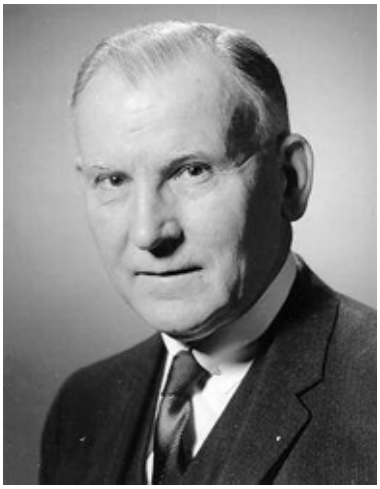

Dr. Donald H. Williams (1907-1999)

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Biographical Information: After training as a dermatologist outside the province, Dr Williams returned to BC in 1937. He was with the BC Ministry of Health, and Head of the Departments of Dermatology at VGH and UBC. Later he spearheaded the development of the Department of Continuing Medical Education and served as its Head from 1960-1967.

Summary: *Tape 1, Side 1:*
Personalities involved in the early medical school--Hickernell, Strong, Dolman, Ranta, Weaver, Kerr; the university hospital; basic sciences vs. clinical
Tape 1, Side 2:
Continuing medical education; Deans Paterson and McCreary; Cancer Institute work
Tape 2, Side 1:
First class admissions; university-hospital relations; medical team work
Tape 2, Side 2:
Early medical school research; financial concerns; Claude Dolman

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Interview with Dr. Don Williams, Friday September 27, 1985

Int.: *Dr. Williams, to begin with could you tell us when you got involved with the Faculty of Medicine? What year were you first involved in what was going on out there?*

D.W.: Well, from the time that I arrived in Vancouver in December 1937 I became involved in lectures at the university to social workers and nurses. That was my first contact. And then I became involved to some extent in the early planning, mainly at that time because of my association with the B.C. Medical Association and I also, after the war was over, was a member of the Council of the College of Physicians and Surgeons. I was honorary treasurer and, in that capacity had an official interest in the development of the medical school.

Int.: *So, in those years there was really a lot of debate going on as to whether there should be a medical school or not, and you were involved in that then?*

D.W.: That is correct.

Int.: *There was a lot of student activity, pressuring for an early opening of the medical school and then there were other people who thought that it should wait until things were absolutely ready. Where did you stand on that issue?*

D.W.: One of the big forces - perhaps before I answer that - was the large number of veterans from the war who came back with hopes, aspirations, and a promise of federal government support because of their service with the armed forces. And they, as I recall, were the dominant force. They were an older group than the usual student group because they had spent what would have been their student days in service overseas. Now, you asked me - what was the other…?

Int.: *…where you stood on the issue? Whether the school should start early or whether one...*

D.W.: Yes, But he wasn't here very long before he and Dr. Strong were in as bitter a battle of personalities as we had witnessed at the birth of the medical school and between Dolman and Dr. Strong. And the Hickernell/Strong feud went on during the days of Marvin …?

Int.: *Oh, the dean. Myron Weaver.*

D.W.: I'm sorry, Myron Weaver. And we had a situation where Weaver, the dean of the medical school and Hickernell were pitted, although Weaver was very diplomatic, he was a kindly, diplomatic man. But that was another…The medical school, sadly, was involved in two major conflicts that related to Dr. Strong's personality.

Int.: *When did the conflict with Hickernell take place? Immediately after, or…*

D.W.: It took place during the early clinical years.

Int.: *Early '50s?*

D.W.: Early 50s when Myron Weaver was the dean, before his health sadly crumbled away.

Int.: *So it sounds as if you would think that a lot of the controversy in those supreme Faculty of Medicine years had a lot to do with Dr. Strong and just his way of dealing with things?*

D.W.: There's one word that really describes him. He was an arrogant man. That adjective. And his arrogance didn't go down with Dr. Dolman at one phase and it ran into conflict with Leon Hickernell within a few years later.

Int.: *Do you think there was anybody who might have been able to ease things over or change things in any way when there was debate about the opening of the medical school?*

D.W.: There was one, in my view, great giant of a man who was, through all of this, right in the middle of it and who sadly died a little over a year ago, and that was Lawrence Ranta. Lawrence Ranta was very closely associated – he was in preventive medicine right from the beginning. There was no question in my mind that there was a need for a school. I was strongly in favour of it.

Int.: *What were some of your reasons for feeling that it was necessary to start a medical school here?*

D.W.: At first it was based on population need, but we were dependent on the rest of Canada and Britain and the United States for our doctors we weren't producing. The other thing is that I felt at the time that we had a unique opportunity of developing a new concept and a new medical school based on that concept, namely, preventive medicine under Dr. Dolman's leadership.

Int.: *Now, mentioning Dr. Dolman. As it got closer to the actuality of a medical school Dr. Dolman was asked to go and do a survey of schools that were in existence in North America and when he came back he wrote a report and gave his views on what he felt should happen with a medical school in B.C. And basically, he felt it would be better to wait rather than to start one right away. I understand there were specialists brought in and they basically backed up his ideas. How did you feel about that?*

D.W.: I was prepared to accept that although my gut feeling was that we should be getting on with it.

Int.: *I think Dr. Dolman also recommended that a hospital should be built at the university, on the university site. Did you think that was a good idea?*

D.W.: I wasn't too sure of that but I became certain later, when I saw the medical school in operation, that it was an unfortunate thing that there were six miles between the campus and its clinical teaching facilities.

Int.: *Do you think this made it particularly difficult for student and faculty as well?*

D.W.: I'm sure it did. And I'm sure that the product (the graduate) would have been a better product if he had, during these critical, formative years, been in the milieu of a general university.

Int.: *So what do you think was the main reason, or main reasons, that a hospital was not built at that time?*

D.W.: I don't recall. You see, that goes back about forty years.

Int.: *Do you think it had to do with just strictly finances?*

D.W.: That undoubtedly was important. The other problem was teaching resources. The medical school got started on a shoestring, both from the financial standpoint and from the standpoint of teaching resources. They went out into the highways and the byways and brought in whomever they could for free - literally. And I'm afraid you tend to get what you pay for. The result was very self-evident, that some of the quality of teaching in the earlier years in the clinical fields was pretty pathetic.

Int.: *Would you say the same thing about the teaching at the university the pre-clinical years? Or do you think it was of a higher quality?*

D.W.: I think, no question.

Int.: *So they really weren't comparable in that way?*

D.W.: No question.

Int.: *Just to go back a little bit. At the same time that Dr. Dolman was doing his survey and his report, Dr. Strong went off as well to do a report. What was your reaction to his findings?*

D.W.: First of all, I thought it was almost a tragedy at the beginning to have two such strong, dynamic, creative personalities locked together in bitter dispute. For a new, infant medical school to be born in this situation was, I think, very unfortunate. So I felt very sad about it. My whole interest in 1ife has had a very strong preventive, social component. That being so, I tended to favour Dr. Dolman. Further, in all the years, fifty or more years that I have been here, Dr. Dolman to me, to this day, I would say is the most brilliant brain, intellectual, that this province has ever had by far. And I've seen them all. Dr. Strong was an entirely different sort of individual. Well, he tended to be what you might call a power broker in the field, a very strong political figure. I wouldn't say an intellectual.

Int.: *Would you say a lot of things that he wrote down in his report were more personally determined by his own personal ambitions than perhaps Dr. Dolman's would have been?*

D.W.: Some might say that. It is so long again since I have looked at the two reports and it is so far back in history and not having refreshed my mind I'm not certain about that.

Int.: *Can you recall what the general reaction was to the two reports? Just how people who were going to be involved in the Faculty of Medicine or people who were just interested in it, reacted to them? Or was there much interest at all?*

D.W.: Among those that were interested in the medical school there was a bitter split. And later on we had another bitter split involving Dr. Strong again, between one of the directors of the General Hospital, who was again a great creator: Leon Hickernell. I don't know if his name has come up?

Int.: *No, this is the first time I've heard of it.*

D.W.: Leon Hickernell came from the States to be the Director of the Vancouver General Hospital and under his aegis of not very many years he made profound changes, both administrative,

organizational, and structural in the university full-time and he was very close to Dolman. And he became the first assistant to the dean, not an assistant dean, to Myron Weaver. I had known him before because of my interest. I had been, almost within months after I arrived from my graduate training at Mayo Clinic, I was made director of the Provincial Ministry's Division of V.D. Control, which was a big area of public health interest at that time, a controversial one and I never dreamed I would get into it. But that brought me into close association with Claude Dolman because he was the Provincial Ministry director of laboratories. So we were both senior members of the Department of Health together. And Lawrence Ranta was in some consulting capacity. But Lawrence Ranta I observed in my capacity as one of the members of the first screening committee. The first three years Myron Weaver was on, one had a chance to observe Lawrence Ranta in action: the humanity of the man, the understanding of students and their problems, a conciliator. He then went from that position to become Medical Director of the General Hospital. He remained there for many years as Secretary of the Medical Board, which is a key power position, and worked under Mr. Hickernell, who was his Medical Director. Lawrence was a tremendous, kindly diplomat, a Rock of Gibraltar, and looking back over the years he was, I would say, one of the greatest forces in the whole picture, particularly in relationship to the General Hospital and the Medical School on Campus.

Int.: *Where did he stand? Which way of going about it was he in favour of?*

D.W.: I'm not sure. I'd say his roots were in Preventive Medicine. He would be loyal to Myron Weaver; he was loyal to Mr. Hickernell. He was always loyal to whoever was his chief.

Int.: *What about Dr. MacKenzie who was President of the University at the time? What was the role that you saw him playing in all of the debate?*

D.W.: Larry MacKenzie was a great diplomat. He wasn't above it in an aloof way but he never interfered in any way that I could see.

