

## SUMMARY

In this interview, Professor Emeritus Peter A. Goodwin, M.D., talks with Matt Simek about his upbringing and education in South Africa, his move to the Pacific Northwest, his career in family medicine at OHSU, and his involvement with Oregon's Death With Dignity Act.

Goodwin's family relocated from London to Cape Town when he was a small boy, and he recounts the reasons behind the move, his early experiences in Cape Town, and his decision to go into medicine. He talks about his six years at the University of Cape Town Faculty of Medicine and his eighteen-month internship. After completion of his training, he joined a private practice in Queenstown, and he describes the types of cases and the level of care that was provided to the area's inhabitants.

After the Sharpeville Massacre in 1960, Goodwin relocated with his family to the United States, and after an internship in Massachusetts, entered private practice in Camas, Washington. He talks about his practice there, his year training in family medicine with Hiram Curry at the Medical University of South Carolina, and his transition into the Department of Family Medicine at OHSU in 1976.

A passionate advocate for physician aid-in-dying, Goodwin goes into great detail about his opinions, his experiences, and his role in the passage of Oregon's Death With Dignity Act. This topic occupies the largest section of the interview.

Goodwin discusses his views on the physician-patient relationship and the role of the family practitioner. He quickly touches on his interest in occupational medicine and the relationship between OHSU's Department of Family Medicine and private practitioners, and mentions a few physicians who have been strong influences on his career and thinking.

In conclusion, Goodwin looks ahead to the future of family medicine—and tells a joke to send listeners off laughing.

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Interview with Peter A. Goodwin, M.D.  
Interviewed by Matthew Simek  
June 4, 2008  
Site: Oregon Medical Association headquarters

SIMEK: This interview with Dr. Peter A. Goodwin was made possible by the Oregon Health & Science University Oral History Program, and conducted at the Oregon Medical Association in Portland, on the morning of June 4, 2008. The interviewer is Matthew E. Simek. And I'd like to welcome you to this forum.

GOODWIN: Thank you, Matt.

SIMEK: And by way of disclaimer, I have to say that you and I have been friends for probably more than twenty years.

GOODWIN: True.

SIMEK: So I might be a little bit biased in my questioning. So the viewer of this program should be aware of that. And what we usually like to do is start these interviews with a brief overview of the subject's early life, place and time of birth—

GOODWIN: Oh my goodness.

SIMEK: —childhood, significant events, schooling, and that kind of thing. So I will just turn the mike over to you and ask you to recount and regale us with stories of your youth.

GOODWIN: Well, I was born in London, England. That was in 1928. And just in case anybody's interested, my birthday is December the eleventh. And when I was three, my parents immigrated to South Africa. And so I spent all my maturing years, if I could call them that, in Cape Town. And went to a famous school, the first school actually established in South Africa. The school was South African College School. It wasn't that upper crust, but it was a nice school, good education.

And then from there, with a stroke of luck, I was able to go to medical school at the University of Cape Town. And the stroke of luck involved a fortuitous scholarship.

SIMEK: Let's postpone the medical school for just a moment.

GOODWIN: Okay.

SIMEK: Because we've just taken a giant leap over twenty-two or twenty-three years.

GOODWIN: Oh.

SIMEK: And so I'm curious as to what took your family to South Africa.

GOODWIN: Well, it was really financial need. England was still very depressed. You know, after the world war and then during the Depression, my parents could not make a living in spite of trying very hard. My mother really worked like a slave, but could not get things going. My dad was not as good a wage earner. But that was the reason.

And Cape Town, South Africa, first of all, there were advantages to going to South Africa because the passage, the ocean passage, was subsidized. So that made it easy. And at the time, I had an older brother who was two and a half years older than me, and a younger brother, who was six months old at the time. So it was quite an eventful trip for my mother.

SIMEK: My goodness. What did your mother do to work so hard?

GOODWIN: My mother actually, at this time, tried to run a grocery store in the east end of London. And it was really tough. It was long, long hours, and very, very little profit therefrom. And my dad had been an inspector on the London, with the London omnibus company. And he became ill, had a couple of things with him go wrong. And he was actually discharged on a pension of two pounds, four shillings a month. And no, he couldn't survive on that. We couldn't survive on that. And he remained in ill health for a lot of his life. Mostly self-inflicted.

SIMEK: Two pounds, four shillings, was comparable to what standard wage at that time?

GOODWIN: I would guess, I was just thinking, at one time the dollar was seven to a pound. I would guess it was about seven to the pound at that time. So that would be fifteen dollars.

SIMEK: And the standard wage would be about what?

GOODWIN: Let me just think. I would think at that time, probably thirty pounds a month.

SIMEK: So two pounds was hardly—

GOODWIN: Couldn't survive on that.

SIMEK: And so Cape Town was quite a change, then, from the east end of London.

GOODWIN: Yes. At the time, I didn't appreciate it, I must say. I don't know how much detail you want, Matt. What happened was that my father somehow, without

any experience at all, became the manager of a hotel in Muizenberg, which was a sort of a resort area. Lovely beach, a beautiful beach, on the Indian Ocean side of Cape Town. So warmer water, a very popular area. And he and my mother, well mostly again, my mother, she really worked. But it became, his health, again, deteriorated, and it became impossible for him to continue.

And so for a while, for about fifteen or eighteen months, we were really on our uppers. We were really poor, and hardly surviving. And then my father got a job selling automobiles. And my mother got a job as a secretary. And they both worked throughout our growing years. From about the age of, my age of about six. And so we kept going. My father, unfortunately, was a very poor provider, and a gambler. So things were never really stable. They were tough.

But I went to a reasonably good school. I had a wonderful schooling. I had some excellent teachers who made a huge impression on me. And I played rugby, I played cricket. I enjoyed those activities very much. I swam for the school as well. So I had a good life. But in a sense, very private like, my parents were very sort of reclusive as well. But still, looking back on my school years, they were mostly very happy years.

SIMEK: What was Cape Town like in those days? Apartheid was still–

GOODWIN: Apartheid wasn't as explicit. There was Apartheid really definitely, but it was a much more open society. There was much more interaction between the whites and the coloreds, mixed race, which had an identity of their own. And then with the Malays, who were an influential and somewhat upper crust non-white; in fact, compared with the coloreds, they were certainly upper crust. They had the Mohammedan religion, which they had brought from the Dutch East Indies. So they were Muslims from the word go. And they maintained that religion, and they maintained their identity. And they were artisans, often. Some merchants. But artisans as well. So they were the builders, the carpenters. So they had certain privileges, and they were a most interesting group.

The Cape coloreds, also, were a very colorful group. Their language was a sort of a bastardized English with a little bit of the Afrikaans; you know, the Dutch immigrants had their own language, Afrikaans. And so they were sort of, although they were incredibly poor for the most part, they were also a sort of a cheerful people who often were a lot of fun to mix with. They would also, they were the servants, for the most part, in Cape Town.

No matter that we were poor. What enabled my mother to work was the fact that we always had a servant. Poorly paid, working long hours. For example, she would come in the morning. She would be there throughout the day. Attend to us when we came home from school. And when my mother came home, she then left. And my mother graciously, because many white women didn't, my mother would then graciously prepare the evening meal so that the maid could go home at a reasonable hour. That was the way we lived, really. And we lived in apartments.

SIMEK: So the influences on you, what lessons did you take from your early life? How did that shape you?

GOODWIN: I think that what my overwhelming impression was of superiority: in other words, I was white, they were not, I was better. I had the privileges. They sort of just came to me by right. I think that really was true. I did have some awareness of the poverty and of the huge disadvantages that the coloreds had, but particularly the blacks.

The blacks were not a prominent part of Cape Town society because they were so isolated. They lived in a location about ten or eleven miles away from Cape Town. It was called Langa. And they worked as the hard laborers. They worked as mine laborers. They were stevedores without any rights. They were the laborers in construction. They had no skills. They did the really hard work. You know, they did the preparation of the lots, cutting down of the trees, by hand. Hand saws. And they would dig the trees out on the slopes of Cape Town. They would literally dig the trees out, using hand implements. And eventually the roots of the trees would be so hollowed out; then they would have somebody climb to the top of the tree. And four or five of them would grab the rope and sort of in unison, and often chanting, they would gradually rock the tree until it came collapsing down. And that was sort of one of the most amazing experiences to watch. It really is sort of, now I think of it as heartrending. At the time, it was exciting.

SIMEK: The tree would come down with the person still in the top?

GOODWIN: No, no, no.

SIMEK: Oh. [laughs]

GOODWIN: Oh, no, no. He would have fastened the rope almost to the top of the tree, and then he would come down. I mean, riding it down might have been an experience.

SIMEK: That would have been exciting.

GOODWIN: Yeah, right.

SIMEK: Interesting. So you went to this school throughout high school? Or did you change schools?

GOODWIN: No. In fact, I went to it throughout grade school and high school. And there again, I was lucky. Because in the senior grades, there were fees to be paid. And the fees sort of increased as you went. And I was able to get a tuition scholarship for the last three years of high school.

SIMEK: What were your interests as a child growing up?

GOODWIN: Well, sport was crucial. Then it was wide ranging because, I used to read a lot. I was a liberal. Even in those days. In a very ephemeral way, if you can imagine being a liberal and seeing myself as so superior. But that was true. In a sense, we had more empathy, you know, as liberals. But nevertheless, we did treat the maids that came to our home, I think, more liberally than most people did. And we saw them as more human than most people did.

And we saw the tragedies, too, Matt, you know. One of the maids that we had was a mixed Malay/colored woman. And she was very light colored. And obviously had a fair amount of white admixture, sort of through the generations. She had two sisters who had, what they called, passed for white. So in other words, they had married white men. And they were part of the white community. So they had a little bit of mixed blood, but they had passed for white. She was unable to see them. She was unable to interact with them for fear of compromising them. And it was a tragedy for her.

SIMEK: So their husbands didn't know that they—

GOODWIN: I don't know that for sure. Oh, no, no, no. The husbands didn't know that they were marrying mixed race people. No, no. Absolutely not.

SIMEK: Different times.

GOODWIN: Different times, yes.

SIMEK: At what point did medicine come to your mind as a possibility?

GOODWIN: My father was a very proud man. Also somewhat, to put it, he was proud, he was also vain. I don't want to knock him. He had some marvelous characteristics. And my older brother, who was really a genius, he was a genius. Unfortunately, like so many geniuses, he was sort of out of place. And he graduated from high school when he was fifteen and a half, and went to medical school on a scholarship. And I think my dad influenced him to do that. I don't think he knew what he wanted to do.

And then, the war had already started. And when he was old enough, he actually joined up for the last year of the war. And South Africa had a sort of a, like a very limited GI Bill. So he got enough pocket money in order to pay for himself and to maintain himself, although he continued to live at home. And that enabled my father to say, "Well, why don't you go to medical school?"

And so I applied to medical school. And I could not have done it except by a stroke of luck. Because what happened was, that just at the time that I would have been entering medical school without any resources, there was a scholarship, a city-wide scholarship, for the first time, established by an outgoing mayor. And when I graduated, I got several school-given books. And one of them was on the history of medicine. And I really, I was impressed, it was really quite inspiring.

And then came this scholarship. And the scholarship committee wanted to know why I wanted to go to medical school. And I had just read this book. And so I could give them chapter and verse. And they were most impressed. And so I got a scholarship, which was a full tuition scholarship for the full six years of medical school.

And remember, Matt, in Cape Town, under the British system, we did not have an undergraduate degree. We had a year of preparation for medical school, and then five years of medical school. That was the way it went. So it was a six-year program.

SIMEK: And there are those who say that medical history isn't important. [laughter] It certainly was in your case.

GOODWIN: Oh, it really was, Matt! Thank goodness. Yeah, indeed.

SIMEK: Now was this in Cape Town?

GOODWIN: Yes.

SIMEK: What was medical school like, in retrospect?

GOODWIN: In retrospect. Okay. In retrospect, medical school and a year and a half of internship: I think my overwhelming impression was one of hubris, which was transmitted to me. A lot of it was ignorance, a lot of it was really bad education. Some of it was good education. We had two professors of medicine who were good. We had a couple of professors of surgery who were abominable. OB/GYN was passable.

We had an excellent experience delivering babies at home as part of the OB rotation. Which was a most interesting experience. Because these were poor people, almost all of them colored, in their homes, in an area of Cape Town that was called District Six. Which was quite a hazardous area. A lot of crime, because it was very poor. But we were immune from that. We were recognized as, you know, succoring the poor, doing good. So we were never interfered with. And it was a very interesting experience.

But so much of it was so, you know, sort of, with such a level of certainty that you sort of left medical school with the feeling that you knew it all. And in fact, when you saw very little going into a rural environment. I knew nothing about, nothing worthwhile about psychiatry or psychology. I had been taught nothing worthwhile about public health, which was crucial in the environment that I went to.

And so it took, when I look back on that experience of this great young doctor, and I think about the errors that I made. And the errors not in a, not just in an individual sense, in a social sense. I was so busy giving black kids fluid, you know, sort of to help their gastroenteritis. And I never thought about why they were getting so much gastroenteritis. You know, a lot of them died as a complication of measles, but there was

no immunization against measles at the time. And so the public health issues, I ignored. I was too busy being a hero.

