Oral History Interviews

Charles Woodward Memorial Room
Woodward Library

Dr. Rocke Robertson

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Biographical Information: Dr. Robertson studied medicine at McGill and served as the first Chairman of the Department of Surgery at Shaughnessy Hospital and Chief of Surgery at Vancouver General Hospital. On a few occasions he was Acting Dean of the UBC medical school. In 1959, he moved to Montreal where he continued his medical and academic career.

Summary: *Tape 1:*
Robertson's background; the medical school start-up from the surgical side; new buildings; clinical and pre-clinical communication; GF Strong Rehabilitation Centre; teaching wards; bedside teaching; admissions process; University/Hospitals relationship; Deans Weaver and McCreary; Children's Hospital; Dean Patterson; building problems; social activities.

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Interview with Dr. Parkinson, Wednesday April 24, 1985

Int.: *So, Dr. Robertson, could you begin by telling us just something about your recruitment to the medical faculty at U.B.C. in the early years?*

R.R.: Well, I was born in British Columbia in Victoria. I didn't go to U.B.C. I went to McGill for my medicine because there was no medical school at U.B.C. in that year, which was 1929, and I went to McGill and spent my whole undergraduate years there in medicine and did some graduate work there. While I was still doing my graduate work I went to war, went over to Europe for nearly five years and when I came back I was sent out to Vancouver, in the army still, to the Vancouver Military Hospital ; so I was home, you might say. And then, when the war ended, I was transferred to Shaughnessy Hospital where I was the chief of surgery there. That would be the years 1945 to 1950 roughly. And I was interested. I was going to go back to McGill to go on the staff of surgery there but I heard that there was going to be a Faculty of Medicine at U.B.C. and I was quite interested in that because I loved living here. So I just waited around awhile to see what would happen and stalled at McGill. Then Dr. Weaver from Minnesota, who was our first dean, came out and I saw a good deal of him. I had been trying to get some graduate training activities going at Shaughnessy - anatomy classes going and classes in surgery and so on

Int.: *This would be like a Continuing Education type of program…*

R.R.: That's right, for the interns and residents in the hospital, so we had a bit of a teaching function but that was the only teaching function in Medicine, really, in Vancouver at the time. I saw a good deal of Dr. Weaver when he was here, just preparing things for the medical school and much to my delight, after a while he asked me if I would stay in Vancouver and take on the chair of Surgery. So I was very pleased to do that, I must say. I then became chief of Surgery at the Vancouver General Hospital and stayed on as the chief at the Shaughnessy so that we had a link-up of the active work at Shaughnessy where the postgraduate training was going on and the work in the civilian hospital, the Vancouver General. By 1950, which was when the medical school started, we had quite a going surgical service in those two places and we were ready to receive students. We didn't have any proper teaching facilities at the Vancouver General and those had to be built. That took a little while. We needed classrooms and research labs and so on. I can't remember when they were actually completed but I should think about 1952 or so. Dr. Kerr probably told you about this. When we moved in there we had really very good quarters. We had our own teaching wards, and in line with those teaching wards on the same floor - with Surgery up above and Medicine down below - we had the offices for the staff; we had the research labs and then the classrooms and auditorium, and so on.

Int.: *Did you actually have students right away, or was it in the second year that the students came?*

R.R.: It would have been in the second year they came to us. They would not have come in the 1950 year…

Int.: *It would have been '51?*

R.R.: Yes.

Int.: *So you had a little bit of time to…*

R.R.: We had some time to get things organized. But we needed time. We had to get a staff together. There had been just no teaching really done, apart from the little bit we were doing at Shaughnessy, in this area at all and we had to try to find who would be practicing surgeons in the community who were keen to get into the teaching business; and their keenness was the important thing. There were very good surgeons, but we wanted to get people who were really interested in the academic side. And it turned out that we had a goodly number who were interested and did join the faculty. It did work out very well.

Int.: *Were most of your faculty people chosen from people already in Vancouver or did you have to go to other places?*

R.R.: No, we needed to have some fulltime people. Actually, I just had two full time assistants in those first years. One was Dr. Alan McKenzie, who came out from Montreal when he completed his training. He had been in the war too but he took his surgical training in Montreal after the war. When he had completed that he came out and joined me, and he was the first really fulltime assistant that I had. He later succeeded me when I left U.B.C. eventually, and was a magnificent surgeon. And Dr. Bobby Johnstone who had trained here with us and completed his training as resident. We took him on as a full- timer. So the full-timers were not people who had been practicing in this community but all the others, the part-timers, were people who were actually practicing here. Mind you, some of them had just moved here. Dr Sargent, who was the other professor in Surgery moved here after the war. He had been in Toronto at St. Michael's Hospital, on their staff before the war. He went to war and came back at the end of the war. Came to Vancouver and got on the staff. So he was an outsider, you might say, a very valuable outsider. He was a splendid surgeon and a very good teacher. He was the other full professor. He was a clinical professor - as distinct from a full-time professor - and he had one teaching ward service and I had the other teaching ward service at the General.

Int.: *Now, was all of your teaching done at the hospitals then? You didn't teach out at U.B.C. at all?*

R.R.: No, not at all. We occasionally went out for a lecture or demonstration or something of that sort but, generally speaking, no, our entire teaching was in the hospital. We had formal lectures in the auditorium at the hospital, in Surgery and the same in Medicine, and then the bulk of our time was taken up with clinical teaching on the wards. The

students were all there and we would have ward rounds with the students. With our offices, where we saw our own private patients and did our own daily work right next to the ward, we were able to pop out to the ward and talk to the students who were working on patients right there. We were just 50 feet from them so it was a very handy arrangement.

Int.: *You mentioned that Myron Weaver approached you and asked you if you wanted to be part of the Medical School. Did he have much to do with you in choosing people to work with you or was that more or less your responsibility?*

R.R.: It was really my responsibility to get people lined up and so on. We worked very closely together and I would talk over every appointment with him. But I would scout the field and work up a list of people and get their curricula all straightened away and so on, and then I would talk them over with him.

Int.: *So his role wasn't really that of getting the Department going, once he got the heads?*

R.R.: That's right, he delegated very well. He was a good dean and he would say, Here's your area, fix it. Do it right. He liked to be consulted and he was a very good consultant. He would pay real attention to what you were saying and sometimes he would come up with some pretty darned useful suggestions. He might spot a flaw in something you were doing and he would bore right in and expose you.

Int.: *Can you think of any examples, or is it difficult to?*

R.R.: I can't think of any specific examples of that now. I carried that general impression with me all the time. No, I don't think I can remember any examples. I can remember one or two people that he did not like, but that was purely on a personal side; he did not dislike them professionally. But no, I can't remember any specific example where he exposed a weak spot in my planning but I'm darn sure he did.

Int.: *Were you properly prepared for students once they were ready to come to you?*

R.R.: Sure.

Int.: *Did you have enough time to get everything ready?*

R.R.: Well, you never have enough time. But I think we had as much time as we needed. We may have failed to fill it properly; we may have been short here or there, but we shouldn't have been. I don't think we were. I think we were able to handle it right off.

