Oral History Interviews

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Dr. Sydney Friedman (1916-2015)

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Summary: *Tape 1:* His recruitment rom MdGill in 1949; early days of anatomy teaching in the medical school; the huts, early staff recruitment; Dean Patterson; Dean Weaver; starting up the medical library; Connie Friedman; visiting lecturers; Dean McCreary; the 'health team' concept; the Dept of Anatomy; cadavers.
Tape 2: The medical students and the curriculum; biochemistry; clinical medicine vs. medical science; social life.
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Interview with Dr. Sydney Friedman, Thursday, February 28, 1985

Int.: *Dr. Friedman, could you first of all tell us about the circumstances of your recruitment? How did you come to be at UBC when the Faculty of Medicine was opening up?*

S.F.: Can I be garrulous like an old man…?

Int.: *Oh sure! (Laughs). Everything! Everything!*

S.F.: I was at McGill. I was trained at McGill and after I got my medical degree in 1940 I continued on and got a Ph.D. in 1946 with an (?). Before that time when I was in the Air Force. After I got my Ph.D. I was essentially quite well trained and I was rather anxious to stay in Canada. I give you all this as background to my sense of what went on.

There weren't very many opportunities in Canada. The Chairs that one wanted were pretty well tied up until quite some time in the future and there was really not much outlook. Meantime, because of the background which I acquired I was interviewed for positions in the States and I was steadily resisting them. I think it was '47 or '48 I got wind of the fact that UBC was thinking of starting a medical school and next thing I heard was that somebody by the name of Dr. Dolman had had a long interview, visited by the chief of my Department. As I was the Number Two man in the Department I was rather surprised that the chief hadn't invited me in. Indeed, I found out he hadn't mentioned me to Dolman, he hadn't discussed it and he hadn't asked me my opinion. Which disturbed me. But at all events, I was interested to see what would happen with UBC because this looked as though it might be the kind of thing that a Canadian might like to do, like to have a part in.

Nothing further was heard until I think it was the spring of 1949 when I heard that UBC had appointed a dean and that they had carried out some interviews. I was rather surprised that I hadn't been interviewed but I paid no attention to it. The next thing I heard was that Weaver, the dean, had visited the Department. I hadn't met him and just nothing had happened. I was again quite surprised and I was talking about this to Dr. Meakins who was a former dean of the Faculty of Medicine. Meakins befriended me on many occasions. I used to go to him for advice and talk to him about my future. He was really a very forward-looking man. I cannot say nice enough things about him because he had a very good view for the individual who was trained both academically and medically and looking for a career that straddled that. This is quite common now but it was not as common at that time. Well, we were discussing it and Weaver (? or Meakins) was just horrified that I had not been interviewed and wondered what was happening. He wrote a letter. All I knew was that he said, "I've written to UBC to find out something. I heard nothing further."

A short time after that I was invited to come out for an interview - that was in November of 1949 - right out of the blue. I have later discovered, because the letter that Meakins wrote is archivable now. The dean has it, it's in the dean's file, and it was read

on the occasion of my retirement. It was quite a sharp letter that Meakins wrote, I must say. At all events, I was out here and I was interviewed and my wife and I were invited to come out. We were the first people out. Well no, we weren't actually the first people out, I should correct that. I was the first professor appointed, not the first person interviewed because, as I have already indicated, there had been these interviews gone on before. At all events, I was invited to bring my wife out and we spent three days here. The interviewing process was something else again, quite different from the interviewing now. First of all the community - when I say community I mean the leaders in the community - were very much intrigued by the establishment of the medical school and anxious to participate. Mr. Hamber especially was very active. And of course these were very rich people and leaders in the community and were expected to help with medical school a great deal, which indeed Hamber did.

Because of this the interviews had an enormous social emphasis. I remember there was a lunch at the Vancouver Club and dinner at Mrs. Hamber's house - dinner and evening. Sorry, again a correction. I'm putting two things together. There was <u>not</u> dinner. There was a dinner at the Hambers that evening that had been arranged but they had not known I was coming and we were due to go back that night. So we were asked to go for cocktails to the Hambers before leaving. And there was intensive interviewing. There were several committees and each time you appeared somewhere you were expected to make a little speech. Not the easiest thing in the world, I was pretty young at the time. I was 33, you know, and didn't have any great age behind me at that point. At all events, it seemed to have gone quite well. We discussed the school and within two or three weeks I was offered the position. I think I was out here the beginning of November and I was offered the position the beginning of December. So those were the circumstances. I was sent the plan for the building which just arrived, I think, New Year's Eve, 1949-50.

Int.: *The plan for which building?*

S.F.: Well, the building that we were to occupy. We were going to take over what was then huts, large huts that had been built for the School of Architecture. They were really drafting rooms. And they said we would take that over. I think there were about 6,000 square feet in the whole thing. And Anatomy, Physiology and Pharmacology.

Int.: *And that is actually where you were housed?*

S.F.: Oh, yes.

Int.: *Just to go back. One thing you mentioned was Dr. Dolman's meeting with your head in McGill. Would that have been on his tour around the area for this…?*

S.F.: Yes. And that's with the benefit of hindsight. That was part of his tour when he went to Canadian schools and American schools and was thinking his Report out. When I came out I had already seen his Report and there was a contrary report or a counter-report from the Medical Association. I'd seen them both.

Int.: *Before you accepted the position?*

S.F.: Yes, I can't remember when I was given them, but…

Int.: *Did the conflicts that were going on about the start of the medical school affect your decision at all? Did it make you think twice about…*

S.F.: It made me think six times!

Int.: *(She laughs).*

S.F.: Actually, there were a lot of things that weren't good about it.

Int.: *(Uumm.)*

S.F.: And when we talked about it, my wife and I, we thought that, well, if it's no good we haven't sold ourselves down the river but we would watch for 2-3 years. I really came out with very mixed feelings about how it was going to shape up. I thought that there was little doubt in my mind. The Dolman Report I thought was an excellent report.

Int.: *So you were basically in agreement with it?*

S.F.: Oh yes. It was only because I felt that surely commonsense would prevail after we got started and they realized that if they set their sights the way the counter-report – I'll call it that - the way that had set its sights, the medical school would go nowhere. In fact, I suspect that that has been what has happened over the years. So with a good deal of trepidation… I think against that was the Right hand, Left hand ledger. Against it was: One, my wish to stay in Canada and try. I think that was over-riding. Two, there was the sense of enormous burgeoning activity, a real sense of vitality out here as you talked to people. Everybody was… I guess it was just after the war and everybody was busy building. There had been an article in Time magazine about Norman Mackenzie who had brought the huts down to expand the medical school for the veterans, and the war drive and so on. I think that was in '47 or '48. That had given me a good feeling. The other thing was that at McGill we had - I can't remember the exact number but I think we had 20 students from UBC always as part of the class. I got to be very friendly with a number of these and, of course, all they could talk about was B.C.

Int.: *Things haven't changed a lot.*

S.F.: No, I suppose. So much so that in 1947 we took a car trip out. I wanted to see what UBC looked like. Nothing to do with medical school. This was just as a summer tourist. There was no Trans-Canada Highway so we put the car on the train to Banff, picked the car up at Banff and drove out to the coast which was harrowing, I can tell you. Some of the dirt roads over the pass were nothing amusing. We lost our nerve at the Fraser Canyon and went down through the States

Int.: *(Laughter). Oh, really?*

S.F.: Completed the trip out west through the States and came up through Seattle and went back through the States. We drove out to see the campus, this was '47, and we were startled. It was very hard to find anything you could define as a campus. There were a few buildings. No character whatever. I think the Library was here and there were some low buildings which I guess in hindsight I now identify as the old Arts Building. And I think that was about it. A few huts scattered around the place. Hardly anything; mostly mud.

Int.: *Nevertheless, there was a feeling of excitement…*

S.F.: When I was here in '49, that's when there was. Certainly. As I say, there was always pressure from the B.C. boys at McGill who urged me to think seriously about it. But as a proposition it was discouraging because the other thing was that there was a building being built on campus, the Wesbrook Building and that was under construction. Weaver had told me - I was disappointed in him - that he had agreed to its construction. Maybe he had to agree, but essentially that was the capital money that was to have started the medical school and I think they had decided that they would build the building for Dolman. I think with reason there was a lot of hard feeling. I think they put him to some tremendous discomfort and really in a sense kicked him, and I didn't think that was going to go well.

Int.: *So the Wesbrook Building wasn't used by the medical faculty at all?*

S.F.: No, not at all. It had nothing to do with the medical faculty. It was years later when something was done - I think, as I recall, Dr. Dolman was moved, not out of the building but he stopped being the head of Bacteriology - some rearrangement was made for him and for the Bacteriology Department in its relationship to the medical school. The medical school took over the responsibility for the Wesbrook Building and the only thing that they moved in was the dean's office. That would have been in the latter '50s, I would think; maybe 1960 approximately.

Int.: *So you were in huts for the first part. How did that work out?*

S.F.: Very badly. (Laughter).

Let me explain. I'm not certain of the figures. They were about 100 ft. long and 50 ft. wide. That would make it about 5-6,000 sq.ft. That's not very much when you divide that between even two departments. We took half the building approximately. That's 2500 sq.ft. hardly more than a good-sized house. We had the problem of cadaver procurement and cadaver housing. Now, I don't know if you know but in anatomy departments they span a broad range. Medical students still have to be taught cadaver anatomy. That part of the subject is 500 years old and hasn't changed that dramatically in that time; perhaps the way it's taught has changed a little bit. It's still the intro-

duction. Anatomists themselves don't do their research in cadaver anatomy. They do it all the way to the fringes of their subject, which is a description of structure by way of techniques you find. And these are usually quite sophisticated techniques which approach physics and chemistry and subjects like that. But a basic requirement for the department is that they must house these cadavers; they must arrange to teach students under proper conditions for cadaver anatomy, which isn't easy. They have to make sure that whatever's done will be publically acceptable if, for any unforeseen reason, it became open to the public. It never is, but if it were. And there has to be a place; some sort of morgue attached. Well, when we first built the building there was no morgue.

Int.: *So what did you do?*

S.F.: The Department of Animal Nutrition was very he1pful . There was a Dr. A1ex Wood. He's dead now. He was the head and he was a tower of strength to the start of the medical school, both experimental animals which were required and housing for the animals, and cadavers. He arranged for a room in the dairy barn to be set aside for the storage of cadavers. It was a very primitive and difficult kind. All that could be said for it was that it was a concrete room and it could be locked and so it was private. 1'11 tell you more about cadaver storage if you ask me 1ater on as a separate thing. But 1et me just say that as far as buildings, which we are talking about now, in the following year I arranged to add a small morgue to the end of the original hut. It was very small but, if you decide you are gong to do something in a small space but properly you can do enormous things. It's like designing the interior of a ship, you make use of every square inch. We put a morgue next to the dissecting room so we had really total control from that point forward of that situation. We only had sixty medical students, the class wasn't too large, and I had a very good technician who started with me. Actually, Dr. Wood found him for me. He had been a pathology technician in the war and when Dr. Wood had been at Suffield this man had run one of the labs. His name was Gordon Crossen. So Gordon Crossen started with me in July of 1950 right away and was a great help in getting the thing organized. We tucked the rest of everybody into what was left after you provided a large lab for the dissecting room. That took, I would say, half the space; certainly 45% of the space.