And so I look back at that, it was a hugely interesting experience. I mean, it was at times exciting. I mean, stressful, but grotesque, as well. You know, for example, I can give you millions of experiences. But maybe just give you one. We used to have cases of diphtheria. So we used to have to treat them. I never was immunized against diphtheria, incidentally. My mother didn't believe in that. But it didn't concern me in the slightest. So here I was one night with an infant unable to breathe, with a diphtheritic membrane down his throat. And here I was attempting to do a tracheostomy on this child on a table in this large ward. And I succeeded. I put the tracheostomy tube in and thought, oh, it was wonderful. It was a tremendously stressful experience. And I went home, and the following morning came into the ward, the baby had died in the night. I was certain it was because the nurses didn't have enough experience to care for a child with a tracheostomy.

Life was very cheap among the blacks. Not quite so cheap among the coloreds. I mean, the number of deaths that I saw and actually witnessed were many, many, many.

SIMEK: What was your reaction to the first death that you, I can't say participated in, a patient you were attending who died?

GOODWIN: Yes. Yes. You know, I can remember one that I will never forget. I mean, I can remember a lot of them. I can remember watching a man with tetanus die. But this case was a man who came in with a heart attack. He was a colored man. Came in with a heart attack. And the nurses called me one night to say that he had had a seizure and was semi-conscious. And I didn't know what had happened. He was shocked and I was so alarmed, I called the resident. In other words, I was new, too. The resident came in. By that time, the illness was evolving. And what had happened was that he had developed a thrombus, you know, a blood clot, on the inner lining of his heart overlying the heart attack where the muscle had died. So he developed blood there, a blood clot. That blood clot, a large blood clot, obviously, had become detached, gone through his major blood vessel, the aorta. Lodged at the bifurcation of the aorta, and cut off the blood supply to both legs.

In those days, there was nothing we could do for that. So over the course of two or three hours, this man, sort of in shock, and mostly in coma, we simply watched him die. And that was an overwhelming experience.

SIMEK: And nothing you could do.

GOODWIN: Nothing we could do. In those days, vascular surgery was in its infancy even here. And never had even been considered in South Africa at that time.

SIMEK: After medical school, would you say that's where your education really began?

GOODWIN: In a way. Obviously I had a lot of factual information, and a lot of clinical skills. There was a lot of really important clinical stuff that we were taught. Of course, medicine in South Africa was still very much dependent on clinical skills, and they were highly valued. So how to examine patients was crucially important. And how to direct one's examination to the patient's complaints. So that, you know, no, I had a lot of education along those lines. And you know, sort of obviously in the same way as medical students here are trained to recognize major illness. That was the emphasis. But the minor illnesses were not as well explained. You know, we used to do outpatient clinics. And there was where we found the more minor illnesses. And for the most part, we were, we learned with the residents. There were no faculty there. And for the most part, faculty was part time and voluntary. So they took what they could get, for the most part. You know, the professors were full time.

SIMEK: In your rural practices, among the poor and the undereducated, did superstition play a role in medical care?

GOODWIN: Hugely. Hugely. And again, Matt, I tell you, I am so ashamed of myself for my reaction to that sort of alternative healthcare. I mean, I used to mock it. I used to mock.

SIMEK: What was it? What did it consist—

GOODWIN: Well, it mostly consisted of witch doctoring. So there were these folk healers who probably had more psychological knowledge than I did. But for example, I can remember, again, I can remember several examples of my hubris. Woman comes in, she's got congestive heart, she's in severe congestive cardiac failure. So I see all the marks that, and the witch doctor accompanied her. And because, they're so fascinating. Anyway, I'll tell you—never mind. But I will tell you why. Because her husband had sheep, he has more sheep, flock of sheep, on the location. So they had come in from the location and the witch doctor accompanying them. The price of wool had just escalated tremendously to I think it was up to 200 pence a pound. And this guy's wool had become valuable. And I kid you not, we used to charge them ten shillings for all hospital admission and treatment. So it was just a single fee of ten shillings. Often we didn't charge them.

So I charge this woman ten shillings. I kid you not, her husband pulled out a roll of notes that were about that thick. [laughs] It was really amazing. And of course, that was why the witch doctor probably came with him.

But that was it, you know. I looked at these cuts that he had made, these ritual cuts. Idiot.

SIMEK: And?

GOODWIN: Well, she went into hospital. She turned out to be, if I remember rightly, I may be making this up. But it turned out that she was incredibly anemic because she'd had severe menstrual bleeding. And we, I can't remember, I mean rarely, we rarely gave patients blood because we had no facilities to do so. And if there was a real emergency, we would get, we had, probably twenty people who would volunteer to come in if we needed blood urgently. And it was almost, it was very rare. Perhaps three times in the time that I was in Queenstown, this rural town that I practiced in.

But we just used to do a straight cross match. In other words, patient's blood, donor's blood. If the blood didn't clot, we gave it. [laughs] I mean, can you imagine what things were like?

SIMEK: And when you said you gave it, was this a direct?

GOODWIN: You know, let me just think about that, Matt. I'm just trying to think what we did. You know, I think it was a direct. Let me just think about it. As I said, it happened perhaps three times in all the time I was in Queenstown. You know, I honestly cannot remember that.

SIMEK: The reason I ask is because my father had a direct transfer when he was a boy with rheumatic fever.

GOODWIN: Interesting.

SIMEK: An Irish Chicago fireman was on one table, and Dad was on the other, and direct transfer.

GOODWIN: You know, I think that was the way we did it. Because I can remember sort of pumping up the blood. Yes, it was vein to vein. Yeah. Interesting.

SIMEK: Now I know the timing is sort of wrong for this because of your age, but were you aware—

GOODWIN: Everything is wrong timing wise because of my age, Matt.  
[laughter]

SIMEK: Were you aware of any difference in medical practice pre- and post-war? Did the war, are you aware of any major change that the war had on the way that medicine was practiced?

GOODWIN: I started in medical school the year that the war finished. It didn't feature. It was never something that really came up. So my guess is, no. in other words, that the medical care for the troops up north probably was pretty primitive as well.

SIMEK: Now I think you mentioned Queenstown. How did you get from Cape Town to Queenstown?

GOODWIN: I was reaching the end of my eighteen-month internship. I did six months in medicine, six months surgery, six months OB/GYN. And I saw this advertisement in the *South African medical journal*. And believe it or not, I have a picture of myself reading the journal, coming across this advertisement, and saying, that's what I'm going to apply for.

And it was a group of three doctors in sort of a semi-rural environment. Queenstown was the center of a large farming population. Mainly sheep and wool. And there were small villages sort of scattered around the district, thirty, fifty, eighty miles from Queenstown. So Queenstown was the largest city with about ten thousand white population, about thirty thousand non-white.

And then, it's a long story about how the practice developed. But the partners got the perception that they could be a, to some extent, a referral source from the smaller dorps in the environment. And the reason that they were advertising was because the senior partner, who had been the president from a rural practice of the South African Medical Association, he was quite a remarkable guy. He was a German guy named Rudolph Schaffer. Big influence on me. He had met a cardiologist from Tulane, George Burch—he was well known in this country as well—who had visited South Africa as a representative perhaps of the American Medical Association, or perhaps was just visiting. Met my partner to be, invited him to come to Tulane to learn cardiology from him.

So he elected to go. And he was away for about eight months in New Orleans. And learned general internal medicine. Came back when I was still there. I then left the practice, and practiced for a time in a town called Stellenbosch. Then they decided that this was such a great idea that each one of them would go overseas and get some sort of postgraduate recognition. So they asked me to come back to the practice. One of them did pediatrics for a year. One did OB/GYN for a year in Dublin. And then we desperately needed a surgeon. By this time, I'd established myself in the practice. So I went to England for two years. I had a two-year stint. The idea being to try and get a fellowship. And I did, indeed, get, was awarded, as a result of examinations and a lot of very extensive clinical examinations, fellowship in the Royal College of Surgeons of Edinburgh. [laughs] It was a great triumph. It was really great. Really, in two years it was a great achievement. Coming out of a rural practice, coming into an academic environment and actually surviving. And it was really academic.

SIMEK: Did you feel like you were blossoming at that point?

GOODWIN: [laughs] In a way, in a way. But I still had a lot of negative feelings about myself, even at that time in my life. I came, I know they had said, my partners said, "Hey, Petey, you have a gift for surgery. You'll be the surgeon." And I, of course I came back, I'd done a lot of surgery, a lot of surgery. And looking back on the surgical techniques that I had, and had needed to develop, I sort of realize that I did a pretty good job. But still, one that was, by today's standards, reckless. Reckless!

I mean, some of the things I did, I had to do. You know, I did prostatectomies on black patients who were obstructed. They had no other option and so I learned to do prostatectomies in Queenstown. And I evolved that process. I first did the most, doing it through the bladder, which is the easiest. And then retropubic, which was a sort of an extension of my skills.

But I also did reckless things. Operating on women with breast cancer who already had glands in the armpit. Doing radical mastectomies. Hopeless chance of cure, you know. And really mutilating. It was very difficult surgery because we didn't even have cautery at that time. So the blood vessels we either padded until they stopped bleeding, or if they were larger, we would have to tie them individually with ligatures. So it was a very difficult and intensive process, and I wished it on myself!

SIMEK: When did cautery come into being?

GOODWIN: Well it was, when I came to the States in 1962, I mean, it was all over. I would imagine that it took a little time to infiltrate Queenstown.

SIMEK: So that was one of the mid-century developments.

GOODWIN: I would guess so.

SIMEK: I thought it was earlier.

GOODWIN: Yeah, it could have been, but not in Queenstown. You know, I'm thinking about my surgery residency. Let me think about that. Oh, definitely had cautery. Of course they did. I remember doing, using a cutting cautery to do radical neck surgery, radical cancer surgery, of which there was a lot.

SIMEK: In Africa in general?

GOODWIN: Well, in Cape Town. It was a lot of exposure to sunlight. And therefore, a lot of skin cancer that had metastasized. In other words, this one skin cancer, squamous epithelioma, that does metastasize. And that was a large amount of the radical surgery that was done. And I happened to be the intern that was associated with the surgeon to do this radical surgery.

SIMEK: So how would you characterize your general—you said that you were still uncomfortable with yourself. What was that about?

GOODWIN: Well, I don't know. I'm not going to go into that, Matt. It's too complicated. It's just too complicated.

SIMEK: All right. So I remember you characterized your practice in Queenstown as being a nightmare practice.

GOODWIN: But it had its advantages. You know, in retrospect, there was a lot of nightmare to it. Lack of judgment, as I said, the hubris, again, that word is so critical in the way I look at myself in those days. Here I am, falsely proud, and at the same time, insecure. I'm not going to make much of that. But the false pride in my professional life and a sense of uncertainty in my private life.

SIMEK: I was wanting to ask something about how in general that differed, but I think we'll get to that when we get to over here, which might be a good time. But at what point did you meet Erica?

GOODWIN: I met Erica in Queenstown. Of course, she had grown up in Queenstown. Let me just think. She was still at university. She was training to be a teacher. So she was probably twenty-one, twenty-two. I would say, I'm going to give her game away. Probably, actually it probably works out, 1955, '56. I would say '56. Give her a year of grace. [laughs]

SIMEK: And this is June fourth of 2008. And in about two weeks you'll be enjoying your fiftieth anniversary.

GOODWIN: That's correct, Matt.

SIMEK: How wonderful, and congratulations to you and Erica.

GOODWIN: Thank you.

SIMEK: How did you make the transition over here? By this time, you're already a world traveler, having been to the Royal College of Surgeons in Edinburgh.

GOODWIN: Yeah.

SIMEK: What made the transition here?

GOODWIN: Well, what really made the transition was the tension between the two white races. I really began to fear the nationalist government. And the sort of, the intolerance among the Afrikaans population at the time. And remember, they had every reason to be intolerant, to be angry. Because they really had been sort of cut out of economic life in South Africa. It was dominated by the British segment of the white population. So now they had gained control of the government, and they were flexing their muscles. And appropriately so, for them. And probably sort of totally appropriately. But it impinged on us. And there was a lot of sort of ignorant prejudice.

Erica and I got married in London. And we came back to South Africa. And four months later, there was a horrible event in South Africa. It was called the Sharpeville Massacre. And the police opened fire on a peaceful demonstration by the blacks against the pass laws, which were hugely oppressive. And many blacks were killed, and many

were wounded. And that really unsettled us. Because that happened four months after we got back.

And then other events sort of kept us unsettled. And then a final event, and there was a lot of tension between the two races, between the two white races.

SIMEK: Let me interrupt just for a second. The two were the British descendents—

GOODWIN: Right.

SIMEK: And the Afrikaans were the—

GOODWIN: Dutch.

SIMEK: —descendants of the Dutch. Okay.

GOODWIN: Dutch. Right. Yeah. And there were about an equal element, population wise. And Queenstown was about equal. When I got there, perhaps a predominance of English-speaking, by the time I left, probably equal or perhaps a predominance of Afrikaans-speaking, Dutch-speaking people.

And what happened was, again, it's sort of an interesting story and so I'll tell you about it. One Sunday morning, *the* Sunday morning, I went to the hospital. And there was a particular nursing supervisor whose name was Sister Roos. That was her family name, Roos. And she said to me, "Doctor—" she was a very nice woman. She said, "Doctor," she said, "you've got to stop this political activity of Erica's."