Int.: *So you couldn't see that he could maybe have altered the direction or eased things over in any way at all?*

D.W.: Undoubtedly he gave the final answer in his position of power but he certainly never to my knowledge - and I 'm pretty sensitive and I was pretty close to the principals – took sides. He had great ability to handle things diplomatically.

Int.: *What do you think was the role of the specialists who were brought in to assess the situation? I think it was Dr. MacKenzie who agreed to bring these people in to have a look and to give their opinions after Dr. Dolman had done his report and Dr. Strong had done his and there was sort of a stalemate, almost.*

D.W.: Here again, not being a Department head at that time, and my memory isn't too…

Int.: *Well, this was just before the Faculty of Medicine was actually opened, too.*

D.W.: I haven't a clear impression on that.

Int.: *Were you involved at all in choosing the first Dean, Dean Weaver?*

D.W.: I was not on the committee. No.

Int.: *Do you think he was a good choice as the first Dean for the Faculty of Medicine?*

D.W.: Yes, I do.

Int.: *What reasons would you give for that?*

D.W.: I thought that he had the ability to pick good people for the first Department Heads which really, to begin with, the first couple of years were basic medical science department heads. I thought he, on the whole, chose well as far as his clinical appointments were concerned. I'm speaking rather generally, so I thought he got the Medical School off to a good start. I thought he was firm, he knew what he wanted to do and yet he was kindly in accomplishing his godls.

Int.: *In 1950, when the Medical School first opened its doors, what was your position on the staff?*

D.W.: I wasn't . . . . My field was dermatology and so my formal appointment didn't come until Dr. Kerr and his Department of Medicine had been formed of which Dermatology was a Division.

Int.: *So was that a few years later?*

D.W.: No, that would be toward the end of the second - end of the third year.

Int.: *1953, around there?*

D.W.: Right.

Int.: *So, did you work at the Vancouver General Hospital, or out of the Vancouver General , or uut at UBC, or both?*

D.W.: At the General I was Head of the Department of Dermatology. At the University it was a Division of the Department of Medicine and at the General it-was a Department of Dermatology but under the umbrella of the General department. You see, d person like Dr. Kerr, as you probably already know, had two hats: he was Head of Medicine at UBC and Head of Medicine at the General; and I was the same. We all were who headed up Divisions.

Int.: *Was most of your teaching done at the Vancouver General then?*

D.W.: A11 of it was done at the Vancouver General because that's where the clinical material was.

Int.: *What kind of facilities did they have set up for UBC at the Vancouver General when you started?*

D.W.: Pretty inadequate, that's putting it mildly.

Int.: *Could you describe them a little bit?*

D.W.: The whole of the Medical School, as I said, started on a shoestring. It's just a miracle, an act of faith, that it got where it did. And due in no small respect to the tremendous contribution that busy, practicing doctors made, gave for free and, of course, in so doing many of them, bless them

- really God didn't intend them to be teachers, and they weren't teachers - and the result was, there was a lot of clinical teaching that I observed that certainly was not top quality .

Int.: *Would you say that students at UBC received an education that was not comparable to what they might have received at other institutions across Canada - McGill, or anywhere else they may have gone?*

D.W.: The best answer I can give - I don't know about those earliest years but I know that, let me say, 15, 20 years down the road, that the Medical Council examination, which is right across the country, is-a good measure of relative quality. And I know that in those years, once the Medical School got established, that UBC graduates were at the top for Canada, and that says something.

Int.: *Somebody must have been doing something right.*

D.W.: So it's an indication that there was a tremendous amount of dedication and sincerity of purpose went into getting the Medical School on its feet. And the Vancouver General Hospital and its Board of Directors, which were largely senior, distinguished business people, went out of their way to help the University Medical School and its clinical facilities work. But they had their money problems. And here again, this is where Dr. Ranta was so important as medical director. He was a tremendous supporter, quietly effective in implementing things. Dermatology was a low subject on the totem pole and certainly I always found that if I had needs that were reasonable, he was always behind me and I got what I wanted or needed.

Int.: *Did you find that Dr. Kerr was much the same, that he was a good person to work with?*

D.W.: Dr. Kerr was an unusual person, a superb clinician -- I would say a clinician in the tradition of Osler, really tops in clinical medicine. I think there were deficiencies as far as human relations and administrative ability were concerned. But I could overlook those because none of us is perfect and his accomplishments outshone any problems. I hope I'm being fair.

Int.: *I think you are explaining yourself very well.*

D.W.: He certainly became recognized - is recognized - as one of Canada's most distinguished men in the hierarchy of distinguished doctors in Canada; is president of the Royal College, which is something very special, and so on.

Int.: *Did Dr. Kerr actually recruit you for your position, or was it Dean Weaver?*

D.W.: Well, I would think that, knowing the way that Dr. Weaver would work, he would ask Bob Kerr, who he thought should head up his division of dermatology. And Bob Kerr, I would think, would make the recommendation to Myron Weaver, who would make the recommendation to the Board of Governors. And the President would make it to the Board of Governors, and so on. So that, I would think that Myron Weaver would give the departments heads a free choice.

Int.: *You mentioned that he was involved in getting most of the department heads into UBC before it started in 1950. What were some of the other jobs that he had to do before the Faculty of Medicine opened? What other roles did he play?*

D.W.: Myron Weaver?

Int.: *Yes.*

D.W.: I really don't know. Well, very obviously, he would have to develop the relationships with Government, the Health Department, for example; with the General Hospital; with the B.C. Medical Association; with the College of Physicians & Surgeons, and so on.

Int.: *Do you think that he might have been able to do anything because of his position to speed up the possibility of a hospital being built out at UBC, or having money allocated in different ways than what it was allocated? Do you think he might have been able to do that, or was that not really his role, or was it just not his...*

D.W.: I would think the question of whether or not there was going to be a hospital there or at the General would be very much on his plate. As a matter of fact, I remember seeing the original legal agreement between the Board of Directors of the General Hospital and the University of British Columbia, and noting its particulars; and certainly his imprint and advice on that would be important.

Int.: *So would you have had any idea that you can recall of where he would have stood on that issue?*

D.W.: Now, this is just an impression; but I never at any time was aware of him being in conflict with the idea of the clinical facilities being at the General. He and Mr. Hickernell worked well together, I knew that. I think, at the time it would have been totally impossible to have funded a hospital on campus. He was here the first I don't know how many years, five years or more. The dean himself and his administration were in army huts; our board room and our screening room were in old army huts, fixed up nicely but still army huts, so to think of a medical school impoverished as to have to live in surplus, left-over huts, in a position to mount a modern hospital was just unthinkable really.

Int.: *But the Government did allocate money to the Medical School, and I would imagine that Dean Weaver would have had a certain say in how that money was distributed. Or do you think all that would been up to Dr. MacKenzie?*

D.W.: Oh no, I would think that the budget for the Medical School would have been prepared by Dean Weaver, there would be no question of that. I am sure there wasn't money, there just wasn't money. And the other thing was, the University under Larry MacKenzie was undergoing an unbelievable post-war expansion, and every dean, and every department of every faculty was expanding and screaming for money. And for the Faculty of Medicine to have got a chunk of money to build a hospital I think was so beyond reason. I think it was just felt, thank God there is a General Hospital who is bending over backwards to help us.

Int.: *So you would say, then, the relationship between the Vancouver General Hospital and UBC Faculty of Medicine was quite a good one from the beginning?*

D.W.: I think generally it was.

Int.: *And they did accommodate the needs of the University without too much trouble?*

D.W.: They never satisfied everybody. Some people were less satisfied than others, and we all had to get on with really makeshift facilities at the General, just as we did on campus.

Int.: *Do you think then that when the Faculty of Medicine did open that it was properly prepared for students or not? We've taken this question within what you've already said, that it was done on a shoestring.*

D.W.: Well, all I can tell you is that at the end of the five-year period, four-year period, when the first class, second class, third class and so on had to write the Medical Council examinations of Canada based on standards set by established practice and experience in centres like Toronto and Montreal and so on, our graduates did well, the product did well. So you've got to give a lot of credit. It must mean that, in spite of shortages of resources, facilities and funds, they produced a product; and they deserved a tremendous amount of credit, everybody did.

Int.: *They must have been all very dedicated to what they were doing.*

D.W.: That's the word. And that is sort of the feeling that Myron Weaver gave.

Int.: *What sort of expectations did you have when you became part of the Faculty of Medicine?*

D.W.: Well, I had been trained in one of the most sophisticated clinical settings in the world for three years, namely, the Mayo Clinic. To come out to this was not easy to take. But that didn't bother me, didn't bother me.

Int.: *Was there a feeling of excitement simply because it was new, as well ?*

D.W.: I don't know that I would put it that way. I can just say that one enjoyed being with students. There's something very satisfactory about being with students in the context of caring for people. Wherever it is, if it’s working in an Indian village up in the Queen Charlottes with very primitive arrangements, it's very satisfying. So I think that that sort of satisfaction, rather than maybe excitement…. would express my feeling.

Int.: *What did you have to do, in particular, to get your Division off the ground, to get it rolling? Can you recall any of the specific things?*

D.W.: Well, first of all I had to plan. I had to determine what the needs were; and, therefore, based on the needs, what the goals were. And then, how I would go about achieving them. And then getting people who would help me and who would understand what we were trying to accomplish. That's saying it in sort of general terms.

Int.: *Did you have to go out and recruit other staff? Did you have very many other people working for you, or in your Division?*

D.W.: Dermatology wasn't a big department, and it wasn't difficult. After the war a good many young, bright people who had heard about Vancouver and British Columbia, a new medical school, a lovely place to live, you can boat and fish - you know. The result was there were really lots of people to choose from.

Int.: *So you didn't have any problems in finding anyone?*

D.W.: None whatsoever.

Int.: *The people you wanted?*

D.W.: First class, well trained, keen. Just tops.