Int.: *Was the lab set up and ready for students when they came in 1950?*

S.F.: We didn't think we'd make it. I sent out detailed drawings and plans beforehand. Buildings & Grounds were at that time a very efficient organization. They assured me it would be alright. I arrived out here on, I think, the 21st May, 1950 and went out and saw that they had stripped the interior of the building right down to starting level. I said, "You'll never be ready in time." And they said, "Don't you worry, Doctor!" There was a Scot who was in charge, a Mr. McGlashon, and he kept saying, "Not to worry." The chief electrician, a Mr. Fletcher, was also the old school type. They were always very laid back and "Don't you worry, Doctor."

Int.: *They got it done!*

S.F.: They were ready and, you know, you had everything. You had that building. We had a separate building, a separate hut nearby in which we put two lecture rooms. And we had one lecture room ready at the time we started. We had to do everything. We had to remember to get the chalk, you know, and the pointers for the lectures, and everything. The physical structure was just about ready in time, just a couple of days to spare. So yes, we were ready for the class. There were another couple of parts to getting ready for the class. You had to have enough cadavers. We didn't quite have enough. We had to go six students instead of four, which was the ideal. There had never been any arrangement for cadaver procurement out here so we had to set those in train. But that's the next part of the story. But we had to have slides for histology and Dr. Gibson, who wrote to me after I first visited, he wrote to me in January or February and said he thought he could get a set made by the technician in Oxford. Would I be interested? So we said, "Yes, if we could get them in time, a basic set of slides." They were done in time and they came here, and there was a shipping strike in that month, the month of August, and they were on board a ship in the harbour for most of the month of August…

Int.: *Oh dear!*

S.F.: … while we kept getting itchier and itchier. I think they came off the ship; I think we got them about ten days before the class started, something like that. It was really down to the wire. That was the most hair-raising part. And yes, we were ready.

Int.: *So the students didn't walk in and have any great surprises? They were able to start classes right away?*

S.F.: They started classes. It was a proper, first year medical class. Physiology was also ready. Dr. Copp wasn't able to get up here as early as I was. He came - when did he come? when did I leave? - just shortly after I was here. He was appointed considerably later, in the spring of 1950 and so I had some months head start. He came to Vancouver, I think it must have been the end of May, beginning of June, just for a visit. And he wasn't able to stay; he had things to do in California. He asked me, would I look after the planning of the building from the physiology end. At that point there was a Dr. Edgar Black who was a physiologist and had been in the Department of Zoology, and Copp had made arrangements to move him over as his Number 2 in Physiology. So Edgar Black was here to work with me and between the two of us we did the Physiology. Pharmacology was not to be taught in that year, so we had a little time to think about it. Biochemistry was to be taught. I didn't have anything to do with that other than Dr. Darragh was appointed sometime in the spring, round when Copp was. They brought a separate hut for him. He got an old hut which was moved over near the Physics building. It had just been moved down from Little Mountain and it was in terrible repair. You could put your foot through the floor in places! And he got ready in time, he was able to delay his lab a little bit. And he had Dr. Zbarsky. You'll have heard all about that. Did Zbarsky tell you that you could put your foot through the floor?

Int.: *(She laughs). No he didn't, as a matter of fact. I was just thinking ....*

S.F.: Well, you could.

Int.: J*ust to go back a little bit. You mentioned the report that Dr. Dolman did and the report that Dr. Strong did. Did it affect you, having a split school? Did it make it more difficult for you?*

S.F.: I think I have a record, wherever you can find it, if you find one vote against it is usually me. Because I was really not prepared to accept the idea of a split school. I thought that a split school to begin with was not tolerable as a proper medical school. It meant that there was no contact between clinical and basic science. It meant that whatever effort we could make in basic science to give them clinical relevance was not backed up by what could be done clinically. So that's as far as split is concerned. And then, as far as location is concerned, the second of the two choices. You can be joined in two locations. If you join at the hospital location, for the longest time you end up with what is really a clinical service orientation rather than an academic medicine orientation. I'd come from a school which had been the leader in Canada for academic medicine and I was thoroughly indoctrinated with the idea that there is only one kind of first-class medical school. You know, at that time, McGill was easily one of the top ten on the continent of North America if not even higher than that and it had been the school which had had the first clinical department of clinical investigation on the continent. Incidentally, Meakins had been the man who started that. That was financed by Rockefeller money and it was a go-ahead place. Well, practice was very important. I think the practice of medicine at McGill at that time and the two hospitals associated with the school was as good as anywhere on the continent, better than most. But the school was not split; it was absolutely dominated and based on the campus.

Int.: *So how did you manage to deal with the compromise here at UBC yourself?*

S.F.: Well, I started off by attending Grand Rounds at the Hospital, the VGH, which I thought would give some sense to them that we were interested in what they were doing. I did that for a year and I found that nobody was following my example. I wasn't getting anywhere and it was costing me a good half-day solid, just the going, the coming, the talking. I decided I would have to abandon that. We tried to start a course for surgeons-in-training in anatomy. That went. We got them out. But there was constant pressure from them. It was inconvenient for them to come out to the medical school in the evening and couldn't we move it down to the hospital. There was no way I was going to move cadaver material to two locations, it was difficult enough as it was. So that didn't work. At McGill I had myself worked in the outpatient department and I put in sometimes two mornings a week, sometimes one morning a week. I had worked in the Department of Radiology as a clinical assistant. There was no way I could do that here.

Int.: *So it really did affect you?*

S.F.: It affected me personally quite a lot. I was very much, because of my background and training, I suppose, very much of a mind that basic sciences should contain a liberal sprinkling of people with medical degrees. You should try always to have at least half

your people with medical degrees. And that was awfully hard to do in a split school because the people with medical qualifications would just be divorced from clinical work. It was no good.

Int.: *What was the relationship like between the faculty at UBC and the general practitioners?*

S.F.: Oh, we got along fine. We just couldn't see eye to eye. What I would regard as goals they didn't although I think Dr. Strong got sufficiently persuaded about the need to get some kind of research going in the hospital. He got that message pretty early and therefore got the money together to build the Strong labs down there. But it was too little. It was not a satisfactory arrangement. The problem was a difficult one for the clinicians. The main thing with the clinicians was that those who were here didn't really realize the meaning of academic medicine. As far as they were concerned, that was lab work for lab people and didn't have much relevance to practice. The clinicians that they brought out here to head their departments were mostly from Toronto. And Toronto at that time wasn't a split school but it was a non-academically oriented school. They read a lot of textbooks but there was nothing in the way of clinical investigation in the hospitals there. Toronto General was essentially a service-oriented hospital.

Int.: *So a lot of those people would have been comfortable with the arrangement?*

S.F.: They were comfortable with the arrangement. They had hoped maybe we would move the basic sciences down to the hospital. Now, interestingly, the people who came from McGill. That was Rocke Robertson as Department head - Rocke Robertson and myself - we were always on a different side to the clinical or even the basic scientists. We were joined a little later on when they got Dr. Tyhurst, also from McGill and also with the same orientation and also in steady battle with the administration to try to do something. These people would never accept the situation.

Int.: *When did Dr. Tyhurst come? It was quite a bit later? So this conflict was there throughout. It didn't really ease off?*

S.F.: I think, when we get to talk about it or when you talk about it with other people… Dr. Tyhurst was always in hot water with the clinical people. It reached a head after he built the psychiatric unit out here. He was essentially responsible for accepting no compromise and plunking the first clinical unit on the campus. He did it out of sheer bloody-mindedness. It was a magnificent set-up. And of course he was in absolute head-on collision with the practitioners and ultimately it cost him his job as Department head. There is little doubt in my mind that is the same conflict, always the same under-current. It was interesting, you know, because they had exactly the same conflict in Seattle. Seattle's began a couple of years ahead of us. They had the same battle with King County Hospital exactly. In fact, it is a battle that is repeated all over the continent; books have been written about it. And when they came to the battle, I guess because their dean was of different fibre than their president or whatever, because their political involvements were different and their dominance was different, they won. The academics won and the hospital was put on the campus. And the next thing you knew,

the University of Washington became one of the leading medical centres on the continent.

Int.: *This brings to mind a question: Do you think it would have been better for the medical school here to have waited before it did open its doors to students?*

S.F.: Yes, it would have been better to have waited. The pressures were enormous. Or it would have been alright to have started this way, with a clear commitment on the part of the Government, on the part of everybody, that the next construction would be on the campus. There was supposed to be that commitment. I was told there was that commitment by Weaver, that was the one part. And the first I learned that that commitment was down the drain was when we moved toward Centennial Year 1957. At the beginning, I think it would have been 1954-55, Dr. Weaver – I'd had numerous run ins with Weaver on the issue of getting the medical school on the campus. He wasn't pressing hard enough; he wasn't strong enough, in fact. He said, "Well," he said, "Sydney. I can only do it your way if I have the backing of the President." And, he said, "I haven't got the backing of the President on this because he doesn't want to face the political struggle that is involved. And I said, "I don't believe that. I don't mean to say you are a liar but I don't think you put it to him well enough." He said, "Well, let's go and do it together." We went and sat in the President's office and discussed the matter. And I came away with the clear belief that the President would not back a real confrontation which this would have had to be. That was the first time I knew about it, and that would have been in 1953 or '54, in that session.

Int.: *So in fact, Dean Weaver didn't have the support of the President, then?*

S.F.: Or he didn't convert him. One of the two. I believe the latter because I think that Mackenzie was a very strong man and could easily have undertaken a fight if he felt that it was justified.

Int.: *Well, it's interesting. It doesn't seem that Dr. Dolman was able to convert him either, though.*

S.F.: I don't know what went on but that must have been it. But Dolman came with a bill, you know. Dolman said, I think it was $93 million. It was an astronomical figure that he mentioned it would cost the medical school to do it properly. And that may have scared them off, I just don't know. But they could have done it piecemeal. Anything as long as their directions were correct. But the clear-cut change happened - I can't tell you exactly whether it was 1954 or 1955 - but I had been told steadily by Weaver that the next hospital construction that the Province would undertake, that is between VGH and the campus, would be on the campus. He came and he told me, I don't remember the circumstances but I think he was a bit shamefaced, that he had just agreed with the Hospital that if they would back him in the future, his future efforts to get a university hospital, if he would back them and withdraw his claim from what was the Centennial construction. The Centennial Hospital was then built down at VGH. And they knew it. That meant that you had put a big, financial investment in new construction. There had

not been new construction at that hospital for a long time. The buildings were old. You could have walked away from them but you can't walk away from a brand-new building in 1957. Meantime, we had been promised our basic science buildings much earlier and we didn't get those until 1961 which was an awful long time to wait. But, depending on how you want to develop the story…

Int.: *Not having proper buildings in the beginning, did that hamper your teaching and your research?*

S.F.: It hampered our staffing and our research; just about everything. It was always - Dr. Copp always talked about potential - great potential. I was about ready to throw the sponge in by about 1955-56. There was a vacancy in Stanford which attracted me. I didn't allow my name to stand. But I came very close to doing it. My wife had gotten to like Vancouver and we thought, well, if we don't fight for this sort of thing, who is going to do it. If Canadians walk away from it, well I'l1 probably never get anywhere but let's keep slogging at it. And I think that was the only reason for sticking with it. At that point I realized that we had to just wait for the buildings - I guess Copp had realized the same - and we would just roll along with it: keep pressing for a university hospital, keep pressing for a unified school and so forth. I must say, Copp pressed the same way I did but I think I'm more bloody-minded than he is.