I said, political activity of Erica's, what is she talking about? Well, she then proceeded to explain. And what had happened was that Erica had been a receptionist, the receptionist, at a very small meeting of the Progressive Party. The Progressive Party by today's standards was retrogressive. But that's by the way. And it was a small party. But for South Africa sort of, among the Afrikaans-speaking, it was revolutionary because—well, I don't need to go into the details.

She said, "Because Erica's picture was in the paper on Saturday. And on Saturday evening, I went to a social at the church. And the Uyses—" I can remember the Uyses, and she mentioned one other family — "they not coming, they're not going to come and see you any more, doctor."

I was just shocked! I thought, what on earth is going on? I went back to Erica and I said, "We're going to leave."

But that was the culmination. That was the sort of the final blow. And so we left about six months later.

SIMEK: And what was the mechanism by which you left? You didn't just pick up and leave.

GOODWIN: No. What do you mean by that? Well, we left with very little, actually, because at that time, doctors were not well paid in South Africa. And we had a furnished home. People knew we were leaving, so we gave most of the furniture away. And we left with really limited resources. We packed up. We went to Johannesburg by train. We flew on Air France. Air France, it was really horrid. [laughs] I can tell you a lovely story about the trip on Air France. Our daughter, we had two children by then, and that was another reason that we decided to leave was because there was so much hatred in South Africa. And we just didn't want the kids to grow up in that environment.

So we had a daughter of two and a half, and a lump, gorgeous lump of six months who weighed eighteen pounds. Erica was a marvelous source of nourishment. But the only thing they had was a sort of a contraption with a wooden platform in an open filigree basket. So you had to attach the basket to the ceiling above you. There was a hook, or there were two hooks, there were two hooks, actually. But to get that child from here to there in that basket was hugely difficult. Because by the time I got her up there, the platform would have tilted, and she was leaning over to starboard or to port, you know? [laughs] It was hard work.

We came, we flew then to London. And then from London to New York we flew Trans World. And Trans World put us in the seat in front of the partition. And there was something, they actually had a table that we could actually put this baby down on. [laughs] And that was paradise.

SIMEK: When I meant mechanism, I meant did you have a job here?

GOODWIN: Oh, yes! Oh, yes, oh, yes. I had an internship to come to. The internship was essential, because no state in the states would allow an alien to practice without at least one year of postgraduate education. And Massachusetts was one of those states. There were only about four. Massachusetts, Maine, Washington, and New York. And New York was sort of doubtful in my mind. And I actually explored Massachusetts and explored Maine. And decided to come out and do the state board examination in Washington, in December of that year. That was '62-'63.

And I passed the state board examination, had interviewed several physicians while I was here. And the one who I glommed on to was really a wonderful physician in Snohomish, Washington, who later became the family doctor of the year of the American Family Physicians. His name was Leon Aller, and he's still alive.

Got there eventually in June of '63 to discover that the Pierce County Medical Society didn't allow aliens to become members of the society. Without membership in the society, I couldn't get hospital privileges. And here I was, my major skill was being a surgeon. And perhaps a father, although that's doubtful.

So after six weeks, I said this isn't going to work out. He was trying desperately to get the Pierce County Medical Society to change its mind. So I had actually interviewed in Camas, Washington. And the senior partner, who I had not met, called me one day and said, "We actually do need a fourth partner."

The senior partner— oh, I had interviewed, you see, what happened was, it was a strange story, Matt. Because I had interviewed a doctor in Vancouver, Washington. But he was sick. He was sick when I was in Vancouver. And what happened was that his office staff, three very nice women, hosted me, took me around, but never, the doctors in hospital, but there was never any suggestion that I would meet the doctor.

So about three months later came a letter from this doctor saying, "I want you to join me."

And I said, "But look, I've never met you. I don't know enough about you."

And he said, "Well, forget it, then."

But by then, we had actually, because of this open negotiation, we had decided to fly into Portland. When I got to Portland, there was nobody here to interview. So I went to the county medical society and I said, "Do you know of anybody who might be interested?" So I actually interviewed three people in that short period. And one of them was in Camas which is about, as you know, about a dozen miles east of Vancouver. And that doctor was a cold fish and really not interested. But the senior partner that was away called me when I was in Snohomish, out of the blue, and said, "We need you."

So I said, "Okay. I'll come and interview you." So I went down to interview him and I liked him. He was an old curmudgeon, but really I liked him. So we agreed that I would join their practice. So I joined the practice in Camas at the end of August.

SIMEK: And your hospital privileges were where?

GOODWIN: This is the fascinating thing, Matt. Because I had explored that. What happened was that the county medical society made their own decision. And so Pierce County said no, but King County said yes. Seattle said fine. Clark County said fine. So, yeah, that was a crucial issue.

SIMEK: So you decided against Seattle? Or it was just you decided for Camas.

GOODWIN: Yes, interestingly again to tell you a little bit about myself. I was scared of Seattle. I thought gee, I've never practiced in a large city. So the country appealed to me. [laughs] That was nice. Snohomish appealed to me. I'd actually interviewed in Aberdeen, believe it or not. Thank heaven that didn't pan out well. [laughs]

SIMEK: Now this, so you joined as a surgeon? Or as a—

GOODWIN: No, as a family doc. I had always been a family doc. I had never been a surgeon in Queenstown. I was always a family doctor, but just doing a lot of surgery. Oh, yeah. We were all family doctors. But each with a sort of a special interest. And the special interest was sort of semi-fake. You know, the surgery was fine, the OB/GYN guy was fine. The pediatrician knew a lot of pediatrics, but he was the fake. [laughs] He used to use his degree in rather devious ways. He even double crossed me one night. [laughs] Never mind. I won't get to that story. Anyway.

SIMEK: Those are the stories that sound most intriguing. [laughter]

GOODWIN: Well, yeah.

SIMEK: How many were in that practice?

GOODWIN: Four. Including me. Interesting guys.

SIMEK: Routinely, what did you see as a family practitioner then in Camas?

GOODWIN: Well, there were the usual things: flu, infectious diseases. You know, the usual gastritis, pneumonia, the usual things. A lot of injuries. Because there was this big paper mill in Camas. So we would see lots of cuts. Lots of bumps, bruises, some fractures. And I had done a fair amount of orthopedics in England when I was training for the fellowship. So I was very comfortable doing a lot of orthopedics that was outside the scale of the usual family doc. I even did meniscectomies. A couple. Then I thought wait a moment, there are people who can do meniscectomies here better than I can. So I stopped doing that.

But I did other major surgery. I used to do gall bladders here, hysterectomies. I even did a thyroidectomy, which was hugely unusual. I had done a couple of thyroid, more than a couple thyroidectomies in Queenstown, because nodular goiters were common among the blacks.

SIMEK: A dietary thing?

GOODWIN: Iodine shortage. Shortage of iodine. Yes. And so there were a lot of injuries, a lot of cuts, a lot of foreign bodies in the eye. And here again, we would not hesitate for a moment to even remove foreign bodies, hot foreign bodies embedded in the cornea. We went ahead and just gouged them out. Today, no family doctor would dare do a thing like that.

We each of us had an obstetric practice. We were thirteen miles from the hospital to do deliveries. Who could do that today? Thirteen miles from a hospital. You know, the malpractice risks just for ordinary family docs are prohibitive. Could you imagine what they would have been like for us in Camas? They would have been absolutely impossible, but we did.

SIMEK: We'll get into malpractice a little bit more later on, but I want to touch on it here because malpractice at that time was a whole different animal, wasn't it?

GOODWIN: Yes. It was manageable.

SIMEK: There was malpractice insurance.

GOODWIN: Oh, very much so. Yeah.

SIMEK: But it was minimal? How did that—

GOODWIN: Well, I think the premiums were not out of line. And certainly, certainly we could manage that. And you know, the thing is that we were open to malpractice suits. I mean, there were a lot of things that we could have been sued for. A lot. I mean, we were close to our patients, and the patients were mostly forgiving.

And I think the same was true in Vancouver. Because there was a preponderance of family docs in Vancouver at that time. And they had a powerful influence on the way medicine worked in Vancouver at that time. I was sued once in Camas in all the time I was there. And I can assure you—

SIMEK: I'm sorry, you were what?

GOODWIN: Sued. Once in Camas. [laughs] I'll tell you, because it's such an amusing story. One really winter's night, a woman patient of mine called me and said her husband was really sick. Really sick. Got a high fever. And I thought, I think he's dying.

So I went down the stormy winter night about eight miles to her home, his home, and saw him. And he had flu. Nothing terrible. And so I gave him some medication of some sort, probably aspirin. And I felt very virtuous.

Some few months later, this woman, who had a big butt, came in there— I'll tell you about the big butt. She had some low back pain. And so I said to my nurse plus physical therapist, "Give her some diathermy." Well, my nurse put the diathermy lamp too close to this lady's bottom. And she got a, I think she ended up with a blister about this size. And she sued me! She sued me! I thought how unjust. I sacrifice myself to go and see her husband. She's got this little burn. She got an award of three hundred dollars from the insurance company. [laughter] That's the only time I was sued. Life is really funny at times, Matt.

SIMEK: I remember talking with one doctor as part of this series who said that the malpractice insurance was a rider on his automobile insurance policy.

GOODWIN: Really?

SIMEK: And I was curious as to, it was a separate policy in Washington State?

GOODWIN: You know, Matt, I must tell you that I have never been a businessman. And the answer to your question is an unknown.

SIMEK: Okay. Fair enough. Okay, I wanted to come back because you are the first physician I've talked with who has voluntarily mentioned a diathermy. I remember diathermy, and I remember the treatments. But you say that to anyone born since 1950 and they don't know what you're talking about. Well, maybe 1960. So say just a little bit about what a diathermy was, and what it was intended to do, and how it fell into disfavor.

GOODWIN: Well, it was a heat lamp, basically, with an element. And it produced heat. So it produced warmth. And the warmth was supposed to relax muscles and joints and so on. And the reason that it fell into disfavor was because ladies with big butts got burned. [laughter]

SIMEK: All right, fair enough. The diathermy machine I remember had paddles. And it was a radio frequency transmitter.

GOODWIN: That's correct, Matt! You're reminding me. You're absolutely right. There were two paddles, yes.

SIMEK: And because of the radio frequency, I suppose they could cause a blister and burning.

GOODWIN: Yes, yes.

SIMEK: If it was not regulated properly or something.

GOODWIN: Yes.

SIMEK: And I remember finding one in a junk store once and seeing these huge coils in there and thinking what a great transmitter this would be. Of course, it would have been illegal because the FCC controls. It was just a giant radio transmitter.

GOODWIN: Really? Is that what it was? [laughs]

SIMEK: And it was used in our cases to break up congestion in the chest and so forth. I don't know if it had any efficacy at all, but that's what they said, anyway.

GOODWIN: Oh. I don't remember ever using it—I used to use it for muscular-skeletal things.

SIMEK: And for reducing big butts. [laughter] We'll get back to technology in a short time.

GOODWIN: Lovely.

SIMEK: How long were you in Camas?

GOODWIN: Seventeen years.

SIMEK: Seventeen years.

GOODWIN: Yes. But the most significant event there to my future progress was that after I became a partner, and that was a long and painful process, these guys were skinflints. But after a few years, I got restless because I realized that my emphasis on practical skills, on technique, had left me sort of really with not a lot of insight about patients. You know, why patients came to see me. The thing that really intrigued me, among other things, was why do some patients listen, and other patients not? Why did some patients, when I said, “You’ve got to stop smoking,” dah, dah, dah, dah, dah. I give them nine different—and they would just blow it off.

And then others would say, “Doc, you know you saved my life. Saved my life. Yeah, Doc, remember that discussion we had about smoking? I stopped.” I thought, what on earth is going on here?

And so I got a little restless and I wanted to sort of go into that. So I persuaded two other partners in the practice at that time that wouldn’t it be wonderful if we each had a sabbatical for a year. And one of them had almost completely finished building a sail boat, forty feet. So he took his family sailing in the South Seas for a year. So he fell for the bait. The second one was a traveler and a fisherman. So he bought a big travel trailer and he went traveling for a year in the States.

It gave me an opportunity to go down to South Carolina. And I got some advice about where to go. I interviewed several places. And South Carolina was obviously a place to go to. They were very well funded in South Carolina. They had a really charismatic neurologist, believe it or not, who was convinced that the only way to build a good healthcare system was to have an underpinning of family docs. And he established eventually six family practice residencies in South Carolina. And he had in the Charleston residency program—

[tape change]

SIMEK: I don’t know the geography of Cape Town and Queenstown.

GOODWIN: Yeah, it’s about six hundred miles. Six hundred and fifty miles, or six hundred and twenty something miles, northeast of Cape Town.

SIMEK: We’re interviewing Dr. Peter Goodwin. And this interview is made possible by the Oregon Health & Science University Oral History Program, conducted at the Oregon Medical Association in Portland, the morning of June 4, 2008. The

interviewer is Matthew Simek. This is tape two of, either two or three, we'll find out how that goes. All right. Well then, let's pick up back again in South Carolina.

GOODWIN: Yes.

SIMEK: How was it that you chose to go there?

