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Berkeley, California

Oliver Goldsmith, M.D.

Kaiser Permanente Medical Care Oral History Project II
Year 1 Theme: Evidence-Based Medicine

Interviews conducted by
Martin Meeker
in 2006

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01-00:01:22

Meeker: This is Tape 1. Today is the 19th of July, 2006 and I'm interviewing Dr. Oliver Goldsmith for the Kaiser Permanente history of medicine project. And let's get started. And with these interviews that are afforded a little more time than some of the others I like to first get a sense of your background. And so perhaps you can begin by telling me when and where you were born and what your family was like if you can characterize.

01-00:02:00

Goldsmith: Well I think sometimes my family background plays into Kaiser Permanente frankly but I'm Oliver Goldsmith and I was born in Detroit, Michigan in 1938, August 13th. And both my parents were infants when they came to this country from Russia in the wave of Jewish immigrants and they first came to New York with their parents, they were babies. And ended up in Detroit. And I was born there. My father was a dentist. I think the only one of six children to graduate professional schools. And we lived in Detroit until about 1946 and my family migrated to Los Angeles. Three brothers. I was the middle son. And we came to Los Angeles in 1946. Moved to the west Los Angeles area and began a life in California.

01-00:03:01

Meeker: What drew your family to California?

01-00:03:04

Goldsmith: Actually it led to tragedy. My father was a dentist, did not like being a dentist, actually was a comedian by his own thoughts and had the idea that he would come to California and become a famous comedian. He was probably an unrecognized manic depressive in the forties and had some mania and some depression but ultimately took his life in 1947 after he failed to fulfill his dream. So the three boys, young children, I was six or seven, were blessed with a very sturdy mother, who was a teacher. A physical education teacher, who also liked Los Angeles and went back to teaching, worked hard, got a credential to teach, sold retail goods till she got her teaching credential. And was a very sturdy devoted mother of her three boys and all went well. All the boys went on to more or less successful lives because of this sturdy mother who stayed a widow and went on to work as a teacher and enjoy her life a great deal. Parenting three boys.

01-00:04:12

Meeker: Had she been a homemaker in Detroit or was she a teacher?

01-00:04:15

Goldsmith: Yes more or less a homemaker but when the tragedy fell she had been a teacher and so she had to take a couple years of school on the weekends in state colleges to get a teaching credential. And then actually continued to teach and enjoyed physical education, teaching physical education, physical fitness.

01-00:04:34

Meeker: Where in Los Angeles did your family --

01-00:04:36

Goldsmith: We first went to Westchester sometime just around the time the airport was starting, I remember orange groves and we moved to Beverly Hills, California near Westwood. She taught in the Beverly Hills school system. Like many parents she wanted us to have the best education she could afford. And so since she was becoming a teacher in Beverly Hills she got us into the neighborhood there across from the school and so we went to the grammar school. Then we went on. My family was a very musical family. All of us wanted to be musicians. And we grew up into high school as kids who wanted to be musicians. And ultimately my older brother became a schoolteacher and a part-time musician. I recognized I was only an average musician and continued to have it as a hobby. And my younger brother actually fulfilled a career as a professional musician. And then by that time I had a very good incident happened. And those 1950s, you could join the Army out of high school. My mother thought I needed some discipline. I wasn't a bad child, I was just kind of a musical kid, not studying as hard. Always loved literature, always loved to read books. Despite my academic mediocrity. And went in the Army. They had an opportunity to go for six months and then reserve duty for seven years. I went in the Army. I went with a bunch of friends, like camp almost. But I --

01-00:06:02

Meeker: Upon high school graduation?

01-00:06:05

Goldsmith: Yes at 17.

01-00:06:07

Meeker: 1956?

01-00:06:08

Goldsmith: 1956, exactly. Went to Fort Ord, northern California. I think it's closed now. But I went there and was an infantry kind of a guy and absolutely hated it but it did the trick. I wrote letters home to my mother that I'm going to become a physician. I wasn't particularly interested in science, I was interested more in trying to be successful in the family, and --

01-00:06:33

Meeker: Whatever gave you a sense that you could become a physician?

01-00:06:36

Goldsmith: Well I have always felt about myself a sense of confidence that I can do what is necessary to do to accomplish a goal, whether it's organizational or whether it's personal or whether it's family. So I come from a sense of discipline. And I felt that I didn't need the Army sense of external discipline upon me. In fact I resented it very greatly. I had an internal candle that I felt was lit and so when I came back out of the Army I decided to go to college. I was a mediocre high school student. In those days you could go to junior college for almost an hour and show your stuff. So I went to Santa Monica City College. You can go for six months in those days. And get all As and all that and get into UCLA. Nowadays you can't do that as readily. So I went, my brother was very competitive with me, we were very competitive brothers, three years apart. He decided to major in English literature because I carried a famous literary name, Oliver Goldsmith, and I liked literature. I want to be a doctor. But I said I'll just major in English literature too. Compete with him.

01-00:07:52

Meeker: Your brother is three years older than you.

01-00:07:55

Goldsmith: Yes and I'll take all the science courses. He too wanted to be a doctor and we kid around to this day he took I think five minutes of chemistry and went into teaching high school Spanish, languages and literature. And I continued to matriculate through UCLA as an English literature major, which I'm very proud of, and I'm very interested in literature, and then I moved on to medical school at UCLA. By then I was back in the mainstream of students moving through professional school. Graduated UCLA 1964 and then I went --

01-00:08:34

Meeker: In medical school.

01-00:08:34

Goldsmith: In medical school. Graduated '64 UCLA so '60 to '64 was UCLA medical school. And then I was trained there as a resident doctor for the next four, five years, finishing my training in 1969, June of 1969.

01-00:08:51

Meeker: That's a very good quick overview. I'm wondering, maybe we can linger on a few issues that you brought up. In particular in interviewing or reading the interviews from the previous phase of the oral history project and interviewing a lot of primarily doctors in this phase, a lot of them actually have a very similar background to you. Midwest birth, Jewish background, family or eventually they migrate out to California or to the west coast. I don't necessarily have any comment on that other than to point it out.

01-00:09:29

Goldsmith: Well, it's interesting. I understand it. There's a couple lighthearted things to share with you about this. One is why do so many doctors like myself have such a fascination with music and often say they play piano and violin, and the lighthearted comment I say is it has something to do with their mother by the way and it has to do with until they were 16 their mother said practice the piano. At 16 their mother said I have another idea. There's another reason for this too. That I'm married to a woman, a non-Jewish woman, who comes from a Lutheran background, a Germanic background. And so in the Lutheran -- in the German family I should say there seems to be a culture of to the mother to the children make me proud, that means home, church, children, kitchen, there's three Ks, I can't -- I don't speak German. But it's an internal if you -- are you German background at all by the way?

01-00:10:30

Meeker: No.

01-00:10:30

Goldsmith: But there's a -- the Jewish mother at least in the tradition I grew up -- go out and make me proud. Do you see what I mean? So and then I did inherit very proudly this sense of get the job done, take on responsibility, carry out what you're assigned to do in life, at least to the degree I've been tested. One never knows what you can do or have to do. But so it's straightforward to me as I think about, that my life in that regard, and then when I project ahead, if you ask my brothers who's the father in this fatherless family they all say Oliver. If you ask what did I become, I became a doctor.

01-00:11:21

Meeker: You said they do say Oliver?

01-00:11:22

Goldsmith: The two guys would say Oliver. And then the next -- this is all romanticized stuff, OK it's not necessarily true, but it's acted out that way when my brothers have had tragedies in their lives and things like that. When I became a doctor it's a father figure if you'll allow. I was drawn to that. I absolutely love being a doctor. It was an accident of choice but I love being -- it's like someone saying I chose piano and I love piano over all other instruments. How did that happen? Could have assigned me to trombone. I like being a doctor. It works for me. And then my wife, who is the daughter of a minister, who was a fatherly figure, was attracted to another fatherly figure. Although we're the same age and all but so and then what happened in the medical group, which will be subsequent discussions, is I became the head of the medical group, go to Oliver. If that isn't a definition of the father, I don't know what is. OK although we're different. So my life has been that. Now I find myself in another company that's actually very much in need of an orderly process, someone at the head of the table if you will, and we're doing it again. It's been my theme. So it all starts with my mother.

01-00:12:48

Meeker: Well it's a question of leadership then as well. And ways in which the leaders conceptualize the meaning of that.

01-00:12:55

Goldsmith: I've always felt by the way that -- I think I coined this in the book I tried to put together -- that I use two terms. Management is what I do. Leadership is a perception of someone else. I don't usually -- I'm not comfortable saying I'm a leader. I realize someone's thinking of me as that so I guess I am but I'm a senior manager, I'm a -- I don't like boss because that's not what doctors use, but I'm trying to manage this thing. I know that I'm called the leader. But leadership is something someone says about me. But it does have certain attributes I think that have been studied.

01-00:13:37

Meeker: People see one as a leader only after that individual has accomplished some competence in the process of management.

01-00:13:50

Goldsmith: That's what I'm saying. And the minute the person sees himself as the leader I think he's in peril of self-delusion.

01-00:13:59

Meeker: It's interesting, and I'm not a psychologist, maybe this is just ways to start thinking about things as we get started here, but this notion really is leaders are not really born or for that matter leaders are not put into place and out of that act achieve legitimacy. Rather they have to have achieved legitimacy through their actions, through earning that position essentially.

01-00:14:30

Goldsmith: In the eyes of others.

01-00:14:32

Meeker: In the eyes of others, which maybe one could see how you develop that particular understanding through your familial experience. The natural leader of the family who was born into that position, the father, didn't -- wasn't able to fulfill that for a number of reasons. And it was the mother who came along and proved herself essentially.