Int.: *It sounds like it was what you had expected.*

S.F.: Well, it really was difficult. I think, in hindsight I'm not sure that such chauvinism is justified. I'm not sure I'd do it the same way again. But there were no other places in Canada that were equivalent and this offered a big challenge. You could try to build a good department with what you had. You couldn't do much in the way of staffing but if they kept the medical class the way they had they didn't need to do too much. I built the staff very slowly.

Int.: *You were specifically involved in recruiting your own staff?*

S.F.: Oh yes.

Int.: *Was Dean Weaver involved in that at all?*

S.F.: Not in recruiting within the Department. He was involved, not even terribly heavily, in recruiting beyond getting the first department heads. He was heavily involved in that. He set up committees.

Int.: *So how did you go about getting people for your Department?*

S.F.: Well, two ways. One, I was a faculty member of the Anatomical Association, the American Association of Anatomist's. I had some very good friends in the Association and members of the executive and they were quite helpful. And there were some training places, well known training places: Cleveland, Minnesota, and a whole bunch

of places like that. They kept me appraised of when people might be interested. I was in competition with American schools and mostly I brought Americans.

Int.: *Were there just not Canadians available?*

S.F.: There weren't. There were a few. I had Dr. Constantinides, who was a Greek immigrant and had gone to the University of Montreal and had worked with Dr. Selye. He came out right away. But the Canadian departments were understaffed, largely because they had grown in a different way to the Americans. Their research was not such a high priority item. They didn't have big departments of research people. Even McGill. When I left it the staff consisted of the professor and head of the Department; the head of Histology, Dr. LeBlanc at the time; the head for gross anatomy which I did; and we had a couple of teaching fellows to help us. That would be for a class of 120 medical students.

Int.: *So it was a much different thing then to what it is now?*

S.F.: Oh yes, much, much different. That was why there wasn't this outlet for academic medical people because even the basic science departments weren't thick. They had ten or twenty jobs looking for people. And in the clinical departments they had clinicians who had to practice and the research facilities were minimal. So there wasn't a big area for staff. So that's why there were no Canadians. The Americans started to expand their research efforts immediately. After the war it exploded. But they had a big demand for staff. So I was able to, and there was a big movement of zoologists from zoology into anatomy. So I was able to make temporary staff positions. They would bring somebody up even for a few years and gradually try to see what else we could do. The other thing was, I had been told to try to grow your own so I tried very hard to grow my own. What I did was, Dr. Hinke was my first summer student. I took medical students out of the school and gave them summer jobs. There wasn't an official summer program at that time. We had the first that was started. I just did it out of my research grants, wherever I could find some money. I brought him out. I brought quite a number; we had a good program going for years but that was the aim of bringing them back into academic work. Most of them didn't go back into academic work but I had some signal successes. Hinke became an academic anatomist; he is professor and head at the University of Ottawa.

Int.: *Oh.*

S.F.: Dr. Webber is the dean. He is one of the people we brought back. He was an anatomist. Dr. Jamieson, who is the president of the American Association of Cell Biology, and Professor Jull was one of my people. There were a number of them. And there were a number of them in other departments. By this time the program grew. So you tried to grow your own to some extent.

Int.: *I guess that would have been one of the aims of any school, really.*

S.F.: Usually, if you have an academically-oriented medical school, anything you start in basic science for these people, it's driven home as they go into the clinical years. Here you've got absolutely flattened right out. By the time the clinicians were finished with them, they had no desire.

Int.: *So it really was quite a success on your part to get any? What about the relationship between the existing science faculties and the medical faculty?*

S.F.: Very strong and very good. At that point I suppose my best friends at the time were with the Department of Chemistry. And later the Department of Economics - that was for more personal reasons. That is, living on a university campus you make friends with historians and people in English and people in Economics and all sorts of things. I think I had a wide set of friends on the campus itself, mostly campus-based. Far fewer friends in the clinical field. There were some but far fewer because I didn't happen to have social contact with them. In a sense I think theirs was the lack because they didn't get this contact with this terrifically broad horizon of people on the campus. And it was very good in those days because, although I suppose we didn't appreciate it, the faculty was a small faculty and we fit into a hut. We could all have lunch quite easily (laughter). I think we resented the fact that there was no liquor licence. We couldn't drink in the faculty club. But we looked forward to getting our big, new faculty club but in a sense that destroyed much of what had gone on in the old faculty club because there had been very intimate contact with campus people. From the standpoint of my own research, my contact with the people in Chemistry was the most fruitful thing for me.

Int.: *And they were helpful to you? You didn't have any problems?*

S.F.: They were more than helpful. I did work related to glass electrodes and I never would have done it if some of the chemists hadn't said, "This is the sort of thing you ought to be looking at." They knew what work I was doing. So to me this was exceptionally fruitful.

Int.: *The beginning of the medical faculty was taken quite well by existing faculties?*

S.F.: Yes.

Int.: *They were in favour?*

S.F.: They were quite happy with them. They liked them, the broadening of the campus. Very much so. So far as I know, they didn't fight the advent of the medical school. They worried about it.

Int.: *There wasn't any problem with finances?*

S.F.: Somehow or other they got persuaded that whatever money the Government was going to put into a medical school it wasn't going to put into a university so whatever went into a medical school wasn't being taken away from them. Two independent streams.

Int.: *They weren't going to get into any hassle…*

S.F.: I think the biggest problem with the budgeting was the fact that it was all done by the Department of Health that looked after the funding for hospitals and so on had absolutely no experience with an educational component in the hospital system, so they were unwilling to fund it. The Education Department, really, probably did not see any real reason why they should fund hospital work. So you had that area, I think that was the real battle. I think it probably went on at governmental levels. The real battle was, how do you fund a medical school with academic components that straddles education and hospital service. Your teachers, your full-time clinical staff that does research, they practice so they contribute to both things. And how do you fund it? So I think some of the battles went on there. I know they did in a lot of provinces until Education and Health got together to fund a medical school in many provinces, it was disastrous.

Int.: *What about money for your own Department, Dr. Friedman? Was there enough to go around so far as you were concerned?*

S.F.: Yeah. I guess you know your sights – it's so hard to see just where you set your sights in 1950 and we are now in 1985 and amounts look different. From my standpoint, the university was very generous. That is, whatever I asked for that was reasonable in the budget, I got. I got what was for that time a good budget for the Anatomy Department and it expanded over time and was well within the mainstream of what was available to anatomy departments in the United States. Our salaries were, as far as the medical school was concerned - there was lots of trouble with salaries on campus generally - but the medical school and certainly the Anatomy Department, I was able just to offer salaries which were at least equivalent to anything that was offered in the States. I could usually go a bit better if I needed to attract people. My difficulty was not at all in having a budget to do it but in finding the people. You might not have a position budgeted but if I came during the year and told Dr. Weaver, or whoever else it was there, that I needed to get another person, they would say, go ahead. So the budgeting was fine. In my own personal opinion I think that, considering the budget the medical school had throughout all its formative years, which I would say take it roughly to 1965, from anything I saw of the budget I would judge that we had a budget that was at least as good per student or whatever as anything available in Canada, if not better, and they should have done more with it.

Int.: *This is another question that comes to mind: why do you think it took so long then to get a hospital, to get buildings, to really…*

S.F.: Motivation. I think that people spoke out of both sides of their mouths. It was university policy that we should have a university hospital and a unified position but there were very few of the clinical people who were willing to fight for it. I remember when Dr. McCreary was appointed as dean, in accepting the position he had to promise publicly that he would support the fundamental principle of uniting the school and the campus. And yet, within a few months of his appointment, he was in my living room trying to

persuade me, would I accept the idea of unifying it at the hospital? We had a big discussion about that.

Now, I don't think he was being duplicitous. I think McCreary was a great realist, you know, a good politician and a realist and I think he worked within the system as he found it. And I think no one was willing to bite the bullet on it. And in fact, I think that a lot of people, and when I say motivation I think that the people who were involved in making the decisions didn't really know what it meant and were not really themselves persuaded that it was all that important. They were, to a large extent, comfortable and happy at the Vancouver General Hospital except for the space. If they could have secured a big gob of space down there they would have abandoned the university hospital on principle, and in the clinch as departments managed to get space, even up to today, and research space, the fire has gone out on that one. I think if - I doubt if there would be a campus hospital at all if McGeer hadn't decided that this is what he wanted and made it a condition for expanding the class. I think that single-handedly McGeer... I don't see any other reason for it. It would certainly never have come in natural evolution. And in fact, it isn't really because of still the same dragging of the feet; it isn't the kind of university hospital you really would have if you wanted a university hospital. It's much too dominated by practice; and much too hamstrung by what's there and who won't come out to work there. So that in fact, you know, it ends up with empty beds, which is ridiculous.

Int.: *You mentioned a little bit about McCreary. What about John Patterson who was the second dean. Can you tell us something about him?*

S.F.: I'll tell you everything you want to know about John Patterson. He was a friend of mine. I told you I had a lot of friends in the executive branches of the American Association. One of my very good friends was Norman Hoerr who was the executive secretary of the Association, and he was the head of the Department at Western Reserve in Cleveland. The educational ferment in medical schools started immediately after the war, in Cleveland. They were the ones who got the grant of money, I can't remember from where, Commonwealth Fund or one of those places, to investigate education and to see about devising a new curriculum. That was Mecca, and well recognized that that was the place it happened. Now, the man who was put in charge of running the program and planning it and who actually in the event implemented it was John Patterson, who was the Associate Dean of Western Reserve, who had started in Norman Hoerr's department as an anatomist. Norman Hoerr himself had been the chairman of the committee that did the curriculum review and brought in the new American medical curriculum. Patterson had moved from his department into the dean's office as Associate Dean and had been in charge of implementing the new program.

Int.: *So he was right in the forefront of a lot of...*

S.F.: He was it. He was the big wheel. And I knew him well as an anatomist. I was on the committee to choose a new dean at that point, with Rocke Robertson who chaired it. Rocke and I saw eye to eye on the kind of thing we needed here because Rocke came

from the same background. As I say, he was the one who was very consistent. He would never take on the deanship on a permanent basis but he was very consistent about where it ought to go. Well, at any rate, I was at the meeting with Patterson and I asked him, would he be interested? We talked a bit and he said, "You have Medicare up there", the usual "up there". We had gone into the full implementation of hospital insurance and we were on the verge of adding the clinicians' services to it. The first part of it was just hospital, then they added the Medicare portion. We were about to do this and he said, "I see this as the pattern that is going to develop throughout North America." He said, "This means the end of free, ambulatory outpatient care as we've known it in hospitals. It's going to be, How do you teach medical schools in a Medicare environment." That would be very interesting: to go there and take it on. He saw it as an experimental area for what needed to be implemented. It was very perspicacious, as a matter of fact. So, in the event, he came here. I remember when he visited for his interview. We had beautiful weather in the month of May and Rocke said to me, "My, aren't we lucky! This is real selling weather."