GOODWIN: Well, the, first of all, as I say, he had a charismatic ego. He was a neurologist who had practiced in Florida and somehow got this bee in his bonnet about the fact that family physicians were necessary to establish a good underpinning for a good healthcare program.

SIMEK: It's unusual for a neurologist to come to that conclusion.

GOODWIN: Yes. It was really strange. Really strange. But he did practice in a rural area. He was in the Florida panhandle, I remember that. Northern Florida.

SIMEK: His name?

GOODWIN: Hiram Curry. And he had established this program in Charleston with two psychologists and an ethicist, a full time ethicist. And then a small group of family physicians.

SIMEK: How does an ethicist bring money into a practice?

GOODWIN: Well, that was it! They were so well funded. He got I think six million dollars the first year to establish these residencies. Which was a lot of dough at that time. So he had lots of dough at his disposal. And he established programs. There were two in the sort of uplands. Greenfield and something else. There were four, I can't remember the other names, unfortunately, when I was there. And eventually there were six. And I interviewed the psychologists when I was visiting. And they really, I thought to myself these guys, I need these guys. And they helped me a great deal. They really bust open the concrete in my skull, and sort of let in ideas that I thought—when I first was exposed to them, I thought that they were just bizarre, outré sort of things.

SIMEK: Such as?

GOODWIN: Well, such as the drug culture. Such as homosexuality and whole arena of transsexuality. And the fallibility of doctors was new to me. [laughs] Almost. No, that's an exaggeration. But one of them in particular was, he really was a free spirit. And eventually the chairman of the department, Hiram Curry, kicked him out because he was just too revolutionary. He was really, he was great, I thought.

SIMEK: What, approximately what year?

GOODWIN: That was 1974-'75. So I spent a year there. And I learned an awful lot. I really, it was one of the best learning years of my career. Perhaps the best. And I had, by absolute luck, I had a South African physician who had been in Israel, who actually settled in Israel, and came to the States that year at the same time as I did. We arrived at the department basically simultaneously. His name is Ron Schneeweiss. And he was an outstanding guy. I really learned a lot from Ronnie. He learned a lot from me in a practical sense, but I learned a lot from him from the point of view of patient care.

And he later came up to the University of Washington and became the chairperson in the department of family medicine. He was highly respected there. Awfully nice guy. So that was a stroke of luck.

And so, the other thing that was fun was because I'd been in practice for a few years and really had a lot of practical skills, I also had a lot of practical questions to ask the consultants in the specialties who interacted with our residents. And so I would really stretch, I would say, "Well, why do you say that? My experience has been a little different." Dah dah, dah, dah, you see? So I really enjoyed it. And they did, too. So it was a fun experience. A real learning experience for me and for the residents.

SIMEK: What were your primary take home points?

GOODWIN: About the consultants?

SIMEK: From being there. What were your key lessons?

GOODWIN: Oh. Well, I think the major lesson was that family medicine was hugely intellectually stimulating. And really worthwhile. And you know, I had a lot of pride in being, in going home, going back to Camas knowing that I now had a lot of new skills. And I tried to influence my partners in Camas with these new skills. You know, the emphasis on community medicine and on history and on listening and taking into account the patient's agenda. Not just brushing it aside because your agenda was so much more important.

But unfortunately, my partners were just not receptive at all. And one of them said to me one day, he said, I was talking about community involvement and how we needed to get ourselves integrated with the major industries in order to have them collaborate. And one of them said, "Oh, Peter, what are you trying to do? Establish a monopoly?" So it just fell flat. So I was disappointed.

And soon after I got back, I volunteered to come into the Department of Family Medicine once a week for a half day. And be with the residents and sort of commune with them.

SIMEK: What department?

GOODWIN: Family Medicine. At OHSU. And it was a weak department. It remained a weak department for quite a few years. I think the essence of the weakness was that neither the chairman nor the vice chairman had any clinical practice of their own. They had just decided that wasn't their bag, that they were going to be administrators. And as a result, I think they lacked credibility within the milieu of the medical school.

SIMEK: Who was the chair at that time?

GOODWIN: Gosh, Laurel Case. Laurel Case was the chairman.

SIMEK: And Bill Fisher was the—

GOODWIN: Bill Fisher was the vice chair. They had both been family doctors. One in Medford, Laurel Case. And one in Portland. Bill Fisher was a very prominent physician in organized medicine. Actually he was, at one stage, I think while he was vice chair, he became president of the OMA. So he was very much into medical politics. And he was a canny politician. But he was also a chain smoker, which lessened his credibility with the residents. There was a lot of tension between the administration of the department and the residents at times. Which I was a contributor to. And by no means was I blameless. Don't get me wrong. I also made mistakes. But I went part time, and then they asked me—

SIMEK: I'm sorry, this was right after you came back from South Carolina?

GOODWIN: Yeah, yeah, right. In 1976. So I'd been back for about six months or so. And then after a couple of years they asked me if I would join the department part time. And so I did. I went two days a week. And then in 1980, they asked me to join full time, which I did.

SIMEK: How did you get connected? Did you just walk in off the street one day?

GOODWIN: Well actually, it was interesting. What had happened was that when I was looking for advice about where to go for this year sabbatical, again, I'm not—well, I'll tell you exactly what happened. What happened was that I interviewed Laurel Case. And Laurel Case said, "Oh, you're just a bit discontented. You'll get over it."

SIMEK: You're just what?

GOODWIN: You're just sort of discontented, perhaps. You'll get over it. Nothing particular. Sort of fairly average.

And I thought to myself, wait a moment. That's not what I wanted to hear. So actually I went up to talk to Ted Phillips, who was the chair of the Department of Family Medicine at the University of Washington. And he glommed on to what I wanted. And he gave me, he actually gave me the four programs that I actually interviewed at. They were

all in the Southeast, because those were the best funded programs. Chapel Hill was one. I'm trying to think of, Bowman Gray, Charleston, and Virginia. The outskirts of Virginia, there was a program there, on the outskirts of Washington. But Charleston was an obvious choice at that time.

And so, to continue, so I joined the faculty full time in 1980. And I just loved being with the residents, really did. What happened was that I insisted, together with one of the other faculty members who supported me, Merle Pennington, that we had to have a clinical practice. That we couldn't continue to be teachers without being current. So that became part of the program. So each faculty member, apart from Laurel Case and Bill Fisher, developed family practices of their own. We only had three sessions a week, three half-day sessions a week. But it enabled me to pull quite a few patients from my Camas practice over to the Medical School. And I continued to enjoy seeing them. They were the *crème de la crème*, you know? They were a lot of fun. So, that continued.

SIMEK: Now this was as you joined the faculty—

GOODWIN: Yes.

SIMEK: You just sort of got your feet wet and then you developed that for a while before you became active? Or were you active right from the beginning?

GOODWIN: Oh, active right from the beginning. Oh, yes, indeed, in every way. In fact, Merle and I, Merle Pennington and I actually got so desperate at one stage that we went to the temporary dean, whose name was Bob Grover, because we felt that the department was being so slighted. And there was a controversy at that time with one of the departments, I don't want to go into detail, but where our residents were being slighted. And we felt that the department just was not giving our residents adequate support. So we went to Bob Grover. And Bob was very sympathetic and, I think, helped us.

I don't want to, I'm giving the impression that Laurel and Bill were sort of not very effective. It's not really true. They were the people, with Merle Pennington, Merle had a significant involvement in establishing the Department of Family Medicine. And that took a lot of effort and a lot of hard work. I think that what they did was they burnt their boats. They sort of had the feeling that gosh, we've accomplished this, we can't ask for more. And that was the sort of feeling that I got from them.

SIMEK: That they burned out personally? Or that there was just nothing more to drain from that.

GOODWIN: That's right. Nothing more to drain from that relationship. They really sort of exhausted that source of giving. So this was where it's going to be, and this is where we're stuck. And again, that's my assessment. Now it may have been very unjust. But that still is my assessment.

SIMEK: Family practice, the idea of family practice, was still relatively new at that time. Is that right?

GOODWIN: It was really, it was difficult to gain real credibility in many medical schools. And sort of the elitist medical schools, the schools that thought of themselves as the primary medical schools, they were least receptive. You know, so I presume that family medicine advocates in the academic environment needed to struggle to gain credibility. There's no question about that.

SIMEK: Was there already the sense in, when you joined the department, was there already the sense that family practice was the underpinning of a sound healthcare delivery system?

GOODWIN: I think we all believe that. Yes, I'm sure we all believed that. And we all believed that we were pioneers.

SIMEK: How did that develop? How did you develop this sense of pioneerism and the idea that family practice should be—

GOODWIN: Well, it really came out of the American Academy of Family Physicians. Those leaders realized that family medicine had to have an academic base. Had to have more credibility within organized medicine. And felt that they were losing ground. And so that initiative came from the AFP, from the Academy of Family Physicians. Which was called the American Academy of General Practice at the time. And there was a lot of opposition to the change of name, because we saw ourselves as general practitioners. But the emphasis had changed to emphasize the importance of the family in providing medical care. So it was family, community. A community approach to medical care. And that really sort of jived with me because of my experience in South Africa, where I had no experience in community medicine, and should have. I would have been able to do a lot more good if my approach had been wider, rather than just relating to a patient.

SIMEK: It's interesting to hear you say that, because when you say that the family practice concept, they felt it was losing ground, was that coinciding with a gain in momentum for specialization?

GOODWIN: Oh, no question. No question.

SIMEK: And that wasn't one of your favorite things, was it? Specialization and subspecialization?

GOODWIN: Well, you know, I saw it as inevitable. But I also saw it as unbalancing. Sort of the lean toward increasing, increasing, increasing technology tended to fragment medical care, and in a sense, was in danger of fragmenting the personal relationship between physician and patient. Physician and patient and family, which I

thought was crucial. And you know, Matt, the business of aid in dying. That was also part of that process.

Because, you know, I noticed the huge difference between death in hospitals and death in practice. And at that time, I was doing house calls. And I would do house calls on really ill patients who might have been into hospital, out of hospital. And I was dealing with two men, one dying of cancer of the prostate, the other, dying of complications from, he had a pulmonary disease and he also had prostate cancer. And looking after these patients in their homes with a supportive family environment, it was so different, you know, it was so heartwarming to be with those patients as both these men died. And then comparing that process with death in hospital, where the patient and family was all so often sort of shunted aside and tended to be sort of, not ignored, but sort of misled at times. “Oh, I don’t think things are quite so bad.” The thought of facing the idea that a patient was going to die was difficult for the medical profession. And that was part of my evolution.

The other part of my evolution was being approached by two men who wanted aid in dying. And the first time, it was just a shock. This couple came into my office. I had met them socially. They were new patients. And he just came right out with it. He said, “I’m dying. I’ve had this cancer for eight years. I’ve had all the treatment that’s possible. And I’m dying.” And he explained why he wanted to end the process, and it was an overwhelming reason. But when he said, “I want you to help me to die,” Matt, literally I felt as though the blood had frozen in my veins. I just had this cold sensation all over.

And eventually I helped him. Because the issues were not just of ill health. I mean, he was suffering terribly. He’d had this cancer for eight years, and it had never remitted. Never remitted. But there were other issues that were just unique. And I won’t go into it because I don’t even know, well, I don’t think there’s any possibility of the patient being identified. But the other thing was that he had been disabled for so long, and his wife had had to look after him. And they both had a professional career. And they were terrified. He already, I mean, he was paralyzed from the waist down. He had had innumerable kidney and bladder infections, and was really in the process of dying. But his wife had been out of work looking after him. And this was in the days before hospice had developed. It was just a fragmentary system in Camas at the time, in Camas and Vancouver. And they were terrified. They had three kids, the oldest of whom was about thirteen. And they were terrified that the family was going to become destitute and that the kids would be frozen out of a decent education, which they had had.

Anyway, after talking with them, visiting at their home, I didn’t know what to do with them. I couldn’t consult with my colleagues. It was illegal. And by luck, I gave them twenty-five Nembutal capsules. Twenty-five. That was enough. About two weeks later, I read of his death in the paper. I didn’t hear from his wife. Later, I talked with her. I was terrified to contact her. I thought if anybody found out about this, I would lose my license. And Matt, every time the phone rang for a while, I kid you not, every time the phone rang, I thought, is this it?

Anyway, what eventually—I stayed, I’m still in contact with this family now. And he died peacefully. She actually gave him the pills and he took them. Because I didn’t know any better, he took the twenty-five capsules and he died peacefully. And I have no regrets. Those kids each had a good education. The wife went back to work. Family rallied around to some extent. And all three of those kids have successful careers and successful marriages. And she has, I think, five grandchildren. And I’m delighted. And that was a huge influence.

Plus, the issue of dying in hospital as opposed to what dying could be. And gradually, you know, I valued hospice tremendously as my career unfolded. But I never got over the idea of the need for dying patients to have more control over their dying. And I just wanted that to happen. And that’s why when we started meeting, the group of eight of us who constituted the Death with Dignity committee, we had lots of discussion over about eighteen months about how we should go about a campaign, about how we should word the initiative. And I was insistent that the patient have control, that the patient must take the medication. And that euthanasia, by injecting the patient, by the doctor injecting the patient, was out. It was not a possibility. And that was what we decided.