01-00:15:05

Goldsmith: Right, right, right, I was trying to think of something. As you said that but I see it that way as I look back. And when we get into the discussion of leadership inside of Kaiser Permanente you will hear me frankly comment on some of this stuff because it's -- I'm not much reading of history, I read some history, but I happened to pick -- there's a four-volume Flexner I think is his name, history of George Washington, biography, maybe you know it. I was actually --

01-00:15:33

Meeker: He's a famous historian.

01-00:15:35

Goldsmith: Yes I was actually only interested in book one, which I read, I found it in a bookstore for five bucks, and it had to do with Washington long before he was President. Because I was interested in what his attributes, upbringing, parents, things like this, were that accounted for the genius of George Washington, because no one would say he wasn't a leader. I mean I suppose someone could. I certainly think of him in awe. Where did he get these ideas of, "I don't want to be king, I'll only serve two terms, screw the Europeans, we go west, take on the British," all those kinds of ideas. How did -- he had this by the time he was 16, 17. Must have got it somewhere in his experiences.

01-00:16:19

Meeker: What'd you learn from the biography?

01-00:16:24

Goldsmith: Hardship, I think he had a moderate amount of hardship. He was actually -- he married into wealth I think but I don't think he was wealthy. I'm testing my memory of the book. But hardship, hardship. A keen sense of himself was acquired early on. I believe he had a keen sense of himself. Which then he didn't do what others did. For example at the time you went to Europe, Ben Franklin, I mean don't ask, you're the historian, Martin, you're going to trick me here, and I'm going to say --

01-00:17:00

Meeker: No, I'm not here to test you.

01-00:17:00

Goldsmith: No but I'm just kidding. [laughter] I'm not posing that. But I think early American leaders went back to Europe for their fountain of knowledge OK, but George Washington didn't. He went west. He said, "We need to build the Erie Canal," before anybody. He didn't succeed at it but he knew we did. Because we needed to get west so the French wouldn't come down into the Midwest or the weirdoes that went west wouldn't become a different country. He had that sense of things. So he could go against the grain. I thought he was comfortable with himself. OK and his biggest thing was I don't want a third term, he would have been a king. And that changed everything in American history, OK, that I don't want to be king, only FDR stayed on. I don't know that history well enough to talk about. But so --

01-00:17:54

Meeker: Well that was in 1940.

01-00:17:55

Goldsmith: Yeah that's right. I learned by reading that that I think hardship tests you, perhaps parent, I can't say much about his parents, but he may have been orphaned early, as I think back, and had an adopted father, stepfather, but certain family experiences. I'm sure genetics to a degree. But and then he became quite skillful in things. He was an engineer. So he developed a professional skill that others didn't have. He did early explorations of the countryside with the British as an officer. British officer, whatever he was, he was a surveyor, so he was talented.

01-00:18:36

Meeker: Another thing I wanted to follow up on about your upbringing was to what degree was your family observant?

01-00:18:44

Goldsmith: Pretty much Reformed Jews, very little deep -- not much, and I'm pretty much a secular Jew, I am a secular Jew.

01-00:18:53

Meeker: So not a synagogual affiliation or anything.

01-00:18:58

Goldsmith: Oh no no no, I have general reservations about organized religion of any kind. Try to be respectful. I am respectful. On the other hand I would put myself up against any religious person in terms of values and spiritual notions and so forth. But terms of organized religion I would be called a secular Jew.

01-00:19:19

Meeker: Do you suppose that --

01-00:19:23

Goldsmith: And proud of it.

01-00:19:24

Meeker: -- your grandparents when they came over from Russia, were they also fairly secularized at that point?

01-00:19:31

Goldsmith: Yes I think early on it began. They weren't to the far degree that I've seen others like way to the left or anything politically. I believe they were middle America people trying to make it so to speak. But more secular. Though we did go to temple, we did have religious upbringing, and I think that also accounts for some of the discipline and some of the sense of study. I often kid around among doctors and say, "Look if it were 1880 we'd all be rabbis." [laughter] It's just something I have that notion.

01-00:20:03

Meeker: Well it was a life of learning and a life of discipline I think is part of it.

01-00:20:04

Goldsmith: Yeah yeah yeah.

01-00:20:08

Meeker: You explained a bit about why it was that you decided to get a degree in English literature at UCLA. And then also taking science courses. Because I see that you finished your MD when you were -- in ‘64. Which you were fairly young at that point.

01-00:20:33

Goldsmith: 23 or 4.

01-00:20:33

Meeker: Yeah so you had already taken the prerequisites while an undergraduate.

01-00:20:41

Goldsmith: Yes and by the way I don’t want to forget in this interview that I have some odd views of Kaiser Permanente that get right back to this. These are really romanticized or idealized or mythological ideas. They’re hardly fixed truths. But I will spin them out for you as we go along. But this is really Oliver talking, OK, for example Germanic Henry Kaiser, business, order, take it down the line, imagine somebody of the German -- and his background was German building tunnels and towers and dams and all this stuff, OK, Sid Garfield, he probably shares similar roots as mine. Know his biography so Sid as they called him --

01-00:21:27

Meeker: Midwest.

01-00:21:28

Goldsmith: I don’t think I ever met him. I really have trouble remembering. I don’t think I ever did. But I believe a Sid prototype I’m not too far from that. He was unique but so we get this Jewish man with a liberal background. I think Sid may have married a non-Jewish woman, I don’t know. And Henry and they worked. It worked, OK. Isn’t that interesting? And so if you take the health plan side of the business, it has probably been more in that model and if you take the medical group business not so much. All the leaders, if you took all the leaders of the medical groups, Jew versus non-Jew, it breaks down a little bit in terms of mostly Jews, I don’t think that’s accurate in my mind. But I --

01-00:22:18

Meeker: But as far as the common culture to follow the analogy that you’re making was that being the business side, the health plan, as more Germanic in that way, discipline-focused.

01-00:22:34

Goldsmith: Yes. If you go back to the Tahoe conference it was these guys, the doctors, and Henry saying -- this is the old history, this is the history as Oliver has heard it, which I love, OK, "Don't tell us what to do, Henry, we're the independent professional physicians," OK, and then finally the lore goes that fortunately Trefethen was brought in as you know to solve the problem because the doctors trusted Trefethen, who I did meet. And then that resolved into the three entities and all of that. The crisis of the fifties. And I actually was one of the early people in the '90s to say this is Tahoe Two. And I believe it was. So it's that same -- we'll get there.

01-00:23:24

Meeker: Maybe that's where that phrase comes from, literally jumping up.

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Goldsmith: Tahoe Two?

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Meeker: But I've used that phrase in other contexts and people don't know what I'm talking about.

01-00:23:36

Goldsmith: You'll find with me I use phrases, I don't know if I was the originator. Sometimes I think I was and someone says, "No you weren't, Oliver, someone else said that." But it doesn't matter. I'm not claiming authorship. I just thought I was. But certainly metaphors like Tahoe Two come to my mind. We definitely did there. Marriage, Kaiser Permanente is a marriage. And monogamy is part of this. These kinds of metaphors I use all the time. I think they're absolutely clear-cut about this program. In the exaggerated sense, I'm Kaiser and you're an expense. You're the medical group, you're an expense. What talk is that? We own this plan. Now some simple-minded person would think own it? You don't own this plan. That's not what I mean, OK, I mean we own it with our history as much as Kaiser Health Plan owns it with its history. I'm not talking legally and fiduciary and all these terms, which I think are correct terms, but they really don't capture what this program is, was, and is meant to be, like I feel about it. So own means when someone says to me the most insulting phrase I think someone could say to me is, "You doctors," and when they talk to me they're talking to the doctors. I always felt, I say they talk to me, they talk to the doctors. "You don't have any skin in the game." Trust me, that was said to me. A number of times. By good people. Who just I think --

01-00:25:15

Meeker: What did they mean by that?

01-00:25:16

Goldsmith: You don't have any skin in the game means you're not at risk financially. I think they mean that. You don't get any bonuses, sufficient bonuses. You're not motivated. It means it's denigrating a person. And I find this -- first it's a reflection of the person's ignorance, I feel sad that they would think that way. I hope I can change their mind. As I did in some instances. Because good people can say this. Just unwittingly. So they mean that you can't trust the doctors to do what needs to be done in this place, OK?

01-00:25:52

Meeker: And what needs to be done is --

01-00:25:55

Goldsmith: I'm the Prussian dam-builder, work 17 hours a day, put your foot to the grindstone, your hand or your head to the grindstone, get the job done, OK, I'm the businessman. Come on already, OK?

01-00:26:09

Meeker: It's keeping the organization financially afloat.

01-00:26:13

Goldsmith: It's, "You guys got so much politics in the medical group you can't even get the job done." Ooh that's a good one, I love that one, that means we in the meta health plan don't have politics? Even my health plan friends would giggle at that one. All kinds of oneupsman trying to -- the point is equality. And we're jumping to the head of the -- to the frontline here but here's my favorite response to this. If you put me in charge of Kaiser Health Plan and the medical group OK you will have total collapse, OK, because I'm not able to do that. If you put the health plan totally in charge of the medical group it will be equally bad, I like to say even worse, OK, it'll fail even faster, perhaps it'll fail at the same time to be fair to my health plan colleagues. The point is it's the magic of the two. Now whether it's -- it used to be medicine and business. It's really both. Business and medicine on the health plan side, business and medicine on the -- that's the maturing definition of this, by the way, in my view. Where it used to be, "We're the doctors, you're the businessmen." It's gotten too rich and complicated in the competitive world of health care to say that as clearly, OK. But it can't be reduced to, "We're the businessmen and you guys are a cost center."

01-00:27:46

Meeker: There's also it seems to me a history of viewing it as the businessmen versus the artists. The right, left brain dichotomy.

01-00:27:57

Goldsmith: I never put it that way but I can see how you can go that way too.

01-00:28:01

Meeker: And also as medicine, especially in the context of the development of things like evidence-based medicine and information systems. Medicine has to become more systematized, more scientific.

