office. I think this gave the student a tremendously excellent experience. Some of the patients were very simple problems with not very much interest but in the ten weeks they were on they would have thirty patients and out of those thirty patients there would be a very good variety and some very good clinical problems. I think the patients were very favourably impressed and received very good treatment. Well, that was all disrupted when Medicare came in…

Int.: *I was going to ask you about Medicare…*

R.K.: …that disrupted that aspect of teaching very markedly. That came along, of course, in the early 60s. But for a period of 10 or 15 years we had very good teaching.

Int.: *What changes did you have to make when Medicare came in?*

R.K.: What happened was that the patients who used to come to that clinic - you see, the way this carried on: these were largely welfare patients, patients whose income was very limited. In fact, there was some sort of screening process that would not allow a patient to come into the clinic if their income was above a certain amount – I don't know what - screened by a social service person beforehand. The medical staff of the hospital received a fund from the Government which was equivalent to something less than 30% of what

ordinary fees would be. It was a lump block grant and we - the medical staff of the hospital - decided jointly that we would not accept that individually but we would use it as an educational fund and we could apply for funds to take us to a medical meeting or a course or something like that. If we wanted to go to Toronto for a medical meeting or Los Angeles we could apply to that fund up to a limit of $200 a year, I think it was - there was some upper limit - to get funds to reimburse; it was an educational fund of that sort. Also, part of it was devoted to providing equipment that could not be provided in any other way and there was a limited amount of money available for that sort of thing. I don't think the fund was very large but it was enough to be of some… It was in lieu of the doctors receiving individual fees. When Medicare came in, all of these individuals, of course, came under the Medicare scheme. They were no longer welfare patients. At least, from the standpoint of medical care they all received their B.C. Medical Plan number and they were quite free to go to a private physician then in the city and many of them chose to do that.

Int.: *Was the clinic still kept open?*

R.K.: The clinic was still open and is still there. It's changed an awful lot in the last… I don't know what it's like now but after Medicare came in what happened was it became largely a social problem: drug addicts, alcoholics, and bums of various sorts.

Int.: *So it wasn't a very good teaching tool?*

R.K.: It wasn't very good from the standpoint of teaching medical students and the medical students became very disenchanted with it then. We had to look for different things to do. We tried to get various other means by which the individual clinicians could take them into their offices and see patients and so on. It didn't work out nearly as well.

Int.: *It would be more complicated to organize.*

R.K.: It wasn't nearly as satisfactory. Well then, let's see, where will we go from here? I'd better backtrack about a few things.

Int.: *You speak about the courses and how you managed to teach the students. Did it all run smoothly? You were working at UBC and at the Vancouver General. Did that work out well?*

R.K.: As far as I was concerned, and as far as the Department of Medicine was concerned, it did because all the teaching was at the General Hospital. My offices were there and we had relatively little contact with the campus except for meetings and so on. About the only time I would be out on the campus was to go to meetings. The clinical departments were not really… It wasn't too difficult…

Int.: *Did you have space right from the beginning at the Vancouver General?*

R.K.: We had… Well, maybe I'll go back and tell you what that was. My first office was - I shared an office room with Dr. Rocke Robertson who was head of Surgery. The General Hospital was under reconstruction at that time and they were building the wing which is along 10th Avenue called the 10th Avenue Wing. It was originally planned as a Long-

Term Care or rehabilitation type of wing but the Medical School decided that they would take that over as a teaching area. It was under construction when I came here in September 1950 and was completed and opened in the spring of 1951. Initially, we had two wards in the General Hospital for teaching patients and these were closed wards under the control of physicians on the faculty. Then we moved into this wing on 10th Avenue and the basement floor, which is called the A floor, consisted of offices for Medicine and Surgery and Psychiatry. My first office, as I was just saying, was shared with Dr. Rocke Robertson and we shared a secretary. Well, then I was able to have funds for a secretary of my own and I had another office in the basement of the old General Hospital. Then we moved over into this basement of this 10th Avenue wing and I had my own office and an office for a secretary, and I had an examining room involved with that and we had a seminar room down the hall. Dr. Robertson had the same accommodation, and then there was the subdivision of Psychiatry. Dr. Davidson had an office down the hall. That was where Dr. Whitelaw joined. He took over the office next door. We made a separate office for him.
Well, we were planning the new extension along Heather Street in the 1950s. We were able to get funds from the Government: $500,000 from the Department of Education and $500,000 from the Department of Health to build this building along Heather Street - I don't know whether you know it; it's still there. That was an interesting situation. Dean Weaver and Dr. Robertson and I would go over to the Government in Victoria to discuss plans and at that time there was probably the best Minister of Health that I have ever had dealings with, Mr. Turnbull, who had been vice-president of Cominco in Trail and he was a member of the Legislature from Trail. This was in the old, combined government - coalition government - under Johnston. I remember going over one day with these clients for this building and he said, "Gentlemen, that sounds like a very sensible idea. I'll have to discuss this with my colleagues and let you know on Tuesday." There was no hanky-panky, no dithering about. Tuesday, there was a letter saying Yes or No. He was a very businesslike fellow.
Anyway, we started that building with the idea of that housing Medicine and Surgery, some research facilities, and the Department of Pathology and all the autopsy rooms and so on in one end; and we were at the other end. We went into that building about 1958. That was a landmark. I had so many rooms there was nobody to fill them and I didn't know whether anybody would ever fill them or not. That soon corrected itself, however. That included two new lecture theatres, a seminar room for our Department, and offices for myself and secretaries and Dr. Whitelaw. And I recruited Dr. Hamish Macintosh as the next full-time head and member of the Department. That would be around 1960, 1 guess.
By this time the School was going well and everything was flourishing. They were getting more funds for budget and expanding. Our first class was graduated in 1954. We had sixty members of the class to start with. One woman had to fall out because she developed tuberculosis and she subsequently married our Silver Medalist, Dr. Cox, who is now Dean of Medicine at St. John's in Newfoundland and she's there. Peggy. They were together in first year and she graduated the year after, 1955. But the class of '54 had its 30th reunion last June. They invited us to come up to Whistler to celebrate the reunion with them, a very interesting time. It was nice to see many of the people whom I hadn't seen almost since they graduated.

Int.: *Actually, I will be speaking to some of them.*

R.K.: It was a very interesting year because a large number of them, you will find in Dr. Ranta's account there, a very large number of them had their Bachelor's and even had their Master's degree. Quite a number of them were veterans, had been in the Services during the war. They were a very mature group of students; they were very good students.

Int.: *You think they were good quality?*

R.K.: Oh yes, they were excellent students.

Int.: *How would you compare them to other groups of students who have gone through?*

R.K.: Oh, I don't know. They were a little more mature, that's all. Older, and many of them had been through the war and some of them had been in charge of a landing craft or something like that at Normandy (laughs). Dr. Balham, he is consultant to the Department of Health in Victoria, was a pharmacist with me in one of the hospitals overseas, when I was stationed up near Birmingham during the war. I knew him in the Army. He turned up; he was a very much older man. They were all very keen.

Int.: *Would you say they were better prepared as a group?*

R.K.: Not particularly. I think they were mature - I think every class that I had contact with, they were always very diligent. They always worked hard.

Int.: *Their experiences had just been different than what most people now have, I suppose. I was going to ask you what Dean Weaver's role was in getting your Department going. Did he have much to do with that or were you left very much on your own?*

R.K.: He was very helpful. He was a physician as well as a physiologist. He had his Ph.D. in physiology and I think he had had quite an experience in clinical work as well. He was very cooperative and very helpful in the early days of formulating. He had made all the arrangements with the hospital, for instance, before I came here, in the intervening year. He came here in May of 1949 and I came in May of 1950. At that time he had an office in the Physics building. That was the Dean's office. He had made arrangements with the General Hospital's Board of Trustees that they would agree to appoint any person who had been appointed to the Faculty of Medicine and that the Head of the Department would (also) be the Head of the Department of the General Hospital. These were mutual agreements, which the Dean had been instrumental in getting set up before I came.

Int.: *So you more or less walked into a relationship with the General…*

R.K.: So very soon, within a few months after I arrived, I was appointed to the Department of the General Hospital. And I think it was largely due to Dean Weaver's work that that went very smoothly. People accepted me and accepted the fact that this would be the case because it could have caused friction. But for the first many years I know my task was very easy, a lot of cooperation.

Int.: *Was there cooperation between UBC and VGH from the very beginning?*

R.K.: Yes, it was very amicable, really, surprisingly so. I think in latter times frictions did develop but not from the early days. I found it very amicable when I was first here.

Int.: *What was Dean Weaver like? He wasn't here a long time; he was here right at the very beginning.*

R.K.: He was an outgoing person, very friendly. He had a tremendous amount of energy. He was able to get on with things and get things done. I wouldn't say he was a brilliant person but he was a hardworking man. Unfortunately, by late 1953 or '54, it became apparent that he was not well. The first inkling that I had was when we attended the annual meeting of the Royal College of Physicians & Surgeons of Canada held in Winnipeg, that would be in January 1954, and he shared a room with me. On the Saturday at the end of the meeting, I came up at noon after the morning session of the meeting, he was packing and said he had to get along home. He put half a bottle of Bourbon on the dresser and said I should finish it off before I went back home. I came back home and on Monday morning he came into my office and wanted the bottle back. I said I was awfully sorry we had finished it, you had told us to finish it, and he started to accuse me of stealing this bottle of Bourbon from him. He got very upset, which was quite a different attitude from what I had ever experienced with him. I thought that this was most unusual, and from then on he seemed to become more and more suspicious of people and accused people of doing different things and so on. It became apparent that he was becoming more disturbed. However, he developed symptoms of angina and - I can't just recall the sequence of events - ultimately he developed a definite cardiac infarction and was admitted to hospital. He came to me as his physician, which I thought was very interesting in view of the fact of his previous accusation to me. Anyway, I looked after him in hospital and he recovered from that and I advised him that he should retire, which he did ultimately. He went from here to Albany, where he carried on for several years. He was head of the Student Health Service at New York University which had a branch at Albany, and he finally died on Christmas morning. He had another heart attack and died in the ambulance on the way to hospital, Mrs. Weaver told me. He came out here while he was in Albany to be present at the dedication of his portrait in the Physiology building, his portrait hangs there. He came out and spent a few days. That was the last time I saw him. He was a very interesting person. He had another lapse - I can't recall just the sequence of it but I think I was mentioning it to you when I was over in Dr. Norris' office. We had an Alpha Omega Alpha Society initation banquet when we started the local chapter of the AOA Society here, our medical fraternity. We had a dinner down at the hotel at which we had Mr. Hamber and Dean Weaver. Dean Weaver gave a very rambling talk that night, which was most unusual; it really didn't make much sense. The next night was Saturday night, and Sunday morning the phone rang here. President MacKenzie was on the phone. He had been there at the dinner and he wanted to know what I thought about Dr. Weaver's behaviour. I said it was most unusual. He said, "You'd better get him into hospital or get him out of circulation some way or another." So I went to see him that Sunday afternoon at his home. He kept me waiting for about half-an-hour before he came downstairs to see me and he was very antagonistic to me. I told him that several of us were worried about his health and would very much like him to let me bring him into hospital for investigation.