It was partly my desire. Partly it was because I had been president of the Oregon Academy of Family Physicians a few years before. So I called just informally about thirty family docs. I had no idea what they might feel about the process. About half of them said yes, under certain circumstances, I could help a dying patient die. But euthanasia? No way. Not one of them could consider. Nor could I. I mean, I couldn’t consider actually causing the death of a patient. I wanted the patient to have that option. So, yeah, I would prescribe. But the patient would have the ultimate decision. Timing wise, pace wise, how wise. That was what I wanted.

And you know, we got the initiative on the ballot. And then the Oregon Medical Association was faced that spring by two resolutions. One came from the Clackamas County Medical Society. And the other came from the outgoing president, I believe, or maybe the past president. And the incoming president-elect, whose name you know. And who’s well known and a good, good friend of mine.

And I went down to that meeting. And I described this case. And I described another case of a second patient who had asked me to die. This was a thirty-nine year old man with pancreatic cancer who had had every sort of treatment. In fact, he had spent fifteen hundred dollars. He was a successful businessman. Married, but without children. And he was, I mean, he was just a scarecrow. Became a scarecrow.

SIMEK: Thin?

GOODWIN: Thin. Right. And that was not, that was not a happy event. I sort of felt like I had abandoned them when they were most in need. And that also implored me to do something about it.

SIMEK: He died without assistance?

GOODWIN: That's right. And, it's a long story. But what happened was that his wife called me, see, she called me in the evening. And she described sort of like a catastrophic event, development, from their point of view, from the planning point of view. And so I gave her some advice over the telephone. I knew that she wanted me to come and visit. But they lived in the country. And I thought, you know, I could be spotted. My car. Somebody might sort of put two and two together. So I was fearful of going out to see them.

And she called me the next day and told me that she thought that she had been lured out of the room and somebody had put a plastic bag over his head. I mean, he was in extremis, I mean really in extremis. He was within hours of dying, anyway. So that, also, was a huge stimulus to my doing something.

And then, so then there were these two resolutions before the Oregon Medical Association. Both in opposition to our initiative. So I went down to that meeting— oh, what happened? I must go back. Leigh Dolin was the president-elect. And I knew Leigh Dolin. I knew Leigh Dolin enough that I could call him, say, "Leigh, I want to talk to you."

So I met him at a café and we had breakfast together. And he said, "Peter, forget it." He said, "There's no hope in Hades." And he also said, "We do it. We help patients die."

And I said, "Yeah, but the trouble is doing it sub rosa, secretly, it doesn't give you an opportunity to consult adequately. It doesn't give you the opportunity to talk openly with a patient or the patient's family." And I thought it was a bad process.

And then I met him again, near Providence the second time. And he again, he tried to dissuade me. So I went down to this meeting, and I told them about these two cases. And obviously they were moved. And as I left the microphone and walked back to the back of the hall, Leigh Dolin was standing there. And our eyes met. I sat down. Leigh went to the microphone. And when his turn came, he said, and remember, he was the president-elect. He said, "We should let the people of Oregon tell us what they think." And that, I think, had a significant influence. Another couple of doctors got up and spoke in favor of the initiative. And the reference committee the following morning came out with their recommendation, which was that the OMA have a hands-off approach, a neutral approach. And unbelievably, the House of Delegates accepted that without a murmur.

And George Waldmann came to me immediately after the meeting and said, "You won."

And I felt like saying, George, I didn't win. We won. And the administration of the OMA were blown away. They couldn't believe what had happened. A couple of them came to me. I think Bob came to me, or Jim, one of them.

SIMEK: Bob Dervedde.

GOODWIN: Bob. Was it Bob Dervedde? Yeah. One of them came to me together with the executive secretary, who was a very nice woman. And they really were delighted for me, but absolutely astonished.

So that's how it worked out. And then we went ahead with the campaign. And we emphasized a couple of issues. At that time, the huge issue was the suffering that terminally ill patients had. That was a big deal. And the other was we emphasized, also, the fact that no government should tell you how you can die. That's your decision. And so that, we won that just by a hair's breadth. Fifty-one to forty-nine percent.

And then the Catholic Church got into the act. Oh, I mean, they'd been into the act since day one, of course, and had provided a lot of funds and a lot of resources to anti-campaign.

SIMEK: I'm curious about a lot, I mean, so many questions come up as you talk about this.

GOODWIN: Oh, good. I'm glad you interrupted me.

SIMEK: Because one of the things that is very obvious is that this was not strictly an intellectual exercise for you. You're very emotionally involved. And you were emotionally involved in those patients who came to you.

GOODWIN: Oh, very much so.

SIMEK: And it's a very emotional thing for you.

GOODWIN: Yes, it is, indeed. It still is.

SIMEK: And so you're deeply involved in it. Not just as something that should be right for the patients, but you really feel this.

GOODWIN: Oh, very much so. Very much so. I still feel it. I have, you know, I'm still involved with this issue. And I do still relate to dying patients. And I called one just a couple of days ago. And he's deteriorating, he's dying, I thought, I almost cried.

SIMEK: This was, you weren't recruited for this, were you? You generated this.

GOODWIN: No, no, I wasn't recruited. What happened was, I joined the Hemlock Society because I felt the Hemlock Society was the only avenue to do something about this. But it soon became apparent to me that the Hemlock Society was too diffuse. The members wanted too many things. They wanted to die whenever they wanted to die. And I thought that's dangerous as all get out. And other things as well. So

I became sort of enthusiastic, but also doubtful. And then, I can't remember who it was, but I think it may have been Myriam Coppens.

Now Myriam Coppens was a social worker at the Medical School. Very enlightened woman. She was German, of German extraction. And she was also a woman who was one of very few at the Medical School who recognized the significance of sexuality in health, and was a sexual counselor as well. She was quite an enlightened woman. And I believe it was she who told me about a man named Elven Sinnard whose wife had caused her own death by putting a plastic bag over her head because of her suffering. And he was so blown away by this that he felt something had to be done.

And you know, it was a process that was bubbling. There had been discussion in the legislature about aid in dying legislation. Which got nowhere. But there had been discussion because Barbara, Barbara, oh, the ex-governor.

SIMEK: Roberts.

GOODWIN: Barbara Roberts' husband was a senator. And he was dying. And he wanted legislation. And he was instrumental in pushing the Oregon advanced directives law. So there was some ferment. So El Sinnard, he was a successful and rich businessman. And he had resources. And he put out a memorandum, I think, the way I understood it was at the Unitarian church, of which he was a member, asking for volunteers. And Myriam Coppens, I think it was, told me about him. And the fact that he had been getting together a group around him.

When I joined, he had a lawyer. He had Eli Stutsman. It was I, a couple of women who had been members of the Hemlock Society, who actually fell away; and then a couple of other women, really a wonderful woman who eventually, believe it or not, ended her life in Florida, interestingly. She had family in Florida. She knew what medication to take. And somehow she got a hold of it and she took it and she died. She had cancer and she was terminally ill.

And so this group, eventually of eight people, really did all the planning. And Eli Stutsman, who also came through Hemlock, and also realized that Hemlock was like an albatross, really. And we divorced ourselves from Hemlock very early on. But Eli was a real driving force, and so was Barbara Coombs Lee. And they were politically savvy. And Eli in particular pushed. And he was the one who insisted that we do professional fundraising, and that we pay the signature gatherers. He said, "Doing it, you will fail if you do it with volunteers." And I believe that he was right.

And so we had professional fundraisers. And I can remember, I wouldn't say my revulsion, but my distaste. [laughs] That he was doing this fundraising professionally. But I'm sure it was crucial. You know, we eventually raised a million dollars, and we needed every penny of it. And the opposition raised more, at least twice as much. But we won just by—and that program, that was very, very interesting because I did a lot of interacting with the medical profession. And you know, sort of spoke with many people

in opposition. Including Miles Edwards, who was the nicest, most reasonable, committed at that time in his opposition. And very influential in the opposition. I later became very, well, I wouldn't say very friendly with Miles, but as Miles died, I became sort of somewhat intimately involved with him. He was a very nice guy.

So then the Catholic Church got involved. First, legally, there was a big challenge. And a district court judge, I think, district court judge in Eugene. Hogan? Mike Hogan? Something like that. He immediately said this was unconstitutional. And so the law was in abeyance. And it stayed in abeyance until 1997, the end of 1997, when the Ninth Circuit eventually overturned his verdict. It was a long struggle in the courts. And that was immediately before the election in November of 1997. That initiative, that time, we emphasized the issue of—because, even within those three years, because of many, many influences, but certainly influenced by the passage of the initiative in 1994. I mean, Susan Tolle came out with an article in which she described the need for, that this was a wake-up call to the medical profession. And so it was! And so between 1994 and 1997, there had been a huge improvement in care for the terminally ill. Partly influenced by passage of the law, but obviously there were many other influences. Hospice was improving its resources and its outreach. And the medical profession had sort of girded up and were now providing information about care of the dying to medical students and to the residents. So there was a lot of ferment.

But we emphasized the fact that, you know, the legislature put this initiative that reversed the law, basically. So we said, go back to 1994. You see what we told you about government interference in your rights? So here's the legislature. We warned you, and now it's happening. That was one of the things.

And then the other thing that they made a dreadful mistake in opposition was that they tried to use evidence from Holland, which they distorted, to prove that the medication, the Nembutal, or the short-acting barbiturate, whatever it was, was going to cause all sorts of calamitous complications. And it was just simply untrue. There were a few complications in Holland. But obviously, people were learning. And many of the complications were caused not by Nembutal but by other medications that they were using, in combination with too small doses of Nembutal. And so we also pushed that, that that information that they were disseminating was simply irresponsible. And mostly untrue. And it was.

And so we won sixty to forty in 1997. And that put the law on the books, for sure. And again, Matt, you know, I was central to that whole movement. I feel so gratified by the outcome of the whole, you know, all the terrible things that the opposition said would happen, that we'd have a huge influx of people coming in. that we'd have Dr. Deaths, that we'd have thanatologists, that people would be taken advantage of, especially if they were poor, or if they were disabled, or if they were especially elderly. None of that has happened. The doctor/patient relationship, they said, would be destroyed. Of course it's strengthened. When I talk to dying patients now, they appreciate my calls, they appreciate my visits. And I'm peripheral to their care. They say that they're so delighted they were able to get a prescription. Many of them didn't get a prescription. Many of them were

reassured. But most, most were reassured by the availability of hospice. That, even for those patients who are considering taking the medication, have so much respect, so much faith in hospice. I mean, hospice is absolutely crucially necessary in the care of the terminally ill who want to die at home.

And that is the other thing, Matt, that is so gratifying, is the number of people who now can die at home. I think the figure is 40 percent. You know? That is just wonderful for them.

SIMEK: How do you respond to those who say that because palliative care is so available, that the need for this kind of legislation no longer exists?

GOODWIN: Well, again, it's a question of who's in charge when you die. If you want to be in charge and that's crucially important to you, then palliative care is a huge crutch. But it's not enough. You want to die in your own home, in your own bed, surrounded by your loved ones at a time of your choosing, as long as you're terminally ill. You have to be terminally ill. And that is the issue. The issue is of ceding total control to the patient. Which is very difficult for the medical profession. And it's not total control. The physician still has a lot of control over the circumstances of death. But it's the patient who makes the final decision. And I think the patient knows best.

SIMEK: There are those who say that the physician shouldn't be involved in that at all. That if America wants, as they say, a suicide law, then America has the ability to vote it in. And they have consistently not done so in all but one state. And that the concern is that, at what point do you say that assistance in dying, or one's ability to take one's own life, is legal or not legal? Or if you have six months to live, or six hours to live or six years to live and you know that you're terminally ill, at what point does it become a good thing versus not a good thing?

GOODWIN: [laughs] Well, you know my reaction to that is to say, look at our law. Look at our law and look what has happened with our law over ten years. None of these abuses have occurred. Patients have died, most of them terminally ill, very close to death, within a couple of weeks of dying. And even if they don't, even if they're terminally ill and they die five months ahead of the time that they might have died, what have they lost? They've lost five months of suffering. So my feeling is that again, it is the patient who needs to be in control. And none of these patients, in my experience, not one of these patients wanted to die. They'd realized that their time had come, but they were so regretful, so sad, as opposed to depressed. Now these patients are not organically depressed. They are sad. And blow me down, they are sad.

I have one at the moment who says, "I've got to live until X, when my newest grandchild is going to be born." And his prognosis is against it. So he's very sad. But my goodness gracious, wouldn't you be? Wouldn't all of us be? You see? So the depression issue, I think, is a misnomer, a total misnomer.

SIMEK: One case that is, I don't know if it's often brought up, but it is brought up, about the, I think it was an Oregon woman with Alzheimer's disease who went to Michigan to see Dr. Kevorkian long before the effects had taken hold. But she was so concerned that she would lose the ability to make the choice, that she wanted to die while she still had that. And it was perhaps years, her death would be years away. But she was successful in Michigan.

GOODWIN: Illegally.

SIMEK: Illegally.

GOODWIN: Illegally! And that's the point, Matt. I mean, to argue that about the law is to, in my way, to strengthen the law. That's to say, that cannot happen in Oregon! Because there are penalties in Oregon because we have a law. People can be sued by the state. We've not had Alzheimer's patients take advantage of the law in that way. None of them! Because doctors know that they are not competent to make that decision.