01-00:28:14

Goldsmith: Well I bet this thing will play out in the university. If I'm the dean of the school of something I'm going to run this as a business. I have to pay salaries, I have to get the custodians, I have to collect the tuitions, I need you to take five classes a semester, don't give me this stuff about I can only do three, I can't hire that many professors, that's the same -- look, I'm the historian, I'm the special fount of knowledge, come on, I'm trying to run the school to succeed. We all have to work together to work this out. But I can't feel that the businessmen only have business and they can't feel the doctors only have one patient a day they want to see. There's some balance there where we work together. Once that works it's sad that the rest of American medicine hasn't discovered that. And that relates to the Tahoe Two. We'll talk about.

01-00:29:01

Meeker: Well this will be an interesting preface or in musical terms an overture to what we will cover as we go along. In medical school at UCLA I wonder what the process of admission was for admitting a lit student.

01-00:29:23

Goldsmith: Well, the idea at the time was they like, the admissions committee, people who've done broadening things, like if you have a liberal arts major and the medical curriculum -- premedical curriculum -- that's better than just I'm a zoology major. And that was true for me. Plus I had I guess sufficient scores because I do believe you have to score. And I believe I had enough additional side experiences, musical, etc., to qualify. Thank goodness I did. I got into most of the -- well let me just say in those years you applied to lots of medical schools. And the top medical schools in the country all rejected me except UCLA. UCLA accepted me. Berkeley accepted me. Those are top medical schools. But like Harvard and places like that, they got the letter very quickly. So I was a good student. In fact the kind of good student that when they look at leaders or people who've led companies they often find. They're strong B students. But you probably have acquired learn. I'm a good strong B student. I'm not in any way beyond that. But I get it. I persist. And I found out that a lot of people who are A students frankly are not as good as they think they are and not as expert as they think they are.

01-00:30:56

Meeker: Too cerebral?

01-00:30:59

Goldsmith: Well a lot of the characteristics going into identifying the truth, what to do, where to move forward, how to get people to follow you and adhere to you

and do the right thing, they have very little to do with brilliance. I'd like to add brilliance to my repertoire but I don't think I have it. But I'm probably in that line of good thinking people, fairly orderly, probably need to persist on a question a lot more than others. If I don't understand that, I don't understand that, can you keep at it? Because I don't grasp things as quickly as I wish I could. But when I get it I get it. On the other hand, I sometimes see lines of thinking that others haven't seen that I feel good about as I get older. Feel good about that. So it's not a test-taking skill but it's a clarity skill if you will. So UCLA accepted me. And in medical school my performance was almost like you could predict. Every year they rate you. And so the first year I was in the lowest category. Third quartile. For me I'm very competitive. That was an embarrassment. I was low, almost fourth quartile, doesn't matter. But each year I went up in my standing in medical school. And at the end I was a very good student. Never the great students, but a very good student. Consistent with my -- I'll study more, I'll make it up on the study side -- I don't know if you were like that. But, I'll make it up more on the study side OK, yeah I'll take Christmas Day and study.

01-00:32:30

Meeker: Very much like that but --

01-00:32:33

Goldsmith: I'll take New Year's Eve and study. I'll go to bed early and get up at 4:00 in the morning, study, OK, memorize the thing. Do it again, do it again, do it again. And so I remember my first day in premed chemistry where all these chemistry guys, not me, sat there, and had to calibrate a scale. I tell the story in my family. It's part of our family lore. That you would be the professor coming over, the teaching assistant. And approve my measurements on the scale. And I could leave for the day. Come back next week and start the experiments. Well every student is getting approved and leaving and I'm sitting there alone. A complete emotional wreck at the age of 19 or 18. Because if I don't get this you can't come back next week and do this. Everybody else will be on lesson two. So the teaching assistant, I'll never forget, I looked up at him. It was terrible moment for me. And I said, "Could I take a break and get a bite to eat?" I was starved and I was nervous and I was at UCLA for the first week and everybody seemed smarter than me. And he said, "Yeah I don't care, I'll be sitting here studying." I could kiss that man. I could give him a million dollars if I had it. Because I went and had a bite and came back refreshed and I did it, it was done, I never forgot, that was it. I went on. So that sense of I'll get it has always stayed with me. So went to UCLA medical school.

01-00:34:06

Meeker: While attending UCLA medical school were you developing any particular interests?

01-00:34:08

Goldsmith: Yes I started off interested in psychiatry. Talking, which I do. Words, thinking, ideas, psychiatry was very hot at UCLA at the time. Psychoanalytic psychiatry at the time. Some of the big names were there. They seemed to be the most --

01-00:34:29

Meeker: Such as?

01-00:34:30

Goldsmith: Judd Marmer was a famous psychiatrist. Franz Alexander was at Cedars. Psychosomatic medicine. One of the doctors that I took a summer clerkship with was in psychosomatic medicine. And I thought psychiatry. Was reading Freud, the usual ideas that you --

01-00:34:46

Meeker: Well Freud and psychoanalysis isn't necessarily associated with a medical degree.

01-00:34:53

Goldsmith: No but psychiatry, to go into psychiatry. So as a medical student I was thinking, "I think I'll become a psychiatrist." Was in my -- words, literature, etc. Less of the chemical sciences even though I was a good student in chemistry. It turns out I was able to do that work. So what happened though is I began to realize that I love this idea of being a medical doctor, just the exposure to other physicians at UCLA. And then I came under the influence of the gastroenterologists, who were primarily talking doctors. Diagnosis, physiology, bedside. A family doctor with a specialized area. And so I changed my mind about psychiatry, fortunately, and I decided to become a medical doctor, an internist, gastroenterologist. So then I did that. And then in the training period of a gastroenterologist, this is 1965, 6, 7, 8, the field dynamically changed into a very technical field called endoscopy.

01-00:35:59

Meeker: Can you describe that process?

01-00:36:02

Goldsmith: Yeah the science of medicine advanced so fast that they discovered how to look in every orifice of the body with lights, cameras, and they weren't able to do that when I was in medical school. So if someone had an ulcer let's say, in medical school you'd talk to them. You looked at the x-ray, you talked to the radiologist, you felt the stomach, you did things like this, you learned a lot, and you knew by the story that the patient had an ulcer. By the time I was finishing my residency you could talk to the patient as much as you want but once you look down in there you could see the ulcer. You see what I mean? So it became a technical field. And I entered the field and I mastered it to the degree you do in gastroenterology for the next many many years. But I think

as I look back I didn't quite love it as much as I thought I would because it got so technical. And even as it got more technical we gastroenterologists agreed to let the guys who were particularly good technically do more of the demanding cases and let the guys who were good talking do less of those cases and more of the other. And I certainly went over here because I knew I wasn't as interested or good at that. You have to have spatial recognition, it's like a surgeon if you will. I'm not good at that stuff. So that was part of the change that happened.

01-00:37:29

Meeker: It seems interesting to me the way that you talked about your entry into internal medicine and development of a specialty in gastroenterology, you compared it or placed it in the context of family practice. And from what I understand and the way in which other physicians have talked about this, the development of a specialty in a particular element of internal medicine for instance is oftentimes discussed in contrast to family practice for instance. Or in a more conventional way in contrast to like a general practice or like a --

01-00:38:14

Goldsmith: Well I'm using a more technical versus verbal mental cognition. The more specialized it became in cardiology or gastroenterology the more technical it became with your hands and your eyes and your skills. Versus cognitive function, thinking, diagnosis, knowing the medical literature, history-taking, talking to the patient, relationship building. And then with my -- so do you see the distinction I'm making? And if you will, business became more technical science, and medical group talking. I'm really on a limb on this one. But I want to also say my literary background, my literature interest and my interest in words, was a profoundly helpful developmental step for me. Both as a physician and as a physician manager. Because physicians don't have an opportunity to do as much word-building, knowledge-building in literature, because they're so technically bound that I found I was one of the fewer doctors who could speak well. And express myself. And find words to say what I meant rather than -- common word, that's stupid, Martin. Well, perhaps another word would be -- I think that might be incorrect, Martin, let's work at how to -- you say, "That's stupid," you've taken offense to me. So I found that I had a wider vocabulary that allowed me to relate to both patients and colleagues effectively, where other doctors were just as truthful, just as goodhearted as I was, often lacked the verbal skills to express themselves.

01-00:40:07

Meeker: Well this plays into a narrative that I've heard other physicians talk about. And that is indeed this transformation from medicine as an art to medicine as more of a hard science, not necessarily what medicine is based upon, meaning research, but more the practice of it and particular elements like diagnosis. Do you think that that's --

01-00:40:35

Goldsmith: In contrast to the art? I didn't find the opposites there.

01-00:40:42

Meeker: No, the historical narrative meaning that for instance when it comes to working up a patient and the diagnosis, the practice of diagnosis, there's a narrative that moves from it being an art to it being more scientific or technical. Is that something that something that you've found to be true or not?

01-00:41:07

Goldsmith: I was with you in the narrative and the taking of the history and the diagnosis. When you move from the next steps it became very scientific, the diagnostic tests, the science, the gastroenterology endoscopy I'm more comfortable in the first half of that narrative if that's where you were going.

01-00:41:29

Meeker: Yeah but is it a historical narrative? Are those differences, is that something that changes chronologically from your experience or has changed chronologically?

01-00:41:39

Goldsmith: Over the life of a doctor? No, I don't think so. There are doctors who are technically scientifically very good from the get-go if that's what you're --

01-00:41:48

Meeker: I guess what I'm asking, has the profession changed?

01-00:41:52

Goldsmith: Oh, the profession's changed in many ways, but the individual doctor I think starts out technically scientifically something, a certain level of ability or narratively verbally cognitively a set of -- some rare physicians are both. I'm not.

01-00:42:11

Meeker: I guess it's an interesting way to put it like that, like there's two different kinds of personalities really or two different kinds of strengths. The way that I've heard it historically is that maybe in the 1950s or 1960s it was --

01-00:42:25

Goldsmith: More of the first.