Int.: *Did you have any ideas in your own mind of approaching your teaching a different way from what other schools had been using or were you more or less following the methods that you had been exposed to at McGill?*

R.R.: We ended up by copying almost exactly, or reproducing almost exactly, what was done in Toronto and McGill. But we didn't start that way. We had *carte blanche* to do anything we liked. There was no tradition. The field was wide open. Do what you 1ike. And we went through in our minds all the possibilities of doing this or doing that. At that time, there was a noble experiment being carried out at Case Western in Cleveland, and I remember Dr. Copp going - I 'm sure he told you about this - going to look at the system that they had, which was a brand-new, out-of-this-world, kind of system where they had abandoned completely the standard lecture program and the division between the departments, the division between Biochemistry and Pathology and Surgery and Medicine and so on. And they would take a subject and deal with it. And every department that touched on that subject at all would get into the teaching of that particular subject. You might be talking about duodena1 ulcers. They would have the medical man there, and the physiologist there to talk about stomach acid business; they would have the psychiatrist there to talk about the effect of that; they would have the pathologist there to talk about the pathology; and the surgeon, and so on. So it was an integrated teaching program. And they would have the anatomist there too and that sort of thing. Well, I remember Harold Copp - and he may have described this to you - one interesting observation he had to make on that. He went to Case Western and watched them at work, spent some days there. The thing that impressed him most was that he would sit in on their presentations - and the reason that I mentioned duodena1 ulcers was that that was the one that he attended - and he noticed that the students were all sitting there with loose-leaf notebooks and they would have in the notebooks compartments for anatomy, physiology, biochemistry, psychology, psychiatry, medicine, surgery, and so on. And when the surgeon was talking they would make their notes on the surgical side; when the medical man was talking, on the medical side .... In fact, they were disintegrating what the staff had gone to so much pains to integrate. So that sort of experience made us pretty cautious about trying anything very innovative.

Int.: *But this was a little later, wasn't it, not right at the beginning?*

R.R.: Not right at the beginning but it wasn't much later. His visit was later but we knew a lot about it before he went down and confirmed a lot of things that we had heard about. I made a tour myself in 1950, before things got going; and I went to the University of Washington and Minnesota, New York, Boston, Toronto, Winnipeg (I think). I made a good tour of McGill as well, went to about eight or ten areas and looked hard at the teaching in all places. They were pretty much the same; there were some differences. But they were pretty much the same and all fairly traditional. I came back and decided that there were one or two things that we did that were not done at McGill and Toronto - We had the students doing research fairly early on. They would have a day a week which was their research day and that, I thought, worked very well indeed. The students could elect to do research in any field they wanted in the faculty and we always had 3 or 4 or 5 students at any one time doing their research in surgery. They would come in on Wednesdays and conduct some kind of research program that you had worked with them on...

Int.: *So, did you have facilities set up right away then for that sort of thing?*

R.R.: We didn't in the first year, I don't suppose. I can't remember the dates, but pretty soon we had enough of them. And if they came to us and wanted to do some research we could find something - not necessarily in the lab, it might be on the wards or something of that nature. That was an innovation. But, for the rest, it was a fairly straight line as McGill and Toronto were in those days, and as they still are, really. Well, there are quite a few changes now, I guess, that was a long time ago.

Int.: *Did you run into any particular problems in getting your department going?*

R.R.: I can't remember any. It worked smoothly. It was one of the very interesting features of this whole business that we didn't have the town-and-gown problem that plagued so many places when they started off. Nearly every medical school that I know of had a town-and-gown problem; that is, the practicing doctors in a community being very upset by what the university was doing, and a row starting between the university and the practicing profession in that area. For some reason, and I think very largely because of Myron Weaver's good manners and activities, we just didn't have that problem at all, not at all. There was no resentment when we moved into the General Hospital and really took it over as far as the teaching side goes.

Int.: *There would have been somebody who was head of Surgery before you came. How did that person... ?*

R.R.: That was Dr. Neilsen, Russell Neilsen, who was a youngish - he was about 55, I suppose, when I came on the scene, and he had been chief of surgery for a while and he just very gracefully stepped aside and said, You do it.

Int.: *Would he have been approached first to take your job, do you think, and he didn't want to do it…*

R.R.: No.

Int.: *It wasn't any problem at all, your moving in?*

R.R.: No, we were great friends. He became the head of the Paediatric Surgery; his main interest was paediatric surgery, and he became head of that section. But he just seemed to be perfectly happy.

Int.: *Did he help you a lot?*

R.R.: Oh, yes, he was very good. I am sure that he talked to a number of people who might have been antagonistic towards this thing and got them to cool down and accept it. He was awfully good. We had lots of trouble with anaesthesia at one time, speaking of difficulties, and I can't remember the year now but it was pretty early on. We had an anaesthetist who was a brilliant fellow but thought that anaesthesiology was the really only important thing that went on in a hospital. And he really thought that patients came

to a hospital to have an anaesthetic - that the operation was of no consequence at all, the anaesthetic was the thing!

Int.: *(laughs) Well, that's the only thing that they really knew about, I guess.*

R.R.: Anyway, it was very interesting. You are asking about difficulties. He had been at the hospital for, I think, a 5-year term or something and his term came up. And he naturally expected, I think, that he would be re-appointed. But those of us who were in senior positions on the medical board at that time didn't really think that he ought to be re-appointed because he was, we thought, a nuisance in some ways. He had built up a very good, a big, department with a lot of teaching going on. But he himself, we thought, was a nuisance. So we recommended to the Board of Trustees that the appointment not be renewed. Whereupon all hell broke loose. The anaesthetists ganged up and said they would strike until he was re-appointed. And I had to say, Go ahead, boys, strike all you want. And I had then to mobilize the surgeons and find out who could give an anaesthetic, and we decided that we would go ahead, just working on emergencies - we wouldn't do any elective work - but we would stick to it and not give in to this strike threat. I can remember one day, having a meeting in my office in the old General. It was quite a big office and it was filled with anaesthetists - there must have been a dozen or 15 of them there, all mad as hops! So we had a real crisis time. But for some reason I never understood, they suddenly dropped the whole thing and went back to work. And he disappeared, went down to Los Angeles, and it all ended happily. He was happy in his new job, and we were happy he was happy in his new job. That is the only kind of difficulty I can remember.

Int.: *That was a problem that ironed itself out, then.*

R.R.: There was a great deal of bluffing going on, at least on their side. We weren't bluffing at all; we just weren't going to give into that kind of stuff and it turned out all right.

Int.: *Let's just go back a little bit to before the medical school was actually getting started. You say there wasn't any problem between the town and gown; but what about the time before, when there was debate about where the school was going to go and whether it was going to be at the Vancouver General, or just how it was going to be set up. Were you involved in that at all?*

R.R.: No, I wasn't, because the decision had been made by the time I got on the staff, and before I was on the staff I wasn't in any position to get into the row at all. I had nothing to do with the university. I remember hearing about this sort of stuff going on and it was clearly impossible to build a hospital out at the university in time to be ready for the students that were going to be coming pretty soon.