Int.: *What year was this?*

R.K.: This would be about 1954 - it would be in the fall of '54, I guess. It was after our first class graduated, just after. He started to accuse me of wanting to take over his job. He said, "All you want is to get my job." I tried to assure him that that was the last thing in my mind. But, anyway, he just dismissed me and we got nowhere. That evening, Dr. Robertson and Dr. Davidson and I discussed the matter and decided that Dr. Robertson and I would go the next morning and see him and try to discuss the matter with him (he and I were the two senior people in the faculty). We got to his home and we went up to the front door. We just saw him running around into the garage, got into his car and went out - disappeared. We never did see him. He went from here, apparently down to Seattle. (Somebody in Seattle had seen him.) Then he went from Seattle to Spokane where he had a brother and he stayed with his brother for a while and his brother got him into hospital - No, he didn't. He went to an hotel and stayed in a hotel and while in the hotel he accused a man of stealing a camera from him. They had a physical set-to in the lobby of the hotel. They called the police and he was actually in gaol. His brother got him out and got him home, and got him into hospital there. He was in hospital for a month. While he was there, this fellow whom he accused of having stolen his camera came up here with a woman. They were at the Georgia Hotel. I got a call from Dr. Andrew, Dean Andrew who was the acting president - the president was away. He said, I want you to go down to the hotel and see this man. This fellow's here wanting to get $5,000 out of the university for damages. So Dr. Darrach and I – there'd been a committee of three of us set up to administer the faculty. There was Dr. Robertson, Dr. Darrach and myself, a committee of three to be acting administrator while Dr. Weaver was away. We went down to the Hotel Georgia and here - if there ever was a gangster and his moll…

Int.: *Oh dear…*

R.K.: …she was a funny looking gal and he was a real tough fella. I got over near the door so I could make a hasty retreat. He wanted the university to reimburse him for damages that he had suffered - I don't know what his grounds were. Well, we managed to talk him out of it some way or another. We sat there for a couple of hours talking to him and got rid of him. I wish I had had a tape recording of that conversation. My memory fails me as to all the details. But he just looked like a character out of The Godfather (laughter) and he was up here to either get money out of the dean or his family or the university but some way or another - I don't know how it ever got smoothed over. He came back and he was very well for a while. That was before he had the heart attack, that's right. Then the heart attack happened and then he retired.

To get back to what sort of a person he was. What other questions would you like to ask about him? His wife, Edna, was a very lovely person. They had a son and a daughter.

Int.: *He seems to have done a good job of getting the Medical School going.*

R.K.: Absolutely, first class. He was an expert at the whole question of getting people to cooperate and work with them. He had laid out the thing well, it was very well set up.

Int.: *When he arrived, there had been quite a controversy over the starting of the school so I guess he had that to deal with. How did he deal with that?*

R.K.: I think he felt he had the mandate to start it at the General Hospital and he set about doing that. I remember, when I first came here in May of 1950 I was asked by the president, Did I think it was possible to set up a Department of Medicine based at the Vancouver General Hospital for two or three years, until they had a hospital built on the campus. That was the aim: To build a hospital on the campus. He actually was sort of planning that in the background but it never came to fruition because the concept of the cost of the hospital was just - I can remember, one relatively senior person at the university I met one night at a sort of reception. He said, What about this hospital? Why can't you build this hospital? Four hundred beds, $10,000 a bed. That would be all it would be, roughly. $10,000 a bed (laughs). This does nothing. He had based his thoughts on the fact that they could build dormitories for $4,000 a room so why couldn't they build a hospital for $10,000 a room. All a hospital was was just lots of rooms. Even in those days it was close to $100,000 a bed to build a hospital with all the facilities and stuff. Well, that fell through. However, before Dr. Weaver retired we had ideas of building a medical sciences building on the campus. I remember, it was while he was ill we had plans drawn up and we actually had a grant promised from the Government. Our plans were several hundred thousand dollars more than the grant and we were trying to pare them down. The building was on the same site as the present basic science buildings. They were being planned back in the ‘50s. All that fell through because of lack of funding at that time. Then Dr. Patterson succeeded Dr. Weaver.

Int.: *There isn’t much information available about Dr. Patterson*

R.K.: I can give you some, do you want that?

Int.: *Yes.*

R.K.: I’m awfully rambling. I haven’t any sequence of thought at all here.

Int.: *I think that’s the way conversations usually go.*

R.K.: There are two or three things I want to go back to. Don’t let me get away without doing that before we leave. Well, Dr. Patterson - There was this interval period where three of us ran things for almost a year, I suppose. Then they started to look for another dean. Dr. Patterson came here from Western Reserve University at Cleveland, from the Department of Anatomy. At that time, the Western Reserve had developed this new concept of curriculum systems approach whereby, instead of teaching by departments, they taught by systems like cardiac, and gastrointestinal and nervous… They’d take a system like anatomy and go right through to the clinial aspect of that system. It was a new concept in those days and those of us who had been brought up in the traditional thing, it really didn’t appeal to us because my argument was that patients are not divided up into systems: they come as a person, and you’ve got to deal with that person as an individual. The end point of medical education, in my judgment, was the chap who was walking down Granville Street with a pain in his gut and came to the doctor and you had to analyze the whole thing. It wasn’t labelled as a heart case or a gut case or anything. That was my objection to that sort of system. Anyway, Patterson, he was thought to be the best of those who had been considered for dean, and he came here. He said, that before he came, he did not subscribe necessarily to that system; anyway, he was not going to introduce it here, he assured us of that.

Well, he was an interesting person; he was a very affable person, very outgoing. On the other hand, he did antagonize people. For instance, he arrived here just towards the end of July - that would be '55, '56; '56 maybe, July and the first Saturday in August - I'll never forget this day, I was down at the hospital and I was sitting at the table in the cafeteria. I'd just bought my lunch tray and was sitting down and he came along with his tray and sat down at the table with me. He said to me, "You're on the registration committee of the local college". At that time the medical faculty had a representative on the registration committee of the Council of the College of Physicians and Surgeons of B.C. We met every month and considered questionable applications from doctors outside who wanted to practice in British Columbia. Most of our dealings were with foreign educated doctors and we had to say whether their education was adequate or whether they had to take more training or whatever. We would have a meeting every month or sometimes twice a month to consider these applications. He said, "You're on the registration committee." and I said "Yes." He said, "You require an internship here before you can practice medicine in B.C., a rotating internship." I said yes, that was one of our requirements, that we had to have an approved, rotating internship after graduation. "Well, we'll have to have that changed," he said, "Suppose we had to bring in a faculty member who didn't happen to have that sort of internship; he couldn't get a licensed practice." I said, "Well, lookit. There's no problem. If you happen to get that let me know and we'll get a special dispensation." I know that, for instance, they wanted to give Myron Weaver a licence to practice without any qualification at all, without any examination. He did actually take the examination, He said he wouldn't. He got his licence with an examination. He insisted on taking the examination to the Medical Council. I said, "But there are other ways, the Council will by special - you just let me know if there is any problem, I'll see if we can't work it out some way or another. Well, that was on the Saturday. On the following Tuesday the president of the Council of the College of Royal Physicians and Surgeons, who was a surgeon at the General Hospital, came storming into my office down in the basement of the 10th Avenue building and threw a letter on my desk and said, "What the hell does your dean think he is doing?" And here was a letter from the dean addressed to the College of Physicians and Surgeons demanding that they change their regulations so that the… Well, that just… he just antagonized that whole group right there and then. And you know, there was a simple way out; he didn't need to do this. He did awkward things like that in several places.

Int.: *I wonder why he would have insisted for that change to start with, why it was important to him?*

R.K.: It was because he said, there might be someone coming on the faculty who didn't have those exact qualifications and they wouldn't be able to get a licence to practice. As a matter of fact, I think it was focused largely on his wife who was a paediatrician and she didn't have one of the stipulated rotating internships. She had studied in the States and had a little different - but there'd be no problem at all if she wanted to get on the faculty and get a licence to practice. We could have easily arranged that through this registration committee because - you know - the qualifications were without any problem and those things were always subject to being… He did this to so many people, and ultimately he just got to the point where it was impossible to carry on. He finally resigned. He was only here for about 2 or 3 years.

Int.: *Two years, I think.*

R.K.: 2 ½ years… He resigned and went down to Vanderbilt. A sequel to that was: I was, about a year or two later I was down on Long Island meeting with heads of departments of Medicine from the States and Canada. We were down there to see about nuclear medicine, about the application of nuclear medicine to diagnosis and so on. The isotopes were just coming in and they had this meeting down there of heads of departments of medicine just to familiarize us with all of the possible potentials. The meeting lasted for three days and we had luncheon and dinner. At each meal we would have table assignments so that we would get around and meet almost everybody. There would be tables for six at which one would sit. The last night there was a more formal dinner with a speaker and so on. I went in and stood behind the place I was assigned. A chap came along beside me and we shook hands and introduced ourselves. I looked at him, and here, he was a professor of medicine from Vanderbilt. He'd looked at mine and he said, Oh, British Columbia. Your dean was Patterson, wasn't it? I said "Yes." He said, "Well, he's down with us. How the hell did you get rid of him?" (laughter) And apparently, he did the same thing down there. Well, he went from there to start a new medical school in Connecticut and I gather did a very good job. I don't know where he is now. I haven't heard from him in a long time. But apparently he did a first class job of setting up a new medical school there, in Connecticut – what's the name? Hartford, Connecticut, that's down there, a new medical school there. But that was Patterson. He really disrupted things badly, unfortunately.