Int.: *(Laughter). It always helps, doesn't it?*

S.F.: Yes, it really did: the mountains just standing at the end of the street. So anyway, he took the job. And he was here for two years. I was a good friend of him throughout and no question about where he wanted to go. But he had two real problems, more than two but his main one was the clinical group who weren't buying the direction he wanted to take the school and they fought him at every turn. That was very distressing to him, not to be fought - he was prepared for that - but he wasn't prepared for Canadians. He had come from an American environment and he found it quite different. He said, "They fight differently here. They fight much more subtly."

Int.: *I was going to say, you aren't quite sure what you are dealing with.*

S.F.: He said, "I'm at sea. I don't really know the ground rules and I really don't sense the moves. And then I suddenly find they've cut my throat when I didn't anticipate it." That was his big difficulty: the American and Canadian environment which was highly politicized.

Int.: *But then, Dean Weaver was an American as well.*

S.F.: He didn't do well.

Int.: *We should talk about him later, anyway.*

S.F.: He did badly. Patterson was a different breed entirely. So he had that battle. He had, in the event, a battle with the basic sciences because we started to plan our building at that point. And he had come, he had done what were called multi-discipline labs and he was trying to persuade the basic sciences to pool their resources. The basic sciences were violently - I included - we were violently antipathetic to the idea of pooled facilities and pooled services: an amalgamation or blending of the three basic science departments.

We didn't like it at all and we were prepared to fight him on it. That was bad. I warned him that he was taking on two battles at once. He really could have done without this second one because he alienated the head of Biochemistry violently, and Physiology less so 'cos Copp was a less violent person. But Darragh reacted quite strongly. And Darragh went to see the president. And the president reacted violently to it 'cos the president was also not backing Patterson. I was at a Senate meeting which will live etched in my memory in which the president raised an issue dealing with Biochemistry and what Patterson proposed to do at the Senate meeting, and rebuked Patterson publicly. Patterson left. So obviously he had not had the backing of the president. The president had obviously been looking for a way to unload him. So that demonstrated again that the battle couldn't be joined unless everybody concerned at the top levels were prepared to do it. Now, of course, it was much worse in 1957. Between 1950 and 1953 it could have been done, could only have been done.

Int.: *Now, let's talk about Dean Weaver a little bit.*

S.F.: Dean Weaver's background was entirely different. First of all we have to deal with people here. Fritz Strong was from the University of Minnesota; Wesbrook was from the University of Minnesota. Certain ties. Fritz Strong was an American but became Canadian. He was an American to begin with. He took out citizenship. His roots were still in Minnesota: the hospital survey group; the hospital management team; the manager of the hospital - I don't know what they called him at that time, I forget his name. It may come back to me - he was from Minnesota. The surveys that were done of the hospital were done by Hamilton Associates, which was a Minnesota team, a Minnesota outfit. His roots were very deep. And finally, Weaver had been assistant dean at Minnesota. That kind of wraps it up.

Now, Fritz Strong controlled this process and I think the selection of Weaver was absolutely in character. Weaver was a nice, nice man. But, you know, assistant deans are not the stuff deans are made of. People who are ready to take assistant deanships are not what you want for deans. And the people that you want for deans may take an associate deanship to run a program or they may take a deanship under the president of Health Sciences. But they will never take an assistant deanship, never. They've got other things to do. So Weaver was an assistant dean. He was a bookkeeper and manager to cross the t's and dot the I's: you work within the system, you don't change the system, Weaver's motivation entirely.

Int.: *And I guess it would be difficult if the system wasn't clear, which it seems it wasn't here...*

S.F.: Yes, he made some terrible mistakes really. First of all, they shouldn't have appointed him. If Strong hadn't dominated, I could have named you half a dozen people in Canada who would have done the job. They would have been dangerous…

Int.: *Were any of these other people approached, do you think?*

S.F.: I doubt it, I doubt it. Wendell McLeod had gone to Saskatchewan and had taken a prairie school and was in the process of turning it into a first class, continent respected medical school, able to attract people from the States to run his departments and how you do that. Now, Wendell McLeod was also at McGill. I'm not using that to demonstrate anything about McGill. But the training was academic medicine at that time. It's academic medicine in Toronto now so we have to remember it's not the same Toronto that I'm describing. I would think from 1955 on you would be hard put to equate the University of Toronto with what went on before. The earlier one was service-oriented clinical. Strong, good clinicians. Well, Wendell McLeod was never approached. He was approached just before we got Patterson and said no. But I'm afraid he was not approached - you know, there's a way of approaching people. I'm afraid that was the approach. But I think he was almost ready to leave, and did in fact leave Saskatchewan within about two years after that.

Int.: *So it was basically Strong's decision to bring Dean Weaver here?*

S.F.: To bring a second-class person. It's not derogatory to Weaver; it spells out the kind of job you want him to do.

Int.: *Do you think that he did as good a job as he could under the circumstances or do you think someone else might have been able to change…*

S.F.: Oh, right away. The first thing that he had in his hands was his professorship of medicine. And he should have got an academically-oriented person. He had the appointment in his hands. He just had to go.. . . . Instead, he brought Bob Kerr, who was a fine clinician and the Number Two man in Toronto, absolutely non-academically oriented. Never done anything academic. And apart from McGill the States was loaded with academically-oriented medical people. And they had Canadians because there were a lot of Canadians who had gone to the States and who would have been interested in coming back to Canada in medicine.

Int.: *Like Dr. Copp. He was in that sort of a position.*

S.F.: He was not a clinician.

Int.: *No, but I'm sure there were others like him.*

S.F.: They were all over the place. So I thought, that's the kingpin, that's where everything goes.

Int.: *The key department.*

S.F.: The key. And there was no way that Hospital people could have stopped Weaver from getting the person he wanted. They had no clout. All they had to do was to bring in the kind of man they wanted. They brought Dirks latterly here, the present person; and there were a lot of them around at that time, both in Toronto and McGill. So he should have

gotten a young man instead of which he went to the other age group. Bob Kerr's considerably older than I am. And he could have got one in the 33-35 year-old age group, 37 year-old age group. He did the same thing in pathology. And we had in Canada the best academic pathology training ground under Lyman Duff on the continent. They staffed many, many departments in the United States with their products, M.D.'s, Ph.D's in pathology. He could have brought them in, and easily. He made no effort. He was afraid to tackle the pathology situation so he temporized. He got a nice fellow to run it and so forth, but nothing. His appointments were so bad, they went along with the system. He probably talked to Strong about all these appointments; he didn't have to. He probably cleared them.

(Interview end for that day)

Int.: *Dr. Friedman, we finished off the other day discussing Dean Weaver. You were talking a wee bit about some of the appointments that he made. Is there anything else you might like to add to that?*

S.F.: I'm not sure. It's hard to recall.

Int.: *Basically the question was how he dealt with his role as dean. What your impressions of the job he did were?*

S.F.: No, I don't think there's very much more to say about Dr. Weaver. I think he was essentially quite a weak dean and I think he had a lot of problems to cope with once we had started off on the footing that we had. Once he had accepted those ground rules he wasn't in a position to change anything further so that I really think that we went rather slowly. We should have at least begun to get buildings, permanent buildings when he finished his deanship, which I think was about 1954-55 but I think we were as far as ever from them. As you know, we didn't actually get into permanent buildings until 1961, and that's eleven years. That's a long time in the huts. I think it put a real crimp in the development of the school. I think that slowed things down tremendously.

Int.: *It sounds like you don't really think that he fulfilled the role that might have been expected of him as dean. Or perhaps he was simply the wrong person for the job.*

S.F.: Well, it really depends on your standards but from my particular perspective of what I expected to happen with the school he was the wrong person for the job for starting the school. I a1ways thought they would have been much, much better off had they appointed even one of the retired, established deans, one of the people who really knew the ropes in Canada, that really knew how to get things done. But I think, as I said earlier, the choice was governed by the ground rules they had accepted, from my standpoint unsatisfactory; I am sure, from those who agreed with the basic position, quite satisfactory.

Int.: *Did he actually have much role in getting your department going?*

S.F.: None whatever. He was very cooperative, I think. I have nothing to complain about as far as budget is concerned nor as far as any of the facilities that were involved. He was in that sense, as far as providing for the needs of academic departments, he was very good. He knew what was required and he carried the ball very well so that we were well funded. I should say perhaps something about the start of the library because he really helped quite a lot. When I came out I found, of course, there was no medical library. For a working scientist this was an impossible situation and one that required immediate remedy. Well, I spoke to Dean Weaver and I spoke to the library people. He put me on the University Library Committee and then he gave me the responsibility of starting up the medical library. I was able to get a mezzanine in the Riddington Room which was large enough for tables to seat about sixty people if they all touched elbow to elbow. But we only had a class of sixty so we were managing. We started off - I decided that we would have a subscription list of 100 or 120 journals for which we tried to get the last ten years, those being the ones we would need immediately. The first budget - I remember looking this up recently - the first budget, I think, was $12,000, which is something quite different from the ones that run into six figures now. Doreen Fraser was assigned as the medical librarian and she did a yeoman job. She really was very helpful in getting things started and under very poor circumstances. She got not only the medical library started here with me but she also looked after our initiation of what was a library, a branch library at the Vancouver General Hospital medical facility. The library grew quickly, of course, from that initial start and it is now quite large. But it was a real handicap and it just had to be started quickly and we certainly had very limited facilities for quite a number of years.

Int.: *Did you have help from other members in the faculty? Staff members? Or were you doing this more or less on your own?*

S.F.: Well, you know, I didn't talk about my wife who is also an anatomist and who helped me right from the start. I must tell you this. At McGill we had worked together and since I was not the head of the department, the department had arranged at McGill for her employment and she was also employed. When I came out here I wouldn't come unless she could be employed and work with me in the department. It was rather amusing because, at that point, there was a strict nepotism rule and they didn't want to break it. But they decided that they wanted to have me and that they would allow it, they would break it and so she was encouraged to come with me. She was given an appointment which actually she and I chose for her, which was research associate professor. She had quite a lot of experience and there was no problem about that. But we decided we wouldn't take a formal appointment in the department because then she would have specific teaching responsibilities that might create difficulties for me or for her. So she was more or less in a separate stream. Therefore, the title research associate professor, which she has kept all these years. The interesting thing is that Dr. MacKenzie called me and he said, "Sydney, would you mind if we just appointed Connie on a yearly basis?" And I said, "Why?" He said, "Well, there's no problem

about appointing her, we'll continue to appoint her. But it's just, if anything happened to you we wouldn't want the next department head to feel that he had to appoint her."