Int.: *Do you think it might have been a better thing to have waited until a hospital could have been built, to have waited a few years, or was that not really a possibility?*

R.R.: It was not really a possibility, I think. Money was fairly short, and to have waited would have been a completely indefinite thing. You couldn't have promised the students anything. And the early students were post-war types. They were very eager. There was strong pressure to get going from the students themselves and their families, and a lot of the university staff and a lot of the doctors in the community. There was very strong political and perfectly justifiable pressure to get this thing going, and everybody knew from experience that if you were going to wait to build a building to get a thing going you are maybe going to have to wait a long time and really treat those people who come in in those first years, while you are still waiting, very badly. So there was going to have to be teaching somewhere else if you were going to start the medical school within foreseeable time. So it was going to have to be the Vancouver General which was acceptable - big enough and so on. So it was a combination of Vancouver General and Shaughnessy. Then, once the General got going and the building was built down there, there was still talk of building the university hospital. Myron Weaver was ill two or three times and I went in as an acting dean for two sessions…

Int.: *So you would have been quite involved… ?*

R.R.: I was deeply involved then. That would have been in 1954, '55, '56 sort of time, and we were then drawing plans for the university hospital that was to be done. And also plans for a building for the medical sciences section: Anatomy, Physiology; Biochemistry. We spent a terrific amount of time on that and we would have meetings out at the university and get the anatomists to say what they needed in terms of floor space, and the physiologists to say what they needed, and so on. But to try to get it all together was just terrible because, as you know, everybody wants everything and nobody wants to give anything up. While it was still on paper you had the chance of getting....

Int.: a little bit more, perhaps?

R.R.: Absolutely. So that was kind of difficult. We didn't really start thinking hard about the hospital until a little bit later; actually, just before I left in 1959 when Dr. McCreary came in and was dean. Then they started to do the acute thinking about the hospital on the campus and I drew plans for a surgical department in that hospital in 1959. The hospital didn't actually get built until 1970 or something like that, or more. But there was an interesting argument while I was there and sometimes acting dean as to whether or not there should be a university hospital at all; or whether it might be better to leave it as a split school, with Anatomy and Physiology and Biochemistry out on the campus and augment the facilities at the General Hospital. And perhaps build a new Children's hospital there; whether it might be better to have a unified school, move the preclinical departments down to the Vancouver General area and have everything in the medical school down there, not associated with the university. That was possibility #2. Possibility #3 was to do what they have done, which was to build a relatively small hospital at the university and still keep on the General and St. Paul's and Shaughnessy. Possibility #4, I suppose, which really could never happen, would be to build a whole hospital facility for teaching out at the university campus, which would be crazy. It would have to be a huge hospital and just isn't needed out there. I must say I was in

favour, and I think Dr. Kerr was in favour, of the second possibility I think I mentioned which was to augment the clinical facilities down at the General Hospital and leave it as a split faculty - there are lots of split faculties in medical schools all over the world, with clinical things split away from pre-clinical, and we thought that was the best solution. But Dr. MacKenzie just put his fist down - I remember one Senate meeting - and said No, there is going to be a hospital on the university campus, come hell or high water. Well, it came twenty years later, I guess - but he had his way. And I think the university hospital is turning out to be very useful and successful now, as far as I can gather. And the General is carrying on too; so it is still a semi-split thing. Most of the hospital activities must be taking place away from the campus, I would think.

Int.: *Do you think that made it difficult for students, or staff for that matter, having it so far away?*

R.R.: You mean the pre-clinical and the clinical? No, I don't think so. The students were doing their pre-clinical work all at one time over the first year & a half or two years, and then they were mostly clinical from then on. So that they were working either at the campus or at the university. They weren't rushing back and forth during the day very much - well, perhaps for some, there might be a bit of work to do. But it was not too difficult; there were no squawks about it.

Int.: *What about just the communication between the clinical and pre-clinical staff? Was there much of that possible?*

R.R.: There was a lot possible.

Int.: *Was it necessary?*

R.R.: Highly desirable, hardly ever attained. It is a very difficult thing to attain in any medical school because they are, you might say, different people. Temperamentally, there are differences between the pre-clinical and the clinical people. I say this without any disparagement at all. They are different people. They have quite different interests often, although they are sometimes closely merged but in general, more often than not, their interests are a bit different and their capabilities are different. You do get instances where there are joint research projects between the two. There are quite a lot of those but not nearly as many as you would like to see. It is becoming more frequent now that so many of the clinicians are highly trained in statistical work, in physiological work and so on, and I gather now from the way people are talking that there is more cooperation and cohesion between the pre-clinical and clinical than there was in my day. So I'd leave it at that. It's a highly desirable thing, what you would like to see, and very hard to attain.

Int.: *Probably, from what you are saying, difficult even if you don't have a split school.*

R.R.: Yes. Well, at McGill, for instance, which is hardly a split school - it's a fairly unified kind of thing - you don't see very much contact between the clinical and the pre-clinical;

some, but not nearly as much as you would think there would be. Places 1ike lots of university places in the States, the state university and so on, they have a whole complex. The whole medical school is there, medical school and hospital and so on, and they might just as well be a thousand miles apart as far as the cohesion goes. So it only works when you get personalities on the two sides who are interested in the same thing and keen to work together; and that's not a very common combination.

Int.: *You did mention that Myron Weaver, the first dean, was quite good at working with people. Did he manage to bring the clinical and pre-clinical people together very much? Or was that part of his role?*

R.R.: I'm sure he would have loved to have done it. He brought the clinical professors, the full -timers, together with the pre-clinical a lot. We used to have a faculty council, which was made up of all the department heads and so on. We worked a lot together early on, and continued to. Even when I was acting dean, we were having meetings of this faculty council once or twice a week. So in that way he brought them together. But I think he was really so occupied with a thousand and one things to do that he really would not have had much time to bring people at any other level together. It was very hard to do.

Int.: *I understand he came from Minnesota. Do you think there were people from Vancouver or from Canada who had been approached to be dean?*

R.R.: I can't tell you because I don't know. I think there were people who might easily have been considered by the President or the Board of Governors. Dr. Strong in Vancouver was one who might readily have been thought of as a dean. Against him was the fact that he had had really no medical school experience at all. He was the most magnificent organizer I ever knew but he had had no medical school experience and he was a very brusque fellow; I don't know how he would have worn as a faculty leader. He was a wonderful man. Do you know the G.F. Strong Centre here?