Int.: *It sounds mainly by his manner.*

R.K.: Just his personality. It was unfortunate, he just didn't have the tact. I think that's one thing Weaver had, was tact.

Int.: *What about Dean McCreary?*

R.K.: Well, I'll tell you a story about that, too. This was back when I shared this office with Dr. Robertson in the old General Hospital in the fall of 1950. One Saturday we were sitting around. We were sitting around with Myron, Dean Weaver - the three of us - in this little office. Weaver said to us, he said, "We've got to get a head of the Department of Paediatrics right away. He said, "We'll have to be teaching Paediatrics here from now on. We'd better get going about getting a head of Paediatrics." He said he had several people whom he'd been talking to or talking about. He turned to me and he said, "Do you know a man by the name of McCreary in Toronto?" I said, "Oh yes, I know him very well. He graduated just a year or so behind me and I knew him in Toronto." He said, "Do you know him well enough to call him up and see if he is interested in coming out here to be interviewed for the head of the department?" I said, "Sure, I could do that." Well, he said, Call him up now. "I picked up the phone it would be about 4 or 5 o'clock in Toronto - I got through to his office and he happened to be still in his office. I said, "Jack, this is Bob Kerr speaking from Vancouver. I've just got one question to ask you…" (laughs) "Dean Weaver wants to know if you'd be interested at all in being considered as head of the Department of Paediatrics here?" Jack said, "Yes, I would."

Int.: *(Laughs.) Just like that!*

R.K.: "Well," I said, "the dean will be down to see you sometime soon. So, thanks very much." And hung up. And that was it. So Weaver went down the next week and saw McCreary and came back. In those days there were no such things as appointment committees and that sort of thing (laughs). If the dean said, that was it. Same with me. If I said I wanted somebody, that was it. But he was appointed head of the Department of Paediatrics and did a thoroughly good job.

Int.: *When would that have been?*

R.K.: Well, that would have been - I guess he came out, he arrived about July of 1951.

Int.: *Right at the beginning…*

R.K.: Yes, right at the beginning, it had to be because we had teaching at Paediatrics to get organized by Christmas, by the New Year of 1952. So he went about getting changes in Paediatrics. The Department of Paediatrics was a very sub-department of the General Hospital. It was just a subdivision, sort of, of the General Hospital and really wasn't at all academic in any way whatever, not an academic department in any sense of the word. So Jack organized it, and his job was we got beds for them, more beds than they had, and we got them to form the health centre of children at the General Hospital, and it became a separate department with faculty; and he was the first head. Then, when Patterson resigned, the question was what to do about deanship, and I think it became apparent to us all that he would be probably the best person to be dean.

Int.: *Why do you think he would have been the best person at that time?*

R.K.: Well, he was good at organizing and he wanted to do administration. Everybody had a high regard for him. I think the feeling was that the dean should be a clinician at that time because the major problems were the clinical areas. By that time, the basic science buildings had been built and basic sciences were pretty well housed but we had as many problems in the clinical areas.

Int.: *What kinds of problems?*

R.K.: Oh-h, the space and the question of what to do about a campus hospital. That was in the background. He would have been appointed about 1958, I guess, and he got organized for a campus hospital right away. That was really one of the primary things and I think that was one of the major reasons he was appointed, that was one of the major factors.

Int.: *And there was money available at that time?*

R.K.: Well, it could have been made available. Yes. Yes, it was indicated. I think it was pretty well indicated that it could be built. The story of that here; again, we're sort of jumping around, maybe I could tell it if you could sort it all out. In April, 1959 it was decided to form a planning committee for the campus hospital. I was scheduled to leave on May 1st to go to Africa for four months on a travelling SIMS professorship. And on the morning of May 1st - it was a Saturday morning - I had a meeting with Dr. Whitelaw and my department. We spent the whole morning sitting planning what we would need, roughly

what we would need in the campus hospital for the Department of Medicine - teaching areas, research areas, offices, and beds and so on. We had that and I asked Dr. Whitelaw to be the Department of Medicine representative on this planning committee when I was away. That was the start of the hospital to be constructed on the campus. I was away for four months from May to September on this SIMS professorship, which was a commonwealth, travelling professor in medicine or surgery, and I visited all the medical centres and medical schools in what was then British Africa and added Malta. Mrs. Kerr and I were travelling together - a very beautiful, wonderful trip. I came back and they had had several meetings to organize the hospital and, oh, in a few months we had preliminary plans drawn up for a hospital and they were modified and changed back and it went on through the '60s until the NDP government came in, and they stopped it completely. They washed it out and they went along to the B.C. Medical Centre on the Shaughnessy site and the Minister of Health at that time in the NDP government developed this plan for this centre on the Shaughnessy site and it was to replace the Shaughnessy Hospital, to tear it down and build a new hospital there.
It was a very, very extensive plan and finally came to $600 million and that was way too rich. I think for the 600 bed campus hospital at that time, I think we had $100 million or $90 million set aside. That was promised by the Socreds before the NDP came in. That would have gone ahead, I think, at that time. Well then, that changed the whole focus of the B.C. Medical Centre which was to be developed at the Shaughnessy site. When the NDP were defeated the Socreds came back in and they started the hospital all over again. By that time Dr. McCreary had become co-ordinator of the Health Sciences and no longer dean, and Dean Webber had succeeded him. They went ahead to build that hospital that was planned, it started just before I retired - 1974; '73-74 - the planning for that started just around my retirement. I didn't take part in that planning at all. I wasn't involved in that because I retired. That's the history of that.

When we first started we had two wards: male and female ward at the General Hospital and there would be about thirty beds on each, I guess. They were just long, open wards in the old building and it wasn't very satisfactory. It was as good as we had in Toronto when I left there but the bedside clinics that we organized were for teaching in second year and third year; and fourth year to a lesser extent. What I did, if I had these individuals in the department, I'd have to look up the actual numbers, I'd have to go to each annual report and find out the actual numbers but there'd be about thirty - about 20 or 30 to start with, I suppose, and it got up to.. but we had other hospitals. What I would do would be: I'd ask them to take a clinic group 2-3 times a week for a period of six weeks at a time and then I would rotate them so they would have only a six week period all at once, and maybe have a six weeks' break, and then another six weeks.

As the years went on, as the third year teaching came on and the fourth year teaching came on I first of all got Shaughnessy Hospital involved. Dr. Murray Baird was head of Medicine out there and he was very cooperative. The arrangement with the Department of Veterans' Affairs was that they should be very closely associated with the Faculty of Medicine. This was through Dr. Warner who was the head of Medical Services and Dr. Duncan Graham who was consultant to the D.V.A. They arranged with each medical school across the country that the veterans' hospital in the community should become closely associated with the medical school from the standpoint of teaching and research and also from the standpoint of residency training. The Department of Medicine at

Shaughnessy Hospital was very good: this was a very good source of clinical teaching patients for teachers. There were several men who were on the staff at Shaughnessy who were not on the General Hospital staff. Some of them were on both and sometimes they would teach at Shaughnessy and sometimes at the General Hospital. A clinician who would have no remuneration except perhaps an honorarium of $100 or $150 a year would maybe teach for 2 or 3 mornings a week for maybe 12 weeks in the year - it wouldn't be any longer than that. Others would have a series of lectures, either on cardiac disease or gastrointestinal disease or respiratory disease or something like that, and they might be paid a little extra for that effort. Some of them would get $500 a year.

Dr. Munro, who taught the whole of second year which would be two lectures a week right through the year or something like that and also bedside clinics; I think I paid him $1200 a year (laughs). There was nothing much more; maybe they would buy a couple of books with it or something like that but it was a gesture, anyway. The first full-time appointment, Dr. Whitelaw. He was – I've forgotten what his salary was. It was not very great; maybe, $10,000 a year, I guess. He was allowed to have a practice as well and had facilities for a practice. He could see patients. We had no definite limit; it was just an honour system and he was able to make his income that way. You wanted to know the other allocation of time. That pretty well explains things. That was when we first started. Really, up until I retired there were still members of the Department teaching in that fashion, without remuneration.

Int.: *You never had problems getting…?*

R.K.: Some of them said they just didn't want to carry on any longer. Then they would leave. Others, I felt, were not doing a job. They'd be skipping clinics or not.... I'd suggest to them maybe they'd discontinue. Then the younger people, as they came on, they were always quite anxious to have a go at it. Then, as we got more so-called geographic full-time people in the Department, we were able to get more and more remuneration for them and by the time I retired I had about ten or eleven so-called geographic full-time in various categories. Then I started at St. Paul's Hospital, too, fairly early on, about 1953 or '54. I sent only two clinics down to St. Paul's Hospital where there were some very good physicians there. We had quite an amount of discussion with the sisters there: it was a sisters' hospital in those days. I had a lot of discussion with the Sister Superior and they were very cooperative.

Dr. McNair, who was head of Medicine when I first came here, he was very cooperative. He retired, then Dr. Hurlburt succeeded him. Dr. Hurlburt was head of Medicine until just recently; he retired just recently. He organized the teaching down at St. Paul's. Then Dr. Whitelaw went to Toronto for 2 or 3 years and then came back and became head of the Department at Shaughnessy Hospital after Dr. Baird retired. And they continued to organize the teaching at Shaughnessy Hospital. I don't know how it is working out now, what Dr. Dirks has done. I have not heard anything recently as to whether any of the city physicians are commissioned - whether he has enough full-time people to do all the teaching. I'm not sure what is happening. But at first we relied entirely on that voluntary teaching, which was very good, really gave the.... When the Medical Council exams came in - they came in in multiple choice examinations in 1967-'68 - that was the first time we could get a quantitative comparison of the medical schools across the country. It's not a very good criterion but it's one criterion, the results of those exams, and our Department is always the first. It's right at the top from the time they started until I retired, from late 1968

to ‘74. Every year we had the highest aggregate percentage of marks in the Medical Council examinations. That's not a completely good criterion but at least they…

Int.: *Gives some indication.…*

R.K.: and the Medical Council examinations were not just memory things at all, there was some - they were designed to be a fairly good test of clinical ability. But I was always very pleased to see… They would send us an anonymous ranking and let us know what our ranking was but they wouldn’t let any of the others. We would get that every year and the Department of Medicine was always up Number One, which was very pleasing to me.