01-00:42:28

Meeker: It was more of the artistic hands on side and as the standards of practice have changed it's --

01-00:42:35

Goldsmith: Well I would say yeah that's probably true but more because there wasn't enough science around like -- and I'm a good example. In medical school it was take a history, the narrative, the art of medicine. By the time I was finished in medical school and training, ten years later, it was the science. It's the science, stupid. I'm not referring to you. Because all this endoscopic equipment was available. It just wasn't available before so the doctors who were like me at the beginning simply flowered into this endoscopic world. They had a ball doing the stuff. Where Oliver was still over here. So but medicine has changed for sure from fifties to this decade because of many other factors.

01-00:43:19

Meeker: But to be perhaps devil's advocate and see that as progress, which probably as far as standards of treatment and care it is progress, meaning that the endoscopic, the technical approach to doing gastroenterology is --

01-00:43:45

Goldsmith: Far more accurate.

01-00:43:45

Meeker: It's more accurate. But I've heard some physicians lament the degree to which physicians are no longer capable of actually using their hands, for instance, to discover an ulcer. Whereas before they used to be skilled.

01-00:44:00

Goldsmith: Well yeah I think there is some de-emphasis on the hands on techniques. I thought you were going toward perhaps in the technical world we live in there is less caring and expression and the art of medicine and the caring for people. I don't know if that's true or not. I'm not sure. I always think to myself, "Be careful, Oliver, from distorting things from this side of your life as a 67-year-old man looking back and thinking we were more caring." I think that could be presumptuous. I don't know. I don't know that we were more caring or not. I don't know that doctors that made house calls in the thirties and forties and sat there while the child died were any more caring than we are, than current technically trained doctors. I know there's a poet William Carlos Williams, you may have read some of his poetry, he was a physician. When you read his biography, which I have, he -- oh that damn patient drove me nuts, I had to interrupt my poetry writing and go see this crazy lady. He had as much frustration with people as doctors do now, so I don't know about the old days were the good days, and the new days were the --

01-00:45:08

Meeker: And concepts like culturally competent care did not exist then.

01-00:45:11

Goldsmith: Well we didn't have those terms yet and so maybe that's an example, people are more -- but that's all broadly through all of life, the culture is to be culturally sophisticated, diversified, those doctors didn't deal with that as much. So but we certainly have gone from a more nontechnical delivery system to a very technical delivery system.

01-00:45:35

Meeker: All of your medical education was done in southern California. Were you ever tempted to perhaps find a residency outside southern California?

01-00:45:41

Goldsmith: Kaiser, Vermont and Los Angeles was the farthest east I'd ever been. The train to UCLA, Wadsworth VA, Cedars Sinai, so I'd never been east.

01-00:45:52

Meeker: You never looked.

01-00:45:53

Goldsmith: I actually tried to get into medical schools on the east coast and I got into a few but I didn't get into the ones that I wanted to and once UCLA accepted me -- what happened is I got into Berkeley medical school, which I wanted to go to desperately. Because I was --

01-00:46:12

Meeker: What is now UCSF.

01-00:46:13

Goldsmith: Yeah I guess that's what it was then. I said Berkeley but I meant University of California in San Francisco. I was accepted there. I wanted to go there. I would have gone there. But because of my mother's circumstances, she made a deal. She said Oliver, "If you stay home at UCLA," which saved money, and she needed one son who was a reliable son, mow the lawn, stuff like that, "I will give you," -- I think she gave me $1,500 to go to Europe for the summer. She did. And I could not turn down my mother, first place. But with that deal it made it easy. I chose UCLA. Gave up my dream of going away like your east coast example. And stayed at UCLA, and then had that summer where I had a unique like the old European you go to Europe one summer to get your adulthood. I hitchhiked acrost Europe in 1961 when you were able to safely with a flag and a guitar. And that was part of my development. Came back and finished UCLA.

01-00:47:20

Meeker: What countries did you visit?

01-00:47:21

Goldsmith: France, Germany, Holland, Denmark, England.

01-00:47:28

Meeker: Do you remember anything particularly notable about that trip?

01-00:47:29

Goldsmith: Oh yes it was very notable because first place it was the coming of age as a man. Meeting people. Three friends went over. Three good friends. And within the first days I realized, “I’m not traveling with these guys.” And I was the one that said, “We’re going to go our separate ways.” And I spent the rest of the summer myself meeting people.

01-00:47:51

Meeker: You could do it on your own.

01-00:47:53

Goldsmith: Yes so there was that notable aspect. I’ve always been interested in languages, began work on French, good ear for that as a musician. Spoke some French, had some experiences that were I guess you’d call them wild, they’re rather mild compared to what people do now. There were no drugs available in those days. A beer was about the strongest thing you could do or smoke a cigarette and get green from that but from a young boy standpoint meeting people and hanging around and stuff like that. So I remember that but I remember again the independence. Now whether in retrospect in life you create these myths of yourself or they’re accurate is probably truth of both.

01-00:48:37

Meeker: Well there’s an expectation that when you do go on a trip like this you’ll have these kinds of experiences.

01-00:48:42

Goldsmith: Yeah but I think it’s nice that you mention it, it’s flattering, but it’s also relevant to the choice I made to join Kaiser Permanente.

01-00:48:50

Meeker: How so?

01-00:48:52

Goldsmith: Well because when I finished medical school and was doing my residency, you begin to look for work. And my intention was to become a successful private doctor in Los Angeles around Cedars Sinai or on the west side. My wife, we were married when we were young, my wife and I met in medical school and so we met and she was a nurse, so we fully intended to have a nice prosperous happy life like any couple, practicing medicine. And you do something in medical training called moonlighting, you make a little extra money by working nights in different emergency rooms and all. And different people were beginning to offer me opportunities. And so there were three opportunities. Not all at the same moment in time. One was in Torrance, California, a doctor’s offering me what then was a lot of money to join his

practice, standard thing. And telling me you have to see a huge number of patients, 50 patients a day.

01-00:49:56

Meeker: When would this have been?

01-00:49:58

Goldsmith: 1968.

01-00:49:59

Meeker: OK so this would have been during --

01-00:50:03

Goldsmith: Yes as I'm beginning to look for work for a career. And he said to me, "You'll see 50 patients a day." I never forgot saying, "Sir, I could never see 50 patients a day." He said, "Iit's easy, Oliver. You just give them a prescription for whatever they complain of and if they come back a second time you send them to a doctor." Well what I'm telling you by story is that's not medical care. The second was I was --

01-00:50:28

Meeker: What do you mean you send them to a doctor? Were you not a doctor?

01-00:50:30

Goldsmith: Well in other words it's all fake. You just give them a prescription, you don't really take care of them. You don't really spend time with them and try to figure out what they are, you're just a charlatan.

01-00:50:38

Meeker: You send them to somebody who's going to lose money --

01-00:50:41

Goldsmith: When he said you send them to a doctor you send them to a real doctor. He meant you'll make a lot of money, you'll see a lot of patients, but you're not really a doctor. It really was funny.

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Meeker: That's to a certain extent the critique of fee for service.

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Goldsmith: No, oh no, I'll fight you on that one.

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Meeker: OK well do it.

01-00:51:01

Goldsmith: Well sure there's many saints in fee for service medicine who practice good medicine, who are bound to good patient care, who would never talk like that. But that was the way he was talking. So I don't say salaried physicians are honorable, I'd like to, and fee for service are dishonorable. You can have a salaried bum, OK, and you can have a fee for service saint. Now I do happen to believe that it plays to more difficulties when you're fee for service. That's why I chose my identity in a salaried practice, which I'm in again by the way. But I would not agree with that at all. The second doctor was at Cedars Sinai where there I was on my way to becoming the very special gastroenterologist to the Cedars Sinai. That would be the hot shot in town, who do the big shots see, OK, and that was my intention, and I was offered a position there as a gastroenterologist. And one day this wonderful mentor to me said, "Oliver, go to the airport and pick up some Saudi for a checkup." I said, "What?" He said, "Yeah." I said, "Dr. Bachrach, I said I'm a doctor. I'm not a cabdriver. You mean go over to the airport and pick this man up?" He said, "Oliver, this is what we do." He meant we do this in addition to our regular practice, it's very lucrative, makes a lot of money. He was a very fine doctor, fee for service doctor. Exemplary doctor, my idol. When he said that to me I said, "Bill," because we were on first -- I said, "I'm not going to the airport." I said, "I'm not going to pick up somebody," this is my independent streak. He said, "Well do you know what that means, Oliver?" I said, "Of course I know what it means. It means that you're not going to hire me. You're not going to hire me for your practice." Says, "It absolutely means that." It was a friendly -- it wasn't mean-spirited. I said, "Well I understand that. I'm not coming here." He said, "Good luck." He didn't fire me because I was in training or something and just that was the agreement. The third doctor I met was --

01-00:53:03

Meeker: I've seen it described as a fellowship.

01-00:53:05

Goldsmith: Yes I was in a fellowship. That was that period of time at Cedars Sinai. That was psychosomatic medicine where I was looking at GI patients from a psychiatric standpoint. That was the fellowship. To work with the psychiatrists on understanding GI patients and understanding psychiatric approaches to treat patients. Because in that period of time we thought ulcers were emotional and colitis was emotional. We don't think that anymore but we did then.

01-00:53:33

Meeker: Were these many Vietnam veterans?

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Goldsmith: No, this was just regular citizens.

01-00:53:38

Meeker: Well as far as the psychosomatic diseases of those GIs --

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Goldsmith: Well psychosomatic was applied to vets too from Vietnam but this population was just average America. OK because at the time people thought an ulcer was stress. It's not. I don't think. But plenty of evidence that it's something else. So I met a Permanente doctor.

01-00:54:02

Meeker: Just a point of clarification on this going to pick up this fellow at the airport. You were against it because it --

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Goldsmith: It demeaned being a doctor.