Int.: *Yes, I do.*

R.R.: I think the development of that is worth recording. I had a lot to do with that. It was an interesting story and should go down somewhere in the annals, and it has some connection with the University. I was the head of Surgery at Shaughnessy at this particular moment, which would have been 1946 or '47 - somewhere in there - and we had a number of paraplegics in the hospital, veterans who were paraplegic, and they had had all the treatment that they could have. They didn't have any more wounds or needed treatment in the hospital, but there was simply no place for them to go. I can remember Frank Turnbull coming to me one day - he was the head of Neurosurgery at Shaughnessy - and he said, Look, we've simply got to do something about these paraplegic fellows in there. They've got nothing to do and they don't need to be in hospital. It's a bad place for them. They are beginning to drink and misbehave and so on. It's just dreadful. We've got to do something about them. So I said, Have you got any ideas? And he said, No, I don't have any ideas but let's do something. So I thought about

it a little bit, and Dr. Strong's daughter had fallen in their house from one floor to another and she was a paraplegic, and he had taken a tremendous interest in trying to get her settled well; and I knew he was interested. And I knew the Workmen's Compensation Board were interested in it because I knew they had quite a few paraplegics to take care of. So I called a meeting one night in August of a year - whatever year it was - and had Dr. Strong and the medical director of the Compensation Board, and Dr. Turnbull and myself - I guess that was the group - and I just said, We've got this problem. Have you any idea what we should do? Dr. Strong said, I think we should have a centre to take care of these people, a rehabilitation centre. And I said Yes, and how do you think we should go about that? He said, Well, I think we ought to form a committee and go to work and see what we can do. Well, that was August, and we said, You'd better be chairman of this committee. So he said, Fine. And I went on the committee. I don't remember having a committee meeting for a few months. The next thing I knew they were starting a financial campaign, which was complete by I should think about the end of October. He went to a few people who had a lot of money and they provided the whatever-it-was, a million, a million & a half, to build this building. He got an architect friend to design things and so on. The next thing I knew we had a groundbreaking ceremony in January…

Int.: *Pretty fast work.*

R.R.: …and the building was opened and patients admitted the following January. It was a year and a half from the just, "What are we going to do about this thing?", entirely due to Dr. Strong's effort. He just bullied and persuaded people and got things done in the most remarkable way. Well, that was the Western Society for Physical Rehabilitation that was established just up near Shaughnessy, which has now built up; they have expanded their role; they are taking arthritics now, and children with all sorts of physical disabilities. It's an enormous success. It's been added to time and time again and it's now the G.F. Strong Rehabilitation Centre. It was one of the marvels of the country, and it all started from some paraplegics who couldn't be taken care of in a hospital decently any more. It was a great story. He was a brilliant administrator. He was one who might easily have been a dean if he had had any medical school experience. I can't think of anybody else locally who would have been a contender for it. I'm sure they canvassed people in Toronto and McGill and so on.

Int.: *I understand Dr. Strong was quite involved in the early stages in planning for the medical school.*

R.R.: Oh, yes, he was. He had a lot to do with it.

Int.: *He went and did a survey of some of the medical schools of North America.*

R.R.: Did he? I had forgotten that.

Int.: *I was just going to ask if you had a chance to read his report or were involved in that in any way, because I think he did a report as well as Dr. Dolman doing a report.*

R.R.: Did he? I remember Dr. Dolman's report. I must have read Dr. Strong's report. I don't remember doing it.

Int.: *Do you recall Dr. Dolman's? What was the general reaction to Dr. Dolman ' s recommendations?*

R.R.: Do you know, I can't remember what they were, I'm ashamed to say. It was a long time ago, and I must have read 50,000 reports since then. I have no recollection. I remember him as a highly intelligent individual. And my general feeling, if you asked me if his report was useful or good and so on, I would have said Yes, it probably was, but I can't remember what the recommendations were.

Int.: *I think some of the recommendations he was making were specifically a hospital at UBC, and not going ahead with the split school but trying to keep it all in one at the university. But as you have already explained, it seems that that was not possible. What about money? Was there enough money for you, for your department, to go ahead and do some of the things that you wanted to do?*

R.R.: In the first year or so, they were really quite generous. I could not take on as many full-timers as I would liked to have had. But we got our building done fairly quickly and it was well equipped. I would say, Yes, we did have at the beginning quite generous funds to get us going. We didn't really need to scream for anything. Later on - nine years later, I was there for nine years - towards the end, we were beginning to be pinched and didn't have the money that we needed for this and that. But at the beginning it was a bit belvedee, good.

Int.: *What about the clinical appointees? You mention that most of them were part-time. Were these people paid for what they were doing? How was that arranged? How were their hours determined?*

R.R.: You ask if they were paid. I think that they were paid something like $100 a year, a purely nominal sum. It was, in effect, a voluntary business. Probably they were paid - I wish I could remember precisely - but my guess is that they were given $100 a year or something of that sort. What we did when we were drawing the thing up, I drew up the arrangements for the staff and assigned them to various ward services. Then I would draw up what lectures there were to be given, what activities there were to be; and I would make a list of the staff people I had and write down the assignments, and then I'd simply call them in and say, Would you do this? There was never any problem at all; they were keen. Every time you get a new thing going it's relatively simple. And it's always relatively simple if you talk to the people about it.

Int.: *Were these people involved in their own practices as well?*

R.R.: Yes.

Int.: *How would they have managed? They just didn't book patients in at the time that they were going to be lecturing, or did they have specific times that they would set aside each week?*

R.R.: They had specific times when they would have teaching assignments, taking students round the wards, or working with students on patients, or marking exams or doing this kind of thing. So they would have specific times. And they would try to arrange their work so that they didn't…

Int.: *So, in effect, by agreeing to work for the Medical School, they were really cutting down on their own income. Because they would take fewer patients they wouldn't have the time, so it really was quite an output.*

R.R.: It was indeed. Mind you, there is an old argument as to whether it's fair to have people this way and not pay them full living wage, as you might say. There's another side to it. The very fact that they have this university appointment and a hospital appointment and so on puts them in a privileged position too. Their position in the community is raised quite a bit. People have patients referred to them by doctors because they are on it. The amount of time that they would actually lose from their private practice, in any individual case, was not very great at all.

Int.: *Was there a specific amount that they were supposed to… ? That was left to them?*

R.R.: That was left to them. I shouldn't say, left to them. Left to the head of the department to deal things out as fairly as could be …

Int.: So that one person wasn't getting overloaded ...

R.R.: Yes, as fairly as could be, but always bearing in mind that you wanted to take advantage of the good teachers, to get the students exposed more to the good teachers than the ones that weren't quite so good. And some of the very best surgeons we had were not very good teachers; and yet you couldn't exclude them from the staff because they were useful. And then, you never know. A person who seems to be a poor teacher may turn out in the end to have a more lasting effect on students than somebody who looks good. I remember in my own student days we had a fellow that I thought was absolutely - we all thought he was a marvelous teacher - he would just make things so plain and say, Look at this: What do you think it is? And you would say, Well, I don't know. Well, he'd say, it could only be one of ten things. It isn't this and it isn't that... and he'd get down until only one was left, and he'd say, Well, that must be it. Every once in a while it was it. As often as not, it wasn't. But anyway, he was a marvelously organized teacher and we thought he was just great. I came to realize, maybe five years after I was out of medical school, that in fact he was a disaster as a teacher. He gave us all the wrong principles to operate on. And some of the people whom we thought were dullards - rotten teachers - they are the people who I now can remember as having said something useful.

Int.: *That's true. It's not always the entertainer either, though to a student they often seem to be the one who is the best. What about beds at the Vancouver General? How were they allocated to the Medical School?*

R.R.: Speaking for Surgery, we had two wards that were allocated to the Medical School: B.3 and B.4, I think it was, and Medicine had similar wards down below. Those were for General Surgery. Then the Orthopaedic Department and the Neurosurgical Department, and Ear, Nose and Throat all had their allotment of beds. They were done really on a hospital basis but they were also teaching beds. B.3 and B.4 which were the general surgical teaching wards, were just university patients, you might say. The Nose & Throat, and Orthopaedic, Plastic, and so on, and Neurosurgical units had patients who were not teaching patients necessarily. Actually, they were. Every patient was taught on if they had something teach worthy to display. They weren't categorized as teaching beds; they were just Neurosurgical beds or Plastic beds, or whatever. But our General Surgical and General Medical ones were classified as teaching beds.