Int.: *Let’s go back to the beginning of the School again. The decision to have a split school was a compromise really, from what I understand. The ideal was to have a hospital at the University right from the very beginning.*

R.K.: Have you read the Strong thing? Have you read the Dolman report? I think Dolman originally suggested a split school with the Centre on the campus and the clinical work at the General Hospital. Strong’s suggestion was to have it all at the General Hospital. Then there had been this group of physicians: there was Farquharson, Wisecotton, and there were three or four people who came out as a sort of special committee before the medical school actually started in 1949. They recommended that there be a unified school on the campus, and that’s what I understood was to happen but in the interval they wanted to get started. In the interim there would be a period in which the clinic teaching would be centred at the General Hospital. The understanding was that there would be a hospital on the campus within three or four years. Well, that never eventuated; it was twenty plus years later. I came into the picture when it was definitely to be a split school with the clinical departments at the General Hospital and the basic science departments on the campus. This had been the compromise or whatever, the arrangement that that was to be.

Int.: *Do you think it was a satisfactory arrangement?*

R.K.: Oh, I think under the circumstances it was the only arrangement. It couldn’t be any other way. I think in all probability, looking back at it, that there would probably have been more problems if there had been a hospital built on the campus than there were.

Int.: *Why do you say that?*

R.K.: Well, just getting it organized and getting patients out there and so on. It’s out of the way. It’s right at the far west end of the centre of population.

Int.: *I guess it seemed right out of the way then, much more so.*

R.K.: Oh yes. I don’t know how it would have worked. I always used to think, looking back at things, the ideal thing would have been to set up a medical campus on Little Mountain. That’s where the UBC was originally to go, long before it was to go out here.

Int.: *That would have changed things considerably, wouldn't it?*

We're just about at the end of this tape. I think I'll turn it off.

(Tape continued February 19, 1985)

Int.: Dr. Kerr, I think we were talking about the fact that the School was a split school. I'm just going to ask you what you felt the dean's attitude towards this was, Dean Weaver?

R.K.: I think I may have said before that the arrangement in 1950 was that the Medical School would begin with the basic sciences on the campus and the clinical work at the hospitals. At the General Hospital particularly and using the other hospitals, Shaughnessy and St. Paul's, as they came in. This concept was started in this fashion so that the medical schools could begin in 1950 with the idea that there would be a campus hospital built within 2-3 years. However, the concept of the campus hospital had to be abandoned fairly soon after that because of lack of funding and it was decided to develop the clinical departments at the hospitals. The offices of all of the clinical departments, that is: Medicine, Surgery, Paediatrics, Obstetrics and Gynaecology, and Psychiatry, were centred at the General Hospital in facilities which at first were very makeshift and then, with the building of the building along Heather Street, the departments of Medicine and Surgery were reasonably well housed at that time. The Department of Psychiatry was housed also in the building along 10th Avenue; the Department of Paediatrics was housed in what became the Health Centre for Children - it had be the semi-private pavilion at the General Hospital. Obstetrics & Gynaecology was housed in the Women's Pavilion, the Willow Pavilion of the General Hospital. This arrangement proved to be satisfactory from the standpoint of clinical teaching. We lacked facilities for the development of research for some time but we were able to conduct quite satisfactory clinical teaching on the wards at the General Hospital and subsequently at Shaughnessy Hospital and at St. Paul's Hospital . We had available to us closed teaching beds which largely housed the patients who were wealthier patients or indigent patients and the Shaughnessy Hospital was, of course, completely available. All of the veterans at Shaughnessy Hospital were available for the purposes of teaching and the teaching was organized under Dr. Murray Baird at Shaughnessy Hospital and under Dr. McNair at St. Paul's Hospital. Dr. McNair was succeeded by Dr. Hurlburt, and then Dr. McNair returned. The concept of the split school, of course, did produce problems from various standpoints: It isolated the clinical faculty from the basic science faculty geographically so that the association between the two was probably the minimum. However, I don't think that this impeded clinical teaching in any way. It a1so presented some problems from the standpoint of the student, although by the time the student got into the latter part of the second year most of the teaching was done down at the hospitals so that they didn't have too much in the way of travel difficulties. All of the teaching in third year and fourth year was done at the hospitals so that the travel arrangements from the standpoint of students was not as great as it might be considered in some circumstances.

Int.: *Would you say that the Faculty of Medicine was properly prepared when it opened for students in 1950?*

R.K.: I think in the circumstances, yes, I think it was. I think the basic sciences were well organized, and the clinical departments became organized by the time the teaching was developed at the spring term of the second year. I think that the facilities were reasonably adequate; of course, not by any means ideal, but the question seemed to be very important that the Medical School begin. In fact, many people thought that it was well overdue. At one time, they were talking about starting around 1947 or '46. But I think it was reasonably well… of course it could have been much better but (laughs) I don't think in the circumstances it was too difficult.

Int.: *Were your expectations met when you arrived in Vancouver to take on your duties?*

R.K.: I felt that my main concern - mandate - was to develop a curriculum of teaching which would enable a student to learn clinical medicine to the point where he or she could become able to deal with a clinical problem in practice after a suitable internship. I think we accomplished the aim to develop that in a student, to enable a student to learn to deal with a clinical problem and learn to make a reasonable diagnosis and initiate a reasonable treatment. I think we accomplished that. We were not able to develop research to any extent in the early days. That came along gradually as our facilities at the General Hospital increased, and also at Shaughnessy Hospital to a lesser extent and St. Paul's Hospital. Research accomplishments were not as great as might have been; however, I felt that our main purpose in the early years was to develop a sound, clinical teaching program and I think we accomplished that.

Int.: *Was there enough money from the beginning to work with? I suppose there could always be more money but…*

R.K.: That's a difficult thing to say. What's enough? No, I think we certainly were dealing with a very meagre budget in the initial years. - However, it did increase over the next twenty years gradually but we never had sufficient funds. I think this is a very difficult question to answer. We are very fortunate in having available a large number of enthusiastic and interested physicians in the city who carried out teaching on a honorary basis - voluntary basis. Without that group of physicians we never would have been able to launch a clinical teaching program. I think the question of funding is relative. While we certainly could have made use of more funds from the standpoint of paying fulltime individuals, I think that the question of development gradually was probably the best way to proceed rather than to suddenly acquire a large number of faculty. However, I think it's true to say that we never really had sufficient funding through the early years.

Int.: *What about allocation of resources between the basic medical sciences and the clinical departments?*

R.K.: Well, I think we in the clinical departments recognized that the basic science departments required more funding than we did because of the fact that they had to pay their staff full salary. They had no individual, voluntary people to rely upon for their teaching and therefore I think we recognized in the early days that the budgets of the basic science departments were necessarily much greater than the clinical departments. I never realized any conflict of interest in that respect, as far as I was concerned. I think any head of

department is always very anxious to develop his department as well as possible but I don't think there was any very marked conflict.

Int.: *What about the relationship between the individuals - the General Hospital practitioners and you and your colleagues at the University? Was that a good relationship?*

R.K.: I think at first it certainly was. There was no friction in that respect, I don't think there was any. I think as time went on there was probably some town/gown developed in later years but in the early part there was always a keen enthusiasm among the practicing physicians. That was not a factor in the early years of the School.

Int.: *One of the comments that I read about the beginning of the medical faculty was that everybody wanted to start a first-class medical school. Do you think that goal was reached?*

R.K.: I think it all depends on what one means by a first-class medical school. I think it is very difficult to assess that in respect to the criteria that one applies as to what one would consider to be a first-class medical school. If one considered the criterion of research funding which I think we were well down on the list for some time; it is only recently that UBC has come up near the two larger eastern medical schools in research funding. The only other criterion that we had was when the Medical Council of Canada started the type of examination where it was possible to compare right across the country, when they introduced the multiple choice examination in 1967-68. We were given a breakdown of the results of the marking of those examinations and each year from that time until my retirement the medical examination from UBC was always ranked at the top, Number One in the country of the 13 or 15 medical schools which were involved in the examination. That's of course not any more a criterion that we had very good students and that they did very well in that examination. But that's one criterion that can be applied. The other criterion which always pleased me was that I was told by hospitals across Canada that their experience with our graduates in the early years and subsequently was that they were very pleased with the quality of our graduates during the intern years. I was told by two of the superintendents of hospitals in Toronto that they would accept any UBC graduate who applied. There was never a question raised that they found them uniformly very satisfactory as far as internship was concerned.

Int.: *Do you think that quality was consistent?*

R.K.: It was for many years. I don't know how this continued.

Int.: *What about the direction the School of Medicine has gone in, where it has reached today. What do you have to say about that? Do you think it's a vision that people have?*

R.K.: I think it has developed very well over recent years, in the period of time when funding could be increased both from the budget and research funding. I think it has certainly progressed very materially and has become, I think, one of the leading schools in Canada in many respects. I think it's developing into a very excellent medical school. I have no way of measuring that, though. I'll speak now of Dr. William Boyd. In the spring of 1951 when the first year was just beginning, the General Hospital and the Faculty of Medicine had invited Dr. William Boyd to come out from Toronto as a visiting professor in

Pathology. I had known him in Toronto very well. He was head of the Department and was just about to retire, or had just retired from Toronto. I was driving him out here - I remember it was in February of 1951; and it turned out to be one of those beautiful days in February of blue sky. He made some remark about what a beautiful place it was. And I'd just got out to the campus along University Boulevard when he said, "You know, I'd just like to come out here and live out here for the rest of my life." So, with that in mind, I spoke to the Dean that day and he said, "Well," he said, "You know. We've got to have a head of the Department of Pathology and I wonder if we couldn't get him to come out." At that time, there were two very excellent patho1ogists at the General Hospital, Dr. Fidler and Dr. Taylor. We had asked them to begin to organize teaching together on an interim basis and they had begun to get slides together for pathology teaching and various specimens and so on, and they were getting organized in pathology teaching in second year. We couldn't really decide which of those two would make the better head of the department. It had been pretty well decided that we would not bring anyone else in; they were such excellent pathologists that one of them should be head of the department. However, we thought that maybe Dr. Boyd could act for a year or two to be head of the department. It would be a prestigious appointment because Dr. Boyd was probably one of the most outstanding pathologists in Canada. He had written textbooks and the name was widely known across the country. So he was approached by Dean Weaver and he immediately decided to come out. He came out in the spring of '51 several times, just stayed for a week or so to help Dr. Fidler and Dr. Taylor organize the teaching and he came out in the fall of '51 to live and take over as head of the department. He was an extremely good 1ecturer; his lectures were just absolutely excellent. He combined humour and factual information in a very excellent way. So he was our first head of Pathology for about three years before he finally retired. He retired from Toronto and then he came out here and retired from here again after 3 or 4 years and went back to Toronto. He decided not to stay on here. I don't know why he went back there.