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Meeker: OK so it put you in a subservient role that meant that you weren't actually practicing medicine.

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Goldsmith: Yes it wasn't me as a person, I'm not too hung up I don't think in stuff like take out the garbage and do the scut work. It was the profession. A physician doesn't go pick up a patient at the airport to drive them to the --

01-00:54:38

Meeker: So in essence it wasn't --

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Goldsmith: -- hospital unless the patient -- you might do it if the patient's sick out of kindness but you don't just provide that service. It was the principle. It was the principle.

01-00:54:41

Meeker: OK so it wasn't so much that the lead doctor, the boss would have been asking you to do this, but it would have been that patients because of their status would have expected that of doctors.

01-00:54:59

Goldsmith: Well I guess in my mind he asked me to do it, he directed me to do it, he ordered me to do it. But I just didn't see that as the role for a doctor. If he said there's a very sick patient coming here with abdominal pain, I want you to meet him at the airport, get him in the car, bring him over here as quickly as -- I would have seen it as a medical transaction, not a taxicab. What it said to me was I'm out of here because if this is the way this is going to be -- again second time, I'm a doctor, not a cabdriver.

01-00:55:34

Meeker: Well it seems interesting then because you look at Cedars Sinai and the one time I've ever spent time in the hospital was actually there and I know that the rooms are really nice and that's where a lot of Hollywood actors go and high-powered people but --

01-00:55:48

Goldsmith: Right, that's what I wanted to become the doctor --

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Meeker: That's what you wanted to become and probably you would get paid for your services, but in order to serve those kind of people you were placed in subservient positions to them --

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Goldsmith: I'm trying to say that I believe it is accurate about myself to say I won't go there. OK and then the third doctor was a traditional serious good physician inside of Kaiser Permanente. His name was Harold Frankl, friend of mine. And his wife. And he was a teacher at UCLA Wadsworth VA and he offered me a job. Kaiser. Salaried. Regular job. No status. Because there was no status of being a Permanente doctor. And I took it. My wife was astonished. "What are you doing, after all these years? Going there?" Well it turned out when I was a resident doctor I had moonlit there that term, made a little money once on vacation working in Kaiser's urgent care. And I found I liked the idea. And when my wife and I were -- when I was a medical student Permanente used to have dinners for young medical students at a hotel. You get a steak and a glass of wine or something like this. And you meet old geezers like me who would influence you to come to Permanente. That was Permanente's way of trying to attract doctors -- remember this is the sixties. So my wife and I would go to these dinners once every six months, have the steak, have the meal, save some money, and we'd leave before the guy even spoke. Because we weren't interested in this. We were interested in something else.

01-00:57:23

Meeker: All right. I need to change the tape.

01-00:57:24

Goldsmith: Yeah and I'll take a break.

[End of Interview 1]

Interview #1: 07-19-2006

Begin Audio File 2 goldsmith_oliver2 07-19-2006.mp3

02-00:00:00

Goldsmith: I'm a bit of a control freak. Are you -- you're in charge despite my attempts to weave the story the way I want.

02-00:00:13

Meeker: Well in many ways your agenda is my agenda. So and I've had a lot of experience interviewing people who are very strong personalities and it just takes a little finesse here and there to redirect, but we're definitely on the path and I found it interesting, the anecdote that you mentioned about going to these Permanente-sponsored dinners and never really taking seriously the -- or really even listening to the pitch that they were offering. And I guess that just leads to a question well what was then the reputation of Kaiser Permanente in Los Angeles while you were in medical school?

02-00:00:56

Goldsmith: OK except for this one doctor who I met in an academic setting who obviously was a very very important respectful person --

02-00:01:06

Meeker: And his name again was?

02-00:01:06

Goldsmith: Harold Frankl, F-R-A-N-K-L.

03-00:01:08

Meeker: Where was he practicing?

03-00:01:11

Goldsmith: He was a gastroenterologist at Kaiser Permanente Vermont downtown Los Angeles. And he could have been anything he wanted. He was just a very talented student of medicine and had the discipline and the finesse and he was a very serious person, the kind of person you go to when you're sick, that's what he was, a doctor. But a really good doctor. And a teacher and a splendid -- a model. Unlike the first one in Torrance that was not even a doctor other than title and the second one who was a mixture, OK. So the reputation for Kaiser Permanente was rather poor. Reputation was this is a -- in my mind, my family mind, it's some kind of an industrial plan, blue-collar, I don't know what quite it is, you go to when you don't have much money. Union people go there. And it's a job. But what I liked was, well, I liked this man, what he represented.

02-00:02:22

Meeker: Did you know anything about for instance the principle of prepayment at that point?

02-00:02:27

Goldsmith: Yes, yes, I thought the -- what I knew for sure was I liked the idea of a salary. I already was rejecting the idea of fee for service medicine for me.

02-00:02:40

Meeker: Why?

02-00:02:42

Goldsmith: I thought I'm not a business guy. I don't like to do business, oddly enough -- look what happened. I don't want to do -- I want to be a doctor from morning --

02-00:02:54

Meeker: So you didn't want to spend your time billing and keeping books.

02-00:02:57

Goldsmith: Morning to night, I don't want to manage people. Look what happened. How little we know ourselves. I want to be a doctor, I want to fulfill all this training and this desire I've had since I was 19 or 18 or whenever. I want to be a doctor all the time. This place you get to be a doctor. They take care of everything. In fact -- and here's this wonderful doctor as evidence of it, he wouldn't do that stuff. Wonderful doctor. They take good care of their doctors when they hire them. They get them all the new instruments. Lots of patients. There was no question at Kaiser you saw everything. So it wasn't just a routine. You saw every kind of illness. I also knew you could do what you want for the patient because there was the card. So the underlying economic principles weren't the attraction, fee for -- capitation, principles, but more you show me this card, you come in sick, I can order anything I want. Anything I need, OK. And you don't have to say no I can't afford that. You don't pay much as a patient. There was no -- maybe a $2 copay, even that we didn't like. And you can fulfill your role as a doctor. The other thing operating in my mind was I am very strong on my family and I knew that middle-aged physicians who are very desirous of success, as I was, could have ruined families. Children, you're never home, I'm pretty much a yes-man, you need me, if you need me to help you, yes, patients call, work night and day, I'm a tireless worker to fault, to a danger. That I might not look after -- the pressures of modern-day fee for service medicine, traditional practice, I was actually fearful they could overwhelm me, overwhelm this value that I hold about my family. My wife, my children, normal things, be with your children on the weekend.

02-00:05:08

Meeker: When was your first child born?

02-00:05:08

Goldsmith: When? 1967. I was about 26. Whatever age I was. Josh was born when I was 25 or 26. About three years after I got married. Married in ‘63 so ‘67. Four years. And in fact when I was at Cedars Sinai I took the other six months off and worked nights somewhere once in a while so I could be home with my son every day. I worked 9:00 to 1:00 and every afternoon I walked around with my son in a carriage, bonded, thought how important that was in family life. So I was worried. I liked Kaiser because they took care of everything. All you did was be a good doctor. In fact our culture at the time was Dr. Kay said, “You’re a nice young boy,” he pointed to me, he said, “All you have to do is come in at 9:00 and leave at 5:00. We’ll take care of the rest.” It was actually the wrong message. But it was one that appealed to me.

02-00:06:07

Meeker: Why do you say it was the wrong message?

02-00:06:08

Goldsmith: Well because as the medical group evolved we needed our doctors to be very involved with the business of medicine, the success, working hard, don’t let the 9:00 to 5:00 limit you, do more, get involved, make it your own, vibrant practice, let it consume you, not -- my joke used to be I’m going to work you till you fall over. Once you fall over I’m going to say I’ve given you too much work. I meant it lighthearted. But to be the opposite of you come in here at 9:00 and you leave at 5:00. We’ll never ask you to do anything more. OK. So that’s what appealed to me, the ability to fulfill myself as a doctor and a person. Personal life, family life. Not necessarily -- and then the salary, the stability, the instruments that they would provide. Not the capitation or the more eloquent public health issues. I was interested in public health. I had done a fellowship in tropical medicine in Mexico City one summer as a student. So I liked general health issues, but not -- that wasn’t why.

02-00:07:16

Meeker: How was it that you then learned about these other issues?

02-00:07:19

Goldsmith: Well soon after joining, I’m pretty alert to things, and I started learning about how it all worked, the idea of the capitation, the group practice. That wasn’t really very clear to me as I joined. That reinforced my decision. The culture. It was a city unto itself, the dynamics of Permanente, dynamics of Kaiser Permanente. I began to enjoy meeting the Kaiser executives. Edgar Kaiser, the son of Henry. Was exciting for me. Just like I was at Cedars. So in my world it became very important to be involved. So you know the old term type A type B, I think type A is driven. I feared my type A personality would ruin me. I thought Permanente would be a restraint. 9:00 to 5:00. The mouse would be controlled. And I showed myself that I broke out of the restraints and a type A ultimately expresses itself. And so even though Ray Kay said 9:00 to 5:00 I came in earlier, I stayed later, and I began to express this characteristic

of myself, working hard inside of Kaiser Permanente. But even then it was not as demanding on my family as it would have been had I been outside. Do you see my point?

03-00:08:53

Meeker: Yes, yes.

03-00:08:54

Goldsmith: So it was protective even though I broke through some of the restraints. This is my story, OK, so I loved the group from the beginning. It was like being in a community. It was my temple. See, my church, my sense of belonging, I liked the dynamics in the department, I liked the politics so to speak, I liked the time management.

02-00:09:17

Meeker: Well what was the content then? To say -- to use the temple metaphor, that involves a liturgy, that involves a history.

02-00:09:25

Goldsmith: Well I'll show you. First place seeing patients. Residents. Teaching residents, that's part of teaching, education. Giving talks, becoming better at my field, studying. Academics. Training others. Early on getting involved in programs to teach nurse practitioners. Things like that.