Int.: *What was the relationship like between the pre-medical part of the University and the clinical at the Hospital, the staff in each of those sections?*

D.W.: One would say that they agreed to each go quietly their own way and, for me, the sadness was that distance made it difficult to meld the two. Whenever there was, as there was every week, medical ward rounds for example, where some very interesting patient would be presented, that had very important biochemical, physiological, pharmacological, anatomical implications, there was no one from this wonderful, dedicated, basic science resource sitting there to speak their piece. And whenever there was teaching going on here, there wasn't a top clinician saying something like, Now, what we've just been telling you about the muscles on the legs has a bearing on this clinical condition.

Int.: *So it really was two separate educations going on at the same time?*

D.W.: Well, they were separate geographically, but they were separate in time too. The first two years essentially was basics; the third and fourth year were clinical. My hope had always been that these two would have merged together and there would have been a mutual strengthening, but particularly, strengthening in the end product of good quality care for the sick person.

Int.: *Thank you, Dr. Williams. We've come to the end of this tape so I'll just turn it over.*

D.W.: Are we through?

Int.: *We were just discussing the division between the clinical and pre-clinical years and you were saying that they really were separate educations in a way, the first and second years at the University and the third and fourth at the Hospital. Do you think there is any way within the context that was given, working with the Hospital six miles away, that could have been handled differently?*

D.W.: Yes, I do. I believe that if a small group of basic science teachers and clinical teachers had been constituted with the task of devising ways and means of integrating and coordinating the two bodies of knowledge, the basic and the clinical , that it could have been easily accomplished. To me it meant two things. It meant the transfer physically, at appropriate occasions - ward rounds, special meetings, clinical meetings - of designated resources from the campus basic sciences to the General Hospital and, in turn, this committee would designate certain people who would be present during learning exercises on campus to let the first and second year students see what the clinical end and relevance of all they were learning as basic science was. I think it simply involved setting up a mechanism. And then it seemed to me that there was so much, so many examples could be drawn from the basic sciences, with their clinical application brought close to the teaching of the basic sciences and vice versa, at the General. That never seemed to take place. Everyone was too busy in their own back yard.

Int.: *Can you think of any specific instances where an individual tried to make some sort of a bridge, or were there none that come to mind?*

D.W.: I'd like to be modest, but I must say that I did it myself in my own teaching. I attempted to, to some extent. But not as fully as I would have liked. And I would say it was really just a testing of the waters.

Int.: *Were you able to keep it up? Or was it difficult under the circumstances?*

D.W.: The truth of the matter was that I didn't have the time, I was pre- occupied with so many other things.

Int.: *Things outside the University and the medica1 school?*

D.W.: Well, for example, I found myself in a ten-year period, right at the height of my teaching responsibilities called in by the Minister of Health and told, 'I have a problem; I need help. Will you head a committee?' And on four occasions in ten years I had to do that. That involved really a miniature royal commission where you had hearings; you received briefs; the chairman had to write the draft report and teaching was going on at the same time; so for some of the concepts and ideas I had, the days just weren't long enough.

Int.: *I can see not. How long were you involved in dermatology?*

D.W.: With the medical school?

Int.: *Yes.*

D.W.: From sometime toward the end of the second year. I was appointed to begin to do my teaching in the third year.

Int.: *That went on until....?*

D.W.: That went on until I retired in, let's see, 1969 I guess it was.

Int.: *I see. So, at the same time you became involved, I understand, in the continuing education within the Faculty of Medicine as well. When did you get involved in that?*

D.W.: That was exactly 25 years ago. I started the 1st July, 1960. And I had a busy, big, consulting, private practice in dermatology, which I closed completely and devoted my full time to developing this department.

Int.: *How did you get involved in developing the Continuing Education?*

D.W.: Dean McCreary came to me one morning at the General. He was just driving away from having made rounds and he saw me and he called me and asked me if I would sit in the car beside him. And he said, 'We're thinking of setting up a Department of Continuing Medical Education. How would you like to be the first head of it?' I said, 'I'd love it.' and that was it.

Int.: *And that was it, right then and there? So did you...*

D.W.: I knew that it was being considered, but in my wildest dreams I didn't relate myself to it at all. I didn't think anybody would even think...

Int.: *And you obviously felt this was an important area to develop at that time?*

D.W.: Right.

Int.: *And how did you think about going about it, and what steps did you take in order to get it started?*

D.W.: Well, first of all it was a new field and so I made a study of all the best departments of Continuing Medical Education that existed anywhere in North America and I visited them all. Before I started out I had perhaps sixty on my list. But I found out very quickly that there were only about a dozen that really were worth seeing. And before I went to them I devoted a great deal of time to learning what I could about adult education, its principles and its practice. And I made a long list of questions that I wanted to ask before I went. And I never stayed longer than two days at any place because I found I could get the answers very quickly. In other words, the first step involved self-education. And then I spent a whole year in setting out clearly what my goals were and how I would go about it. And at the end of one year I had a complete detailed blueprint of what my program would be each succeeding year for five years. And, do you know, at the end of five years it had almost worked out. One of the rare things that I don't think any other department had in the University - they may be doing it now, I don't know - but every year I got an annual report out. You see, if everyone did this your job would be so...

Int.: *It's all there.*

D.W.: Here is the whole story. And to give you an idea (rustles through papers), there was my plan sheet at the end of the first year of my program.

Int.: *You opened up clinics in these specific places: Upper Vancouver Island?*

D.W.: We took the - my whole philosophy was, except for a few courses, to take all the courses off campus.

Int.: *So you sent out information to the doctors within the Province and informed them that you would have these courses available to them within the different areas: Kootenay region, Okanagan, Central Fraser Valley and Vancouver Island. Then they came to a specific centre and they had their courses there, so it was very convenient for them. There wasn't any correspondence type of course given.*

D.W.: The point was that it was a two-way street. Our teachers, when they would go out, would not give lectures. They would simply introduce a subject, for 5 minutes, 10 minutes. Everyone would sit around a table and then the local doctors, who would know what their problems were, they'd set the agenda. And the thing was just a free-wheeling five hours.

Int.: *So each region would have possibly totally different programs going on depending on what their specific needs were?*

D.W.: That's right. But then these university teachers would also go out with - for example, each of the courses would be on a specific area. It might be paediatrics, the next month it would be obstetrics, and so on. Now, the paediatrician would know that there was a recent advance in the care of the diabetic child that he had found out about at a recent meeting, that wasn't generally known. And at an appropriate time during the day he would say, 'Do any of you have any children with diabetes?' And several hands would go up. He would say, 'Would you be interested in hearing the latest treatment from Harvard? Because it isn't in the textbooks yet.' And, of course, there would be. And the teachers would come back on campus with an entirely different idea of what they should be teaching. And so it had the impact on the teaching; it was very considerable.

Int.: *Where did you get your teachers from? Were they from the clinical departments that were already set up, or did you get teachers from the outlying areas who ... ?*

D.W.: No. For example, suppose we were putting on a program on cardiology for five hours in Trail. At the beginning of the year, when all the detailed planning, the logistics for the whole year's program were going on, I would go to Dr. Kerr and say, 'We would like the doctors in the areas to tell us what fields they would like,' and I'd say, 'Now, Dr. Kerr, Trail has asked for a day on cardiology. Who would you like to go out?' Dr. Kerr and all the department heads learned very quickly that if they didn't send out their best teachers it would reflect badly on them. And so the result was, that although Dr. Kerr might have - say - sixty people teaching his students, he would only pick about six or seven that he would trust off campus with the practicing doctors. And to be invited by your department head to go to Prince George or to Prince Rupert was a badge of honour.

Int.: *So that was to be my next question, actually, were these doctors eager and willing to go off and give these lectures to the outlying areas?*

D.W.: Tremendously enthusiastic.

Int.: *So you got a good response?*

D.W.: And well received. And of course the other thing is, if they create a good impression in Trail, the first thing they know they are starting to get patients referred from Trail.

Int.: *That's true too, I imagine, yes.*

D.W.: And that strengthens them and the University.

Int.: *What was the response from the practicing doctors? Did they.. . .?*

D.W.: Oh, it was tremendous - very favourable.

Int.: *And they felt the lectures they were given were worthwhile?*

D.W.: We had a questionnaire sheet, and a very careful one, one that they had to think and work on well, which assessed the subject matter and the teacher. And the teacher, when it got back, knew, and so did his department head, how he had done. They were very concerned if they got black marks.

Int.: *Did that happen very often?*

D.W.: No, because they realized that they had to produce. It was a very successful program and it became literally a world model. And we had, over the years, visitors from all over the world coming, spending anywhere from 2-3 days to a month, just observing our program.

Int.: *And you were involved, as the head of this program, from 1960 until 1969 when you retired?*

D.W.: I stayed on until .... 1967 was my last year, and in '68-'69 the medical program had been so successful that Dean McCreary, who had then become coordinator of all the health sciences, asked me to head up a new continuing education program for all the health sciences. So then, what had been a trial model in the Faculty of Medicine, then I expanded to take in everything: nursing, pharmacy, dentistry, rehab medicine.

Int.: *And were all of these other areas handled in the same way?*

D.W.: The same basic principles. And here is my first report of the big expansion of the program.

Int.: [*They look at the report]. So it looks as if you were involved in a lot more communities in the Province as well, once the other health sciences were involved in the continuing education?*

D.W.: The entire Province.

Int.: *And again, did you recruit people from the University to go out and teach the courses?*

D.W.: The same pattern.

Int.: *The same pattern again?*

D.W.: Yes, but in each health science they determined their own program. But by and large, the general principles were the same.

Int.: *And again, was the response good from the people out in the field?*

D.W.: I think the answer is that the programs are going strong in all fields…

Int.: *Today?*

D.W.: …whereas when I first got into the field it was a brand new concept and now it is just accepted in all health fields that you keep up to date.