Int.: *When patients were brought in and they knew they were going into these wards, did they know beforehand that they would be part of the Medical School and maybe used as teaching material?*

R.R.: We weren't nearly as legalistic in those days as people are now. I rather think that we didn't give anybody a piece of paper saying, Look, you are on the teaching thing. Everything was taken for granted. I never remember a single fuss at all. No problem.

Int.: *I think it might be a lot different now.*

R.R.: Oh, very different now. You've got to give people legal instructions as to what their position is, their rights are, and so on. In those days things were very easy.

Int.: *That must have made it a lot easier altogether to start the Medical School .*

R.R.: Much easier. I can't remember a law suit involving the services I was in charge of for a good, long time. I can remember a problem being about bed allocation, which was an amusing thing. I was very keen to have our B.3 and B.4 services, which were the two general surgical services, to have both male and female patients in the same ward. There were 4-bed rooms and 2-bed rooms, and I thought we ought to have x number of rooms for the female patients and x number of rooms for the male patients. But the nursing staff said, No, this won't do; we'll have all sorts of trouble if you mix up the men and the women. We ought to have all the women down on B.4 and all the men on B.3. I said, No, that won't do because we want these two services to be complete individual services. You can't have it, it just unbalances the whole thing. You've got to mix them up. No, said the nurses, That won't do. Anyway, we had fairly bitter arguments.. ..And I won. We set up our wards with B.3 having men and women and B.4 having men and women. We hadn't been going for more than two or three months when - to my horror - when I appeared on the ward at crack of dawn and the head nurse said, Look, we've got a

problem. Last night one of the women patients came from B.4 and was found in bed with a man on B.3. I thought, Oh God, we' re in real trouble …(Telephone interruption) .

Int.: *So, where were we?*

R.R.: I was just telling you about the lady from B.4 who was found in the bed of a gentleman on B.3. And I thought, My God. The nursing staff are going to get after me and say, We told you so, that this was going to happen. Later that morning I heard that one of the interns in the hospital had been found in one of the bedrooms of one of the nurses in the nursing home, right across the street. So I realized I had a point and I could point out to the nurses that, even in the best of controlled circumstances you are going to get this kind of thing happening, and changing the arrangements on B.3 and B.4 wasn't going to fix anything. But, you know, they never said a word. They never came along and said, We told you so. So we got away with it finally. (Laughter.) But we had those kind of tussles going on in these formative years. But that worked out all right.

Int.: *So you didn't have any problem with availability of beds?*

R.R.: We seemed to have enough.

Int.: *And there were enough different kinds of patients for you to work on?*

R.R.: I think the patient mix that we had was really very good. And the students were rotated round through these various services. They would spend more time in general Surgery than they would in any other, but they would spend a bit of time in each of the services, and got an inkling of what was going on in Neurosurgery and . . .

Int.: *How did you conduct your teaching with your students at the bedside?*

R.R.: I'd love to take you round and show you. It's an interesting process and it's a lot more than just teaching what the patient's got to show. You are really trying to inculcate in the student an approach to a patient. How are you going to appeal to this patient, this person, to tell you what you want to know about them and give a good account of their symptoms? To get the most out of them that you possibly can; to engage their confidence and engage their respect - this kind of thing. It's an approach which is very important. If you run up to somebody and say, What have you got? you get next to nothing out of them because it just startles them. So you've got to say, Where are you from and how many children have you got? You've got to make a decent approach. So that's part of 'How do you go about it.' That's Part I, to make the contact on favourable terms. Then you try to elicit the patient's story while the student is there and that takes a bit of doing and a bit of skill as often the patient doesn't know how to describe her or his symptoms. You've got to bring it out and get them to explain what kind of pain they are having and where it is and when it comes on and what does it do to them and what other troubles have they got. Then, having taken the story, you come to your physical examination. You have a nurse there and she will undress the patient, and you will examine whatever you need to examine. All the time the student is there and watching

you, perhaps in their first episode or two. Maybe, the next day, you'll get the student to do everything that you have done before, on another patient, and get him to go through the whole process. And you'll check him up here and there, later on when you are out of the hearing of the patient, you'll say to them, Take it easy. Don't be so brutal, or Don't be so silly, or Just be a little more factual.

Int.: *How many students would you work with at a time?*

R.R.: Maybe - well, it varies a lot. It depends what the occasion is. I should think never more than four if you can possibly avoid it. So you would often have a group of four students and an intern and a resident, and yourself. Maybe five or six. They would gather around and that would take pretty well the whole circumference of a bed. And it's a little tough on a patient to be surrounded by a lot of eager people so you've got to approach them a little carefully.

Int.: *What were the students like, the first students that you had? 1951 would be the first batch, I guess, that you had contact with. Were they the type of students that you had expected, that you really wanted in medical school ?*

R.R.: Oh yes. They were a grand lot, that first batch that we had. One of the best classes of all was that first lot. There were a lot of veterans in the class, older ones who had been around and knew exactly what they wanted. They were all very definite about getting on with the job and they were a fine lot. I think we can say, Yes, they were a fine lot.

Int.: *Were you involved at all in procedures in choosing the students?*

R.R.: Yes, a lot of us were. We were a big selection committee and it was a very interesting process. I think there may have been eight or ten of us on the selection committee, the dean and several of the fulltime heads, and the students would all have filled in their application forms and their photographs, and letters from their ministers and letters from other doctors, and their full grades and so on at school and university. And they would ship these applications around. I forget - there were something like 400 applications in the first year, I think something of that order, and fifty spots. These would be shipped around to each member of this selection committee a bundle of a dozen or 15 or something, and we would all make our own notes on each application. Then we'd come to a meeting - we had a very large number of meetings - and the name would be read out of the first fellow you were going to think about, and the Dean would just go round the table: How do you grade this fellow? - A, B, C or D? There was a pretty good unanimity, opinion on the thing, and we were able to whittle it down without too much fuss into the fifty that we thought were best, and they turned out to be a very good lot. We did have one interesting example, to show you how fragile that process of application and application studying is. It was this. One of the applicants was a lad whose name I have long since forgotten. He had a perfect record. He was straight A's; his minister thought he was a wonderful boy and his family were just great, and his doctor thought he was a most likely fellow, and he had letters from scout leaders and everything you could think of. We poll graded him right on the top flight of the thing.

We went right around the table, I can remember, and everyone said A or 1 or whatever his category was at the top, until we got to the last fellow and he laughed. He said, I'm very interested to hear what all you people thought about this. It really makes you wonder. I happen to know all about this fellow. He said, Really, he's a most doubtful character with a bad record. He's been dealing in drugs and he's on the RCMP's surveillance list, and he did this awful thing and that awful thing. He described them all. He would have been a perfectly dreadful fellow to let in but we would all have stepped right into the gap; there wasn't any way for us to know. On paper he was super.