02-00:09:50

Meeker: OK well we're going to go in depth on a lot of those issues you just mentioned. But before we move on --

02-00:09:58

Goldsmith: It felt like home. I made the right decision. Early on it was obvious to me, this is the place to be, even though salary was not as good. Earning potential in those years was not as good. Status was not as good. Was the only guy ever to do this from UCLA medical school. Not only guy, but no one in my class went to Kaiser. But the fulfillment day to day was rich.

02-00:10:22

Meeker: I assume that that has changed in the decades since then.

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Goldsmith: Yes, yes, over the decades we get --

02-00:10:30

Meeker: When did you notice people from medical schools like UCLA, Harvard and so forth starting to come through Permanente?

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Goldsmith: Well yeah there was no question in my group of people who joined Permanente I think all of them came from odd places and didn't have the same background of training that I had. And I was the first, except for Dr. Frankl, this outstanding physician, I was the first true middle of the road addition to the group. But the rest weren't. I'd say in the late seventies. It was the exception in the seventies when just a middle good American trained doctor full blast was joining. There were many but maybe 30 percent, 50 percent. But by the eighties it was obvious we were attracting better and better and better. By the nineties we're getting the cream of the crop. So I always say, "When they were hiring me they weren't very discerning." My wife always says, "Oliver, that doesn't look good for you."

02-00:11:34

Meeker: Well also during that period of time there was what has been described historically as a doctor shortage. In the United States overall in the late 1960s.

02-00:11:46

Goldsmith: My whole life in Permanente has been feeling like there's a doctor shortage. I never felt there wasn't one.

02-00:11:54

Meeker: Well demographically apparently there was --

02-00:11:56

Goldsmith: Yeah in different times. In the United States every decade they announce there is a doctor shortage, there isn't, or there's a shortage of internists, now it's primary care.

02-00:12:02

Meeker: The perpetual crisis.

02-00:12:04

Goldsmith: Yeah nurses, etc., etc. And whenever you catch up with it now you don't need to catch up with it, it's a cycle thing. But basically it was hard to recruit doctors when I joined, that's for sure. But it seemed to me it was hard to recruit doctors my entire career. Because you kept raising the notch what you wanted. So by the nineties --

02-00:12:25

Meeker: And then doctors also, graduates also raised the notch of what they wanted as well.

02-00:12:32

Goldsmith: What they wanted. Medicine got more specialized, now there's six different kinds of cardiologists and four different kinds of gastroenterologists. Plus expectations rose plus our demands for different kind of physician changed.

So I think I would have been hired by Permanente throughout its history I like to think, but I can tell you many of the doctors who came in around the time I was coming in probably wouldn't have been hired now. Wouldn't get in. So our expectations rose. So we always perceived trouble getting doctors. Plus we were growing fast so we needed even more.

02-00:13:07

Meeker: What was it about the background or education of those doctors at that point in time that would make them no longer qualified?

02-00:13:18

Goldsmith: Well I think doctors then were often coming out of let's say foreign training. They had matriculated through -- just good doctors but they perhaps didn't go to an American medical school. Perhaps they had been in practice in different settings and it didn't work out. And so they were coming to us as a second choice. Versus let's say a UCLA residency graduate trained in a UCLA school. OK not to say you always get the best here but in terms of just a class of doctors we weren't getting them. Like we were now, we are. So -- and then plus the medical group at the time, early on, and I think I was one of the people who influenced this, we used to have an expression, "He's a good doctor, but." Meaning he's technically a good doctor but he's a jerk. But we still better keep him.

02-00:14:19

Meeker: Because he's a good doctor.

02-00:14:21

Goldsmith: He's a good doctor technically. He doesn't get along with the nurses, doesn't get along with the patients, he's a bozo, patients don't like him, I'm exaggerating, he doesn't work very hard. He doesn't have the group identity. But he's a good doctor. That was the culture at the time because we needed doctors so much and we were growing so fast and technically good was the ticket. But over the seventies and eighties and surely in the nineties we listened very closely to 'the but.' I believe I contributed that understanding to the group. That for a group of our size, which actually expressed itself in groups of five doctors, ten -- you can say 5,000 doctors but it's the five of them work together. You have to get five people who work together. Doesn't matter how big the group is. We needed to address 'the but.' But he doesn't get along with patients. That's extremely difficult problem. But he's rude to nurses. Extremely difficult problem. But he's not productive. Extremely difficult problem. We now pay far more attention to that. Thank goodness.

02-00:15:33

Meeker: I think later on we should talk about how it was that you dealt with the cases, 'the but' cases.

02-00:15:39

Goldsmith: Yes well first was that story, ‘the but’ became very important. Fact, the joke about Oliver was I used to say, “They never said that about me.” The joke was they didn’t say the first part either. But you had to get the joke. “He’s very smart but.” It was usually he’s very smart but. They never said the very smart about Oliver.

02-00:15:58

Meeker: So you never got to ‘the but.’

02-00:16:02

Goldsmith: So my friends would always kid and say, “We never got to the but with you, Oliver, because the first part was never said about you.” Just as a joke. Because doctors are all bright. Show me a doctor that’s not bright. They’re all bright. I’m bright if you take all doctors. But that’s not enough to practice in our medical group. You needed camaraderie, group identification, productivity, work with staff, in fact the whole role of a doctor at the time was going from I’m the doctor, you shut up, you’re the patient, I’ll tell you what to do. From we are working -- it’s we. We are working together, let me go over the choices, we’re equal. I’m giving you your choices. You know what I mean. There’s a flattening of the patriarchy of medicine so that was developing. So we needed to find doctors who are more comfortable like that.

02-00:16:45

Meeker: And patients are now perhaps better educated about their conditions or the care options available.

02-00:16:52

Goldsmith: Of course, yes, yes, yes. We know that almost every patient carries in an Internet article to a doctor. If they aren’t we tell them to.

02-00:17:04

Meeker: Just before we move on because this is a second phase of a very long oral history project, I wonder if you have any anecdotes to share, any memories to share, of meeting who might be termed the founding generation. You mentioned Ray Kay.

02-00:17:27

Goldsmith: By the way don’t short-change the next, the last ten years, because that’s a critical part --

02-00:17:30

Meeker: OK we won’t.

02-00:17:32

Goldsmith: Well early on my opportunity was very special because somewhere in the early seventies, ‘74, ‘75, maybe you have my CV. I got elected to our board of

directors. And if I could tell that story it fits in in my own story and that was simply that there was an episode that happened.

02-00:17:55

Meeker: If you hold on one second, I want to just adjust this so it's on.

02-00:17:59

Goldsmith: There was an episode that happened that I like to tell. This might be my last time to tell it. Where the chairman of the department, the chief of the department, who liked me, came into the office, to the meeting, with his nurse. Manager. And said, "Everybody is going to work an extra evening." Like an order. And while I had conducted myself as a dutiful quiet 9:00 to 5:00 -- not 9:00 to 5:00 but person trying to -- I remember standing up like the movie Network where the guy says, "I can't take it anymore," Peter Finch, standing up in front of 70 people, saying, "Wait a second," she, the nurse, ordered me to work an extra night once a week. That is not the deal. I don't like that. I'm not going -- this is not fair. I work for Dr. Yetra. He can order me to do that, even that's unfair. Because the commitment, the agreement with Permanente, was one night a week. That's the contract. Now I was overreacting a little bit but I was very angry. And I got up and I wasn't even a partner. I stood, sat down, said, "Oh God, where'd that come from." And there was applause.

02-00:19:12

Meeker: Where was this done?

02-00:19:13

Goldsmith: In the department of internal medicine at Sunset in 1973 or 2, something. There was applause. And I realized personally I liked that. It made me feel good. I spoke up once. I usually don't speak up. I do now but when I was younger, I wasn't a college president guy or anything like that. I was just a guy trying to survive and get my work done. That led to my being on the board. Then I ran for the board of directors. And I found I liked public speaking. I liked talking. People listened to me. That's pretty intoxicating when you're a young guy who's never had that experience before. And I ran for the board. That led me to meet a lot of the people so I can respond to your question. So the most famous night was a wonderful lighthearted story where my wife and I, we went to a banquet, a very sumptuous banquet, where the board of Kaiser was there at a Beverly Wilshire Hotel, if you know where that is, where in those years you had cigars and liqueurs after dinner and it was right out of Cedars Sinai, it was right out of Hollywood, and my wife and I meeting these people was a tremendous experience. I'm sure Edgar Kaiser was there. The son of Henry. And I'm sure all of them were there. I was just a board member. I wasn't an administrative manager or leader or anything. I just was a Young Turk if you will. And in the middle of the night my wife and I probably I had probably too much to drink. Maybe a second drink or something. It was such a wonderful experience. The medical director of the time, Dr. Baker, who's in our lore, called me up and said, "Oliver I need you

to make a house call." Well I remember waking up from a sleep and saying to my wife, "Get my black bag." And she said, "The kids are playing with it." And I said, "Put some medicine in it." She says, "What medicine?" I said, "Throw some birth control pills in it. Throw whatever you got in there. I got to go see this man." OK driving up to the Beverly Hills Hotel, putting him in the hospital at Kaiser. I've never had someone get silk sheets on their bed, it was unlike Kaiser. Middle America. Brings an executive secretary with his charts and all of this. And he had an ulcer by the way.

02-00:21:23

Meeker: Is that why they called you of all the physicians possible?

02-00:21:27

Goldsmith: Well I was a gastroenterologist, I was on the board, I was there that night, I was a good doctor, I wasn't -- he knew me, Dr. Baker.

02-00:21:36

Meeker: None of the other doctors around him could have treated him in this way?