He and his wife went back. They lived just over the way here, a couple of blocks away from here. I remember on New Year's Eve - that would be 1951-52 - my wife and I decided to walk down and see the Boyds and just welcome them. They had bought this house and spent a month or two redecorating it. We just walked in on them and we sat having a little chat on New Year's Eve. Mrs. Boyd was showing my wife the new curtains they had bought and how they had repainted the whole house and everything was all nicely fixed up, they were so pleased with it all, and New Year's Day when I got up I looked out my back window here that looked right down onto the Boyds' house and there was white smoke coming out of their chimney. I said to my wife, "My, they must have a fire on down there. I wonder why they might have got a fire on in their fireplace this early in the day?" So, anyway, a little while later I phoned them up to wish them a happy new year. "Oh, he said, We're having a lot of trouble. My furnace has exploded." So I went down, and by this time it was about eleven o'clock in the morning, and they were huddled over the dining room table trying to get something to eat in their overcoats. What had happened was that when they got up he noticed that their house was cold and he opened the furnace basement door to see what was wrong with the furnace and a great blast of explosion went on and blew out smoke all over everywhere; there was fuel oil smoke all over the place and their curtains and everything was soot all over everywhere. They had all their doors and windows open trying to get the smell out of this and he was trying to get the furnace man on New Year's morning to come and find out what was the matter. It was a day about like this, with fog and cloud and rain. In Maclean's Magazine that month there was a centerfold,

a panoramic picture of Vancouver, of the North Shore mountains. He took this magazine out and held it out (laughs). He said, “This is what Vancouver’s supposed to be like.” But they were several weeks getting their place fixed up after that. Dr. Boyd gave us a very excellent start in Pathology here. There’s a museum down at the General Hospital named the William Boyd Museum - Pathology Museum. I think it’s been moved. I don't think it’s there any more. I think the Library’s taken over that area and I don’t know just what’s happened to it now. I think it’s probably out on the campus. But it’s named the William Boyd Museum. He collected specimens and mounted them, and made that contribution. That was the story of William Boyd.

Round about 1949 Dr. Strong and Dr. Ross Robertson began to consider the possibilities of cardiac surgery here in Vancouver. To facilitate this development (Dr. Ross Robertson was the cardiac-thoracic surgeon. Not Rocke Robertson, Ross Robertson), and to facilitate the development of this aspect of cardiology Dr. Strong was instrumental in developing what was named the B.C. Medical Research Institute. And by the spring of 1950 they had taken over what was the ground floor of the old pathology department at the General Hospital. They leased this from the hospital. The organization of the B.C. Research Institute developed funds, largely by Dr. Strong who collected several hundred thousand dollars to fund the development of this research institute.

By the fall of 1950, the renovations of this part of the building had been pretty well completed and it became necessary to appoint a director of this institute. Dr. Strong was most anxious that this institute be associated with the Faculty of Medicine and there was some question as to how close this association should be. Dean Weaver did not want to have any direct connection, but he was cooperative in working out some relationship with the institute and I could see no reason why this institute should not continue because there was a source of funding for this which was not available any other way. So this was primarily a place where Dr. Ross Robertson could develop his skills in cardiac surgery by animal experiment, animal work. There was an operating theatre put into this building, a small animal operating theatre with animal holding rooms, offices.

We began a search for a director and the person chosen for that position, and Dr. Weaver was still dean, was Dr. Kenneth Evelyn from Montreal. He was in the Department of Medicine at McGill and had one of the highest reputations for medical research in Canada. He came here in about 1953, I guess (somewhere about that time), and became director of the B.C. Medical Research Institute. We also in that institute developed the first isotope - radioactive isotope - area to begin the use of radioactive iodine in thyroid disease, with the centre of the isotope, the calibration and storage facilities in this research institute. Dr. Hamish McIntosh was the clinician who did the clinical work. We started with radioactive iodine diagnostic facilities for thyroid disease and then further treatment. Dr. Ross Robertson initiated his animal work in cardiac surgery and then ultimately developed clinical cardiac surgery, which was developed at the General Hospital and then later in the T.B. hospital (tuberculosis hospital). They had that on the General Hospital site. Well, as things went along, the B.C. Medical Research Institute continued its work in the facilities which were available until 1958 after Dr. Strong had died and it became apparent that these facilities were inadequate and the General Hospital wanted them back again. So the B.C. Research Foundation which was the parent organization of the B.C. Research Institute - the B.C. Research Foundation was the fund-raising branch of it - had funds on hand of some $70,000, which was considered to be adequate to build another floor on the Heather Building at the hospital. This floor was shelled in and turned into a research laboratory

which was named the G.F. Strong Research Laboratory in memory of G.F. Strong. And this became affiliated with the university, with the Faculty of Medicine but was not really a part of it although the arrangement was that the facilities of this unit could be available to any member of a clinical department. There was a medical board - a small medical board - which would allocate space for members of clinical departments. As it turned out, it was almost entirely used by the Department of Medicine as the Department of Surgery had some animal facilities of their own at one end of it. But the major part of the G.F. Strong Laboratory was utilized by Dr. Evelyn himself, Dr. Price and Dr. Ford for research purposes in the department. This was continued, and I think still is continued, at the G.F. Strong Laboratory. It became finally a unit of the Department of Medicine, it was finally an integral part.

Int.: *That's very interesting. There isn't information about that, at least, that I've heard of.*

R.K.: Very little. That was really the beginning of clinical research in Vancouver: the B.C. Medical Research Institute. It was started just before I came here and it provided the facilities for what medical research we could develop in the early days.
Dr. Evelyn, when he was appointed director of the Medical Research Institute, was also appointed professor of the Department of Medicine - Associate Professor first and then was promoted to full Professor. He was interested in hypertension and he did a lot of research, particularly in serum protein finally. He was plagued with ill health. Shortly after he came here - I could tell you about him, he was a very interesting person. He was dependent upon four medications which had provided their discoverers with the Nobel prize. I don't think he would mind me recording his medical history briefly now. He came here - and I knew he was not well but he and his doctors in Montreal assured me that he could manage but, as it turned out, his health deteriorated but he lived for - well, he just died about three or four years ago and he lived to retire at the normal age. During the war he was in the Air Force doing research on night vision and various other aspects. While in the Air Force he developed anaemia. Then he developed a disease called sarcoidosis, and this affected his adrenal glands. The adrenal glands were diseased and he developed Addison's disease, which is an adrenal insufficiency. With this he was first given what was available, an Upjohn extract of adrenal cortex. Then, when cortisone was discovered in 1947-48 he was started on cortisone, which was fine but he went down to Boston for a year from Montreal. A professor of medicine there put in some pellets of cortisone into his back, to be absorbed slowly. However, these proved to be deleterious in that he developed diabetes with these and, by the time he got back to Montreal one day, he was in diabetic coma. He was dependent, first of all on cortisone which gave Hench and others the Nobel prize. Then he became dependent on insulin for his diabetes which gave Banting and Best the Nobel prize. He also developed hypothyroidism and had to take thyroid extract, which had given Kendell the Nobel prize; and he also was anaemic, which required liver extract, which had given Cassell and Minot the Nobel prize in 1923. He had four medications. But he was a very brittle diabetic and he would go into hypoglycemia - too low a blood sugar - very frequently. He had multiple hypoglycaemic attacks. But he rallied around and continued to do his work. Basically, he was an excellent person as far as research was concerned. He continued on that. After I retired, he was still a member of the Department. That's the history of Dr. Evelyn. I guess he was probably the first, because of this funding from the Medical Research Institute, fulltime appointment in the Department of Medicine, really. He was an excellent teacher as well.

Int.: *Did you receive funding from other organizations as well?*

R.K.: As the years went on, yes. The first funding in that respect was from the T.B. Society. I was on the advisory board of the old B.C. Tuberculosis Society. They had become interested in the research into respiratory disease and they proposed - or, I made the proposal for them - that they fund a chair, a professorship in respiratory disease. This would be somewhere around 1960, I suppose. I could find these dates but I don't know where I could locate them. I'd have to go back to the Dean's office, I guess, to get all these dates and appointments, but we had funding to support a chair in the Department from the Tuberculosis Society, $13 or $14,000 a year, I think, for salary. We appointed Dr. Stefan Grayowski. He is just retiring this year. He has been head of Respiratory Diseases at the General Hospital since then. He was really (laughs) a character. I could maybe tell you the story. He is a Pole - Polish. During the beginning of the war he had been in Poland. He had to go into some military service. He was put into the Merchant Marine and when war broke out he was on a ship in New York. They couldn't go back to Poland because the Germans had invaded Poland. So he went back to England. Just about that time Dunkirk happened and the Polish Division was evacuated from France from Dunkirk. He enlisted in the Polish Division of the Polish army and the Polish army was up in Scotland. He had started in medicine in Poland and he wanted to continue in medicine. The Poles started a medical school in connection with the University of Edinburgh and he went into the Polish medical school and graduated with a degree from Edinburgh. (Stephen Drance, also a Pole, and now head of Ophthalmology, was in that same group of Polish medical students.) After he graduated he went back into the army and went across to France after D-Day and went across all northern France as a medical officer in the Polish army and then went back to Britain. He wanted to do some graduate work and he got some graduate residency jobs in various hospitals. One of the hospitals he went to he went around and saw a door with "Dr. Poland" on it. He thought they didn't know how to spell his name so he thought that was probably the room he'd have, and here was a red-headed woman physician, Dr. Betty Poland. They were married and she's now in the Department of Obstetrics and she's the.one who's in charge of the test-tube baby deal. He came out to Vancouver and got his membership in the Royal College of Physicians in Canada and was in Ontario in the T.B. Division of the Ontario Government and became very well-known as a tuberculosis specialist. He was the one that we decided was best qualified to come over here into that position, sponsored by the T.B. Then the Arthritis Society decided that we should get some money from them if we could do the same thing for arthritis. So they subsidized a position in arthritis and we appointed Dr. Dennis Ford, the head of the Arthritis Division in the department with funds from the arthritis division. That would be somewhere around the late '60s, I should think. So I managed to wangle one here and there and things like that. Oh, and then I must tell you; this is something about the Eric Hamber professorship. Mr. Hamber was chancellor of the University when we first arrived. He was very interested in the whole development of the medical school and he was instrumental in persuading the political side in Victoria - the government - to foster the medical school. You may hear some stories about that from people; I've just heard stories second-hand about that, where they passed a resolution or an act in the legislature unanimously that there be a medical school set up at UBC. He was, I think, in the background, instrumental in that. So when we started we always honoured him; we always asked Mr. Hamber to come to all our banquets. He was the chancellor of the University for several years when we first started. He was

always very interested in me and my family. He was a very wealthy man who made a lot of money in the lumber industry. He and his wife were childless and they used to have both us and my three boys to their summer place up the Valley. It's now been turned into a heritage house up there in a park - What was the name of it? Minnakehe or something?