Int.: *They are not the kind of things you write down on an application form, are they? (Laughter.) I don't imagine there were too many applicants of that sort…*

R.R.: I don't think so. No.

Int.: *…particularly in the beginning of the medical school at UBC.*

R.R.: Oh, no. He must have been a quite extraordinary, outstanding character.

Int.: *What about the relationship between the Vancouver General Hospital and UBC, and between the staff at the Vancouver General and the staff at the university. Was that quite a good working relationship, or was there really not very much contact so that there wasn't really any relationship there at all?*

R.R.: Let's see how I'll handle this one. Over the years, the average level of relationship would be very strained, I think, between the two. In the very earlier times when Weaver was working and so on the relationships were really quite good. He worked well with Mr. Hickernell who was the executive director of the Vancouver General and was a member of the board of trustees of the Vancouver General. He was a very useful member of it and got on well with the rest of the board. I think you would say in the early years that the relationships were really quite good with the university. Later on, they became very strained indeed. For the past 10 or 15 years I think there has been a lot of tension between the Hospital and the University, the Hospital feeling that the University wasn't able to get the building arrangements that the University ought to have got with the Hospital. The University was dealing with others at Shaughnessy and St. Paul's, and so on. I think there was that kind of bad feeling going on although I was at a distance at this time.

Int.: *But you would say, in the '50s and even the '60s, there was quite a good….*

R.R.: I think so. I can't remember any serious rows.

Int.: *What was the attitude of the general practitioners in the Hospital to the faculty and staff at the University?*

R.R.: Perfectly good. I was saying earlier on in the interview that there was hardly any town-and-gown problem. That was most evident in the General Hospital itself where I think

there were 1200 people on the staff, and maybe 200 of the university staff on the Vancouver General - I wouldn't know what the number was, but something like that. So there were hundreds of people with admitting privileges at the General Hospital who had nothing to do with the university, and they weren't hostile as far as I can remember.

Int.: *You spoke a little bit about Dean Weaver. What about his relationship with the staff at the Hospital and his relationship with the people at the University?*

R.R.: I think they were uniformly good. He had 'outs' with Dr. Strong at the Hospital. Otherwise, his relations with Dr. Kerr, for instance, who was the head of Medicine at the University end of the Hospital, were awfully good - with Dr. Kerr and myself, and the others in the Hospital. I think he was universally popular. I think he was very well liked by the pre-clinic people too at the University.

Int.: *Would you say that he did a good job of being dean?*

R.R.: *Yes, yes.*

Int.: *those first few years?*

R.R.: He was not well for part of the time. He had two breakdowns. But on the whole he did awfully well.

Int.: *He had a lot to organize, a lot to get going.*

R.R.: He did indeed, and he was perfectly wonderful. The school was due to start in September of 1950. They were converting old huts that Dr. MacKenzie had brought down from Bella Bella or somewhere like that on barges - I think he stole them or had them stolen - and brought them down on barges and installed them on the campus; and they were fixing them up inside to make Anatomy labs and Physiology labs. Dr. Weaver brought his own very good carpenter and he brought his own lathes and saws and did a lot of the work himself but, as the days approached to opening school they were still not complete and he had that staff of carpenters and workers of all types just working like mad. And by God, they got it ready – I think it was just a day before the students were to arrive that they put in the last nail - largely due to his effort. Then they had a party. Has anybody told you about the party? It was great fun. It was a picnic thing that he put on for all members of the faculty and all the people who had built the buildings. We had it out near the university in a field somewhere. We barbecued salmon, I remember? Did you ever have salmon barbecued; they did it in a pit, I'd have you know. They dug a foot deep pit and put a fire in the thing with some embers and spread out the salmon on stakes and hung them over the thing. The salmon would be – oh, five feet away from the embers. And gradually, after hours, you would see a little bubbling on the far side of the salmon and you'd know that it was cooked almost through, and they would turn it around. Anyway, my recollection is that the salmon was the key point, but we had baseball games and running races for the kids; barbecued salmon and lots of fun.

Int.: *Was this for the staff?*

R.R.: No, it was really to honour the workmen who had worked so hard to get the building finished.

Int.: *For the workmen and the faculty, but the students weren' t involved in it?*

R.R.: No, there weren't any students. They hadn't come yet. They came tomorrow or something like that. It was a great party and it was just an example of the way he did things. He was such a nice fellow.

Int.: *I think you mentioned already, but I'm not quite sure if you were there when Dean McCreary was appointed dean; or had you left by that time?*

R.R.: No, I was still there.

Int.: *Could you tell us something about Dean McCreary?*

R.R.: He came early on on the staff. He was the appointee in Paediatrics. There were four main clinical appointees at the beginning: Medicine, Surgery, Paediatrics and Obstetrics. Dr. McCreary came out in that first year and right away he got busy and tried to develop his paediatric service. There were two sets of paediatric beds that he had anything to do with. I think there was a small ward down at St. Paul's; but there was a section in what was then part of the semi-private pavilion in Vancouver General. It was a children's ward. And there was the small Vancouver Children's Hospital somewhere off in I've forgotten where it was now. But it was about a 50-bed hospital somewhere out west. He didn't have many beds in Paediatrics and they weren't very well organized. And he set about right away to try to get a proper children's hospital going. Right in the first week he was here he started on that. He didn't actually get a children's hospital during his lifetime but there is one all set up in the Shaughnessy complex now. But I don't think it was opened before he died. But he worked like a beaver to get that going. He was a magnificent worker and a good organizer; but he was up against something tough in getting this children's hospital going. It was an expensive proposition. There were a lot of people against building anywhere and separating the children. They thought the children ought to be put in a general hospital area. It was a bigger problem than he ever dreamed it would be. He had come from the Hospital for Sick Children in Toronto and fe1t that he would like to reproduce that out here, a smaller example but along the same general lines. He came very close two or three times to getting it signed and dotted but never quite did. But it was well on its way when he died and was finally produced three or four years after he died. A pleasant fellow, very intense; a splendid doctor, a splendid paediatrician. Did very little practice after he got here because he was just so busy trying to get things organized. And then he adopted the same intense tactics of getting things going when he became dean. He started to work right away on the university hospital then, and it was for him that I drew up the plans for the surgical department. In 1959 we would have meetings at seven in the morning in his office down at the General

and talk about these plans. The psychiatrists would be there, and Dr. Kerr from Medicine would be there and we'd battle over space requirements. That would be in 1959. I forget when the university hospital was opened. It wasn't until 1978 or 1980, I suppose.

Int.: *It was quite a while after, yes.*

R.R.: But he was a very intense, very good fellow.

Int.: *Would you say he was a good dean?*

R.R.: I was only here for 6 months - less than a year - during his time. I couldn't say. He was intense, trying to get things done that were awfully difficult to do and obviously miles away from getting them done. While he was trying to do these things the school was running perfectly smoothly underneath all this turmoil to try to get bigger things done. So things were working alright while he was dean and I think his plans were along the right lines alright. He was trying to get funds from the Federal Health Grants, I remember that was the big job that he had and I think he was successful there. I think the money was granted and did eventually help to build the hospital. But he was always wheeling and dealing at a higher level, trying to get a big hospital built or a bigger hospital built, or trying to get $30-million or $50-mill ion or whatever it was from this or that place. So I can't say from my own direct experience whether he was a good or bad dean. He didn't have time to have any results to tell. On the whole, I think he was regarded as a good dean. He was well 1iked by everybody, I think.