Int.: *(Laughter). How interesting!*

S.F.: That's quite a, you know…, our attitude to women and wives has changed considerably in the intervening years. But you must remember, she was probably the only wife employed in the same department - there might have been one other but they were an instructor, or something of that order but nothing of this type. But getting back to the question of library. She was exceptionally helpful in the library and probably did more than I did about it. And really the two of us were the basic library committee. We co-opted some people in later years but mainly the two. Dr. Gibson, of course, was always front-running, trying to get things funded, but that was kind of a different area of operation. We started that. Together we started a series of lectureships in the faculty. There was nothing in the way of funds for the lectureships and our first lectureship that was established was the Simmons & McBride lectureship. Simmons & McBride was a funeral house here, morticians, and they were very helpful actually to the department of Anatomy. Mr. Simmons, Ed Simmons, asked if he could do anything and I suggested that he set up [a fund] and he did. It was quite a handsome little fund which we had on a yearly basis. It ran for a great number - I can't remember if it was ten or fifteen years. We more or less hand picked the people we brought. I remember we brought Hans Selye in the early years and he was a big drawing card and could fill any number of halls. I remember I was driving down Broadway with him and he passed the Simmons & McBride funeral home and he tipped his hat, (Laughter) which I thought was quite touching. So we ran that and then we got some other funds. I can't remember where the funds came from for the lectureships but we had 3 or 4 lectureships and we could bring distinguished people to campus and that helped. Another great help in trying to get us off the ground scientifically was help which we got from the Department of Anatomy at the University of Washington. The head of the Department there was a good friend and very helpful. He asked if we would like him to arrange to send up visitors that he'd got in his place, as a follow-up in Vancouver. We got many distinguished people that way. But we were in the boondocks, especially with the kinds of huts we had and…

Int.: *It was difficult to get people*

S.F.: I remember Olaf von Euler visiting in the Department, probably about 1954 or '55 I should say. A few years after he visited us he got the Nobel prize, that was his stature. I remember him saying in my office some condescending remark like, "You really have got quite a research department here", as if he hadn't expected it, you know. I could see his point. Nobody did. We were thought to be pretty primitive. (pause) So where were we?

Int.: *We'd talked about Dean Weaver. I thought we might talk about Dean McCreary. Have you something you might say about him?*

S.F.: Well, I think Dean McCreary's a totally different type of person to Dean Weaver. I should say, I think it's only fair to say that I've said that Weaver was unsatisfactory from my standpoint but I should say, because I'd like it recorded, that he was a very, very nice person. You couldn't help like the man. The fact that he had difficulties in the job is neither here nor there. He was helpful, cordial, pleasant. I never heard him speak a harsh word. 1 never heard him do anything rough or anything that anybody would have found offensive in the slightest. McCreary was, as I say, totally different. Not that he was offensive. He was aggressive, bright. He was alert, he knew what he wanted and he was politically much wiser, much more settled. Had he been the first dean I think we might have had clear sailing provided he had taken on the task of having a university hospital, if he had accepted the initial ground rules; I think it might have been quite a different situation. He was the right kind of dean in all respects. He knew what was required and where he wanted to go. I had great differences with McCreary because they were philosophical differences. I respected him; I'm sure he respected me but we were often at absolute odds. And I suppose that's because I'm a purist and I wanted a certain kind of thing and he was a pragmatist and knew what he could get. I felt that in one respect I could have wished that he had had a different education He came up through the Toronto system….

Int.: *Which you've already said was quite different.*

S.F.: Quite different, and so what he would have set out as goals would have been automatically quite different to my own. I think this explains the conflict that arose between him and Tyhurst. There was a big conflict and I think the underlying issue was two very strong-minded people, two aggressive people, with a basic difference in upbringing. Tyhurst came from the McGill academic medicine tradition and McCreary came through the Toronto tradition. You've probably heard a lot about it already; you may hear more. Well, one of my early encounters with McCreary was he came to my house and tried to talk me into going for a combined medical school at the Vancouver General Hospital. And I suppose, being young and brash, I wouldn't buy it. I'm not sure that I was right. He may have been… In the way things developed I'm not sure that the Vancouver Hospital clinical set-up was ever moveable to the university and perhaps we might have done better to go the other route. It's unsatisfactory but I don't think it's as unsatisfactory as what ultimately developed. So he tried to talk me into it and that was a non-starter. I think, looking back on it, he went out of his way to see if he could persuade me to his viewpoint. He couldn't, and I think he just gave up on me as a bad job and realized that almost everything he would bring up I would oppose automatically because I would take the other position. Which I think is correct. But he was responsible, I think, I don't know the in's and out's of the Hall Commission but he was the man in the Hall Commission who I think, if he didn't initiate it certainly pushed the health resources funding plan. And that made an enormous difference to all the medical schools in Canada. It made a big difference to us. But it's an ironic quirk of fate, in a sense we didn't benefit as much from the health resources fund as many of the other medical schools.

Int.: *Why is that?*

S.F.: For example, Alberta got themselves a real, first class university hospital. They had a university hospital, which was the Rockefeller one but was very small. They got a real good building attached to them and real development of the medical school. You know, we were left with a balance of about $50-million which wasn't used except at the very, very last moment for the construction here so in that sense we got rather less than other places. We got the correct amount of money. I just mean we couldn't use it at the time because things weren't moving. And McCreary came very close to getting a university hospital at one point and I think he blew it. I think he blew it for reasons that I suspected might happen but I don't think he did. He was anxious to put political pressure on the Government to get the hospital built with the health resources funding. He had the planning well along. He got their approval for the planning and then they began to slow it down and then finally it disappeared. But during this period when he got it started, he got it started on the basis of this health team concept. The reason he started the health team concept, and I'd like to talk about that, which I think was a very misdirected thing. It was a political gimmick as far as he was concerned. He thought by doing that he would recruit strength from the people in dentistry, he would recruit strength from people interested in all of the ancillary sciences, and that the concerted effort would be impressive to the Government. In the event, the concerted effort looked very costly because, as you added each one of these ancillary things, you tended to increase the costs and responsibilities so what looked like something manageable became something that looked as if it might become quite unmanageable. That is at least my interpretation of what happened.

Int.: *It's interesting.*

S.F.: So it looked like a good move to get political clout, I think in the event what you did, you got the increased political clout but at the price, at a very high price.

Int.: *You think this actually slowed down the progress?*

S.F.: I think it did. I just sense that it did. I have no real evidence for that statement. I haven't talked to people in Government to find out if that's what happened but I would think that that might have been a factor.

Int.: *But this is the way that it eventually did go, through the combining of the services, wasn't it?*

S.F.: Yes, it finally did. Because once they had embarked on this so-called health sciences grouping there was no moving back from it. But in part it was a good move to coordinate the health sciences. That was alright, I wasn't against that. But I was against this team concept.

Int.: *Then why is that specifically?*

S.F.: Well, let me explain. I didn't know what he was talking about at first. He came one year and started talking about the health team as if, around the bedsides, you were really going to have a committee of people. And I couldn't see committee treatment of people at all. And I couldn't see sharing responsibility between the physician and the nurses in an equal way, between the physician and the physiotherapist. I could see a sharing of responsibility but by no means of equality. There had to be responsibility and it had to rest with the physician. You could decide it could rest with the nurse but it had to be with somebody. And obviously the way they were set up, unless you revolutionized it, it would have to be the physician. And I thought to talk in any other way was eye-wash. Now he talked about how this health team could be in some respects, taught together and he tried very hard to get courses started that all would attend in common. But that is impossible. The only thing that people would attend in common was History of Medicine and that wasn't interesting enough to hold them. There was no way you could teach people of such disparate backgrounds.

Int.: *Would they have had the proper prerequisite courses?*

S.F.: No. The level of education was totally different. You couldn't talk Mickey Mouse to the young doctors; they weren't going to have it. And you couldn't talk above the head of a physiotherapist or dental hygienist who might be coming in with no university training or one year of university training. You're dealing with such a different kind of person. You might have coordinated their efforts by having seminars together after they were all graduated. But I think the instruction was just a mistake.

Int.: *Did they actually go this route?*

S.F.: No, it never materialized, but I think it was upsetting to the faculty for years. Now, I don't know what put it in his head. It came almost as a bolt from the blue and it just happened that about six months after he started I was at Gainesville. I was invited to a symposium there, at Gainesville in Florida. The dean there was a man by the name of Haro. It turned out that Haro came and talked to the group and he talked health team and health team concept. McCreary had just been there in the previous year. I timed it and it was just after he had been to Gainesville. He had picked it up from Haro and he had picked it up with all the related paraphernalia that surrounded this particular gimmick. Haro was a different kettle of fish; he was not even trained as an academic, he was trained as a clinician, as a physician. They moved him in - I think he had political clout, political knowledge, and this was a nonsense thing. It took nowhere. It never took anywhere else and it even faded at Gainesville. I think McCreary knew what he was doing when he tried to bring it in and it was a good talking point but I think very misguided because I think it divided efforts. It made a lot of friends and enemies.

Int.: *So how would you describe what finally came out of that idea of McCreary's, the Health Sciences Centre as it is now?*

S.F.: I don't think it's related at all. I think almost every medical school has a health sciences group. It's never through the Mickey Mouse route of the team concept.

Int.: *It simply is because you have all these people?*

S.F.: Sure, health science centres are everywhere on the continent. Long before anybody thought of the team concept there was a health science centre at McGill, a health science centre at Toronto, one every school you could name in the States. It is just a natural development. I don't think McCreary initiated that. I know he didn't; he had nothing to do with initiating it. It was a natural development that all of the health science groupings and buildings get located as close to one another as possible.

Int.: *But they don't teach…?*

S.F.: But they don't teach. They don't interact. They don't teach together anywhere. They may, as I saw in group seminars where you can discuss the needs of a patient.

Int.: *It's interesting about Dean McCreary. There was a lot that happened during his time as dean, a lot of growth.*

S.F.: I think he was a very effective man. And I think it is a shame that the hospital didn't come while he was dean. I'm sorry he couldn't move it. I think he probably would have done it if he could. I think he would have made this last move. He really got boxed in. I give McCreary full marks for that, you know. I don't go along with some of his political philosophy of how to go about things and so forth, but very effective and things did happen. Sure. The IRC Building here was absolutely typical McCreary. Dr. Gibson, who was a really good fundraiser, managed to get the money together and McCreary filled it in a way. But if you actually look at what happened to it, we built on top a set of administrative echelons, administrative kind of floors designed for something that never happened. The deans in many cases were reluctant to house themselves here. They've housed themselves in two areas which has always split them from the faculty. Each one of the faculties that has a dean's office here except for Medicine, each one of them resents the fact that the dean's office is over here and there. There was absolutely nothing to it and you almost had to, it was just because the building was so nice that the deans ever accepted their quarters. One floor remained totally unfinished and was then given over; the top floor, I think, was then taken over in part or in whole by Habitat, which I think is still housed here. I don't know. The medical faculty have no need for it. And another floor, the second floor, was also not really filled with anything useful: Continuing Medical Education. That's another thing which McCreary got going. But he got that going and he got Rehabilitation Medicine going; he started both those. And I think in a sense in both of those he probably did not do it the way he should. Let's take Rehabilitation, which was very necessary. He started that on a shoestring by essentially getting help from the existing departments to kind of try to staff it. He staffed it with people who were devoted but essentially untrained for anything beyond. It was the poor, limping sister. I'm sure Dr. Cronin, who was a very good person - I was very impressed when she decided she would come here. I hoped she could turn it around. I doubt that even she's managed to take it off its poor relation status. Now, that was because McCreary knew that it

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S.F.: continuing medical education. This university had a very good continuing education department, general department, not specifically medicine and it had gone ahead very well under John Friesen. And McCreary decided to do the same for medicine. Again, he was filling a need. He decided that he would fund it and start it on the back of the medical school, thereby losing the opportunity of funding it and staffing it on the backs of the medical profession which is where the responsibility for funding really lies. So I think the saying, It's a classic error, and I think in my judgment, he made it there too. But these things happened. Continuing Education happened; Rehabilitation Medicine happened; Dentistry happened; lots of things happened.