Int.: *Minnekada?*

R.K.: Something like that: a beautiful house he had up there. They'd live up there in the summer. He'd always have us up there every summer, a day up there and the children would be out in the fields. He had horses and I don't know what all. A lovely time. Mrs. Hamber was a very charming hostess. They'd have all sorts of dinner parties. He told me that any time I had a visitor that I wanted to entertain, let them know and they'd have them in their home and so on, that sort of thing. I was involved with his physician with his various illnesses and so on as a consultant. Actually, I looked after his final illness. He was a very interesting man. His physician was away and he called me one Saturday afternoon to come and see him as he had some trouble with his back. He had a severe pain in his back which had come on. I examined him at home and I finally said to him, I think we should get you into hospital and investigate this. And he said, "What do you think it is?" I said, "Well, it's not possible to say until we get more information and further investigation." I said, "It could be arthritis, it could be a disc." He said, "Could it be cancer?" I said, "Yes, there's the possibility of it being cancer."
I got him into hospital to have an X-ray and his back was just riddled with cancer from his prostate. All he asked me was, "Was it what you thought it was?" I said, "Yes." He said, "Is there any cure for it?" I said, "No. They could probably alleviate it to some extent with hormones." He said, "Keep me comfortable; that's all I want." Well, the hormonal treatment didn't really help him very much. He was well on in his '80s. He was in hospital for a couple of months before he died but he never asked me another thing. That was all he said. He asked, "Was it what you thought it was?" and I said, "Yes, it was." He said, "How long have I got?" I said, "It's very hard to say. It might be three months; it might be a year." "Well," he said, "Keep me comfortable."

I visited him all the time in hospital. After his death - not long after - Mrs. Hamber expressed the wish to establish something at the university - UBC - to commemorate her husband. The local manager of the Canada Permanent Trust Company who was her financial advisor suggested that she meet with the dean (who was Jack McCreary at the time) and discuss the matter. She expressed the view she would like to have funds to provide for the establishment of a chair in the Department of Medicine, in which her husband had expressed particular interest. So Dean McCreary and the manager of Canada Permanent Company and I met with Mrs. Hamber and her companion, Mrs. Rice, in the Canada Permanent board room, at which time it was decided that she would provide funding to the university, the income of which would provide funds towards the chair in the Department of Medicine and it would be called the Eric W. Hamber professorship. She provided $500,000 which, in those days, provided an income of $25,000 a year towards the salary of the head of the Department. I was appointed the first Eric W. Hamber professor; I was the first named professorship in the faculty.

Int.: *What year was that?*

R.K.: I'm afraid I can't say - I can't remember for sure. I'd have to look that up. It would be somewhere in the '60s. It was during Dr. McCreary's deanship. That fund came into the Department of Medicine budget as funding toward the professorship and, as far as I know, it still continues. Mrs. Hamber is still living as a recluse. We used to see her quite frequently but, for many years now, she just doesn't want to have visitors. We have tried on several occasions to see if we could come and visit with her but she said that she would prefer not to so I haven't seen her for many years. Dr. Dirks was appointed to succeed me upon my retirement. He wrote a letter to Mrs. Hamber but I don't think he has seen her either. A very sad situation, but I gather… she must be well on in her nineties.

That's the story of the Hamber professorship. Not long after that Dr. McCreary's father died. He was a businessman from northern Ontario. He had left a modest estate from which Dr. McCreary arranged that some funding – I'm not sure how much that would be, but a similar amount, was given to the university to subsidize the chair of Paediatrics and its now the McCreary Chair of Paediatrics, the second-named professorship in the university, in the faculty.

Int.: *Now, Dr. Kerr, there were some more things that you had thought of that you would like to add to the tape?*

R.K.: One of the items that I thought might be of interest was the location of most of the lectures in clinical subjects in very early years. When we first started, most of the lectures were given in a very low ceilinged lecture theatre in the basement of the Vancouver General Hospital. This room had been a psychiatric ward at one time and was named like the lecture room, "X". It was a long, narrow room and very difficult to speak in; however, the students put up with the situation very nobly. At least the chairs were comfortable. That was about the only thing that could be said about the room; otherwise, it certainly had very few in the way of amenities. When the building along Heather Street was built in 1958 we had two rooms in that building, one lecture theatre seating about 150-170 and another, steep-sloping amphitheatre seating about 100 individuals. These amenities were very much better from the standpoint of lecturing and we were able to continue on in those areas for a long period of time. In fact, I think lecture room "B" is still being used. Lecture room "A", the amphitheatre, was converted into library space in the last 8 or 10 years.

Int.: *Were you involved in planning these lecture rooms?*

R.K.: Well, I was involved in planning the medical - the Department of Medicine in that building - the lecture theatres were originally planned by Dean Weaver. The plans were drawn up by Dean Weaver before his retirement and they were followed subsequently, when the building was built during the latter part of his time here, and we occupied it in the late 1950's. The building was started when Dean Weaver was still in office. He had planned all of the general areas in the building but all the planning of the building that I had any part to play in was "B" Floor, which was the Department of Medicine. It was on the same floor as our teaching wards in the 10th Avenue wing of the General Hospital. The whole of the "B" floor was devoted to our teaching, provided our teaching wards for patients in the teaching beds.

One of our requirements in the early days of the beginning of the medical school was a

requirement for a thesis in the final year. This was a requirement that a student provide a thesis before graduation. At first it was felt that this was analogous to a requirement of a graduate student. The topic of the thesis was usually selected by the student, often in consultation with a faculty member. The faculty member acted as a sponsor of this thesis and not only assisted the student at times with the thesis but also criticized and evaluated the thesis. It was a requirement for graduation and had to pass the judgment of a sponsor as a satisfactory effort. Some of these theses were extremely good and well done but, as the years went by, the students became less enamoured with this and looked upon it as a chore and, after several years, the thesis requirement was discontinued. However, we felt at that time, the beginning of the school, it served a useful purpose to give the student an opportunity to assemble information from reading. Some of these theses were based on work which the students had done during their summer vacations, research projects under the supervision of members of the faculty. And the thesis was a report of this sort of thing in the same way as a graduate student thesis would be required.

Many of the social activities of the students were of interest. In the early days there was a formal medical ball each year. This has been continued in various forms. At first it was a very formal affair, very often with the chancellor, Chancellor Hamber, present and it was usually held in the Hotel Vancouver and many faculty and their spouses would be present. They were very enjoyable social events. I think most of these activities could be obtained probably more satisfactorily from the students of the time.

Int.: *I would think -yes.*

R.K.: You would be able to get information about some of the other activities in the early days.

Int.: *Things like the graduation banquet. Would that be part of the medical ball?*

R.K.: No, there was usually a graduation banquet held in the early years. I think the first one was held in the old Devonshire Hotel down in Vancouver and some of the members of the faculty were present and the members of the graduating class. This was the pattern for a few years. Then the event at the time of graduation became a reception held by the dean somewhere in the university campus; latterly, in the Instructional Resources Centre.

My first contract with the university, in September of 1950, stated that I was appointed Professor and Head of the Department without term; and this, in my understanding with the president of that time - the president and the dean - was that my professorship was without term; that is, I had tenure as far as my professorship was concerned. As far as the head of department was concerned, I was head of the Department of Medicine at the pleasure of the board of governors. In other words, I could be relieved of the headship at any time that they felt necessary. In addition to those terms, my contract read that I might devote 10 per cent of my time to a consulting practice in medicine. I rather facetiously asked the president, when I heard of that, was I on a 48 hour week or what that time represented? He replied that it was inserted there as a rein which they could pull in if I got out of hand.

When other members of the Department came on as geographic fulltime people with a salary from the university and the privilege of practice, my feeling was that they had

certain obligations to the university in the way of teaching, research and administration and, provided they carried those out, I felt that it was an honour system from then on, that they could utilize the rest of their time in practice if they so wished provided they carried out the functions which I required of them. This system worked very well. However, toward the end of my professorship, efforts were made to regularize this whole question of private practice by establishing ceilings or some other arrangement. However, up until the time of my retirement no arrangement in the clinical departments was accomplished. Since that time I understand there has been a definite pattern of ceiling arrangement for the clinical appointees put into process.

In 1959 I was offered the position of Sims Travelling Professorship. This is a very interesting appointment which was provided by a gentleman by the name of Sir Arthur Sims, who was a New Zealander who had acquired a considerable fortune in New Zealand in the sheep and cattle-raising industry; and also had interests in several other parts of the world, including Africa, and I understand he owned some property in Canada as well. Shortly after the Second World War he and Sir Arthur Port, who had been a consultant surgeon in the British army, conceived the idea that a subsidized, travelling professorship would help to consolidate the ties of the Commonwealth and the Sims Travelling Commonwealth Professorship was established based on the Royal College of Surgeons in England. The terms of reference of this professorship were that the professor and his wife or spouse would travel throughout the medical centres somewhere in the Commonwealth teaching, meeting, and exchanging views and information for a period of at least four months. The funds were provided so that at least two, and sometimes three, professors a year were appointed in this fashion up until the 1950's. In the mid-1950's, only individuals from the United Kingdom were appointed. They went to Canada, Australia, New Zealand, British Africa, and in the 1950's two Canadian surgeons from Toronto were appointed at one time; and I was appointed in 1959. The appointment was made by a committee consisting of the presidents of the Royal Colleges of Surgeons of London, the Royal College of Physicians of London, and the Royal College of Physicians and Surgeons of Canada, the Royal College of Physicians of Australia and the Royal College of Surgeons of Australia. My commission with Mrs. Kerr was to visit the medical centres in what was then British Africa. We started in South Africa and went to what was then Rhodesia, Ghana, Nigeria, Uganda, Kenya, and Malta. It was said that this should not only be an academic and medical visit, but also the terms included the word "ambassadorial." It was a very interesting experience. I spent from May to September 1959 in travelling in this fashion with Mrs. Kerr.