SIMEK: On a personal level, if you were faced with terminal illness, would you consider this option?

GOODWIN: Of course I would consider it. Whether I would do it is sort of uncertain. You know, I might fall in love with one of my hospice workers. Who knows why, Matt? I'm joking, of course. But the circumstances might totally change my point of view. So no, I'm not committed to killing myself or helping myself to die. I am committed to having the option.

SIMEK: Is it true that the Hippocratic Oath bans physicians from giving any potion that will end a patient's life?

GOODWIN: [laughs] You know, again, Matt, I think that that is such an irrelevant argument. When did Hippocrates live? What does Hippocrates know about modern, what could he have known about modern medicine? Did he in fact write this? Who knows? You know, and in those circumstances, at that time, there might have been hugely important social reasons for his pronouncement that are simply not relevant today. And if people say that, "Well I took the Hippocratic Oath," my response is to say, "I took it with 120 other graduating residents. It didn't mean the slightest thing to me at the time!" It was almost as though when I was out there, sure, I won't cut for stone, you know. But I did cut for stone, as it happened, you see. You know, you're not supposed to cut for stone, according to Hippocrates.

SIMEK: I'm unfamiliar with that portion of it, when you say cut for stone.

GOODWIN: Well apparently it had to do with cutting for kidney stone. That is what people think. I don't know what he really meant. Cutting for stone. Cutting for stone may have been, never mind, no, my imagination's now running rampant. I don't know.

But again, I think it's just, it's five thousand years old. Are we going to be tied to that forever? No. Not me. Not most people.

SIMEK: There are not many states that used the Hippocratic Oath in its original form anymore, are there?

GOODWIN: No. No. Matt, I want to say something about the issue of why this hasn't succeeded in other states. And the reason is obviously there's a significant proportion of our population who are opposed to this. To that, there is no question. On whatever grounds. Moral, social, ethical, religious. I respect them all. And I also respect the right of any organization to support its belief systems. When these organizations are extremely powerful, they have an overweening influence on what happens. And that has happened. I can give you examples of how the process has been distorted by underhand techniques. By really nasty, nasty videos that have been broadcast on television. Really, really misleading, nasty videos. And I can also tell you, because I have personal experience, of how beliefs influence, this is just such wisdom that's coming out of my, this is original, okay? How beliefs influence one's perceptions.

And I know of a marvelous example where a physician who is in a very influential position, is committed to opposition to physician-assisted suicide, as he calls it, will describe the death of a patient or the terminal care of a patient, in ways that are totally untrue. But he's an honorable physician. I know them to be untrue because I tended this guy at his death, you see? And I thought, what? When I heard about this, I thought wait a moment. If I remember rightly, this was the primary care physician who turned this guy down when he asked for help in dying. And I looked back at my notes, and there was his name. And he's making all sorts of claims about the terminal care. I could go into so many details about this case. But it was so revealing to me that these people have huge influence because they speak so righteously. And some of them are righteous. Some of them are nasty bits of work, really nasty bits of work. I can mention a couple of names, but I'm afraid of the libel laws. But some of them are really nasty and liars. And they are liars from beginning to end. I'm sure that this guy is absolutely sincere. And he wrote a scathing letter about this case to one of the legislators who was considering aid in dying legislation. It was a scurrilous letter. Because it was so untrue. But I bet my bottom dollar that he wrote with absolute conviction.

SIMEK: This was an Oregon physician?

GOODWIN: An Oregon physician. He wrote to the legislature elsewhere describing this case, describing why it was such a travesty. And here I am, I was there, man! I was there with his family! There was not the slightest evidence of the claims that he was making so righteously. It's just amazing! When I saw it, I thought man, now I understand. And in fact, I have called this physician on several occasions and said, "You know, I'd love to talk to you," because I respect this, I really do feel that he, unlike some of the others who I've interacted with, is actually a good guy. But he refuses to meet with me because he has a position of authority on the other side.

And I wouldn't be critical of him. I really wouldn't, Matt. I would say to him, "Look, let's sort of talk about what happened."

SIMEK: And how do you think that would go?

GOODWIN: Well, I don't think it would—you know what I think would happen? You know, I have talked to physicians, I mentioned one earlier, who to me, in private, basically said, "I've changed my mind about this. I think the patient should have the right." Who never go public. But I don't know what would happen. I think we would have a very interesting discussion. And I would acknowledge, I promise you that I would acknowledge exactly what I've told you, that I believe this guy, unlike so many of the others, is truly an honest guy. But, you know, he's in an environment where religion is hugely important, and where power is hugely important. And I don't think that he's in a position to reverse his role.

SIMEK: Well, several questions come to mind. And one of them is the 51 to 49 vote. And I'm curious as to what you think that indicates. On the one hand, there are those who say, well, that indicates that the majority of the physician community really just has no opinion on it. And I'm curious if it might mean that a good sizable amount of the physician community may have a position on it but are unwilling to say so. So I'm wondering if you have any sense of the underlying feelings of the medical community beyond that vote as to, is this a deep, serious issue with the community, or does the medical community think we already have measures in place, whether we have it or we don't have it doesn't really make all that difference? But if the people want it, then okay. If the people don't want it, then okay, we'll still continue with what we're doing. What is your sense of what that vote meant?

GOODWIN: Well, it was 51 to 49 vote by the people.

SIMEK: Oh, I'm sorry. I thought this was the medical association vote that you were—oh, okay.

GOODWIN: No, the medical association accepted the recommendation of the committee. And unanimously. There was no opposition. Which was so astonishing. You know, they just simply said, yeah, okay, that's the way it will be. The reference committee came back with that recommendation.

SIMEK: The newspapers reported that as a change. The OMA opposed physician-assisted suicide before. And now the OMA has no position on physician-assisted suicide, which is a change in position, they reported.

GOODWIN: Yes!

SIMEK: So did that affect the campaign?

GOODWIN: Well, I think it did. I think it was hugely favorable. And you know, in 1997, the OMA House of Delegates voted to support the initiative from the legislature, which would have canceled the initiative. That was in 1997. And I'll tell you, I went to that meeting, too. Man, when I think about that meeting now, I can't help but, I mean, it was so, I'll tell you what happened. The opposition basically stacked the House of Delegates. And the resolution was simply bizarre. It was a pack of lies. The "whereases" were just a pack of damn nonsense. And for the medical profession to accept them after what had been going on for three years, I thought was ridiculous, you know? And I really didn't take the resolution seriously.

I went down there. They'd packed the House of Delegates with their supporters. And I spoke in opposition to this resolution. And I was, first of all, there was so much nonsensical evidence that I asked to give a second statement in refutation. I was shouted down. I never got another opportunity to respond. And so they passed the resolution supporting the legislature. And what happened? They got licked 60 to 40. Because nobody then gave them the credibility, that was the thing. It hardly stirred, it hardly stirred any comment from the press about the fact that the OMA had changed its mind. And that is the sort of pressure that can be exerted by our opponents. I mean, they are so much better organized than we are. They've been organized for a lot of years, you know. [laughs] And they have lots of resources.

And so it was, I think, and the amount of misinformation that is still being spread about the Oregon law. I don't want to compromise people who are in a position where they are experts in the field, and they know how the information is being distorted, and they also acknowledge that they simply don't have the power to change those perceptions, because those perceptions are being pushed by very powerful elements. It's not whether they are good or bad or right or wrong, they are powerful.

[tape change]

SIMEK: This interview with Dr. Peter A. Goodwin was made possible by the Oregon Health & Science University Oral History Program, and conducted at the Oregon Medical Association in Portland on the morning of June 4, 2008. The interviewer is Matthew Simek. And we're now on tape three of three.

GOODWIN: Oh, wow, let's hope so. [laughs]

SIMEK: This is really a wonderful interview, and I appreciate you taking the time to talk about all of these things in so much detail. It's marvelous. I think where we left off, I wanted to ask you about the various campaigns in various states. And one thing that was brought to my attention was that this obviously has an intellectual component. And of course it has a huge emotional component, and a religious, moral, ethical side to this. But when you debate this in a political forum, it becomes an argument of sound bites. And the more effective of those is not on the intellectual plane, but on the emotional plane. Much as the political campaigns for public office. That those that seem to be the most effective are those that stoop to the emotional sound bite, rather than any

intellectual debate on policies and so forth. And I see that that possibility happens here in other states that are looking to what Oregon did.

And a couple of things I wanted to ask you about. One of them is how did you address the problem with arguing against an emotional campaign against you? I mean, how did you deal with that when it was a concept, an idea that you wanted to get across, and yet you were being bombarded by the emotional/religious side of why this is a terrible thing.

GOODWIN: Well, it's really interesting. I'm laughing because of the tension there was between me and the other members of the committee around the 1994 campaign. Because they wanted me to avoid the word "suicide." And they felt that this was not suicide. This was so different from suicide, in every parameter. And I felt that it was such a well established phrase within the medical community that to fight against it would be in vain, it would just turn people off. So I stuck with "physician-assisted suicide" in talking with the medical profession. And now I regret it tremendously. Because that is such a colored phrase. It's like them talking about us "killing" or "allowing killing." And they do. They talk about us killing patients. And one can only argue from a rational point of view. And I think that the, it's the whole point about aid in dying is that it is a rational argument. So I felt that we had to stick to rational arguments. And so when they talked about killing, I said, my response was, "Killing? Nobody's using a gun. It's ridiculous to talk about our killing. These are patients taking some medication which we have prescribed according to a proposed law. This would be legal behavior. So what is wrong with it if it's going to be legal, and if it's going to be supported by the electorate?" So that was one of the arguments that we used.

And so I would like to emphasize the fact that I have always thought of this as a rational response to a medical problem. And it is the most, it is one of the deepest medical problems. Perhaps the deepest medical problem is how to deal rationally with terminally ill patients.

SIMEK: What do you think in that campaign was the deciding factor? How did you address it so that the electorate would understand and vote for it?

GOODWIN: Well, I would say, I think, again, emphasizing the rational. See, in 1994, when pain and suffering were still very much a concern of the terminally ill, of patients and of the terminally ill, we emphasized pain and suffering. We said, it's terrible that dying patients should suffer so. By 1997, things had so changed that to emphasize pain and suffering would have been sort of not quite irrational, because there was a lot of, still, of pain and suffering. But it was a much less pressing issue. So we emphasized then the issue of patient rights. We should not allow the legislature to determine for you how you're going to die.

And the other argument we used, again, was a rational argument saying look, the evidence proves that our opposition are using distortion in talking about all the terrible tragedies that are going to occur using this medication. The evidence just is not there.

And we had people from Holland giving us testimony about how misleading that information was.

SIMEK: Have you been asked to be an advisor to other states?

GOODWIN: I have volunteered to be an advisor to other states. In fact, I have said, let me go. I have not yet had that opportunity. And I truly don't know why. Maybe, perhaps, because I come across as too emotional. I just don't know. But the powers that be, Compassion & Choices, the national organization, has not seen fit to use me in that way.

SIMEK: Were you involved in fighting off the national campaign by our United States attorney general some years ago?

GOODWIN: Oh, yes. I was very much involved.

SIMEK: How did that unfold?

GOODWIN: Well, it wasn't a very active role. We had attorneys representing us before the courts. I was one of the chief petitioners. I, Eli Stutsman and Barbara Lee were the three chief petitioners petitioning the courts to overturn that verdict by Judge Hogan.

SIMEK: And I'm speaking of our Attorney General Ashcroft.

GOODWIN: Yes.

SIMEK: Oh, and that was—

GOODWIN: Yes. That went to the Supreme Court. I think that that was, I don't think I was involved with that at all. I think that there were so many amicus curiae briefs on both sides, of course.

SIMEK: So when you were talking about district court, you were talking about U.S. District Court in Eugene.

GOODWIN: That's right. In Eugene. That's right.

SIMEK: Oh, okay. I was thinking Oregon district court.

GOODWIN: Oh, no, no, sorry, I think I may have misled you because I didn't emphasize it was a federal district court. That was Judge Hogan.

SIMEK: And then it went to the Ninth Circuit.

GOODWIN: Ninth Circuit.

SIMEK: Which would be in San Francisco.

GOODWIN: That's right.

SIMEK: Yeah, okay. All right.

GOODWIN: And they heard the case here. It was a two to one majority decision by the Ninth Circuit. And then the opposition asked to have a full, a panel. And I believe that the Ninth Circuit turned them down.

SIMEK: What is your prognosis for other states adopting similar legislation?

GOODWIN: I think that it will take time. But I think that change will occur inevitably. In the same way that Holland was the pariah, now Belgium has adopted similar legislation. And there's a movement in Western Europe moving in that direction. Now, you know, when I say that, Matt, then I think about the world in general. And I think to myself, how is the world moving? You know, I think the world is sort of consolidating its religious beliefs in response to threats from outside. In other words, the Christian Church is beginning to see a huge threat from the Muslim hierarchy or whatever. And so religious ideas seem to be hardening. And so that may have an adverse influence on anything that seems to encroach upon a religious belief system.

SIMEK: We probably shouldn't go there, because I'm so mystified by that whole area of in Islam, suicide is just absolutely forbidden, and yet there are suicide bombers every day.

GOODWIN: That's right.