Int.: *Were there other aspects of continuing education that you got involved in? Did it get into any sort of research sort of topics or was it strictly lecturers and information given that way?*

D.W.: The best answer I can give to you is this. That I defined what continuing education was in a number of lectures that I gave. This one I gave in Belfast at the Royal Victoria Hospital, the Sir Thomas and Lady Dixon Lecture, in May 1969. I put it this way: 'That continuing education was first the scholarly habit of planned daily reading and study in a home library sanctuary as an integral part of a doctor's workday. Secondly, the periodic return every 3-5 years for 3 months or

more of intensive study. Thirdly, the day-to-day informal and formal colleague association and patient care in the community hospital, teaching hospital, group practice, and by consultation. And fourth, the attendance at scientific sessions of learned societies. And fifth, attendance at short courses. I maintain that the finest and best form of continuing education is the private, personal study in an individual's what I call home library sanctuary. And the lowest form, the sixth form, is going to a course.

Int.: *So how does that relate to what you were setting up through the Faculty of Medicine?*

D.W.: Well, one was attempting through the mechanism of the course to encourage the broader phi1osophy of lifelong scholarly pursuit.

Int.: *Do you feel that that was successful?*

D.W.: Not very. Because I think, if you were to take a survey of the number of doctors who have a little room or a corner of a room with a shelf of a few books and who spend a few hours there each week, I wouldn't be surprised if it was a very small number. But in a1l, as Browning said, not in quite these words, 'What is Heaven but to attempt to reach for?', and one of the roles of the Faculty of Medicine and Health Sciences is to inspire its students to reach for the stars. They may not touch them but they should try.

Int.: *And perhaps some of them at least did that.*

D.W.: So all I do know is that the general response and feel of the profession was good.

Int.: *And do you think that it actually contributed to the quality of care the people were getting from these doctors, that it improved their practice of medicine?*

D.W.: I don't know.

Int.: *Was there any way that you could judge that or determine that?*

D.W.: There were ways, but life hasn't been long enough and I'm on to other things. But those are some of the exciting things that people in the field could do. A very simple one that I suggested to local communities; for example, was a doctor in neurology would go into the community and would teach that they could do without all these specific, highly advertised drugs and instead use the good, old-fashioned humble phenobarbital. You can go back into that hospital and go into the pharmacy and find out whether the doctors in that community are still advertising the expensive, brand-name drugs that are advertised widely in their medical journals or are they starting to use the phenobarb? There are very simple ways of measuring.

Int.: *I can see that that would be fairly easy to do?*

D.W.: Quite easy.

Int.: *Yes, but you don't know of anything of this sort that had been done in order to… ?*

D.W.: Yes, a very complete study was done by two brilliant local nurses in the nursing field in British Columbia. They did a survey of all of British Columbia's approximately one hundred hospitals.

They took, as I recall -- I have the report here -- ten new, important, relatively simple nursing procedures that would add to the comfort and the care of patients in hospital with certain conditions. They found out whether these were being used in the hospital or not. And, believe it or not -- and this is an evidence of the importance of the university association of a hospital, and this is rather confidential -- they found that almost all of them as I recall were being used at the Vancouver General Hospital, which was the main teaching hospital. St. Paul's Hospital, maybe four of them. And many of the hospitals, none of them. They found out why they weren't being used and they were showing where the blockage took place. Sometimes the medical board of the hospital was responsible. They show that the older the nurse in charge of the hospital was the less likely the new things were to be adopted. They showed that a nurse in charge of a unit, small or big, tended at the end of five years to settle into a rut. I suspect this applies to everyone. I 'm quite, sure that many doctors find a formula that fits into their lifestyle, produces the income that permits them to have the type of car they have and the sort of boat they have and belong to the golf club they belong to and so on, and some of these factors determine the quality of care, sadly.

Int.: *Would you say, then, that the fact that the Vancouver General did become a teaching hospital would have kept it at a high level?*

D.W.: No question at all. There is no question that the presence of the tremendously rich clinical resource of the University of British Columbia did wonders to the care of quality provided by the General.

Int.: *You feel that they have maintained that high level of care throughout the... ?*

D.W.: I've been away from the Hospital for thirteen years so I can't speak of recently but I would assume it would be.

Int.: *And what about St. Paul's? It was used and is used still, I understand, as part of the teaching facility within the University. Do you think it has affected their quality of care as well? And, I imagine, the Shaughnessy and the Children's Hospital?*

D.W.: Wherever there has been a linkage between the academic resources of the University and an institution providing care, I think there can be no question that the quality of care has been enhanced by that linkage.

Int.: *So, in that sense, starting the Faculty of Medicine within the sort of confines that they did, which in a sense was a compromise really, to use the Vancouver General Hospital, was a positive move if you look at it this way?*

D.W.: That's right. As was the decision to start the medical school.

Int.: *Do you think that this beginning was a satisfactory beginning, then, generally speaking?*

D.W.: As I say, it was an act of faith based on dedication.

Int.: *Uum-mm. Another thing I'd like to talk about a little bit was the other deans that were involved with the Faculty of Medicine. We spoke a little bit about Myron Weaver. What about John Patterson, who was the second dean. Were you involved with him very much at a1l?*

D.W.: At that time I was head of the Division, the University Division of Dermatology. My chief was Bob Kerr, and the relationships were between Bob and Patterson. My principle observation of John Patterson in action was as a member of the medical board of the Vancouver General Hospital, of which he was a member. I must say that I was impressed with his dynamism, but somewhere along the line he appeared to run afoul of some of his department heads, I believe in the basic sciences. I never was party to too much information about it except that there were some department heads who were very hostile to him.

Int.: *I understand that he was never able to get some of his ideas off the ground, that there was opposition to some of the things that he wanted to implement. Can you think of why? Was it the way he presented them or were the ideas simply not the right ideas at that time for U.B.C.?*

D.W.: As I recall, I thought his ideas were good. I thought his problem was in human relations. I've seen a number of department heads come and go and for some reason or other the screening committee failed to ask some key questions of people with whom they had worked elsewhere about them. And the Faculty of Medicine, even to this day, is saddled with the cost of people who it never should have been. And if there's any sort of criticism that I would have about the whole process of selection, it has been the failure to put a top emphasis on the ability of an individual to lead harmoniously.

Int.: *What about Dean McCreary? How did he fit into his role of dean of the Faculty of Medicine?*

D.W.: I have to declare my hand immediately because I am a hero-worshipper of Jack McCreary. God makes Jack McCrearys very rarely, and he was a great visionary and leader; tremendous energy. He inspired you -- me, at any rate -- by saying, 'This is the job. You go ahead. You do it your way. I'll be behind you.' If he had one fault it was that he was too nice. He never laid the heavy hand on. He attempted always -- and I sat from the time I was head of the Department of Continuing Education, on the council of the Faculty, which is the sort of governing body of the Faculty of Medicine, the department heads. So one saw him operating over a period of years, and he always attempted to work by consensus. He had people who didn't have the vision that he had and he was always kind to them. Many people would have lost their temper, he never did. But he was truly a great man and a great visionary. He had the concept of the health sciences team…

Int.: *And was able to put it into effect, as well*

D.W.: … and he introduced it. I became, as the years passed, close to him, not socially but from the standpoint of sharing his dreams. I'm speaking in general terms of him. I think he was a great dean. I don't think he was appreciated.

Int.: *Why should you say that?*

D.W.: I don't think we're all capable of understanding the people that are above us. They see a vision that we don't. They look from Olympus and see the big scene; we're down in the forest with the trees, and that's the difference. It isn't any criticism of the people that are in the forest.

Int.: *So do you think that he transformed the Faculty of Medicine, then, into what it is today? That his ideas were the right thing at the right time?*

D.W.: In his latter years he was a disheartened, disillusioned man. You couldn't name, at the end of his mission in life, five people in the Faculty of Medicine who had embraced his concept of the team working together on behalf of the care of the patient. You couldn't name five. The only one I could name clearly was Sydney Israels, head of Paediatrics, and of course that's a natural anyway because Paediatrics is a team family concern; everybody's in it. It's different when you have a coronary, somehow or other, or break your hip. Syd Israels had the big deal and, sadly, died too soon, too quickly. Oh my. You see, I've stopped. That's the sad story of Jack McCreary. And the result of it was I reached retirement in '69 and I got a call from the Minister of Health, whom I had never met, who was an economist from U.B.C., Ralph Loffmark, with the Social Credit Government. He said, 'I'm in trouble with cancer. I've got four specific cancer problems on my desk in Victoria. I hear that you've been involved in helping the Ministry on three other occasions. Would you come over? I want to talk to you.' So I said to Jack, I said, 'I've just had a call from Mr. Loffmark.' And he said, 'Oh, don't commit yourself to anything,' he said, 'I 've got something for you and I haven't told you about it (this was a month before retirement). He said, 'I'll tell you about it when you come back from Victoria tomorrow.' So, Mr. Loffmark told me his problems and as a result of that I became chairman of three successive commnittees of Government, of the Ministry of Health over a three-year period; and was chairman of the committees that laid the new, conceptual foundation of the new, $81-million cancer institute. That was my last formal baby, and that was done three years after retirement. But, anyway, Jack said to me, when I came back, he said, 'At last, after eleven years, I've got the money. The personnel to staff the Health Sciences Centre are waiting in the wings, and we've got the bricks and mortar (he meant, the architects for the buildings) ready to go. He said, 'We've spent thousands of hours, pages of minutes, and we've overlooked the key element in the whole mix. And that is, How do you meld together in the team the disparate elements: the dentists, the pharmacists, the physicians, the nurses? How do you get them to work together? Nobody has done anything. Will you stay on for three years? I've asked the president and he's agreed that there will be funds found for you to devote half your time to the Ministry's Cancer and half your time to the UBC concept of the health care team. So I took on those two jobs for three years after I retired.