Int.: *Dr. Kerr, could you tell us about the Family Practice Department at UBC?*

R.K.: Well, this is a very interesting development over many years. When I first came to Vancouver, there were a very large number of physicians on the staff at the General Hospital so it was not what you would call a closed hospital by any means. At first, any physician practicing in Vancouver who had satisfactory credentials could be admitted to the staff of the hospital. I remember very well that criticism concerning the large number - it may have been up to five hundred individuals at one time. When I [went to] Quebec, Toronto I heard criticism about the large number of physicians on the staff.

Int.: *It does seem like a lot…*

R.K.: This was, of course, very unwieldy but, on the other hand, I could see it from the standpoint of providing the means by which the general practitioner was able to participate in hospital affairs to some extent, and attend ward rounds and other activities within the hospital from the standpoint of continuing education on his part, keeping up to date as much as possible.

As the years went by, it was decided that there should be a Department of General Practice established at the General Hospital. This finally was accomplished, and a Department of General Practice was formed which allowed the head of that department to sit on the Medical Board and participate in hospital activities in a much more meaningful fashion. About the same time, there was a movement throughout Canada to develop a college of family physicians analogous to the Royal College of Physicians and Surgeons, which would have as its aim an educational function quite apart from the political aspects of the Canadian Medical Association. I was very fortunate in being asked to sit with the nucleus committee here in Vancouver with Dr. Tim McCoy and Dr. Bob Stanley, and two or three other general practitioners to come up with a recommendation concerning the formation of this college, which was carried out in the '50s. This stimulated the activities of the general practitioner throughout the country and, at the same time, Dr. McCreary and I felt that it was important to establish an academic area of general practice. My feeling at that time was that the academic input of the general practitioner was very meager but it could be developed into quite a meaningful situation whereby the general practitioner would be in a position to apply at the individual patient level the background science of medicine. The general practitioner also could participate in research programs at the general practice level, which has been accomplished to some extent. In looking for the way in which this could be developed it was finally decided that this should start as a division within the Department of Health Care & Epidemiology in view of the fact that clinical practice bridged all of the clinical departments: Medicine, Surgery to some extent, Obstetrics, Paediatrics. It was felt that no one department could house it except for a department such as Health Care & Epidemiology. In this Department a division was established, and Dr. Clyde Slade was asked to be the first head of that division. Dr. Slade had a background of internal medicine and had a practice in the city and also was qualified in psychiatry and had a very keen interest in the practice of medicine as it applied to patients. He proceeded to develop an academic division of general practice within the faculty.

Int.: *What was the reaction of the other faculties to his starting this division?*

R.K.: Well, I think the clinical departments were quite happy to have this situation develop. The Department of Surgery was very concerned that the general practitioner who was not qualified in surgery should not continue the practice of surgery as many of the old general practitioners used to do in the community. And I think quite rightly the Department of Surgery felt that the practice of surgery should be confined to those who had had adequate training and experience and a qualification in surgery, and the general practitioners who were involved in this quite gladly agreed to this. Some of the individuals in the basic sciences questioned the validity of establishing an academic department of general practice because of the fact that they felt that the academic aspect of that particular field of medicine was not well developed and it would dilute the academic quality of the faculty. However, I think this objection was overcome and the division prospered and continued to increase in its activities. One of the first activities that the division developed was the

development of a General Practice unit at the General Hospital and also a General Practice unit on the campus. The purpose of this was to provide the means by which students and residents could see patients under supervision in a clinic setting and become familiar with the problems of general practice. These clinics were established, one at the General Hospital and one at the campus, in the early years of the life of this division.

One of Dr. McCreary's major contributions to medicine, not only here at UBC but across the country was his development of what he called team approach to the practice of medicine. That was the cooperation of the physicians, the nurse and the therapist as a team approach to the treatment of patients. He saw this in action at a medical school at Gainesville in Florida. He and I went down there to look at this school of medicine as one of the newer developments in the United States and he became convinced that that was the direction in which we should go; namely, to have an area of health sciences on the campus which would allow all of the various professional groups to come together and come to mutual understanding as far as care of patients was concerned.

It was his approach that really developed the Health Sciences Centre on campus with the faculties of Medicine, Dentistry, Nursing, a School of Social Work, the Faculty of Pharmacy all together in close contact with each other so that the exchange of information, exchange of viewpoint, and concentration of the joint viewpoint of clinical care to patients could be fostered. He also approached the Federal government after the Royal Commission - the Hall Commission - with which he served in an advisory capacity. He approached the Federal Government to provide funds for the expansion of medical schools and development of facilities of existing medical schools. As a result of this approach, for which he was largely responsible to the minister at that time, the Honourable Judy LaMarsh, they developed the Health Resources Fund, which was $500,000 to be matched by provincial governments, towards the development of health facilities in the health fields. This fund was instrumental in the development of not only new medical schools but the development of facilities at existing medical schools right across the country over a period of 10-15 years.

Int.: *He also managed to get quite a lot of money from people, I believe, 1ike the Woodwards?*

R.K.: Yes, he was instrumental in having funds from the Woodward Foundation for the library and the health resources centre - the Instructional Resources Centre - at the campus which was partly financed by the Woodward Foundation.

Int.: *This was one of the reasons there was so much development during his time as dean.*

R.K.: That's right, and after his retirement as dean and coordinator of Health Sciences he became the medical director of the Woodward Foundation for several years before he died.

Int.: *Dr. Kerr, could you a1so tell us something about the School of Rehabilitation?*

R.K.: During Dr. McCreary's deanship it became apparent that there was a need for training facilities for therapists in the fields of physiotherapy and occupational therapy, there being no school in British Columbia - I think there was only one other school in Western Canada at that time. So that, in the '60s, in became apparent that this need was very acute that

rehabilitation of elderly in many areas of medicine was becoming increasingly necessary and the need for therapists in this field was becoming acute. As a result, it was decided to establish a school here in Vancouver and it was felt that it was desirable not to separate physiotherapy and occupational therapy but to include both of those disciplines in developing an individual which was called a rehabilitation therapist. This concept was developed largely because of the fact that in smaller hospitals throughout the province and in facilities such as the Arthritis Centre (Arthritis Association) program it was sometimes impossible to have two individuals involved; it would be desirable to have one individual who could accomplish both fields of rehabilitation in an individual patient. This philosophy was finally accepted as the direction of the School of Rehabilitation. It was the search for the first head of this school that resulted in the appointment of Dr. Brock Fahrni as first head of the school. His background was very interesting in that he and Dr. Wallace Wilson at Shaughnessy Hospital really began a program of rehabilitation of veterans which became the pattern for the program for veterans right across the country. He developed the whole concept of assessment of the physical requirements of the veteran, what the veteran could accomplish, and developed an assessment program and a program of facilities at Shaughnessy Hospital and in the community to provide the best possible care for this group of veterans. His concept of rehabilitation seemed to fit in with the requirements that were needed for development of a school. He recruited the faculty and developed a very good curriculum and this school was part of the Faculty of Medicine. It was a school within the Faculty of Medicine and has continued in that situation. The concept of the joint rehabilitation therapist continued. I understand that only within the last year or so consideration has been given to separating them again back into separate disciplines of physiotherapy and occupational therapy.

Int.: *What about the beginning of the Department of Psychiatry? Was it a sub-department of your Department?*

R.K.: Psychiatry began as a division of the Department of Medicine under Dr. George Davidson who was the first head of that division. He recruited several practicing psychiatrists in Vancouver as teachers. He undertook a program of lectures and clinic groups in psychiatry, largely in the final year although there was also some teaching in third year, and there was also a small amount of teaching in second year, introducing the student to the examination of the psychiatric patient. This continued on for a matter of only 4 or 5 years, when it was decided to establish a separate department and Dr. James Tyhurst was appointed as the first head of that separate department. That would be in the ‘50s - I can’t remember the exact year. This was centered largely at the General Hospital at first and students also had some experience out at Essondale in the way of clinical experience. A separate psychiatric unit was established at the General Hospital under the direction of Dr. Tyhurst with separate beds and outpatient facilities. It was in the early ‘60s that the beginning of the Health Sciences Centre was started with the building of a psychiatric unit on the campus. Dr. Tyhurst was instrumental in designing and establishing the philosophy of this unit.

Int.: *Thank you very much, Dr. Kerr, for contributing your part to the tape of the history of the Faculty of Medicine.*

Interview with Dr. Kerr continued on Tuesday, March 5, 1985, (Part V).

Int.: *This is a tape of the interview with Dr. Kerr on Tuesday, March 5, 1985, (Part V).*

R.K.: I'll talk a little bit now about the two subdivisions of the Department of Medicine that were developed very soon after the beginning of the Medical School. One was Dermatology. Dermatology was a sub-department of the General Hospital under the direction of Dr. Donald Cleveland. There were 4 or 5 dermatologists on the staff when I came here. Dr. Cleveland was a very able person and a very good speaker and a very able dermatologist. However, unfortunately, shortly after the medical school began, Dr. Cleveland suffered a stroke which left him completely aphasic and he 1ived for several years in a nursing home, completely unable to speak and with a haemoplegia. Succeeding him, Dr. Donald Williams was appointed as head of Dermatology and he developed a very good sub-department in which teaching was conducted in the form of lectures and demonstrations in the outpatient department and also in the dermatologists' offices, where the students were able to see examples of common skin diseases.