02-00:21:37

Goldsmith: Oh yeah, yeah, but he was in his hotel, it was the middle of the night. He probably got a call from one of his staff, "Art, what do we do, Mr. Kaiser's ill." And he's probably thinking, "What do I do. Well Oliver was at the banquet, he's a young gastroenterologist, he's a good doctor, we'll call him," he could have called anybody but he called me. And I was honored. So I put the patient in the hospital that night 3:00 in the morning and you go through these things, got home about 3:30, 4:00 in the morning, fell into a deep sleep. And overslept. The only time I ever overslept in my career. Woke up about 9:00 in the morning. Oh my God I'm late. Go in, I get to the office about 11:00 in the morning. And to my relief as an internist, there's Mr. Kaiser sitting there reading the paper looking good. Well any doctor loves that the next morning after you've hospitalized someone thinking they're gravely ill. And so I walk in and he says to me in this irascible tone, "Where the heck have you been? I need a phone." because in those days you had to order a phone.

02-00:22:44

Meeker: OK in the room.

02-00:22:46

Goldsmith: Mr. Kaiser, I'm very sorry, I overslept, I'm late to the office. I'm so glad you're feeling better. I'm so embarrassed. I failed you -- I didn't say that. But you know what I mean. I haven't acted like a doctor, you should get there at 7:00 in the morning, be a doctor. He was better so there was relief on my face. And he says to me, "Young man, do you know what's going on in," I think he said Puerto Rico. I said, "Me -- just a young doctor trying to get through the day. No, what?" He said aluminum -- he mentioned the chemical that goes

into aluminum. I'm just blanking during this interview what it was. It was a chemical. And I said, "Is that a vitamin?" Because he asked me do you know what this is. And I said, "Is that a vitamin?" I don't know, I'm trying to be nice, he said, "It's aluminum foil." Fast forward. There was a crisis in his businesses in Puerto Rico or somewhere. He stayed in the hospital a couple of days. He was a very nice and gentle aristocratic man, remember he's from one of the two families or three families of this country that were major industrialists, he was in fact a very kind, courtly man. And I was a young -- very young doctor in his eyes. And the ending of the meeting was very very important to me. Because when I sent him home -- he actually the night before said, "I'm going out to a restaurant." I said, "Mr. Kaiser you can't be in the hospital and just go to a restaurant." He said, "Yes I can." I said, "Mr. Kaiser --" I'm thinking lawyers and what if he gets hurt outside. What do I do. He said, "Don't worry about it. I'm going to a restaurant." I said, "What do I do." So he went to a restaurant. So the next morning I go to visit him and I remembered something, turned out he had an ulcer. He showed me his travel itinerary. Which was wildly crazy. Like London tonight, Costa Rica tomorrow, it was a madman's travel. And the next morning I remember driving in to discharge him. He was fine. And my mother used to say when she pumped me up to be a doctor, "Doctors sit with kings." In other words you're very important. Doctors sit with -- so I'm driving to the hospital. So I sit down with him and I said, "Mr. Kaiser, I'm glad you're better but can I tell you something that most people I guess just never tell you? Can I just talk to you as a doctor?" He said, "Yes." I said, "You're nuts. You're leading a life that is self-destructive. Can't believe you do this. This is the cause of your problem." I said, "I hope I'm not being mean to you but I am telling you what I think as a doctor. You asked me." He said, "No go right ahead." And I was looking down and suddenly I heard him cry. And he said, "You're right," he said -- and then he told me some stuff in his family, some trouble that I don't think is relevant because it wasn't that big a deal but it was just simple stuff that all of us have as family members, OK, nothing that astonishing. But the troubles he was having. And I said, "Well you need to change your life. You need to -- you can't live like this and have an ulcer and get sick like this." He thanked me. Shook hands. I think I saw him once more just to say hello once. Went back into his lofty life. So I met him. And I met most of the others at the time. Vohs was interviewed in the early years. I had a deep sense of admiration for Mr. Vohs. I knew him slightly. I met most of the players of the time that you could name. Not the first generation, the guys right in the second generation.

02-00:26:42

Meeker: So you said that you don't recall meeting Sidney Garfield.

02-00:26:45

Goldsmith: No. I may have been at something where he spoke. Do you know what year he died?

02-00:26:50

Meeker: He died in ‘85 I believe.

02-00:26:52

Goldsmith: I probably was at something where he was in the room. I might have shaken hands with him. But no. I knew Ray Kay very well. So there I’m very -- he hired me. He wrote on my chart, “Nice boy.” So I knew Ray very well. He encouraged me from the very beginning. But some of the figures, the names you mentioned, were northern California so I didn’t have --

02-00:27:10

Meeker: Morris Collen.

02-00:27:12

Goldsmith: I met Morrie through the years but more later after I was -- he was retired. I met him a number of times. And earlier I might have met him.

02-00:27:19

Meeker: In what context?

02-00:27:21

Goldsmith: Well we had a federation banquet once and Morrie was there and gave a talk of the history I remember. Sitting with him and talking. He’s a wonderful --

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Meeker: And Cecil Cutting as well.

02-00:27:31

Goldsmith: I met Cecil Cutting I think but just a meeting, not close. Morrie I was actually warm evening, engaging evening together. I think I met Cecil Cutting once or twice.

02-00:27:40

Meeker: In these brief encounters, did you ever get a sense of the history of the organization or what was it that drove them to devote most of their life to it?

02-00:27:54

Goldsmith: Yes I absorbed the lore of the commitment to patients and populations. Being good doctors. And the economic principles. By then capitation and group practice and all the stuff pretty much established itself, the Tahoe history. I was immersed in the opportunities we had. Some of the wishful thinking we had began to get into my mind.

02-00:28:22

Meeker: Wishful thinking?

02-00:28:24

Goldsmith: Well, that we were something -- I use the expression, “the sun would always shine on Kaiser Permanente,” and sense of our destiny. Which I liked but I don’t know how true that --

02-00:28:36

Meeker: Well but I guess in the most blue sky formulation possible what would that destiny have been or?

02-00:28:44

Goldsmith: Well it might still happen but certainly it came to a screeching halt as an expression for the time being. That we are the wave of the future. That not only we’ll be everywhere we are but we’ll be in ten more places. And this is the way medicine is moving. It hasn’t moved that way in my view. If it has it’s at snail’s pace, and certainly Kaiser Permanente hasn’t expanded in -- if anything we’ve contracted.

02-00:29:15

Meeker: When do you think the brakes on that vision were applied?

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Goldsmith: Well, now this is good because I think it prompts me to say. I suppose around the time I was becoming the medical director, 1994. The realities had already been known for a few years that we were in trouble.

02-00:29:41

Meeker: Competition with other HMOs and so forth.

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Goldsmith: Well the reasons for it were I think if you take the eighties, let’s say at our highest expression, expansion, success, growth, I think by the nineties there was external competition, people who wanted to be Kaiser Light like. Looking like they might succeed. Most of them went down the tubes. But looking like they might succeed. Two, the general competition from the industry, various economic factors. Perhaps employment factors. And then inside the group there was a lack of successful leadership. Inside the organization itself. Which we can talk about. And there was also I think a magical thinking about who we were. So I think the combination of the external reality -- four things -- the external reality, the lack of successful leadership, and the self-delusion inside the organization moved ahead and then add some big mistakes. Simple mistakes I say yes, the answer’s no, I say go there, you should have gone that way. What’s two plus two, I say five. Just dumb little mistakes.

02-00:31:15

Meeker: We’re going to talk about some of those a little more. During this -- roughly looking right now at this period, the first ten years in which you were there, which you were working as a physician at the LA medical center and then also

about halfway through that period, but in your capacity primarily as working as a physician during this period of time did you have any involvement in medical research or any clinical research?

02-00:31:44

Goldsmith: Yes I would be probably called a minor -- I was very involved in the residency and teaching and giving talks.

02-00:31:54

Meeker: Well perhaps we should talk about that. I don't really have much information.

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Goldsmith: That I was strong in. I was a teacher -- we had GI fellows. That's doctor specializing in gastroenterology. Who'd always rotate with me. I would teach them. I was very active teaching residents. They would rotate with me. So I was very involved in the residency. I tried to do a clinical project, a clinical research project. And actually did one or two. One for sure. More than a case report, which is just incidental academic. And I did one and was proud of it, but as I was going -- after I completed it I began to lose interest. I actually reported it at a national meeting and was proud of myself, but I never kept going on it. So it never resulted in a publication. It was an abstract. Which is far short of a publication. I regret that I didn't complete that.

02-00:32:55

Meeker: What was the research?

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Goldsmith: Well it was very important to me at the time. I think important in medicine. We had fiber optic flexible sigmoidoscopy. And the question was does it discover disease early. We now know it does. But I launched a study of 1,000 patients with me and my colleagues of patients who were truly asymptomatic. Everyone knows if you come in with bleeding and you put this instrument up somebody's colon you might find something. But do you find enough when they have no symptoms? So actually I was cleaning that up and excluding the patients with symptoms and I studied 1,000 patients and I had all the data. This was a true good population to study because they were essentially well people. And we discovered the frequency of finding silent colon cancer, silent polyps and all, it was a good study. So that was a true effort to do an academic study.

02-00:33:54

Meeker: Had you been familiar with all the work done on this up at northern California? OK so --

02-00:33:59

Goldsmith: Mm hm. I thought my work was actually -- could have been even far more contributory to this. But I'm not sure. I never published it so it didn't matter.

02-00:34:11

Meeker: One of the unique things about that study ultimately was the findings in which they did --

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Goldsmith: Right, probably remember the study better than I do now but --

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Meeker: Well the findings changed over the years depending upon --

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Goldsmith: I was aware of it to a degree.

02-00:34:29

Meeker: OK but one of the unique things about it beyond the finding itself was the fact that it was -- part of that was the discovery of how unique Kaiser was in that with its members you had a set population that you could follow longitudinally.

02-00:34:52

Goldsmith: That was the basis of my study. At least to follow a set population. I didn't do it longitudinally.

02-00:34:57

Meeker: Like Framingham.

02-00:35:00

Goldsmith: Yeah that opportunity was there and is there.