And I devoted three years to what I called applied social psychology. My first year was devoted to learning about the behavioural sciences at the age of 65. And I prepared a report at the end of my three years for the university on the elements of melding together the care team. And so, in doing this I had a lot to do with Jack McCreary. I stayed on three years at his request to work solely on the health team concept. So this is very close to me and I have devoted, since retirement, part of my time to a study of our present system in British Columbia and I have produced enough material for a 350-age book, which I reduced to 68 pages, entitled "Toward Abundant Health," subtitled "New Initiatives for Fragmented Health Care (Non System) ," which embraces my philosophy of health care and what I think should be done: the initiatives specifically. I've got nineteen specific things that should be done, that I think should be done.

Int.: *In a preventative vein?*

D.W.: In an organizational vein. The reason I mention this is that here, I'm approaching eighty years of age, I am still moved by the spirit of Jack McCreary to pursue his vision, into close to my eightieth year.

Continuation of interview with Dr. Don Williams on Monday, September 30, 1985:

Int.: *Dr. Williams, perhaps today we can start off by talking somewhat about the students that were involved in the Faculty of Medicine in those first years. I think you mentioned the other day that you were involved in the screening committee for the first class, was it?*

D.W.: Right.

Int.: *Could you tell us something about the process that you went through in order to choose those first students?*

D.W.: Well, first of all I should say something about the almost hoard of students that had accumulated over the waiting period, looking toward the day when a medical school would open. As I recall, there was something like 700 or 800 waiting for sixty positions and a large group of these were older applicants, mainly men who had seen service during the war and had a sort of special call on the University and its resources for their education. And then there were the accumulation of very bright, young graduates from high schools throughout British Columbia who were waiting and waiting and waiting to get into the new medical school that was being planned. So, the first group was a very special group, and I would say a highly motivated and highly endowed intellectual group; a very special group. The selection committee was interesting. These anxious, waiting applicants -- many of them had used all the influence they could muster in the community, political and otherwise, to make their case for admission -- and the political pressures were such that that first selection committee had, as I recall, 25 members on it including the president of the University! It was such a special new experience . After the first year it settled down to a smaller group, as I recall, perhaps ten or a dozen.

Int.: *Were you on it in further years?*

D.W.: There were certain members that were on it permanently, like Dean Gage, Lawrence Ranta as the assistant to the dean, and there was someone from the University counseling office. These people were permanent. Those of us who were in the practice of medicine or were teaching were on for a three-year period. And I went on again, later on, for a second three-year period after a lapse of some years -- which was also an interesting experience to see the difference between the previous and the type of student coming in.

Int.: *Did you notice a great difference between the students, those applying?*

D.W.: Other than the first year, really no. With one exception, and that was the increasing number of women that were coming in, and absolutely top quality applicants -- that was very striking. I'm not sure. I think perhaps that's all I have to say about first ...

Int.: *So the quality, obviously, in those first years was very high quality. Do you think these students were well enough prepared for medical school?*

D.W.: In what way do you mean?

Int.: *Well, would they have had the right prerequisite courses to be able to deal with any medical school in the event there wasn't going to be one at UBC?*

D.W.: Well, again, I think as I mentioned before, one of the best indications that they were well prepared and that they had a good program was the success in the Medical Council examinations at the end of their -- on graduation. They did very well, which reflected very well on an infant medical school.

Int.: *Do you think they had fears that they weren't going to get as good an education as they might have had had they gone to another school, you know, one that was established? Or do you think that was really a concern that they had at the time?*

D.W.: I wasn't aware of it if they did.

Int.: *You mention that there was a pre-medical society. Do you think that their activities had very much to do with the fact that the medical school did open in 1950?*

D.W.: No, I don't think so.

Int.: *The reason I ask that was because I understand they did take a petition to the Government in Victoria, stating that they felt it should open as soon as possible. But you don't think that was really an influencing factor?*

D.W.: I wasn't aware of it being important.

Int.: *Do you think the students themselves were very much concerned with the fact that they were going to be faced with having to use Vancouver General Hospital and U.B.C., the fact that they had a split school? Or do you think that was of much concern?*

D.W.: I don't think that entered their minds.

Int.: *What about the difficulties in transportation, or just the facilities under which they were being taught? Do you think that was difficult for them?*

D.W.: I was going to add that the only problem I could see was the problem of them getting back and forth. But this didn't seem to be an obstacle to them.

Int.: *They managed .... What about research and academic and activities? Do you think they were curtailed in any way by the facilities, the fact that they were working in huts that were not ideal?*

D.W.: If you compare what was available ten years, fifteen years later and look back they certainly did start on a shoestring as they did in teaching facilities and in every aspect of the medical school. As I mentioned, it was an act of faith.

Int.: *But the students seemed able to deal with it without too much problem?*

D.W.: That's right, yes. I think it had a lot to do with the tremendous enthusiasm and dedication of everyone and the leadership of Myron Weaver in the early years before his health crumbled away.

Int.: *What was his relationship with the students like? Was he involved very much with them directly?*

D.W.: As I recall, it was a very good one, a warm one; a kindly, concerned one.

Int.: *Did he actually do very much teaching, do you remember, or not?*

D.W.: I don't think he did any teaching. If he did any, it was minimal.

Int.: *Would you know, perhaps from a clinical point of view, but you might also know as far as the teaching that went on out at U.B.C., the pre-clinical years as well: Do you think that the students did receive any unique methods of teaching? Did people take this opportunity of a new school to approach things in a different way at all?*

D.W.: I don't think so, to begin with. I think they brought with them the traditional teaching. If you take Dr. Kerr as an example of as fine a clinical teacher as you would find anywhere. He would bring with him the Toronto tradition. And the same applied, I think, with all the clinical teachers. They brought with them the background that they had grown up in themselves. And they were carefully chosen. So I think the clinical department teaching got off on a good, sound traditional base.

Int.: *I think we talked a little bit about how the clinical appointees -- appointments -- were made, but how were their hours determined? How did you work it all out with the clinical people because they must have still had a lot of their own practices to deal with? Did they just not take patients during certain hours, or….*

D.W.: Oh, you just simply gave up time that you otherwise would have devoted to patients, which meant that you were making, in many instances, very substantial personal contributions in the form of reduced income. But the thing is, that wouldn't even enter your mind, it was just the joy, pleasure, of being part of a new medical school; the stimulus of being with the young, bright, keen minds of the students. All that was your compensation.

Int.: *You really didn't see too much change in the type of students who were applying to medical school over the years?*

D.W.: Really not, except I suppose after the first twenty years the number of applicants increased tremendously. I'm not sure of the figures, but it seems to me I hear figures like 700 and 800 for the sixty places. And this was not at UBC alone, this was across the whole North American Continent; all schools were faced with a tremendous number of applicants. The result was that schools were able to set up extremely high scholastic performance records for admission, I'm not too sure that that was entirely good because I'm not sure that brilliance in making grades equates with the warm, human qualities that go toward caring for people.

Int.: *This leads me to ask you, What were the types of things you were looking for in those first students? What were the criteria you used to choose the ones that were brought into the first class?*

D.W.: I don't recall what they were then but, later on as we became established, every applicant had to go through the MCAT examination which every applicant in North America had to go through

so that each student would be measured against the 10,000 or 20,000 students applying to all the schools in North America and the United States.

Int.: *When was that started?*

D.W.: It seemed to me that that started relatively soon after the school started. I would think that was started in Myron Weaver's time. He introduced, as I recall, a battery of -- I think there must have been at least four -- tests of this general nature. I think some of them were dropped later on, and I'm too far away from them really to give you much detail.

Int.: *You mentioned that there were more and more women applying as the school got older. What would you say was the reason for this?*

D.W.: I think the general, if you like to call it, emancipation of women that followed the second war, the role that women played during that war, opened up the doors everywhere in every way, and medicine was one. I'm sure that our earlier attitudes, in which medical schools were almost totally male sanctums, was not a good thing. There are so many fields that are particularly suited for women, and women who are homemakers as well: things like X-ray, pathology, possibly administration, public health and so on, 9 to 5, five day a week. And so many women that graduate -- some people complain about wasting taxpayers' money educating them and then they get married. But the truth is that after they get their own family established, 2 or 3 children, you find that they are back…

Int.: *Particularly nowadays.*

D.W.: … in these special role jobs.

Int.: *I understand there were three women who were accepted into the first medical class. Do you think they would have found it particularly difficult, or not at all; or how do you think they would have fit in?*

D.W.: It's awfully hard for me to say, but I would think they wouldn't have the least bit of difficulty. You wouldn't be thinking scholastically…

Int.: *No, I was not.*

D.W.: …you were thinking male chauvinism.

Int.: *Just the way they would have been treated.*

D.W.: Oh, I think not. They would not have any problems.

Int.: *I think we talked a little bit the other day about the relationship between the pre-clinical and clinical teachers. What about the relationship generally between UBC and the Vancouver General Hospital? How were the patients who you were teaching with at the Vancouver General Hospital determined? What wards did you work with? How was that determined?*

D.W.: In the earlier days they were mainly what one would call 'relief' patients, patients on social assistance. That all changed with health insurance, when every patient became really a private

patient. And that opened the doors for everyone who went into the hospital, private or public patient, to be used for clinical teaching.

Int.: *So you had the freedom to use any patient as a teaching… ?*

D.W.: Once health insurance came in. Up till then the teaching population was largely social assistance.

Int.: *For instance, say, in the maternity ward. Would you use all of the maternity ward, or all of any of the wards that you were dealing with? Or was just one section of it being used for teaching?*

D.W.: I don't know about that.