SIMEK: So it's a mystery to me.

GOODWIN: [laughs] It's one of many. One of many.

SIMEK: Yeah, how the thinking goes. Is there any area in this that we haven't covered that you'd like to? In the physician aid-in-dying?

GOODWIN: Well, there are many issues that we could further discuss. But they are issues that have been raised: you know, the fact that physicians might be making a profit from this. Well of course the physicians don't. I mean, this is just a nuisance for most physicians. A real nuisance. Because it takes a lot of effort. It takes a lot of time. The administrative hurdles that physicians have to jump are significant. And so when physicians are asked for aid in dying, the law itself is in fact a hurdle. So Compassion & Choices of Oregon has set out to be of as much assistance to physicians who are asked to aid in dying as it's possible for them to do so. So they do help administratively. And they do help in sort of educating physicians about the requirements of the law, and how most easily and most effectively to meet those requirements.

SIMEK: So for those who may charge that this is a cavalier or a casual thing for physicians, it is not.

GOODWIN: Oh my goodness, it is certainly not a casual, easy process. Not at all. In fact, you know, there's no doubt that the law is a hurdle to many physicians, and therefore to many patients. There's no question in my mind. The physicians would much, particularly physicians who are not familiar with the law, they don't want to get involved. Not in any which way.

SIMEK: So it takes a dedicated patient to see this through.

GOODWIN: And a dedicated physician as well. A physician who really, I think, understands the importance of this issue to a patient who wants this option. And to just brush it aside because a physician is in a position of power, I think, is arbitrary. But I think it's frequently done. It's not done arbitrarily. I don't think physicians do it arbitrarily. But the outcome is arbitrary.

SIMEK: I have a few more questions in other areas I would like to pursue, if you're ready to do that.

GOODWIN: Sure. Without a donut, I don't think I'm going to manage.  
[laughter]

SIMEK: Maple bars, please.

GOODWIN: Okay. Let's go.

SIMEK: All right. And if you'd like to come back to anything we've talked about, we can do that. This is not a linear process. We can jump around if you'd like.

GOODWIN: Okay.

SIMEK: Let's see. You answered that. We talked about specialization and fragmentation. One thing we sort of skipped over is why you protested full time ER doctors. I remember you were pretty active about that.

GOODWIN: It was because I felt it would fragment my relationship with my patients. What could be more holy than my patients? [laughs] That was it. Because you see, in Camas, what we used to do was we had a night call. If there was an emergency to handle, we'd handle it in the office. Putting in sutures, we did it all the time. You know, even putting casts on, we did that all the time. Doing minor surgeries, we did that all the time. I used to do vasectomies in the office.

SIMEK: On an emergency basis? [laughter]

GOODWIN: What a cute thought! Yeah, with the wife protesting next door. [laughs] Sorry. I lost my train of thought. Oh, about the emergency room. That was the emergency room issue. So we used to go down at night if we recognized a patient, we'd just go down. If we didn't recognize the patient, we might call the police in Camas and say, because we knew most of them, we'd say, "Look, I'm going down to the office. It's two AM. Why don't you just drive a van around and just rattle the door. Just to be certain that we are safe." And they did. It didn't often happen, but they did.

SIMEK: And would this be because of drug-seeking patients?

GOODWIN: That's right. Yes.

SIMEK: So it was to preserve the doctor/patient relationship. Now you also had an involvement with workers' compensation. What was that?

GOODWIN: Oh, yes, yes. I did. What happened there was that when I left Camas to join the faculty, the mill manager of Crown Zellerbach, which had a dominant role in the community, asked me to be their industrial physician. And so as part of that role, I became involved with occupational medicine and industrial medicine, and then with workers' comp. And because there were lots of injuries, of course. And I tried to sort of have a preventive role. So I would sort of go around the mill, look at certain things and make suggestions. Sometimes just to be at the mill and see something happen was just amazing. To see some of the really physically stressful jobs. So it was helpful. And it was really a learning experience for me. It was very valuable learning experience.

And I remained very interested in industrial medicine and occupational medicine until probably, almost until the time that I retired. And I was involved for the short term in OHSU with a committee that was organized to try and cater to occupational medicine injuries. So they would have that resource and actually sort of make some money out of this. That didn't really get off the ground, not really well, anyway. And I was, you know, obviously at OHSU I was involved with other committees. I really enjoyed those experiences. You know, I was on the admissions committee for a while. I was on the surgical case review committee, as it was called at that time. And in fact, as a family doc involved with family medicine, for one year temporarily I was the chairman of the surgical case review committee. Reviewing surgical cases around the institution. It was really quite amazing. It didn't last long. But it was fun while it lasted. [laughs]

SIMEK: Did you feel that your surgical practice was a little out of date when you were doing that?

GOODWIN: Yes, it really was. It really was. Oh, yeah. It was a question of really of asking questions, really, of criticizing. And so I thought that my role was an appropriate one for a while.

SIMEK: I would imagine that you had quite a reaction to the advent of managed care in the '80s.

GOODWIN: Yes, indeed.

SIMEK: How did that unfold?

GOODWIN: Well, initially, very favorably. The emphasis on a hugely important primary care role, as we thought, regulating medical care. And regulating it in a positive sense. In other words, making it less wasteful, making it more responsive. We felt that was a great idea. We were very much in support of that process.

But it rapidly became, we rapidly became aware of the fact that family medicine was being used by the insurance companies in order to decrease their costs. You know, I have a marvelous example of that. My brother is a family doc who also immigrated to the States, and was in Virginia. I won't tell you what town he was in. But he was involved with the start of primary care, you know, sort of organized by the insurance company locally. The first year, he got a bonus, believe it or not, of some tens of thousands of dollars because his care of patients was so less expensive than others. Because he was like me. He used to talk to patients. When a patient came in with a tension headache, he didn't send them for a CAT scan. He said, "Look, I think dah, dah, dah, dah. And I want you to come back in a week or ten days and I'm going to see how things are going." So he saved them a lot of dough. So he got tens of thousands the first year. That was all. The next year, it was \$642 bonus. You know? [laughs] So they squeezed down. And so, coming from the insurance companies, I think it was doomed to failure. And still is doomed to failure.

SIMEK: And yet you felt that medicine was overboard at some point. I'm remembering your story of your rugby injury as a young man.

GOODWIN: Oh, yeah.

SIMEK: Tell that story. I think that tells a lot.

GOODWIN: Well, I'm not saying that that was a reasonable thing to do. Because if that happened to me today, or to a grandchild of mine, I would not have approved of that care. But what actually happened was that I was knocked out playing rugby. And my recollection was of coming around. I can remember exactly how it happened. So I may not have been knocked cold. Or I may have recollected what happened. But anyway, my recollection was that I was knocked cold. I was on the ground. I felt incredibly dizzy. I got up, I sort of staggered around. I think maybe somebody might have helped me. But there was no actual interruption of the game for any length of time. I was the fullback, so I was the final defensive player. I continued to play. By the end of the game, I had a headache. I took the bus downtown and took the bus up home. And by then, I had a real, real headache. My mother got alarmed, she called a doctor. I must have seen a doctor three times in my whole childhood career. The doctor came to my house, examined me carefully, said that I would be all right. And I recovered, started rugby practice the next week, and continued to play. That was what happened.

Now I'm not suggesting that that would have been ideal. In fact, if I had been properly treated, the coach would have come onto the field, would have taken me off the field, I would have been observed, I would have got a headache, I would have gone down to the emergency room, I certainly would have had a CAT scan. So again, the developments, sometimes, are hugely positive. Now I got better because I didn't have a cerebral hemorrhage at all, or not a big enough one to influence my emotional well being.

SIMEK: But you did have a concussion.

GOODWIN: Yeah, I certainly did have a concussion. No question. And that happened one other time, with very similar consequences. And so I don't know where the rights or wrongs of things are. Obviously things progress, and with everything else scientific, there is a huge amount of good, and a huge amount of sort of like perversion of the advances. So everything becomes much more expensive. Partly because it needs to become much more expensive, and partly because there's a wastefulness that comes from thoughtlessness. It comes from inadequate clinical care, inadequate time in assessing patients adequately. But I am in no way, you know—technological medicine is, I mean, I'm alive because of technological medicine. Otherwise, I would not be alive.

SIMEK: In what way?

GOODWIN: Well, I had a lymphoma which developed in 2001. Well, if I had that lymphoma develop in 1969, or 1974, I would never have survived. And my wife would have been left with four young kids. And what a blessing it was that I didn't get it until 2001. And here I am, cured! So my goodness gracious. I mean, technological care is just crucial. But it develops so quickly that it can't be available for the total population. And that's why basic medical care is crucial. And it needs to be provided by some sort of low level, and I mean low level technologically, technologically low level care. But the vast number of people with low level care will recover from almost everything they get. You know, if you have a strep throat, an antibiotic will fix it. You don't have to go to the emergency room. You don't have to go to a consultant in pediatrics or an otolaryngologist. And nor do you have to have your tonsils taken out.

SIMEK: I get the feeling that in this day of technological possibility that people more easily overlook the body's natural ability to recover.

GOODWIN: I think that's true. I think that's true.

SIMEK: And they think that intervention is required in all cases.

GOODWIN: Yes. Yes. And I think that's true, that has always been true. It has always been true. In Queenstown, I used to get patients coming in from local communities. And I'm going to tell you a different story. In Camas, the patients used to come over from the mill and say, "Doctor, I've got a sore throat. I need a shot of

penicillin.” And I thought what are they talking about? A sore throat? They’ve got an upper viral respiratory infection.

I said to them, “Look, in Queenstown, before I left, I gave a good friend of mine penicillin shot because he had a strep throat. And he almost died in front of me from an anaphylactic reaction. You are not going to get a penicillin shot from me for a viral upper respiratory infection.”

Well, it took about six months, and that business of taking penicillin shots for a sore throat disappeared from up there. The story got around. You see? And that’s a good illustration of how technology can be abused.

SIMEK: Plus, it works against itself when you develop resistant strains.

GOODWIN: Yes, exactly so, exactly so. And the whole idea about you’ve got a virus infection so you develop a bronchitis. So the doctor said, “Oh, you’ve got a bronchitis. Here’s an antibiotic.” Well, it was totally unnecessary for the vast majority of people. If your health was not otherwise compromised, you did not need an antibiotic. And yet it was absolutely common behavior. And that is one example.

And then you go up the scale. And I think the same thing is true. But again, it’s a very difficult issue.

SIMEK: Do you see the family practitioner as the gatekeeper for technology?

GOODWIN: No. I see the family physician as knowing his patients. Being anchored in a community of patients. However that may work out. And therefore being in a better position to assess the necessities that are presented by that patient. And then to refer freely, to refer freely. Whenever you’re in doubt. And I used to tell the residents, I said, “In primary care, the diagnosis is often not the primary consideration. The primary consideration is assessment of risk. How much risk is there, and how are you going to deal with the element of risk?” So, you know, the child has upper respiratory infection and has a little bit of an ear pain. Should you give an antibiotic? Where’s the risk in giving versus the risk in not giving? Okay. And I mean, that’s a very simple example.

A patient comes in with chest pain. You take a history. And the chest pain seems that it could be cardiac. You can’t mess with that; that has to be assessed. But if a patient comes in and says, “You know, Doctor, I’ve had this pain in my chest. It seems to be here, or it seems to be in the back. And when I play tennis, it comes on for a minute or so. And then as I warm up, it goes away. And I never get it under any other circumstances. I mean, I can climb hills up the wazoo. I climb mountains. I never get it.”

I would have to think to myself, wait a minute, what is really going on with this guy? Is this coming from his spine? Is it possible coming from his spine? Is it possible that it is cardiac, but atypical? And then having, sort of having assessed risk here as a possible diagnosis, then you’ve made, then having assessed the risk, you say, “Look, I

can't mess with this. I'm not sure. I think we need to check out the heart and then we can deal with other issues."

Or you might say gosh, the story is so atypical, and this guy did have an injury to his back four or five years ago, he just told me. And the pain seems to be similar to that. And he can climb mountains! There can't be anything wrong with his heart. He doesn't have a family history. He doesn't smoke. I know his cholesterol is okay. So I might say, "Assessing all those things, I think this is muscular." But the risk has been minimized by my thinking, by my doing some extra tests and then coming up with the idea no, this is not cardiac. Certainly not cardiac. And that's what a good family physician could do.

SIMEK: Well one of the things about medicine is that you learn from others. I wonder who are the movers and shakers in your world who provided the influence to you and the training to you, who you respect as the real influences in your career.

GOODWIN: Well, I think there are so many. But the interesting thing is that in some ways, they were helpful, and in some ways, my teachers were a real hindrance. The idea of hubris, you know, the idea of knowing it all and things don't change. I mean, I had some course directors at medical school who were abominable. And I had some, the two professors of medicine were great. They really taught me clinical skills.

More recently I think, and I have been reflecting on this. And I would like to mention two names. One is Dutch Reinschmidt. Dutch was just a marvelous guy. He was an internist who was so immersed in the benefit that primary care could offer. And did so much to educate primary physicians around the state. I mean, he was, by himself, he was an institution. And I, for several years, for quite a few years, helped in the development of the primary care refresher course. And it was such a wonderful experience with Dutch. Because Dutch was not just wonderful and innovative and constructive. He was also avuncular. He was such a nice guy to be with. Really was a nice guy. I loved that relationship. And I remember when his son died, what a tragedy that was. And then—

SIMEK: Did you travel with Dutch?