Int.: *It sounds in some ways, the trend was really starting right in 1950 when they started the medical faculty and these things were kind of done in the same manner.*

S.F.: Yeah, I think that's true. That's exactly what happened and I think that that's what I said earlier on. If you accept certain ground rules then you continue that way. The Department of Anatomy was very well staffed. It had a large staff relative to the number of students and it did a lot with it and it was well funded. I imagine there may have been some envy of Anatomy on the part of my basic science colleagues. But if there was, it would again arise - not the envy but what happened in the Department of Anatomy was in its smaller way a use of that same principle that I talked about, in the other direction. I would never set an added responsibility for the Department of Anatomy without securing funding first.

Int.: *So it's basically planning in a lot of ways?*

S.F.: No, I don't think so much planning as, you've only got to go a short distance. You can plan, but suppose you say, we should do such-and-such additional teaching. We"ll start it this year on the basis of no assistance, of no increase in staff for this new responsibility. But it's understood between us that next year we'll get an increase in staff to go ahead. If you do that you're dead!

Int.: *You don't get it...*

S.F.: Because all sorts of things can happen to make it impossible to fulfill the commitment. Meanwhile you have already demonstrated that you can fulfill the commitment without the extra staff member. I think that applies where there's Rehabilitation Medicine or Continuing Medical Education, or what.

Int.: *This is interesting because I recall the last time we spoke you felt you did have adequate money. And a lot of other people didn't feel they had adequate money. I imagine in some ways this explains why there is that difference.*

S.F.: Yes, I have at no stage [felt that the Anatomy Department was underfunded]. The Department of Anatomy was understaffed in the early stages. But that was my choice. It was understaffed because I didn't really want to hire people that I didn't consider were the kinds of people we wanted. So I wanted to train as many as I could. I wanted to get Canadians where I could. In the event we ultimately did. So it was a matter of going slow but it wasn't from any fault of the front office failure to support me. So the Department of Anatomy, as I say, when I finished being department head I think we had a staff, both in size and facilities, second to none anywhere.

Int.: *Another thing that I'd like to talk about, Dr. Friedman, are the buildings that were put up in 1961, the planning that went into them and that kind of thing. Did you have a lot of say in what you actually got in the end as far as your building was concerned?*

S.F.: Well, probably in what I got from all buildings. Kind of interesting in a small sense, there was an interesting little piece of history that you remind me about. We always talked about buildings right from the start, right from 1950, that was the main topic of conversation at all faculty meetings. Even when there were just three people, what was then the Faculty Council.

Int.: *You must have had a lot of ideas stored up by the time the building was…*

S.F.: Well, more at the end. When that first year was developing I said to Dean Weaver that I'd got wind of the fact that there'd been a lot of new medical school construction in Europe, post-war. They'd really had a big catch-up program and I thought it might be useful if I went and visited these European schools. He said, yes, he'd go along with that. He financed it and I went the second summer I was here; I guess that would be '51. I went in '51 and I started in Edinburgh, which hadn't done much building but which was about to. I went from there to Oslo, which had just completed buildings; through Sweden which had completed a lot of buildings because Sweden had a full medical plan in place at that time. Then I went right down through the Low Countries and all the way down into Italy. A six-week trip and I came back and I wrote a report. In the report, the thing that had impressed me most, which I conveyed to my colleagues, was what had gone on at the Karelinska Institute in Stockholm. The basic feature of the Karelinska plan was that two departments were joined together at their centre and could expand at their ends. And everybody bought it. And that was in fact what we built. We decided that if you built one floor on top of another in a stacked building, if there was a need for expansion you could only expand by shuttling everything up or shuttling everything down, there were always movements all the time. And that was one of the buzz saws that Patterson ran into. I told you that he ran into difficulties here from Western Reserve. He wanted a conventional stacked building, and everybody by this time would have no part of it. In the event I think it has been a lifesaver because we have all expanded. We have expanded through two phases of expansion and it was all done with individual

departments expanding without too much difficulty. To some extent we had some difficulty because we weren't six departments. The Cancer Research Institute formed the sixth to make three pairs of two. Then, when The Cancer Research Institute went it created an opportunity for an expansion, the last expansion for Anatomy, which was the third one, although had that not happened there was a plan in place for expanding off the other end. So we had a lot to say about how the buildings got planned. We didn't have a lot to say about how much money we had because the first buildings were built for a budget of $2 million - incredible now, of course, for the three buildings, A, B, C as they were called. A little over $2 million and we stayed within budget. Yes, they were certainly built on the cheap. But I suppose $2 million then was a lot more money than it is now. But it's not that much more.

Int.: *Not really. (pause) What about the lay-out of the buildings? The research facilities, and your labs and lecture halls? Were they designed to your own specification?*

S.F.: Each department had total control over the interior fittings, within reason. But we had total control. And Anatomy had special requirements, with a dissecting room and a morgue. And I must say we were able to build state-of-the-art. There was a show place for anatomy facility. That's always a big thing in anatomy departments, quite different to any others. It's costly and you can cut corners. We decided that that was the one thing we wouldn't cut corners on. We built something that I think was the equivalent of the show place in Europe in the way of facilities. It wasn't lavish but it was good. It's still a really nice place to visit. On the research floors we planned it for maximum flexibility and there - I don't know what the other departments did but I was impressed with what the Department of Chemistry had done here a few years previously. They had had a building expansion and they had built a flexible lab arrangement. The essence of the plan was that, given that you kept the walls of a given room, you could change the furniture and kind of set up to suit almost any kind of experimental work. And Chemistry's needs aren't that different to Biology or Anatomy, or even Biochemistry's needs. So I followed their plan pretty well. Their plan even included the fact that if you knocked out walls and decided to change the shape of a room, you could still make use of this modular plan. So we used modular construction and it was very, very efficient. We've changed many of the labs many times. The last expansion that we did into Cancer's space - the department was now much, much larger than it had been in 1959 when we did the first plan - and being a larger department now our interests were much broader and everybody participated in the design. It's a good design but it's quite different to the first and it's not nearly as flexible and I think they are finding it, in a sense they'd probably be happier with Chemistry's flexible plan. As I say, I don't know what Biochemistry or Physiology did.

Int.: *Did you find you had enough space and that the space has continued to be enough over the years?*

S.F.: Yes. I think the clear answer to that is not more than we need but not less.

Int.: *And with the possibility of adding?*

S.F.: Although I have to say, in some cases you have to stand up to be counted. Let me tell you one story which will illustrate my point. When we built the first plan, I pointed out that the plan for a histology lab - I may have done it in a letter to the president, or certainly to the dean - the plan for the histology lab was such that it permitted no expansion beyond the sixty students. And that if the building had to be expanded for more students the lab would have to be torn out and relocated. It would have been a dead loss. I said, I know that Dentistry is in the wind but it would be well to know beforehand about it. I got a firm answer back from the president through the dean, "No Dentistry is contemplated". Well, of course, Dentistry was started two years later, I think, and the histology lab was absolutely torn out. We were all heartsick because it was a costly lab and it was scraped clean, nothing could be saved, right to the walls, to be rebuilt. That's the first example of that. The second example is even more horrendous. When we built the expansion for Dentistry, that was phase II, for the first time we were to get a proper set of labs and we were to get a proper lecture room. We had used a temporary, small lecture room in the Anatomy Department. We were to get a proper anatomy lecture theatre in the building. The first plan was for sixty medical students and forty dental students, which was a hundred students, and I said to the dean that this won't do, the plan must be for at least 120 medical students plus ancillaries, which was 140 for that space. It could not be expanded. There was no way you could expand the end of that building, which was going to be three stories high and they were locked in. I really threw down the gauntlet on that one to the point of where, at one stage, I had really raised so much hell about it and been over to see the dean. I had a visit one afternoon from Dr. Foulkes, the pharmacologist. And Foulkes said, "Sydney, what has happened? I have just heard from Dr. McCreary that you have resigned over this building." And I said, "No, Jim, I didn't resign. I simply said that I wouldn't tolerate the building being built this size (laughter)." And he said, "Stick with it. And it finally reached the point where one night Dr. McDonald who was a friend of mine and I had been on the committee that brought him as president, I was informed that I would receive a visit that evening. My wife was out, and so he came over that evening and went over the situation with me and said, "We'll build it to the 140 size."

Int.: *So you got it!*

S.F.: I sure did. I wouldn't have designed it, in fact. But there are some places where you just have to insist; there is no way around it. I would have accepted the shell without putting in any seats because I was so certain that they would expand the medical school. Which in the event they did. They have been able to. In the event it's turned out to be the worst bind that we have on the expansion of the medical class because we knew that we could go to the point that the room would hold 160+ or _____ if you really squeeze, which they have done in the last squeeze. But it's meant that you must, beyond that point, teach in two sections. But that we were willing to face because 160, that's enough people in a section, anyway. But I think anything less than that and we would really have been in an awful situation, just plain not tolerable, not acceptable. If you are the expert in your own field you have to, nobody else is going to carry that ball, so you

have to do it. There are points, I suppose. I never believed in resigning because that's a futile gesture. I don't mind resigning…

Int.: *If that's what you want to do but not to please somebody else.*

S.F.: …but if you do that it's your last weapon and you've blown it. If they say, "Well, goodbye", shaking your hand, you've lost the battle. So you're better not to do it. You're better to go always to that point, to think of all sorts of ways of obstructing the change which you don't agree with but in fact you win the battle if you don't resign. And there are always these kinds of battles.

Int.: *One of the other things you were going to talk about was the cadavers, the storage of cadavers when you first came here and also the procurement of them.*

S.F.: Alright, we'd better talk about that because I know, a lot of the things I've talked about have been personal bias, opinion. You gather, I'm a very opinionated person. But this is not a matter of opinion. This has to be probably down in the record. All anatomy departments must function under some kind of Government regulation which gives them the right to dissect cadavers. There was that right written into what's called the Medical Act of British Columbia at that time, that allowed any physician, if he could secure a cadaver, to dissect it. It was only done occasionally and, when I arrived, one body was being dissected at the Vancouver General Hospital under that arrangement. I had gone into this matter before I came out. You know, anatomists never have to deal with this kind of thing when they walk into established departments; these things are always ongoing, you pay no attention to them. But when I knew I was coming to a new school I had to find out about it. I had schooled myself quite well and I knew what was required. I said we could operate under that act for one year but it must be changed to a regular anatomy act which would give the University of British Columbia the total control of cadavers' procurement and dissection. Nobody else. There couldn't be a body at the Vancouver General Hospital that I couldn't control. That act was in fact written and passed. I can't remember the exact date but it was certainly quite early. It was the first anatomy act in British Columbia.