Int.: *What kind of control did UBC have of their role at the Vancouver General Hospital?*

D.W.: As I mentioned the other day, they had a legal agreement which was relatively brief but it was a very strong document -- I don't remember the specifics of its terms -- and it forged a very strong bond between the two. Further, at the beginning, there was a very strong bond between Dean Weaver and Mr. Hickernell, both of whom were American and both of whom were young men who had come about the same time to Vancouver and each in his respective area of responsibility; and they worked very closely together. Then, as I mentioned, Dr. Ranta, over long years, after being with Dr. Dolman in Preventive Medicine, became assistant to Dean Weaver and then he became medical director at the Vancouver General Hospital. He was a powerful force for bonding between the two. But Dr. Ranta had a tremendous strength, on campus outside the Faculty of Medicine, where he was very highly respected.

Int.: *So would you say then that the relationship was a good one and in the end it functioned quite well and using VGH -- it ran smoothly?*

D.W.: In such relationships there are always problems. But they tended to be resolved and one of the reasons was that the heads of departments had two hats …

Int.: *Ah, yes. You mentioned that.*

D.W.: … and this was a wonderful bonding. Dr. Kerr was head of Medicine at the General and was also academic head of Medicine at the University. So he could talk to himself about a problem at the University and solve it so far as the General was concerned. So this in itself was a very basic bonding factor.

Int.: *Was this the way it had been done in most teaching hospitals in other areas or was this unique to Vancouver, the VGH and UBC?*

D.W.: Well, I'm not speaking too certainly but I would think that it was the same arrangements unless a university had its own teaching hospital such as the new University Acute Walter Koerner Unit.

Int.: *What about curriculum planning? Were you involved in curriculum planning at all? Or was it quite a different thing at the Vancouver General from what it would have been at UBC?*

D.W.: Are you speaking of clinical curriculum planning?

Int.: *Well, actually both, we should talk about. You would have been involved more in the clinical, wouldn't you?*

D.W.: Right.

Int.: *How was that approach?*

D.W.: Well, here again it was easy because you had two hats -- I had two hats. So that I worked very well with myself! So our problems were the problems of money and space.

Int.: *Was there enough money?*

D.W.: There never was enough money and there never was enough space.

Int.: *Is that how you managed? With not enough money and not enough space - in spite of it all.*

D.W.: That's right. And our graduates, we've been proud of them. I think they would say that by and large they had a good education.

Int.: *Were you involved at all in the pre-clinical curriculum planning?*

D.W.: In the basic sciences, no.

Int.: *What about the other memories? Of the administration in those first years? Who worked closely with Dean Weaver? Or did he work mainly on his own.*

D.W.: He had, as all deans had, the governing or advisory to the dean, the Faculty Council, which consisted essentially of the heads of departments. This council meets regularly and discusses and advises the dean on problems and suggests solutions. It's the Cabinet.

Int.: *Were you involved in that at all yourself?*

D.W.: While I was head of Dermatology, no, because I was an academic division head. But as soon as I became head of a department, Continuing Medical Education, I became a member of Council.

Int.: *Can you think of any special issues that came up -- you know, any particular problems or difficulties -- or not?*

D.W.: We were confronted constantly with problems.

Int.: *And were they handled quite easily within the group?*

D.W.: As I mentioned, I was on the Council during a period when Dean McCreary was the dean and chairman of the Council. And if I had one criticism of his management of Council was he was in many ways too kind. He liked to get a consensus and many times I felt wasn't as firm with some members as he might have been. That was his kindly way.

Int.: *I understand there was a building built at the Vancouver General site for UBC. Were you involved in the design of that building or discussions about it?*

D.W.: No.

Int.: *Not at all? Did you use any of the facilities in it?*

D.W.: Yes, that was before I was head of Continuing Medical Education, while I was in Dermatology and I had an office in that building. But the main planning would be done by Dr. Kerr as my chief.

Int.: *Did you find the building sufficient?*

D.W.: Very quickly it was inadequate.

Int.: *And I don't imagine you would have been involved at all in the planning of the basic sciences buildings out at UBC.*

D.W.: Not at all.

Int.: *No. Where did you work out of when you were involved in Continuing Education?*

D.W.: That was in the… We had fine quarters, as you know. Now the whole of the second floor of the Woodward is Continuing Education and while that was being built I was… our offices were originally in the Wesbrook, on the top floor of the Wesbrook. Then we moved to use part of the top floor of the Woodward Library for a 3-year period until we got our beautiful new facilities in the Woodward Instructional Resources Centre.

Int.: *Did you find your working conditions tolerable? Did you have enough space? Were you able to manage quite well with what you had?*

D.W.: We had beautiful space, and at that time Dean McCreary -- I was used quite a bit for trouble shooting, and at that time the faculty had grown like topsy to the point where they were spending in excess of $4-million a year on research. And had no policy, and no administration and no organization. And all this money coming in and being used. And just total chaos. So Jack McCreary took me out of Continuing Education -- by that time we had expanded into all the health sciences -- and for three years I was associate dean in charge of research coordination.

Int.: *I see. And when would this have been?*

D.W.: This would have been about 1966-69. That's when I retired. So I had the job of straightening out policy and process with respect to research for the whole faculty, for all the departments. It involved the gifting of money by individuals and by organizations; and funds received by the various voluntary health agencies and Medical Research Council. A very different job, very different.

Int.: *What are some of the other ways you worked closely with Dr. McCreary?*

D.W.: The main one was after I retired and stayed on and worked on the question of how you got doctors and nurses, for example, to live together amicably. And that's still an unresolved problem. And so on. You see, the basic problem was that at UBC we, traditionally, as all medical schools, we trained all our health sciences vertically in isolation. Then we expected them, when they got out, that they would suddenly all work together. Instead of starting right at the beginning and having joint classes, getting to learn how to work together.

Int.: *Was that difficult to do, though? Would not certain areas be at a different leve1 of knowledge than others?*

D.W.: Yes, that's right. However, there is what you'd call common-to-all knowledge, certain basic knowledge that they could all take together during, say, their first year and then move on. Mind you, in spite of that, we have examples of superbly symphonized teams as in heart surgery, for example. And certain medical procedures where they work with the finest precision in timing, in every way: just wonderful teams. The level of team that is basic and important is the team at the general practice level. And the problem that we have is that we have these countless dedicated, wonderful supporting health agencies and health-related agencies and doctors who are either not aware, or if they are aware don't recognize, or if they recognize and are aware are too busy. And the result is that the patients don't get, in my view, the full value of what is available in the community. The doctors seem to be in such a hurry.

Int.: *Just to go back a bit to the earlier years of the Faculty of Medicine. We didn't talk at all about library facilities. What were the library facilities like, both at the University and at the Vancouver General Hospital?*

D.W.: I would say they were very good. There was the best of cooperation from the library and from the people at the top of the main university library. The College of Physicians and Surgeons developed a library for doctors, which was a great help. By and large we were blessed, I would say, with a very good library service; very good.

Int.: *Could you explain how the clinical teaching was carried out at the Vancouver General Hospital? Is that possible, to sort of explain how that was done?*

D.W.: Basically, it followed the Oslerian tradition. This was Dr. Kerr's strength in medicine. It was a small group of patients with a teacher around the bedside. That was the basic setting. The other setting was the care of the ambulant patient in the outpatient department of the Vancouver General. And in spite of its shortcomings, I think it did a tremendous teaching job there. And it had for many years Dr. Mac Whitelaw as the director. He did a first-class job for a long period of years and they made a great contribution to clinical teaching.

Int.: *Do you think the goal of a first-class medical school at UBC was achieved?*

D.W.: The goal? I don't know what the goal was.

Int.: *I think it was mentioned in Dr. Dolman's report as well as Dr. Strong's. This is what they, what most of the people involved in those first years of starting the Faculty of Medicine wanted. Do you think that was achieved?*

D.W.: The best way to answer that, I think, is to say that they, I believe, all passed their Medical Council; they all got internships in hospitals -- there is a screening process involved there. Many of them went on to graduate studies. And what we know of a good many that we saw from time to time, they made good doctors as far as we (knew). I don't know that anybody did a study of it, but that's one's general impression.

Int.: *Last time we talked a little bit about the relationship of the medical faculty with the other faculties in the University and you mentioned that it would have been impossible to build a hospital because it cost too much money and there were a lot of other faculties starting up at the time. How did you see the relationship between the Faculty of Medicine as it was and the other faculties out at UBC? Do you think there was any, you know, jealousy about funds or anything of that sort? Or was it generally a good feeling?*

D.W.: It's hard to be sure. On one hand I would get the impression that members of other faculties had a feeling of pride that their university had a medical school. And yet one would hear that sentiment expressed. And then one would also hear the feeling of anxiety that the needs of a good Faculty of Medicine are so great that they will take a larger proportion of the financial pie than we would like to see. I think that's the sort of thing a dean deals with.

Int.: *Do you think Dean Weaver had to deal with this?*

D.W.: Oh, I'm sure every dean, sitting in meetings with the president and vice-president, dividing the pie.

Int.: *Do you think the prospect of better financing might have been easier if the medical faculty had opened later than it did? Or would it really have made very much difference?1950 was the first year.*

D.W.: This is a guess, but I don't know that it made much difference. I'm just trying to think of what the general economic background would be. I'm not sure about the answer to that one.

Int.: *I think it was 1952 that the Wesbrook Building was put up. What was the reaction of people in the medical faculty to that building being built?*

D.W.: I don't remember any.

Int.: *Do you think that having the clinical years separated from the pre-clinical years left a sort of spiritual division between the two groups that worked in those areas, and also for the students?*

D.W.: We discussed this before, and there is no question that the distance prevented the enrichment of the clinical education on the one hand and the development of the relevance of basic science to its clinical application and care of sick people. No question.