Dr. Donald Williams left that position during the 1960s to become associate dean in charge of continuing education; I'll deal with that later. He was succeeded by Dr. William Stewart. One of the outstanding developments in the sub-department of Dermatology was carried out by Dr. John Mitchell who became interested in the dermatological sensitivities to various plants. He studied this in great detail and was particularly interested in the dermatitis which developed in people working in the forest. It was thought to be due to cedar. However, he demonstrated that this dermatitis was not due to the cedar itself but was due to the lichen which grew on the trees in the forests. He, along with the botanists, was able to isolate the material from the lichen to which the patients were sensitive, and this was usnic acid. He demonstrated, for the first time really, that the one racemic form of usnic acid produced a sensitivity while the other racemic form of this same molecule did not produce a sensitivity in patients; this was a very unusual phenomenon. Following this, Dr. Mitchell produced a very large book which has become sort of a classic, which outlines the plants throughout the world which produce skin-sensitivity; there are hundreds and hundreds examples of these skin-sensitivities which he has studied throughout various parts of the world.

The other sub-department which was developed early on was the sub-department of neurology under the headship of Dr. Charles Gould. This sub-department was responsible for the teaching of neurology by lectures and demonstrations of neurological conditions. They worked very closely with the neurosurgeons in this situation.

Int.: *Was this different from the department Dr. Gibson was involved in?*

R.K.: Yes, Dr. Gibson was the Department of Neurological Research on the campus whereas this was clinical neurology based in the hospitals. One of the interesting experiences in the Department was the polio epidemic which occurred in 1956. This was the last polio epidemic just prior to the development of polio vaccine, just before the development of the Salk vaccine. We had about 30 or 40 cases of polio in Vancouver; many of them were sent down from other parts of the province to a special unit in the infectious disease hospital at the Vancouver General hospital. One of the features of this, of course, was the

development of respiratory paralysis. The use of the iron lung at that time before all of the modern developments of control of respiratory function had been introduced: the patients were placed in the respirator, in a tank respirator, and alternative positive and negative pressure inside the tank was produced. Dr. C. G. Campbell, "Chargo" Campbell, he was called, did a very outstanding job in the Department of looking after these respiratory patients, and we had at one time ten or fifteen these respiratory cases in respirators at the General Hospital; and they subsequently were taken up to the Continuing Care Hospital on 59th Avenue in Vancouver. Some of them, I think, are still there under treatment.

Another interesting situation that happened, again during the '60s. A cruise ship in the P&O Line came into Vancouver, having about 120 patients suffering from typhoid fever aboard. This was due to a fault in the sewage disposal on board ship. These patients were looked after, part of them at the General Hospital and part of them at Shaughnessy Hospital. The interesting thing about it was that only one fatality occurred from the 120 patients. They were treated with ampicillin usually. Some of them were quite ill, others were only relatively mild cases. The bacteriological aspect of this was carried out by the public health laboratory. Dr. Charles Rally in the Department of Medicine was responsible, largely, for the care of the patients in the infectious disease hospital at the General Hospital; and Dr. Whitelaw and his staff at Shaughnessy Hospital. This was a big undertaking and fortunately resulted in a happy outcome. Some of the early research, clinical investigation which was carried on in the Department took place in respect to cortisone and ACTH. This of course, had just been introduced prior to the medical school and we organized several programs of treatment in arthritis and in rheumatic fever, and various skin diseases, studying various aspects of the effect of cortisone and ACTH on these diseases. One interesting patient, I recall, in Paediatrics was a young child who, it was calculated, had been bitten by three- or four hundred bees, he had 300 or 400 bee stings. He was brought in in a very poor state but recovered with ACTH under the care of Dr. Reg Wilson. Dr. Palmer and Dr. Bagnell were involved in this investigation work along with Dr. Macintosh. There were two investigation units established, one at the General Hospital with six beds and the other at the Shaughnessy Hospital with six beds. Dr. MacIntosh was in charge of the one at Shaughnessy Hospital along with Dr. Palmer, who was in charge of the one at the General Hospital.

Following Dr. Evelyn's arrival , Dr. Evelyn took over being in charge of this clinical investigation unit. Various diseases were investigated in a metabolic sense. Dr. Evelyn arrived and he carried on his studies in hypertension and also began studies of serum proteins with special instrumentation which was obtained. Dr. Ford, very early on, began his studies of mycoplasma. His first laboratory was in the basement of a rooming house where he lived up on 13th Avenue. We had no other facilities for him so he set up a laboratory in this rooming house basement where he began his studies of mycoplasma. Dr. Whitelaw was interested in haematological and had equipment whereby he could take slow-motion pictures of movement of white blood cells in culture. It was in Dr. Whitelaw's lab that we had a fire. He was doing the cell cultures and had a hood in which there was a small gas burner. The technician left the room for a short time and while she was away apparently a leak developed in the tubing of this small burner and filled the hood with gas, which then exploded. The whole room was ablaze. Fortunately, the building was concrete and the fire was contained to that one laboratory. However, there was a lot of damage done to the laboratory itself and to the instruments there.

The question of tuberculosis was of considerable interest in the early years, in the 1950's. When I first arrived here in 1950 at the General Hospital, we continuously had 8 to 10 open cases of tuberculosis on the wards of the General Hospital in some form of isolation. We were unable to place them in sanitaria or any other facility. There was a hut set up on the grounds of the General Hospital to house some of the patients who we could not send to sanitaria there was no room. This, of course, over the next twenty years changed completely. A sanitarium was constructed up on 59th Avenue in Vancouver but, by the time that was finished and opened, the use of the various chemotherapeutic agents for tuberculosis had resulted in a very marked change in the whole picture whereby the hospitalization was very much shorter, if necessary at all, and the number of cases discovered in the community became less and less as the years went on.

In order to house Dr. Grybowski when he arrived - I referred to him before as coming in as head of the Respiratory Disease division of the Department - we took over facilities in what was called the Nurses' Annex, which was a frame building on the north side of 10th Avenue between Heather and Laurel. This was shared with the Department of Psychiatry. Dr. Grybowski had his offices and the offices of his division in that building for many years; in fact, it was just torn down in 1979 and '80. The library facilities of the General Hospital were developed in the Heather building. These were meagre at first but gradually expanded. They were a branch of the UBC medical library and these have, of course, become very important from the standpoint of the students and the faculty at the General Hospital.

You were asking about the preceptor program and I would like just to comment on that briefly. Early on in the medical school - I can't remember exactly when it began - it was considered important and desirable to offer to the students in the summer between the 3rd and 4th year, when there was a vacation in that period, to offer to the student the opportunity to be with a general practitioner for a month or maybe two months in order to acquaint the student with the aspect of general practice. It was felt that this would be very helpful to the student to gain not only clinical experience but also the experience of the art of medicine and the art of handling situations in general practice. With the help of the general practice group up to, I think, thirty or more general practitioners - not only in Vancouver but throughout the province were recruited, expressing their interest and willingness to have a student come with them for that period of time. This meant considerable sacrifice on the part of the practitioner because it slowed up his practice as far as handling his patients was concerned and also impinged on his own time in many ways because he had to take time to talk to the student and supervise his work, and so on. However, the student gained a great deal of experience in their relationship with patients. They often assisted the physician with deliveries and what surgery might have been done in the practice. They learned the first aid procedures, sewing up cuts and that sort of thing. The student, however, was able to contribute to the general practitioner's practice by being able to spend some time with a patient, taking a prolonged history and doing a careful examination, of which they were quite capable at that time in their undergraduate studies. Doctors quite often commented on the fact that they were quite a considerable help to them in this respect. This program, as I understand, is still continuing, just to what extent at the present time I'm not sure. Now, it's conducted at the end of the second year rather than the third year because of the fact that the third and fourth year were amalgamated and no

vacation time was present between those years. I think this program was extremely successful and I think it also resulted in a very large percentage of our classes going into general practice. In fact, I think in our graduating classes there is a very high percentage, larger than in some other schools, of individuals going into general practice rather than continuing on with specialty practice.

Int.: *Is this preceptor program something that other medical schools do?*

R.K.: Sometimes, I think that some of them do. I'm not just sure; I don't know what the program is across the country; I don't know what the situation is.

Int.: *Was it started right at the beginning of the medical school?*

R.K.: I'm not sure exactly when it was. I can't recall exactly when it was started but it was very early on. It might well have been with the first class but you'd have to find out from some of the students. I would have to look up the records to find out. I think it was probably a few years later, though, before it started.

Another item that I'd like just to comment upon is that of the question of continuing medical education. There were many courses offered here locally by the Vancouver Medical Association, by the B.C. Medical Association, by the General Hospital. St. Paul's Hospital had a refresher course every year for physicians. The one at the General Hospital was very largely attended. There were a hundred enrollments every year at which, for 2 or 3 days, a program of continuing education would be carried out. However, this was not coordinated in any great way and, in the late '60s, it was decided that the faculty should organize a definite program of continuing medical education. It was decided that Dr. Donald Williams would be a suitable person to carry this out. He had been head of the division of Dermatology, as I said before. He had a lot of experience with administrative work and Dr. McCreary appointed him as associate dean in charge of Continuing Medical Education. He developed a very extensive program of various courses, but particularly clinic days and short courses throughout the province whereby one or two individuals from the faculty would go out to centres in the province and led a discussion seminar on various topics with the local physicians. Evening courses were organized in the Vancouver area. This has developed into a very extensive form of medical education within the faculty.

Early on in the 1950's Dr. Russell Palmer and Dr. W.W. Simpson built a dialysis machine based on the old Kolff dialysis machine. This was used at the Shaughnessy Hospital and at the General Hospital for patients with acute renal failure. It was a very large machine with a rotating drum and it was handmade by the mechanics at the General Hospital or elsewhere. Then other, more sophisticated dialysis machines were introduced for acute renal failure. There was the program for chronic renal failure. It became apparent from the work in Seattle that this was a feasible procedure to continue patients on who had chronic renal failure. Dr. John Price was instrumental in the adult field and Dr. David Lirenman in Paediatrics developed a very excellent program of renal dialysis based on the General Hospital. This was started in one of the wards at the General Hospital for the dialysis machines and this progressed on to have patients continued on for many years, coming in two or three times a week for dialysis. Then renal transplant was developed subsequently. This program was one of the early programs in Canada and demonstrated very

conclusively that patients could be carried on on these programs, living reasonably good 1ives. Some of them actually returned to work. One young patient I remember, one of the first patients that came on, was a young boy in his teens - 13 or 14 years of age - who continued his schooling and carried on for many years, coming in for dialysis two or three times a week.

Int.: *Thank you very much, Dr. Kerr.*