Int.: *And it has the specifications that you put into it?*

S.F.: Yes, they put in all… I had said most of the things that were required and the Government people had written an act to encompass it and also to look after what they wanted. It provided for a chain of command that would allow an unclaimed body to come in to the Department of Anatomy should we wish it. That was the essence of the thing. Or a donated body, should we wish to accept it, to come to the Department. It allowed for no cadaver dissection anywhere except through me, through the head of the Department of Anatomy. I don't think they cancelled the Medical Act. It stayed in force but there were so many over-riding provisions in the new anatomy act that really nobody could have gotten a body anywhere in the province without my okaying it. You might ask, why was this necessary? It was necessary for a very simple reason. If you are going to have cadaver dissection, if cadaver remains are ill-treated or if access to the

public is permitted, you can get stories in newspapers which can be derogatory and which can create problems. So that you must have control of where the material is, who has access to it, and under what circumstances it's maintained. So it is a clearcut responsibility. So I could still, if I wished, have allowed cadaver material at the Vancouver General Hospital but I would have been the responsible agent. The risk involved is greater than it would seem because at that point we were just switching to all sorts of social welfare which meant that the number of bodies being unclaimed was diminishing. They were the responsibility of Medicare all through the system and people's burial, if they wished burial or whatever, was provided by social assistance of one kind or another. The number of real indigents was declining and actually, we found ourselves initially in conflict in the procurement of bodies with the morticians. I'll come back to that. At any rate, we knew that we would have to start a voluntary donation program, which we did. We were probably the first medical school in North America to start one. We had articles put into the newspapers encouraging people to leave their bodies for scientific purposes. People responded nobly and I would say now it's 100% donation, has been for years. It's a program which is now in force in just about every medical school in North America. They all run similar programs and all cadavers used in anatomy departments are procured that way, I would think. So there's been a later anatomy act written which is broadened to include the donation of organs and tissues; it's now the Human Tissue Act and that's superceded the Anatomy Act. We cooperated with the writing of the Act so the anatomical things are still in place. Once you are into a donation program you really have to be careful because one bad story in a newspaper ruins the whole program. In fact, this happened. This happened at Queen's University where a family claimed remains some time after - they can with us too - and the burial plot was found to be very inadequate and there were all sorts of bad stories in the newspaper about mass graves and things like that. It was a Donnybrook and it took them several years to get over it. So this is a ticklish situation and one must exercise… always act as if disaster could happen tomorrow. So I was a real bug on that.

Int.: *You didn't actually have any disasters to deal with?*

S.F.: Never.

Int.: *So it worked?*

S.F.: It worked. Now, let's get back to bringing the cadavers in when we first started. Dean Weaver had arranged with a local mortician to look after the embalming of the bodies till I got here. And he looked after a storage facility for these bodies. He'd been to Seattle and seen how they were stored in Seattle and arranged for similar storage facilities, which was in oil in one of the animal barns. It was a good room. It had just been built. It was a full cement room, fully lined and was just the storage of cadavers there.

Int.: *How did you transport them from there to…*

S.F.: First to get them there. Getting them there, they were brought out by the hearse and put in these oil tanks. When I got here I was shown that there were seven bodies that had been procured; a few more when I started. It's a wretched method of storage; it's one of the world's worst. And when the bodies were brought in there, to get them to that facility which we had to use for the remainder of that year because I couldn't get another one built right way. To avoid any distress on the campus they were always brought in in the dead of night and I would meet the mortician at, I think it was called the mink barn, I would meet him there while he delivered the cadaver. Of course, it was kind of a farm out here. People who watched must have been surprised to see these eerie lights at midnight out to the mink barn. But that's the way they were stored. The following year I changed the system to a standard conventional system and had a morgue built adjacent to the hut. From then on, while it was a difficult storage situation it was a manageable one. But the first year just moving them, taking them out of oil and moving them where you don't really have facilities for that sort of thing, was quite wretched.

Int.: *How did you manage? When did you do that? In the middle of the night as well?*

S.F.: No, the bodies were brought over with, I think, Dr. Wood the animal nutrition man who had been helpful, and the mortician and me, and I think two other assistants looked after the transfer of the bodies to the dissecting room for the first year. And then I got, I think I mentioned my technician, Mr. Crossen who had started at that point, he looked after the transfer of the remaining ones at the end of the year, and that was the end of that bad situation.

Int.: *So it didn't actually last too long?*

S.F.: Oh no, we got it under control right way, just as soon as I possibly could We had the new morgue built just that spring but it couldn't be tackled before then. (pause)

Int.: *Do you have much more time?*

S.F.: No, I think that's another… Are we still at…

Int.: *Well, I was going to ask you about students, what the students were like, the first students that you had. Were they well prepared for medical school? How did they compare to students in later classes?*

S.F.: The students in the first class were marvellous, really wonderful, because to begin with they weren't that young. A high percentage were veterans. I was of an age with many of them. That's the first thing. Second, they had accumulated over a couple of years. They were all people who would have been accepted by McGill as part of the B.C. contingent and they would have gone over a two-year period to McGill, which was I think I mentioned the standard group. So they were, on balance, well prepared. I can't quite recall whether we managed to pass the whole class without a failure or whether we had one failure in Anatomy that first year. We may have. But they were a good class to

work with. First, of course, they were tremendously enthusiastic and they were prepared to put up with all the shortcomings; they were just here. So there was a very warm relationship.

Int.: *You don't really think it made it extremely difficult for them working in the huts and travelling out to…*

S.F.: As far as basic sciences were concerned, I would say for the three departments, I would bet that they got a better education here as the first class, than they would have anywhere on the continent. They were a handpicked group and they were nursemaided.

Int.: *So they were obviously the kinds of students that were wanted for that first year?*

S.F.: Oh yes. And a lot of them went on and did nice work afterwards. Yes, they were.

Int.: *What about students in later years? Did they compare?*

S.F.: Yes, for several years. Sixty is not a difficult class size and we were able to fill it comfortably. I think in some years we probably went a little bit close to the edge of students. In other words, our failure rate rose. It rose alarmingly at one point. I can't remember the exact year. It was the latter '50s and I can't remember why; I've no idea what the reason for it was. But judging by failure rate, that doesn't mean a student may just have to repeat the year or repeat the course or whatever. But at least it's an index of what your acceptances are like. But sixty is a good size to work with. The province, after the first class where you had a pile-up, could probably have done with fifty places rather than sixty efficiently, in terms of failure rates and so forth. But that's not to say the people who got through shouldn't have gotten through. I'm just talking an abstract planner's sense what they could have been able to get through with. But I think the classes were good as long as they stuck to the sixty. And then, as we moved into the '60s, the number of sixty students is a tight number. Then of course your standards rise again and your failure rate drops. When you increase your class size you push it the other way. The first classes, I think, were very good. The first three or four were outstanding.

(Continuation of interview on Thursday, June 13, 1985)

Int.: *Dr. Friedman, we stopped the other day talking a little bit about the students and just what they were like. I thought we might add a few more questions concerning that. One of the things that came up in talking to some of the students, for these tapes actually, was the question of whether they were overworked. Do you feel the students were overworked in that first class in particular?*

S.F.: No, I don't think they were, actually. I suppose, as you look at what students do now you might think they were overworked. But there's been a great change in medical

curricula since that time. At that time the amount of Anatomy, Histology and Physiology that they got, which would be the subjects I was directly concerned with, was just about the same as in all Canadian universities, a bit heavier than it was in American universities at that time. Students always had a sense of being rushed. There was one reason, though, that did make for a certain amount of rush and that was timing. This university had a tradition of students working in the summer to put themselves through. I don't mean medical students, I mean just other students. When the medical school was started, no concession was made to the fact that the medical year needed to be longer. So, in fact our year was shorter than it was in other Canadian universities so we had to put the same number of teaching hours into a shorter time. I can't remember the exact time when they finished each year, I think early in May by contrast with McGill where I had just had the same experience the previous year before coming, it was the middle of June, which was six weeks longer.

Int.: *I see, that makes a difference, actually.*

S.F.: There was a great condensation.

Int.: *Actually, you were the only professor that I asked this question of, simply because I've spoken to the students in between seeing you and most of them did mention that they felt there was an incredible amount of material thrown out. And they seemed to think that they might have been used as an ideal and it might have slackened off. So I think it's good to get your opinion on this.*

S.F.: Actually, another part that was different was the working day, the number of lectures, etcetera, put into a day. It was 8:30 to 5:30 here at UBC and it had been 9:00 to 5:00 at the eastern universities. The day is longer by an hour and, in fact, they were getting more teaching hours per day, although the same number of teaching hours per year, as in other schools. In fact, rather less, I think. When I came out here I streamlined the Anatomy course from what we had had at McGill. It was, in fact, shorter by a good fraction. Since that time though, all schools have cut back quite a lot on what they taught so there is that difference too.

Int.: *Did you feel that you were teaching in any different ways here compared to other medical schools or compared to what you were used to at McGill?*

S.F.: Oh yes. As far as my own personal experience in anatomy was concerned, I changed the course considerably from the one at McGill because I was trying to draw on my own experience in trying to relate anatomy to clinically relevant things. So the course was much more clinically oriented than the one I had come from.

Int.: *Did you have any thoughts yourself that you didn't want to repeat some of the errors that you had seen in your experiences, that you wanted to change it in some way just to improve on?*

S.F.: The main thing we did, which was totally different to the anatomy taught in other schools, was we planned and instituted and integrated what we called an integrated anatomy course. We considered all aspects of our teaching: histology, gross anatomy, radiology, neuroanatomy; all part of the same package. We never taught anything in histology before the students had a chance to see the same material in gross anatomy. That was a distinct change from what was tried anywhere else. And it did make a difference. Because one of the big mistakes I found at McGill was that everything was taught in such watertight compartments that you could easily be looking at, say, lung tissue in histology two months before you even knew what a lung looked like in the cadaver, so there was total dissociation. In the same way, we tried to integrate the material with radiology so that the students would be left, if we could do so, with an idea of living anatomy rather than cadaver anatomy. Cadaver anatomy was standard in all medical schools and I think this is a bad heritage because students weren't going to deal with cadavers after they left the first year. They would be seeing aspects of anatomy, either in a pathology department in the form of tissue sections taken at operations or postmortem, or they would be dealing with x-rays of living people, or they would be actually looking at and examining living patients. So we tried to change the orientation to living anatomy, that was a distinct innovation. We probably weren't as successful as we would have liked to be. It took quite a long time. I think ultimately, ten years later, that part of the course was quite successful.

Int.: *A couple of students mentioned that they felt that what was trying to be achieved was a different grasp on medicine from other schools. It sounds like you are confirming that that was your impression?*

S.F.: I can't answer for Biochemistry and Physiology.

Int.: *That was going to be my next question, actually, if you <u>did</u> have any idea.*

S.F.: I have some idea of biochemistry. Biochemistry suffered from what I always took to be the affliction of most biochemistry departments in North America; that is, they lacked clinical relevance. The people who were doing the teaching were biochemists, scientists, with very little contact with what went on in the clinic. This showed, I believe, here as it did in other schools. There were some notable exceptions in other schools to this but it was, I think, a common affliction. Physiology, I think, was not bothered that way because Dr. Copp here did have a medical degree, did have an idea of clinical relevance and did try to make his course clinically relevant. So I think Anatomy and Physiology might have been a1right that way but Biochemistry might have suffered.

Int.: *Another thing some of the students mentioned, and this may be simply a different way of presenting the other question, but they seemed to think there was an urgency, with exams being thrown at them all the time. Would they have got that same feeling in other schools as well?*

S.F.: No, the big difference here was the students who first started into the medical school had no 'older brothers' as it were to talk to. They had no second, third or fourth-year

medical students to help them over the hurdles, to explain why this was important or how to handle the other thing. So I think that for the first, I would say as many as three classes would have been under that kind of disadvantage relative to other schools. What seemed like a great impact here, because their point of comparison was with undergraduate teaching which was vastly different; that would not have been the experience they would have had had it been an established school. It would have been what was expected rather than what was unexpected.