GOODWIN: A couple of times. A couple of times. And I traveled by air on one occasion with him. That was to Pendleton, I think. Yeah, that was fun.

And then I think Bob Taylor, who became the chairman of the department, was a wonderful inspiration. He was just exactly what the department needed. A guy with standing, who'd established himself as an expert in a very different environment. I mean, he really was an innovative and creative guy. And he was just wonderful for the department.

And in a sort of a slightly perverse way, I think Susan Tolle has influenced me. Because in her early years, I think when she was still a resident, she was also aware of the lack of insightful care of the terminally ill. And that was, that started her on her career as an ethicist. She went away to Philadelphia or somewhere and did a fellowship in medical

ethics. And I think that she has been wonderful in remaining neutral as far as the law is concerned. But still being objective. You know, so she wrote a couple of articles examining the law, and so explaining its impact. In an article after the 1994 ballot measure passed she described the results as a “wake up call” to the medical profession. She wrote another article about what had happened as a result of passage of the law. And she acknowledged that healthcare for the terminally ill had improved tremendously, partly because of the influence of the passage of the Oregon Death with Dignity Act.

And so, you know, and in a sense, those two articles, from a totally independent observer, who had to be totally independent, I think—I’ve acknowledged, I recognize those as some sort of validation of the act and of my involvement in it.

SIMEK: Another person in family practice, Lowell Euhus.

GOODWIN: Oh, yes. I know Lowell very well.

SIMEK: React to him.

GOODWIN: Well I think he was the, he was emblematic of a family physician who really gets involved in his community and provides the sort of care that that community needs. So he was an insightful physician, and he was also a very practical physician. And those two, those combinations really served his community very well. I mean, he’s isolated and he’s provided a lot of care, wide range of care.

SIMEK: Sort of a man after your own heart, the rural physician.

GOODWIN: Yes. In fact, Lowell and I used to compare our experiences. And I must confess that I was, in a sense, envious of Lowell. Because Lowell was a lot more insightful in his environment than I was in Queenstown. I was, of course, a lot younger. But he made me think of what might have been.

SIMEK: Speaking of what might have been, you said that you felt that one of your early lackings was in public health.

GOODWIN: Yes.

SIMEK: And one of our mentors was Harold Osterud.

GOODWIN: Yes.

SIMEK: And can you talk a little bit about Harold?

GOODWIN: Yes. Again, I have fond feelings about Harold. Again, he did a lot of good things as far as public health is concerned. He was very insightful. He did a lot of statistical work about the distribution of physicians in Oregon and how it was important to have physicians in local communities, small rural communities, who could provide the

sort of care that rural communities needed. He was very supportive of family practice. And a nice, gentle guy. Really, he's not humble. But sincere, not puffed up. Is he still alive, Harold?

SIMEK: No. He died about five years ago.

GOODWIN: Several years ago. Yes, that's right. I remember.

SIMEK: Just a couple more questions and I'll let you get on with the rest of your day.

GOODWIN: Okay.

SIMEK: One of them is where do you think— malpractice has become a huge thing now, and liability. The people perceive their physicians differently now than they used to. And one of the results is that we're losing many specialties or semi-specialties from rural practice—

GOODWIN: Yeah.

SIMEK: Because of the liability issue. They don't do enough volume in OB/GYN, for example, to justify the enormous premiums in case of the one bad baby case that might come up. How do you think the doctor/patient relationship has eroded to the point where it's difficult for rural practice to maintain the skills they need?

GOODWIN: I think one of the issues is that life in our society has become so precious that any loss of facility is a real loss. And then patients look for some sort of recompense. And I think the second reason is the legal profession. Obviously they're wanting to make a living. And they're looking for cases. There's no question about that. And the ready availability and the publicity that's involved make it much easier for the patient to sort of regard it as almost as a right, you know? It's happened so often, why shouldn't I sue?

And you know, the other thing is that the public has been conditioned to expect a perfect result every time. And then, I think, obviously the lack of adequate communication and the lack of confidence by the physician in the patient, doctor/patient relationship. So in other words, the relationship is sullied. And then something goes wrong. And then the patient feels aggrieved. So again, trying to understand your patients as well as possible, and it's obviously not possible. I mean, the lady who sued me— [laughs] So there's no cure. And I think there are some things that could ameliorate this.

And then the other thing, of course, is the issue of expertise. You've got to say to yourself, I cannot do this in Antelope. Or something like that. It just is not something that I can cope with. It's not something that my small hospital can cope with. I've got to get this patient out of here quickly. So, again, sort of risk assessment might minimize that.

And I've been involved in malpractice on both sides of the arena. And each one of them has taught me something about the other.

You know, for example, being on the defense makes one realize that there are certain things that initiate the suit that might have been avoided. And I can give you many examples. I can give you an example of a patient of mine who suffered a terrible, terrible surgical result. And some months after the surgery, after a level of rehabilitation, she and her husband came to see me and I realized that they were angry. And so I called the surgeon immediately. I said, "Look, get your insurance company onto these people, and make sure they get what they need. Because otherwise, this is going to cost them millions." And it would have. I mean, she was totally disabled for life. And that's what happened, see. So again, there is some influence that we can exert. So that's one thing in the sense of prevention of the malpractice case.

On the other side, there are lawyers. I worked with a lawyer who was an absolute, he was, he so distorted the issues. And he was very clever. I thought, I'm never going to—and he was, I got involved with him almost by accident. He was actually on the—no, he wasn't on the defense side. I was on the defense side, and he was an adjudicator. And that's how I got to know him.

And then somehow he took a shine to me and he said, "I'd love you to look at this case." And I looked at this case, and then realized then that he was—and the trouble is that he won this case. He was so tenacious, and so sort of almost nasty. And I felt really bad about having been involved with that one. But some of cases I've been involved with on the plaintiff side, I sort of thought, this has got to be settled. This has got to be settled. And then you think to yourself, well, wait a minute, the defense attorneys get paid by time. So the longer these things can be stretched out, maybe the more they benefit. At times when I thought about the, sort of the obstinacy with which these cases were tested, was partly, very often, on the defense side. So, again, I don't know the resolution. All these things.

SIMEK: Do you feel that the current availability of an enormous amount of information to the patient through the internet and so forth that wasn't available before, or through advertising by the drug companies and so forth, has affected the doctor/patient relationship? And if so, positively or negatively?

GOODWIN: I don't have a lot of experience in this regard. But I would say again that the internet could be a hugely valuable tool. And many physicians are using it as a hugely valuable tool, in the sense of communicating with patients. And I think from that point of view, it's a great idea. And if patients have that sort of relationship with their physician, then I can only see the internet and additional information for the patient as being beneficial.

When the information is, as long as the information is appropriate. And it often isn't, of course. On the internet, it often isn't. But when it comes to drug companies

advertising, man, when I see these advertisements, I just get sick, because they are so biased, you know.

SIMEK: The purple pill.

GOODWIN: Yeah. The purple pill's a wonderful one. And the other one for prostate hypertrophy is another one. Oh, it sickens me when I see it. The implication is that if you have to go to the bathroom more frequently than you used to, that you need to see a urologist and get this medication. You know.

SIMEK: What was your relationship in the Department of Family Medicine at OHSU? Your relationship with the outside community.

GOODWIN: Well, soon after I joined the department, I got onto several OAFP committees, including the scientific assembly committee. And I was chairperson of the scientific assembly committee for several years. And so in that regard, I was fairly well connected. I think that there may have been physicians who thought that I should be doing this, that or the other differently. And then as president of the Oregon Academy, which I was for a year, I thought that year was sort of, to me, unsatisfactory. I didn't accomplish many of the goals that I'd set myself. And I think the problem was that I was seduced by other activities. And so I feel a little dissatisfied with that year.

SIMEK: Do you sense that there was still tension between family practice on the hill and family practice in the—

GOODWIN: Oh, absolutely not. Absolutely not. The department, again, Bob Taylor is largely responsible for this and John Saultz as well, the present chairperson. No. We are hugely involved with the Academy. And hugely influential. In a good sense. The chairperson, there were two chairpersons. Again, Laurel was very supportive. As he came out of practice in the state, he was very supportive of the academy, and had a close connection. But I think Bob Taylor and John Saultz have advanced the department, department's role, and beneficial role, with regard to the Academy. I think they're very tight.

SIMEK: One last question.

GOODWIN: Yes.

SIMEK: Based on your forty-plus years, fifty years—

GOODWIN: Yeah, fifty. More than fifty.

SIMEK: More than fifty. You've seen a lot of developments. What do you see in the future for family practice? Or for medicine in general. I don't want to limit it.

GOODWIN: Well, let me start with family practice, because I think that it's going to be hugely influential. I, see, I still feel that family practice should be the basis for any sort of rational system of healthcare, as it is in much of Western Europe. I mean, in England, in Holland. In Holland, family physicians are called *huisarts*. *Huis* is house, and *arts* is a specialist. So they're specialists in house care, care of the household. And I mean, that's a hugely significant word for them. And the same is true in Germany. You know, where family doctors have a huge, important role. And I think that it does hold costs down. Here our costs are twice as much as the average country in Western Europe. And our healthcare is thirteenth, or something like that, in the world. Those are the basic characters.

Now again, there are other things that influence that. There are certain populations that are less healthy than others. Take less good care of themselves. But still, thirteenth! We're not very good.

And so, I think the major reason is that our healthcare system is so fragmented. And the fragmentation comes from a poorly organized, poorly funded primary care system. The primary care system, I mean, it really does gall me that I never made \$100,000 in practice, never did. And then could look at consultants who did routine stuff. I mean, once you've done four cardiac surgeries, putting in a stent, how much more stress is there? I mean, I used to do a lot of surgery. The first hysterectomy was terribly stressful, the first prostatectomy. But then afterwards, they actually became fun. You know, there were times when I was having an emergency and a blood vessel escaped. And so you're really panicking like all get out. But generally, it was fun. We'd listen to music, we'd tell jokes.

Now I don't see why a cardiac surgery who tells jokes – often bad jokes – makes \$10,000 for every operation he does, okay? And I don't see why ophthalmologists can do eight or nine cataract surgeries in a morning and make several thousand from each, while I'm seeing patients and taking the primary responsibility for assessing risk, and then sending them to the ophthalmologist or sending them to the cardiac surgeon, I get \$120. See, I think that's not right. As long as this disparity persists, we're going to have family physicians who are really stressed time wise, and who are not going to achieve their potential in providing healthcare. I think it's skewed, terribly skewed!

SIMEK: It always strikes me how many people go to the emergency room for primary care—

GOODWIN: Yes.

SIMEK: —because they can't, they don't have access to primary care in any other way.

GOODWIN: Yes. And it should be automatic. That's why when I think about universal healthcare, I don't see it as government-controlled. I see it as institution-controlled. And the institutions need to be carefully set up. So I think some sort of

regional authority that has incentives built into it, for it to be efficient, and for the physicians that they administer to be efficient, and to have incentives to be efficient. And I think that with technology today, those sort of statistics could be readily apparent if we really set our minds to it. So you have a regional authority, say, for four states, or something like that. And those four states have some level of homogeneity. And then you can set up parameters for healthcare, which might be that our immunizations among children should be 95 percent. And if you get 95 percent in a practice, a group practice, you get a bonus of some sort. But if you have, if your incidence of back surgery is six times the average nationwide, then you need an incentive to do certain things to bring that incidence down. And that's it. Some sort of rationalization of healthcare on a large scale. But responsive. That's what I would love to see.

SIMEK: That's a wonderful place to end.

GOODWIN: Oh, thank you.

SIMEK: Unless we've failed to cover something that you would really like to talk about.

GOODWIN: Well, I have a joke to tell you. It's an old joke.

SIMEK: Please do it. [laughs]

GOODWIN: It's a really naughty joke. Is that going to be all right?

SIMEK: Yes.

GOODWIN: Well, it's a story about a telephone, and some of you may have seen this, a telephone call.

"Hello, is that Mrs. Jones?"

"Yes, it is."

"Mrs. Jones, this is St. Alban's Hospital. We've got some really disturbing, bad news for you. You know, Jones is a very common name. And our lab got two specimens, separate specimens, from two Mr. Joneses. I mean, mixed them up. And we don't know which is which. And one of them was positive for Alzheimer's. And one of them was positive for AIDS."

And the woman said, "Well, can't you do the tests again?"

She said, "No, we've dispensed with these samples."

And so Mrs. Jones says, "Well, what am I to do?"

So the voice at the end of the line says, "Well, what I suggest you do is you drop your husband off downtown. And if he makes his way home, don't sleep with him."

[laughs] I think that's lovely.

SIMEK: [laughs] Thank you, Peter A. Goodwin. This interview, and the humor, was made possible by the Oregon Health & Science University Oral History Program and

conducted at the Oregon Medical Association in Portland on June 4, 2008. The interviewer was Matthew Simek, who appreciated the joke. And this is the end of tape three of three.

GOODWIN: Oh, thank you, Matt.

SIMEK: Thank you so much, Peter. What a joy this was.

[End of interview]

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