Int.: *Do you think the Faculty of Medicine was addressing itself to the needs of the Province generally?*

D.W.: Well, I'm sure you are too busy to look at what I have written as the result of just my voluntary studies on the health care system. But in that summary you will see, among nineteen basic concerns that I had, one is that no one, -- no one has set up the machinery for identifying and recording the state of health of the people of this province. It's true that we do have mortality

records but we don't have morbidity records. We don't have a picture of, let us say in the field that I'm in and know something about, we don't have a picture of what are the twelve commonest skin disorders in British Columbia. And what cost does each year their morbidity involve? Now, we should have an inventory of the state of health of the people of British Columbia because if we have an inventory I, as a teacher, would look at it and say, Here are the ten commonest conditions. These are the ones that I should be teaching the students how to handle best when they get out to Prince George and Trail and Smithers. Sure I should pick an occasional example of a disease that indicates the tremendous ramifications of other systems, nervous systems and so on, kidneys -- you name it -- causing the disorder. Until we have an inventory and then we look at that inventory, take a census every five years and say, Well, death of young people from alcoholism, alcoholic drivers, has gone down because our students in preventive medicine are getting a lot of…

(end of that side of the tape)

Int.: *Dr. Williams, this question that I am about to ask relates somewhat to your time in Continuing Education as well, but I'd like to go back more to the beginning of the medical school first. Do you think that the opening of the Faculty of Medicine helped to make the general practitioners in the Province just try harder and update their skills before there was any continuing education available, just the fact that there was the presence of a medical school?*

D.W.: I don't think that at that point in time it had any great impact upon general practitioners. At that time, general practitioners as a group had not organized and weren't recognized as a political entity, as they are today. During the early years of the medical school it would have been almost unthinkable that there could be a Department of Family Medicine, it wasn't even dreamed of in those days. And yet today we have a flourishing full department, and have had for some years. So that its relevance at that time was, I would say, negligible.

Int.: *0.K. Do you think that, prior again to the opening of the Continuing Medical Education Department, there was a growing interest in better teaching - you know, better skills for the practitioners who were out there? Or was this something that came as a surprise to them, that there was going to be something available for them?*

D.W.: The genesis of the concept of continuing medical education, of life-long learning after graduation for the practicing doctor began in the United States. And Dean McCreary, when he became dean, recognized this as one of the new trends that had tremendous potential and felt that the medical school here should get into that form of education.

Int.: *So it really didn't come from any pressure from the doctors who were out in the field?*

D.W.: Mind you, one should add that once he gave the leadership to it and the concept was presented to them through the B.C. Medical Association, at that point the profession entered into the idea enthusiastically.

Int.: *What about research at the beginning? We talked about it a little bit when we spoke before. But was there very much research going on through the Faculty of Medicine when it first opened? Was there the opportunity for it, or if not when do you think that really began?*

D.W.: The basic medical scientists who came to the Faculty at its opening brought with them ongoing programs of research interest. So, from the day the doors opened, the basic medical sciences were in business. Of course, the clinical fields didn't really enter the picture in an active way until the third or fourth year. And because so many of the senior people had heavy administrative and teaching responsibilities in this new school they didn't have the time for the research that later on became a growing part of each department's active program.

Int.: *But, if a student had wanted to research a particular topic, do you think that it would have been fairly easy for them to go ahead and do so, or not at the beginning?*

D.W.: I'm not too sure about what the situation was at the beginning with respect to research space and funds necessary. We do know that the school as a whole functioned in old army huts for a number of years before it got its fine, first, basic medical science block buildings on campus. So one suspects that the first few years weren't easy years for people in research.

Int.: *Why do you think it took as long as it did for those medical science buildings - the basic science buildings - to be built up at UBC?*

D.W.: Here it was a matter of money. First of all, it was the factor that funds came from the Government, and when the Provincial Government was ready to release them then things went ahead. And the other thing too, during Dr. Mackenzie's presidency there was a tremendous post-war expansion of the whole campus and so this infant medical faculty was competing with starved, established faculties and schools and departments. So everybody was competing.

Int.: *Do you think other faculties had a fairly positive attitude towards the medical faculty overall?*

D.W.: I really was not in a position to know because, in the earlier years, I wasn't deeply and actively involved clinically. But one did hear rumours from time to time that many faculty members on campus recognized that when a university took on a faculty of medicine it took on the most expensive faculty on campus. And so I'm quite sure that this was a problem. The magnitude of it and the nature of it I don't really know. I do know for sure that it did come up with the most recent development of, specifically, the new Walter C. Koerner Acute Care Unit. That tremendously expensive operation was viewed with great anxiety by many non-medical faculty personnel, and understandably.

Int.: *Well, yes, when that amount of money is being involved.*

D.W.: The pie is just so big that comes from the University's Council.

Int.: *There was talk about starting a medical faculty in the '20s. Why would you think there was such a long delay in establishing the Faculty of Medicine at UBC?*

D.W.: I think there would be many factors. The population of the Province was relatively small, and consequently the number of doctors relatively small. The larger, eastern, established schools like McGill and Toronto, and the schools of Great Britain and the United States, were providing for

many years, and still are, practicing doctors for the Province. So that they were able to get along without a medical school and really, living off the gratuity of Eastern medical schools, in U.K. and the United States.

Int.: *Would you think there were an awful lot of hopeful medical students turned away from those other schools, students who would have been accepted had there been a school here?*

D.W.: There may have been, but it wasn't the sort of organized pressure that I would suspect was felt increasingly in the past 15 to 20 years.

Int.: *Why do you think there was difficulty in mobilizing support in the different quarters such as the medical profession, the University itself, the Government, and even the community?*

D.W.: Well, this is a personal view and I don't know how valid it is but I don't think there was a clear concept in the minds of the leadership in Government, in the University generally, and in the medical profession in providing the care in a coordinated way: one voice saying powerfully, These are the needs for the Province, therefore we need to be producing so many doctors ourselves to meet this need. Later that came, as we got into manpower problems. Their genesis began with the war, when suddenly a tremendous number of practicing physicians suddenly just moved out of the community into the armed forces. From that day on, medical manpower became a very public issue and there was organized and concerted concern.

Int.: *Do you think that perhaps one of the reasons they weren't well organized was that there wasn't really the need at that time? Or do you think it was personality, or…?*

D.W.: The need may have been there but it was not recognized, and a forceful voice proclaiming the need with a solution wasn't too evident.

Int.: *What would you say were the important factors to explain the difficulties and delays in getting the Faculty of Medicine started towards the end of the Second World War and in those immediate post-war years? Could you identify any specific thing that would have made it hard to get going then?*

D.W.: Well, I think everyone, at that point in time, was rushing back to re-establish a base in the civilian community. And so there was a hectic period there, for a number of years, when Me-first was the natural and pretty self-evident philosophy. It wasn't until men who had been away from their practices and got back, and then - with the growth of population - the need began to surface increasingly.

Int.: *What about financial shortages? Were they quite severe then?*

D.W.: I don't know the magnitude of them myself but again we come back to the factor of tremendous expansion under President Mackenzie with a growing province and probably booming economy.

Int.: *Would you have any idea what role the B.C. Medical Association and the Vancouver Medical Association played in getting the Faculty of Medicine going in the end? Would they be very much involved in it?*

D.W.: Their voice was, at that time, I think, largely involved as a supportive one. But the decision power didn't rest with them. As I recall, they were consulted and they established committees to work closely with the Dean in developing the medical school and, if my memory serves me right, the town-gown antagonism which has been present in many communities for many at that time was very minimal. Certainly, when I got into the field of Continuing Medical Education, the cooperation of the B.C. Medical Association was superb. They set up a special very strong committee just in continuing medical education, its purpose being to support and establish an active liaison. So that aspect of education with which I was closely associated, I couldn't speak too highly of the support that we got from the Association. But that was later.

Int.: *And you are not really familiar with what the reaction was in the early years.*

D.W.: It's hazy but my general impression was that, aside from small problems of personal political difficulty, I would say that the development of the Faculty of Medicine enjoyed good support from the Association.

Int.: *What about UBC itself? How anxious was the University to promote the founding of a medical school in those early years?*

D.W.: Here again was the problem of a person in a clinical field functioning in an environment 6 - 7 miles away from campus. And until I got on campus full-time in Continuing Education I really was not in a position to flavour what the response of the other faculties was.

Int.: *How well, would you say, did the representatives from the Medical Association and the University work together in promoting the idea of the Faculty of Medicine?*

D.W.: You are going back to the very beginning.

Int.: *Yes. (pause)*

D.W.: My memory is that there was enthusiastic support.

Int.: *Talking about money again. Do you think they estimated correctly or closely the amount of money they would need to start a Faculty of Medicine? Or do you think the estimates were low? I think when Dr. Dolman presented his report, a lot of people might have thought that his estimates were quite high. Do you think they were out of line, or was he out of line?*

D.W.: No, I don't think they were out of line and I don't think he was out of 1ine. We all recognize in retrospect that the funds provided were a mere shoestring. It is just amazing that a Faculty of Medicine got on as well as it did in the early years and this was due in no small degree - and this could be interpreted, and I think should be interpreted as an indication of the loyalty and support of the medical profession in the Greater Vancouver area, in that many - I think literally several hundred - of the best practicing clinicians, largely in the specialties, gave of their time and themselves, literally gratis, for years. They saved the University and the Province a tremendous amount of money.

Int.: *Were they paid anything for the work that they did? Or how was that arranged?*

D.W.: Yes, they were. I can tell you what I got as head of the Division, that is, the University Division, of Dermatology of the Department of Medicine. I got a cheque each year for $100.

Int.: *My goodness! Even then that was a very small amount.*

D.W.: This was the head of a Division, a clinical division.

Int.: *So I imagine that the people who were teaching under you were given that much less.*

D.W.: $50 probably. And I am sure a lot got nothing.