Int.: *Another thing relative to students: Do you think that having the school split affected the students in a negative way? Do you think it made it particularly difficult for them, or not really compared to other schools?*

S.F.: When you say, 'compared to other schools' you have to define what you mean. Compared to other split schools, no different. But students in split schools are under a great disadvantage, period. The disadvantage is that their approach to medicine becomes boxed. It becomes not the pre-clinical or basic science years versus the clinical years; it becomes pre-medicine and medicine and that means that their attitude's biased. Also, because the clinical people who are teaching them have no contact with basic scientists, there is no permeation of the clinical teaching with basic science concepts. So it is almost as if the basic sciences had been irrelevant to their education. That's a universal feature of split schools and is why split schools are very undesirable. I imagine it goes on even today.

Int.: *One other thing that I wanted to just mention was your own artistic abilities and how you use this in your anatomy classes. Could you just mention a little bit about that? I'm just curious, really.*

S.F.: Nothing really to say about that. I did have some background training in art school. Years ago when I was in high school I went to an art school at the same time, for three years I think. But my approach, I suppose, because of my own personal bias, my approach to anatomy was always visual. I always remembered things that I saw. I could remember things more easily if I saw them than if I heard them or read them. If I got them by all three routes, of course, I could really remember them. So I had a tendency to feel that with anatomy it was something that you saw, it was there. It wasn't an abstract science, it wasn't something that was theoretic. It was just something that, if you couldn't see anatomy, if you were blind and couldn't see anatomy you couldn't understand it. So my teaching made every effort to make sure that the students got a three-dimensional sense of what they were looking at. So much of anatomy illustration is, of course, two-dimensional; it has to be on flat paper. Yet the actual material is three-dimensional. It's very hard for a student, for example, when he first looks at text- books to put together, say, the front of the arm and the back of the arm and recognize them as the same arm he's just looking at, one from behind and one from the front. So that's what I try to do.

Int.: *It must have added a lot to help them. It sounded like it, from talking to some of the students, which is why I thought I would mention it. (pause) Is there anything else you*

can think of about the students in particular, that relates to what we have been talking about here?

S.F.: There were a couple of firsts as far as the students were concerned. One of the things that sticks in my memory was the fact that there was no tradition, of course. There couldn't be any tradition of medical research where there hadn't been a medical school. So we were faced with the problem of trying to get this sort of thing across to students, and picking up and encouraging those students who might be interested in the research aspects of medicine as well as in the straight practice of medicine. The beginning that we selected, and I think Dr. Copp and I were the first to do it, we decided that we would take students from the first year class who wanted to do lab work in the summer. We would start them off as lab summer students, find them some money and keep them on. And that kind of program, summer, medical, research studentships of one form or another, is a very common ingredient in almost all medical schools, if not all, now. I don't know of any place that used it before we used it here and the first summer we used it was the summer of 1951, the students from the first class. I think Dr. Copp had a couple of summer students and I had two or three. The second class, I think we increased the number of students that we took on. I might say I was able to do that because I was well funded with research funds right from the time I came. I came with some research funding from the Life Insurance Medical Research Foundation, I think from the American Heart Foundation, and what was then the Medical Division of the National Research Council.

Int.: *Now, would you have gone about procuring that money and making those arrangements yourself or would that have been done here at the university?*

S.F.: Oh no, I arranged to get the funds myself. I was the applicant and since I was the first professor - unless we count Dr. Robertson. I think I told you, there was an argument over who was the first professor appointed. But he didn't have any research funds and I did, so I guess I had the first research funds in the Faculty of Medicine. I was at liberty to use those as I saw best for the research work, and I thought the best was to use a little bit of it for student training. I have a feeling, but I couldn't swear to this, that Dr. Weaver may have helped with a bit of money. I don't know where he would have got it from. Let me tell you a bit more. As a result of that program some people that I well recognized, Dean Webber for example, started with me as a summer research student.

Int.: *In that first year?*

S.F.: No, no. He was much later. Dr. Hinke, who was much before him, I think he is now Professor of Anatomy at the University of Ottawa, started that way. Dr. Auersberg, who was an NCI Fellow in the Department of Anatomy here also started with Dr. Constantinides about that time. There were a lot of people who actually started into academic medicine with their first introduction via the summer research training. We were very proud of it because it picked up a lot of people and it stimulated a lot of interest; it was an ongoing thing. And it spread. I think all departments were into it by the second or third year.

Int.: *It sounds like there were a lot of rather innovative and really positive approaches to teaching in the first few years.*

S.F.: I don't think we taught at all as they had in the departments from which we had come. We were all young enough at the time we came to really want to do it differently. I don't think we just grafted what we had been through. We had to meet the same standards but it was quite different.

Int.: *That kind of thing often has to do with the person's being young too. They are more inclined to try something unusual or different, different ideas.*

S.F.: I think I may have told you, I was 33 when I was appointed and I was 34 when I met my first class, and I think Copp was a year older than I. So we were pretty young. I'm sure we felt that this was a very challenging opportunity and we were not at all interested in doing it the same way.

Int.: *Mm-mm. O.K. One of the other things that I wanted to talk about today was something about the clinical appointees and yourselves in university pre-clinical years. What was the relationship 1ike between the people here at UBC and the people at the Vancouver General Hospital?*

S.F.: The relationship was good in the social sense. It was cordial; we liked one another; there were no great enmities or anything like that that I knew about. But we lived in different worlds, quite distinctly different worlds. To give you some illustration of the problem: At McGill I had spent two mornings a week as a physician in the outpatient department. That was to sort of keep my hand in and to keep in contact with clinical colleagues. I was not at all unique in that. Lots of people did that sort of thing to keep in clinical contact. I spent time in radiology. I even took my periods of rotation as the resident in radiology while I was an anatomist, staying overnight and taking emergencies and so on. When I came out here I was determined to do the same thing and even more so. I made a point of going to the Grand Rounds as they called them at the Vancouver General Hospital, which were held on Thursday morning early. And I did that regularly, I think for about a year, maybe into the second year. But to do that cost me more than a whole morning, just to go to that clinic - till I got there, got back, and talked to a few people, etcetera. And that wasn't profitable, it wasn't a good thing to do. There was no chance of going to work in the outpatient or anything like that. I couldn't spare the amount of time that would be involved because of the distance. The reverse was also true. There was no traffic back from the Hospital, from the clinical people, back to the university, or very little because of the time consuming nature of things.

Int.: *So there really wasn't very much contact in your working environment, hardly any at all?*

S.F.: Hardly any at all.

Int.: *So do you think there was any way of integrating the clinical work and the basic sciences, that it could have been handled? Or was it just impossible because of distances?*

S.F.: I'm not sure if it really could have been handled. I think a few, simple things might have helped. I think a shuttle bus service could have been implemented and might have done a lot of good, so that there was no parking problem and there was just the distance problem: a regular service. Nobody thought of simple things like that. And I don't know whether it would have done any good.

Int.: *What did you feel the attitude of the clinical appointees was? Did you think they were inclined to want to have that contact or not really?*

S.F.: I never felt there was any great drive on the part of the clinical people to have a basic science component. I think the drive was really from the basic scientists who felt left out rather. I suspect, but I could be maligning them. It's not fair.

Int.: *But it's just your impression?*

S.F.: It's my impression. And I think in part that depends on background. There was certainly a difference in the way we felt about things between the people who had come through the Toronto system and those who had come through the McGill system. McGill had probably the first department of clinical investigation in North America. It was Rockefeller-funded and was set up as an experimental department. It was a very active department at the Royal Victoria Hospital, which was an off-shoot of the Montreal General. Research was very, very much to the fore at McGill, in the teaching and everything else at that period. At that period clinical practice was the main thrust in Toronto. And that showed. People who had come through the two systems had different attitudes. It was quite amusing sometimes when we talked, to get into discussions in the faculty - I think it was called Faculty Council at that point. We would get into discussions and there would be a vote on some matter of philosophical approach. It would be interesting to see the vote split and it would be the people of the two kinds of educational background, just as simple as that.

Int.: *It's interesting how that sort of thing carries on. People don't really change. So I suppose in that sense the type of school you set up is important in what kind of attitudes those people are going to carry with them for the rest of their career.*

S.F.: I think that is absolutely true. Without quite realizing it. I've tried to avoid saying anything pejorative; I don't mean to be critical about this because it's just a fact of life. You get it a different way. But it spills over because, as you say, we tend always to think back to the schools we came from as if in fact they haven't changed in the fifty years since we left them. I'm sure McGill now bears absolutely no relationship to the school I went to as a medical student. And that's equally true of Toronto and every other place. But it's surprising how, when we met in conclave over the first ten or twenty years of this school, how it was as if Toronto and McGill were as they had been

(laughter) in the origin. And then, of course, with the split school it didn't help things. There was such a conscious, driving effort to make a bridge but it was not do-able. And it is very interesting in that connection that Dr. Copp and I, because we saw that exact same thing were absolutely unwavering in our determination and drive to get an integrated school and a university hospital. Other people didn't really know what we were talking about most of the time.

Int.: *I got the feeling, especially from a lot of_____, that it was simply desirable to have a school. Other things really didn't matter much in the end.*

S.F.: No.

Int.: *One of the other things I would like to talk about today is some of the social activities that happened in those first years, the medical balls, the graduation banquets, I think somebody mentioned skit nights, that sort of thing. Were there any things you can recall about that? Any anecdotes?*

S.F.: I'm not very good at anecdotes, not my forte. Socially it was a whirl. In a sense, first the community welcomed this new medical school and people who had come to teach with open arms. There was enormous drive to be nice to us, to make us feel at home, to bring us together. So much so, actually, that I think we were so often together - the clinical staff and the basic science staff - in people's homes that we got tired of seeing one another in that context. We were seeing one another in a social context all the time. There was that element. As far as the students were concerned, the party I remember most is the very first party that the first-year students had which they had in, I think it was the stables of the barn down at the foot of McDonald, way down on the flats. There used to be a kind of dance floor, nightclub out there; it was really out in the boonies at that time. And they ran this first year party. They invited the staff, and the staff were all young enough to go and have a good time. I remember that very well. Then, of course, we did all go to medical balls and the banquets and so forth. Those were, at least in the early days, popular. You know, everything starts fresh; no traditions. Without any kinds of traditional background the students ended up having the same kinds of medical balls, the same kinds of skit nights, the same kind of banquets as they had had in all the old established schools. I don't think they copied them, I think they just naturally gravitated into that form.

Int.: *That's interesting. These things seem to have carried on, traditions do, in the later years.*

S.F.: I would say there was one big difference here compared to McGill and, I imagine, Toronto, and that was that there was a very good working relationship between students and teaching staff; not just working relationship, somehow or other, we spoke to one another on a equal footing. At the older schools the professors were up there and the students were down here sort of.

Int.: *I imagine that had a lot to do with several things: the fact that it was a new school and, as you mentioned, you were younger and close to some of them in age.*

S.F.: It could be.

Int.: *Well, there aren't any other things that I have specifically in mind to ask you about. If there is anything that you would like us to end with, any things you've thought of or any comments that you would like to make?*

S.F.: No. I think it will be very interesting to see if anybody ever listens to this 25 or 10 years down the road and, if so, if they can make anything of it.

Int.: *True enough. Thank you very much for your time, Dr. Friedman.*