Int.: *What about Dr. John Patterson, Dean Patterson? You were here when he was here as dean. He was here just for a short time. Why do you think he didn't stay longer than he did?*

R.R.: He was a strange man. I can remember sitting on the Search Committee looking for a dean. I was acting dean and I didn't want to be dean. I had refused to be dean. So I was very keen for this Search Committee to do its stuff and get us a dean - anybody but me! We had a pretty good Search Committee, and Patterson from Cleveland, he was from the Case Western Reserve, his name came up and was strongly backed. I remember Sydney Friedman introduced his name into the list. There were one or two leads that we didn't follow up that we should have followed up because it turned out that he had had some difficulties in the past that we could have discovered if we had dug a little deeper. In any event, he came out - he was a pleasant sort of person at the beginning. He had very big ideas. He wanted to see the premier right away, as soon as he got here. I can remember, when he came out here, by way of entertaining him we took him to dinner one night and then we went to the Theatre under the Stars - do you remember that?

Int.: *Yes, I do.*

R.R.: Mr. Bennett happened to be at the Theatre under the Stars that night and the dean insisted that I take him up and introduce him right away and he tried to get a date with

the premier. So he was very pushy that way. He had some extraordinary attitudes to people, I think. He was rather brusque and he had a number of rows. He didn't seem to like it here and he didn't endear himself to the local group. It wasn't a happy appointment at all. He had a lot of capability. He was an eye man, an ophthalmologist, really, or an eye pathologist – something to do with the eye, I've forgotten just what. But I think he had an idea when he came out here he'd have all sorts of money and be able to reproduce Case Western and so on. Money was hard to come by, and the buildings were temporary and nothing was happening much. That wasn't for him; he wanted to go on to greater things. I've forgotten where he went. I don't remember where he went after he left here.

Int.: *I should know. I think it's on one of the other tapes somewhere. What about the buildings that were finally built? Why do you think it actually took so long to get buildings for the pre-clinical years at UBC?*

R.R.: There are a number of reasons, not the least of which is the slowness of people to make up their minds about what they will settle for. I say this again without ma1ice. They were behaving like normal people but normal people aren't very good at accommodating each other. I sat in as acting dean on many, many meetings of these people trying to get a plan that we could say was a working plan and they could start to get some architectural drawings on. There were delays. I think there were times when, if we had had some working drawings that we could have presented, we could have got the thing going. There was money that we could have got from the Government.

Int.: *Earlier?*

R.R.: A lot earlier. I'm drawing on my memory now but I've got that very fixed in my mind. I told them, For God's sake, let's get something settled because if we don't we're going to lose time, and lots of it. Well, we didn't get agreement reached as to how much space this department and that department could have; so there were those delays which cost us plenty because, by the time we came along with some kind of a plan, the money that might have been ours had dissipated. So that's reason number 1. Reason number 2 is very simple. They were in competition with all sorts of other faculties and departments in the University - the Library and places of that sort - that needed space in the worst possible way. And they were in temporary quarters but still workable quarters; they still had something. And I'm sure there were faculties - I've forgotten what they would be now - that were really crammed for space and needed to get somewhere. So money that could have gone to Medicine went to other things because their need was greater. But I have always felt if the fellows had been able to .... or perhaps if I had been tougher on them and hit them on the head and made them come to a decision, it would have been better.

Int.: *I believe there was a building built at the Vancouver General in 1957. If they had had plans drawn up for the buildings at UBC, do you think they might have been built before that? Was money that went into the building at Vancouver General money that could have gone into buildings at UBC?*

R.R.: I don't know what the '57 building was.... What was it?

Int.: *I'm not sure whether it was the Centennial Building.*

R.R.: Oh yes. No, I don't think those were competing funds. The Centennial Building was a purely private building. There was no teaching went on there. So it was a Department of Health building and would not have had anything to do with the Department of Education. In other words, it was not . . .

Int.: *It was not a UBC building.*

R.R.: No. The Centennial Building is a purely private pavilion. Rather, it replaced a private pavilion.

Int.: *You mentioned there were facilities built for teaching right at the very beginning. I imagine they were absolutely necessary, and that money wasn't money that could have been used in any other way.*

R.R.: Absolutely, and interest money spent right at the beginning too. Again, I have forgotten when we went into those buildings but it would be '52 or '53, something like that.

Int.: *What about the general allocation of resources between the clinical and pre-clinical years. How was that determined?*

R.R.: We had to draw up a budget every year, obviously, and it was determined at budget time by the dean - or acting dean; I had to do about three budgets, I think - and there would be the normally expected arguments each time with each department putting up its good reasons for wanting more of the wealth, then the dean would eventually have to make the decision. That was the only way you could do it. You could never reach a consensus on a budget; somebody's got to sit down and say, It's got to be this. You'd think it would be simple to say, Alright, we've going to have a 5% increase so we'll just have a 5% increase across the board. But that's not a good thing to do because not everybody needs a 5% increase and some people need a lot more than a 5% increase at any one moment, so across-the-board doesn't really satisfy the situation. So you have to go over everybody's needs very carefully and try to really work out what's going to happen. But, in those days, the decision was really made by the dean. After consulting everybody he would try to get as close to the truth as could be, and he never was able to satisfy everybody by any means. Now, the subdivision between clinical and pre-clinical was no different, really - at least, the difference between them than the differences between the departments on the clinical side and the departments on the pre-clinical side. You know, everybody was pushing for an advancement. The pre-clinical budgets were always much bigger than the clinical ones because they had a lot more staff as a rule, full-time staff, and a lot more equipment and so on to be purchased; a lot more teaching materials to buy than we had. So much of our work was done by these volunteers we were talking about, who weren't a big strain on the budget.

Int.: *We talked a little bit about the general practitioners who worked part-time. Do you think that starting a faculty of medicine helps you make them more aware of their own skills and just generally helps to make doctors aware of their own skills and improving them in the province?*

R.R.: I do indeed. There isn't any way you can measure that kind of thing but I think you can point to a number of the activities that go on when there is a medical school there that wouldn't have gone on if there hadn't been a medical school, that make it almost certain that the medical school is a good influence if it provides those activities. We developed a lot of post-graduate teaching sessions. We had touring groups going around the province, clinical days here and there: Rossland, Trail, Kamloops, this kind of thing. We had the practitioners in the Vancouver General, for instance regularly attending the pathological conferences at the Vancouver General and the surgical theatre clinics, and this kind of thing. So there would be all sorts of these kinds of teaching activities they would attend. Then there was a lot of surveillance in the hospital, looking at problems that would develop in the hospital. Somebody would report that patient A was not getting proper care and you would just leap right into it. In days before the university, I don't think that was as common as it became. Particularly on the surgical side. Errors in surgery are often much more apparent than in any other area, very obvious as a rule!

Int.: *(Laughs.) I would imagine. I think that was one of the goals of starting.*

R.R.: One of the reasons.