Int.: *Did that change over the years at all? Were they paid more or is it still the same situation now?*

D.W.: They began to bring in the geographic full-time man, the man who was appointed full-time and his work on the teaching wards was paid for by the B.C. Medical Plan, and the funds that he brought in from the patients he saw went to pay for his appropriate salary with surplus going to the operation and administration of his department. Now that movement which got under way - I was going to say 20 years ago - has gathered momentum and it has meant that there have been more and more full-time salaried men in the Faculty of Medicine and fewer of the voluntary type that provided the backbone of clinical teaching in the early years.

Int.: *Why would you say these people were so willing to contribute time?*

D.W.: I think there are a number of reasons. There is no question that there is a special pleasure in being associated with your colleagues in teaching and learning. Your association with the University confers prestige upon you among your colleagues and you are in a preferred position in your profession to be recognized by a university appointment.

Int.: *I can understand all those reasons. It still seems that they must have put in an awful lot of time. Was there a limited amount of time that people were allowed to contribute to the University, or could they give as much time as they wanted, or how was that determined?*

D.W.: The head of a department could decide on the schedule of time: the number of lectures required and who would give how many lectures and so on, so those allocations were arranged by the department head.

Int.: *Oh, I see. And I suppose you could simply say they were able to give one day a week, or two, or half a day, so many hours or whatever?*

D.W.: And he would make the decision on who would do what.

Int.: *How important would you say was the difference of opinion between the Medical Association and the University on the question of the location of the Faculty of Medicine? Do you think this was simply resource-oriented or was it a genuine, philosophic difference of opinion?*

D.W.: The main determining factor here basically was money and, the established care of patients at the Vancouver General Hospital, which was our largest hospital. It was there, and at the least amount of money it had the resources, it had the beds - they were already there - and so a deal, and a very generous one, I think, from the standpoint of the Vancouver General was made to step

into that gap and, having done that, that put off the day when the University had a hospital on campus.

Int.: *Would you say it had anything to do with the Medical Association wanting to be able to control the activities of the Faculty of Medicine?*

D.W.: I had never been aware of any overt or covert attempts by the B.C. Medical Association to control the Faculty of Medicine. It's true that from time to time there arose strong, forceful leaders in the profession that may have had their views about it, but officially I don't think that was the feeling of the profession, of the Association.

Int.: *After Dr. Dolman had presented his report and Dr. Strong had done his report there were - was a group of experts who were brought in to give their opinion of the situation. Do you think this desire to have an outside opinion was a desire to have a neutral umpire to settle the differences between the two different groups? Or do you think it was primarily the desire to have an expert opinion and get some people who had experience in the field?*

D.W.: The difference between Claude Dolman and Fritz Strong became a very bitter one, as I recall. I think the University felt that there would be no problem at all, that the Dolman report would be welcomed with open arms and strongly supported but there rose a voice around Dr. Strong which took strong exception to it. So I think the University was embarrassed by the personal nature of this hostility and one of its diplomatic moves was to hear to strong views in the community, Let's get a referee. I think if there hadn't been that dispute they'd have gone straight ahead.

Int.: *And they wouldn't have bothered with the other then, of getting the experts? Who would you say was the person most involved in getting the experts in? Whose idea would that have been?*

D.W.: I'm not sure, but it became a problem that attracted the President's attention and so I would think that he had the deciding voice.

Int.: *Just going back a little further then, what role do you think the question of including the Institute of Preventive Medicine in the founding of the Faculty of Medicine had? Do you think it played any role at all? I understand that was the idea in the very beginning.*

D.W.: That was Dr. Dolman's.

Int.: *Yes, this was how he saw it getting off its feet.*

D.W.: I must say that I was saddened by the fact that a new medical school, truly based on prevention and led by one of the most brilliant minds in the medical field that British Columbia has ever had, was thwarted because I think Claude Dolman, in his youth and his brilliance and his vision and with the emphasis on preventive medicine, would have produced a unique, new type of medical school that would have revolutionized medicine, but that was not to be and one can only postulate that that was unfortunate.

Int.: *Do you think Dr. Dolman was a victim of a lot of the circumstances that happened around that time? Or do you think that he played a role himself in creating some of the circumstances?*

D.W.: I think there are people who would claim that his personality, in spite of his brilliance, may have been rigid with respect to certain people and the concept that they represented that he had to deal with. He was certainly a different person from Jack McCreary. They were both, in my view, extremely capable persons but quite different in nature.

Int.: *Do you think the Medical Association and Dr. Strong, who went off to do his report, were worried that Dr. Dolman might become the first dean of the Faculty of Medicine, and they wanted to block that possibility?*

D.W.: No question about that in my mind. That's the extent to which the feud degenerated, if I may use the word.

Int.: *So would you say that's one of the reasons why Dr. Strong went off and did his own separate report?*

D.W.: I would suspect that was correct.

Int.: *Were there any arguments put forward by anybody other than Dr. Dolman at that time, in those early years, for having an integrated medical school, one that didn't have the pre-clinical and the clinical years separated? Do you think there were others who were in favour of that?*

D.W.: I never was too sure who Claude Dolman's constituency was on campus outside of the immediate associates of which Dr. Ranta -- whom unfortunately you can't interview -- he was the man who was in the middle of everything, he was on campus and would have given you a tremendous picture of what went on in those early days in great detail. That's one of the tragedies of leaving this sort of thing too late.

Int.: *Yes, I think there were quite a number of people…*

D.W.: I've been after them to do something about this when he was still 1iving three years ago. Anyway.

Int.: *We talked a little bit about this earlier, but Dr. Dolman concluded that what was needed as far as financial resources was much greater than what people had anticipated. Do you think most people agreed with him, that there simply wasn't the money there to add more to the chunk that they had to work with? Do you think people simply couldn't envision what was needed?*

D.W.: I think both were factors.

Int.: *I think at the very beginning Dr. Dolman was the spokesman for both the University and the Vancouver Medical Association, and then he slowly separated from the Vancouver Medical Association. It must have been rather difficult for him to have been playing those two roles all the way through as well and it seems to me that he was involved in a lot of other activities through the Government. Do you think he simply might have had too many things to do? Were there other people who could have done some of those things, or were there not people available at that time?*

D.W.: He was director of the Provincial laboratories, which was, as far as I know . . . . . then he also had some function to fulfill for the Connaught Laboratories, so it is true that he may have been

stretched a bit thinly; but it is also true that at the beginning there was a real honeymoon between himself and, as I recall, the Vancouver Medical who saw him as the Great White Knight who was going to lead them, and then they began to develop this other voice around Dr. Strong. And Dr. Strong was a very powerful, political figure with great presence, commanding figure. And once poor Claude was up against that, the battle was over.

Int.: *Do you think Dr. Dolman had the support of the President, of Dr. MacKenzie, throughout all of this?*

D.W.: I assumed he did, and I would think he would have to have had.

Int.: *I understand Dr. Strong was Chief of Medicine at the Vancouver General prior to the Faculty of Medicine opening? Was there any problem in having him accept Dr. Kerr, who became Chief of Medicine through the Faculty of Medicine?*

D.W.: There could have been. I don't think I was aware of that. They seemed to work together.

Int.: *Are you aware in any way of how the planning for the Faculty of Medicine was done in those few years prior to its opening -- 1947, '48, '49?*

D.W.: Really, no.

Int.: *In some ways it seemed that Dr. Dolman had a vision, an idea that he could see in the future with the Faculty of Medicine. Do you think that any of the other people really had a vision of what was going to happen? Dr. Strong, for instance. Do you think he could see what was going to take place down the road?*

D.W.: I think Dr. Strong's vision, which would be Dr. Kerr's vision, was the traditional vision of the medical school. For Dr. Kerr, the University of Toronto's Faculty of Medicine, was one of the finest in the world. And I'm not sure what --- I think Dr. Strong's background was Minneapolis, the University of Minnesota, wasn't it? And certainly that's my post-graduate degree, University of Minnesota. I got my Master of Science in Medicine when I was at the Mayo Clinic for three years, so I know it's a fine institution. Both Dr. Kerr and Dr. Strong were products of the fine types of traditional schools and I think both of them saw an extension of that model. But Claude really had a vision.

Int.: *It seems to have been quite different from everyone else's.*

D.W.: Very. Very.

Int.: *Do you think it might have been better had the Faculty of Medicine sort of grown the way he had anticipated it. Or is it possible to make that sort of comparison now? Do you think Dr. MacKenzie could have altered the direction that was taken in any way, with his position?*

D.W.: One of Dr. MacKenzie's great characteristics -- and incidentally I'll be dropping in with my friend, the former deputy minister, Dr. Eliot, tomorrow after we've lunched at the Faculty Club, to see Dr. MacKenzie. We see him every two or three months for a little visit. Dr. MacKenzie -- one of the great characteristics he had in his presidency was that he made the new, burgeoning, growing University relevant to the people of British Columbia. He was their man in office. Now,

in that way he listened to people. Well, Dr. Strong had a very powerful influence on many people in positions of power and I'm quite sure that Dr. MacKenzie's ear would be bent on many occasions by people pleading for Dr. Strong so that Claude was facing a pretty unequal, political battle, I suspect.

Int.: *Just one final question. What were your expectations when you became involved with the Faculty of Medicine, and were those expectations met?*

D.W.: You are referring to Dermatology?

Int.: *Dermatology and Continuing Education.*

D.W.: I'll separate those because in Dermatology I was involved in the' development of a minor division of the Department of Medicine in a traditional way, with inadequate space, funds and so on. We all, our little group, went far beyond the call of duty in providing time from our busy practices, very generous time for teaching. So one was struggling to produce an effective teaching program, again, on a shoestring. Now, the picture with Continuing Medical Education was entirely different. My chief was Dean McCreary, not Robert Kerr, and Jack McCreary was a man with great vision. Getting into a new field and being the first university, full-time department in the field in North America and funded by Kellogg Foundation for the first five years, and everybody was excited about it. So it was just as different, my feel about the two of them.

Int.: *Thank you very much, Dr. Williams, for all the time that you have given.*