Int.: *Not one of the main ones but it was certainly a spin-off…*

R.R.: A by-product of the medical school which can be very good. It can be negligible in some of the American schools. The universities, that is, the medical schools, are right outside the community's activities. They are just little ivory towers by themselves. But we weren't. We mixed pretty well, I think.

Int.: *Do you think that… Well, first of all, I think one of the goals of the people who were involved in getting the Medical School going was to have a first-class medical school. Do you think that goal was achieved?*

R.R.: It's awfully hard to say. I'd love to be able to say definitely, Yes, it's a first-class school. If it's not first-class, it's come fairly close to it. I don't think I could bring myself to say it's an absolutely first-class school. It hasn't yet, and it takes a very long time to get to be first-class. It is unusual for a school to be first-class from the word Go. I think it has had its ups and downs. I remember times at which it has been a little stronger than it has been at other times. I doubt if you could say that it has reached the first-class category yet. I think that a pretty good base has been built and I think if the economy of the province improves and the University could get some more money to spend to attract some more staff, it's just on the verge of being first-class. So I'd say, high second-class, and could easily be first-class if it was just given a break.

Int.: *So you would say that, from the beginning, it had to do with finances, really not having enough money available to do a lot of things that most people would have wanted.*

R.R.: Oh, yes, if we could have had another surgical department, for example, the medical department could each have had another half-million dollars a year, which sounds like an awful lot but that will get you maybe each six or eight good, full-time people. By the time you have paid their salaries and their secretaries' salaries and bought them some space and so on, it is all used up.

Int.: *Do you think having the school split would affect whether or not it was a first-class school?*

R.R.: I never thought so because I did not see the unification of the faculties, where they are unified, as being a very effective unification. And I looked at a lot of schools. I don't think splitting was a big factor.

Int.: *I think if we could talk a 1ittle bit about some of the more social things, some of the skit nights and graduations, those sort of things, times when the staff got together. Can you recall any of those things specifically?*

R.R.: Yes, we had a lot. I'm pretty vague on them now. We'd have departmental parties from time to time. Maybe 1'll start from base. We'd have a lot to students to our house, for instance. Every week we used to have a research night for our department at the Vancouver General. My wife and Dr. Allan McKenzie's wife and Dr. Murray Johnson's wife would produce a supper down at the lab. I had my office down at the General Hospital. And the staff of that ward and the students that were working on that ward would eat some supper, and then two or three students or staff people would put on a display of the work that they were doing on that research night. That was a weekly thing that exposed us to the students who were assigned to us. We'd have dinners each year, graduation dinners - I can recall going to those - and all the staff and students, and graduation dances, that sort of thing. We had those. I have some pictures at home of some of those dinners. About games: We used to have hockey games with the interns. I suppose there were some students there, I don't know, but that was great fun. We'd rent the Kerrisdale Arena and take the interns out and have a match between one staff and another. We were lousy hockey players because nobody in this part of the world is brought up to skate properly, but it was great fun.

Int.: *Did this usually involve the pre-clinical as well as the clinical people?*

R.R.: That didn't. That would be just clinical people. The dinners and so on certainly involved the pre-clinical.

Int.: *What about beer and skit nights? Do you remember any of those events?*

R.R.: Yes, I remember one night in particular in an hotel downtown somewhere. Mac Whitelaw gave a speech and we had - I don't think it was a dinner, I think it was a beer and skit-type evening - and he gave a hilarious speech. I remember it was a great success and there was a lot of talking back and forth. I think we had several of those with one or two members of the faculty speaking. Those were beer and skit-type things, with probably the graduating class. I don't remember; there have been so many since then.

Int.: *I'm sure, yes. Going back to 1950 or '51 is a long time. What about preceptorships? Were you involved in placing students in any of those?*

R.R.: I don't think we had any of those in my time.

Int.: *It might have been a little later.*

R.R.: I think it was a little later. I don't remember getting involved; we may have sent students on to doctors to work for them in their offices. I can't remember whether it started. We certainly talked about it but whether we actually did it before I left, I don't know, I can't remember.

Int.: *What would you say just the general level of teaching was within the Faculty of Medicine? Do you think it was quite good?*

R.R.: I think, quite good. Just going back on the Anatomy and Physiology and Biochemistry, I think it was probably very good. They were all first-class people. Pathology with Dr. Boyd, William Boyd. Have you heard about him?

Int.: *A little bit.*

R.R.: Well, you should have something on your tapes about him. He was a Scot, William Boyd, who took his degree in Edinburgh, I think. He was involved in the British Army, in the Field Ambulance, in the First World War. He wrote a book on it, a lovely little book. Then, somehow or other he got appointed to the chair of Pathology in Winnipeg, University of Manitoba. He had really not very much knowledge of Pathology at that time. He told me, told us all, that he learned most of his knowledge of Pathology on the boat coming out from England to Canada so he could teach at Manitoba (Laughter.) But, anyway, he eventually became a great pathologist and a great writer of textbooks. Boyd's Pathology was a standard. He wrote half a dozen different textbooks: Pathology for Nurses and Pathology of Internal Disease, and Surgical Pathology and so on.... He produced these textbooks at the speed of light and they were marvelous things to read. They were splendid texts. I can remember, while he was here - he went from Manitoba to Toronto and was Professor of Pathology in Toronto. He retired there at the age of 65 and he was inveigled to come out here and start the Department of Pathology out here as a sort of a post-dated doctor. He did splendidly when he got here and he got things going wonderfully well. All the students loved him. While he was here, I remember him giving a party one night, a social event, a cocktail party. All the faculty went to it and he

announced at the party that the reason for it was that he was celebrating the occasion of his millionth volume of textbooks that he had sold. His publisher had just advised him that they had sold a million; he was that kind of person. He and Dr. Hal Taylor who has long since left produced a very good Pathology Department, I think. Medicine was very strong under Dr. Kerr. Obstetrics, I think, did a fairly good job. Obstetrics is not an easy thing to teach. It is awfully cut and dried, and easy to do. There is not so much variation in that as there is in many other fields. Surgery, I can't say how good it was; it's a little difficult to say. I never felt that we were as good as we could be. We could have been better, I thought, but I don't know how we were judged at all. I was never satisfied, but I guess you shouldn't be; it's pretty complacent to be satisfied with what you are doing. That's about it. The Pharmacology and so on were perfectly good under Dr. Foulkes - I think the teaching was good.

Int.: *Another thing that has come to my mind is the question of a thesis. I understand that this was required in the first few years and then was dropped at a later date. Were you involved in that at all? Would students have chosen a thesis under you, perhaps?*

R.R.: I did have one or two students under me, I think. I had more at McGill later on - I think I did; well, I'm sure. At least in my Department, if not under me directly, in my Department, students who came to do their research work in our Department and would write their thesis on the research work that they had done. I can remember several of those: McGraw was one particularly good one. He's been a very successful young orthopaedic surgeon, I think. So we were involved in the thesis game, but I don't know why it was dropped. It must have been after my day.

Int.: *I think it was too. The students were tired of it. (Laughter.)*

We're just about at the end of this tape, Dr. Robertson so I'll turn it off.