02-00:35:05

Meeker: This was something that this kind of research, this longitudinal research based on particularly in northern California Collen and his medical records system. Provided a great base to do this kind of research. From my understanding that kind of research hasn't emanated from southern California in the same way. Why do you suppose that is?

02-00:35:29

Goldsmith: I think because we did not have the research leadership to push on that. I think people like me -- and when I was in my leadership role -- would have supported that and we did have some research. But longitudinal population studies I don't think it was brought to my attention to support those at a high level. Northern California its culture began that way, Morrie Collins, people like that. It just was the leadership and the time was ripe and even a person like me in my clinical years, by the time I got to publishing a study which I didn't do, I was already wrapped up into other things and was realizing that I guess I didn't care that much about that. My emphasis was other places. We had research doctors in southern California. We do have studies. Some of my

colleagues might say, “Wait, I want to disagree with you, Martin.” We did a lot. I cannot say we did. I think northern California always carried the flag.

02-00:36:26

Meeker: Some of the studies, like the sigmoidoscopy study, were setting out to influence standards of care for instance in the clinical setting. What impact did the northern California studies have on southern California Permanente? I can imagine that in the larger medical world the weight of the Permanente studies may be -- I don’t know, lesser, or different.

02-00:36:58

Goldsmith: Lesser. I don’t know that the impact of our studies was -- I bet it was more impactful outside than sometimes in our own places. We never had a forum where northern California would come down, say, “Let us share with you this dramatic result so that you can change your practice.” We never had a forum for that. We always were insular. So the results of the northern California Permanente research may have been impactful outside more than even on Permanente. Although there’s some studies inside of Permanente, I know we did a couple on estrogen and birth control pill’s impact on the endometrium toward cancer at high doses. I think had some impact. So it had some impact. But I don’t think we ever at those years organized our research as a strength inside the medical group to strengthen the medical performance. It was freethinking research guys who could have been at the university, had the opportunity to do it inside of Permanente and were supported. Do you see what I mean? It went right to national journals. You’d think it would have gone to the Permanente medical groups first. To assimilate. I don’t believe it did. I’d like to think it did but --

02-00:38:11

Meeker: Well it is an interesting way in which one can talk about the atomized atmosphere within the medical groups and between the medical groups. As opposed to a real close federation between --

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Goldsmith: The medical groups up until the federation were always very distinct entities. That’s a point you know.

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Meeker: That’s what I’m getting at, yeah.

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Goldsmith: So you’re asking about it in a research basis. I’m confirming it. But we were always independent. Well, we legally are independent medical groups. But it was far more than that. It was not in my backyard, therefore stay in your backyard. It was interpersonal differences at the leadership level. They still exist by the way. People didn’t like each other. The leaders. And so we needed a common enemy to bring us together. We’ll get to that story. But we

were very different. North and south were different as two different tribes. They never met. Met once in a while, they'd meet on something.

02-00:39:24

Meeker: Do you remember there ever being efforts to meet? Efforts to bring the doctors together?

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Goldsmith: No. I know I can tell about the efforts I made.

02-00:39:35

Meeker: But that was during the creation of the federation.

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Goldsmith: That's after '94 yes but if you say prior to '94 there were meetings, there was the predecessor to the Permanente federation under Ian Leverton in the nineties, eighties. That my predecessor was a member of. And they would meet.

02-00:39:55

Meeker: What was that called?

02-00:39:59

Goldsmith: It had a name. Not the federation. [laughter]

02-00:40:03

Meeker: It's in the records, right?

02-00:40:03

Goldsmith: It's the Permanente -- I don't know. It had a name.

02-00:40:10

Meeker: It's not discussed much these days.

02-00:40:12

Goldsmith: There was a group of ten guys, whatever the number of medical -- were men and women I guess, mostly men. And they met and there was a leader and they tried to develop policy. They tried to develop where we should go together. But I think there was so many differences they didn't jell very well. And the health plan was frustrated with that by the way. Correctly frustrated. That's what they meant by a lack of successful leadership. Each person himself was very strong and very capable. My predecessor was very capable man but he couldn't very well set up a good relationship with northern California because he himself couldn't get along with the guy in northern California.

02-00:40:58

Meeker: Who was his colleague in northern California?

02-00:40:59

Goldsmith: I'm speaking of Frank Murray. Bruce --

02-00:41:02

Meeker: Sams.

02-00:41:02

Goldsmith: Sams so Bruce and Frank didn't care for each other. So they respected each other I suppose, but they couldn't work very effectively together. They disagreed with each other. And so when I took over I entered into that club but it was ineffectual. Among ourselves we felt it was ineffectual. And we felt -- and we knew the health plan felt it was ineffectual. People blamed different parts of the reason but it was ineffectual.

02-00:41:29

Meeker: OK so you said that you weren't too much involved in research but you did play a role in education. Can you describe your involvement?

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Goldsmith: Well like I said I was actively giving talks. I'd give talks at the medical schools. I'd give talks wherever I was asked. I'd prepare academic presentations. I was training the nurse practitioners how to be nurse practitioners. I was training the residents and the students. I'd go to UCLA and give a grand rounds.

02-00:42:00

Meeker: So you had a faculty appointment at UCLA. How does one achieve that in medicine?

02-00:42:05

Goldsmith: Well in those years because you're going there and taking a rotation they award you it, I don't think it pays anything. They award you an instructor position or assistant professor. And I rose to associate professor. And so that was the position I had. I suppose I still have it. But I have to say I lost interest in -- I got so involved inside of Kaiser Permanente that I stopped doing that in the mid eighties probably. So whatever I achieved academically at UCLA, I was a well thought of teacher from Permanente. There were growing numbers of us beginning to do that. But I just stepped out. It didn't become very important to me to continue doing that. Mainly from a time standpoint.

02-00:42:57

Meeker: How did you rise from assistant to associate professor?

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Goldsmith: I think I called my former professor and said, “Can I qualify for that?” And he said, “Write up your application, what you’ve done,” and they made me associate. I’m sure I wouldn’t qualify for clinical. I never tried.

02-00:43:13

Meeker: What is the difference?

02-00:43:15

Goldsmith: I don’t know. I never paid much -- I lost much attention to it. It was just a title that they bestowed on you.

02-00:43:25

Meeker: Well then maybe you can describe this process by which a clinical physician starts down a path that removes you from that and brings you more into an administrative or business capacity.

02-00:43:41

Goldsmith: Yeah I certainly did not remain an academic, whatever academic means, I was never considered a principal academic guy inside the Permanente system. I did what I could academically and at the university but got absorbed in other things. Administratively, it was simply that I began to show an interest in those things, and my first interest was in what’s called nurse practitioner training. Again I remember saying this. You guys meaning the establishment, it is stupid to have a board certified internist like me see a 19-year-old woman for a comprehensive physical when it turns out she’s pregnant. You’re wasting my time, you’re wasting your time. Why don’t you people train nurses to do this. Well it happened to be around the time we were training nurses. And so someone said, “Oliver why don’t you help train?” So I became the director of the nurse practitioner training, which was my first opportunity to take a managerial opportunity, do something with it. So five sturdy RNs from Permanente at the time and I worked together to upgrade their skills. Then little by little I began to accept administrative appointments. Like chairman of a quality committee or --

02-00:45:05

Meeker: Can we pause on the nurse issue? That’s come up several times because Kaiser Permanente uses nurse practitioners a bit more than other organizations do. And it is not a move without controversy. Because in essence there’s a seeking to greater leverage doctor time by having them not do these tasks that others that don’t have as much training can adequately do.

02-00:45:39

Goldsmith: Well actually I believe thoroughly in that. In fact I would take it to the belief that I think I coined this one too but again perhaps someone else will say, “He didn’t coin that, he stole it from me,” but I think I coined. Once you take the economics and you turn them around, which we have done, where it’s --

change the dynamics on their head and it's called capitation, it leads to the following. And I express it this way. Make the patient into the doctor. In other words take -- forgive my words, the most uninformed person about medical diagnosis and treatment and here's the highest treatment, let's say a cardiac surgeon, most expensive piece, neurosurgeon, cardiac surgeon. And then everything in between is general practitioner, nurse practitioner, nurse, you get where I'm going, patient. The better the economics work you see what outcomes you can get by doing this. Get this patient to do their own cardiac surgery. Let's start with that. If I could figure out a way to get the patient to do their own cardiac surgery, which by the way would be good health, your expenses go down. That's the principle I believe.

02-00:47:09

Meeker: Well that's in essence the principle of one of the founding principles of Kaiser it seems to me because the idea is it's preventive medicine is keeping people in health so you don't have to --

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Goldsmith: I used to tell the story here's my idea. I take 3 million Kaiser members in southern California and I get them all in the Coliseum and -- USC Coliseum and I have a microphone and I say everybody in this room henceforth will be vegetarian, will not smoke, will exercise, and will have the appropriate tests done every period of time and continue to pay me. OK I will take care of all of you. And you'll pay me $7 billion a year. And I don't need anybody else in Kaiser Permanente to help me. You will continue to pay me because you'll say, "Oliver this is great, I'm healthy." Of course this is a story, that's the idea, preventive health. So the nurse practitioner substitution or moving the nurse up to a nurse practitioner up to a doctor or whatever you want to say here is simply part of that spectrum. How about making the patient -- because we know as doctors that when a doctor is ill or a doctor generally speaking is often easier to work with in some modalities because they're already a doctor. They know how to take their own blood pressure. They know medications. You don't spend an hour talking, lecturing about medications. Because they know. So they become more informed. You see what I mean? So it's just that spectrum all the way up so let's say a general surgeon versus a vascular surgeon. I wouldn't mind helping the general surgeon learn a few vascular techniques. You see where I'm going? Or the vascular surgeon learn a few cardiac and on and on and on. So there's opportunities all through here. The nurse practitioner is only one of them. An RN can be better informed than she is or he is. That's how I see it.

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Meeker: Or a nurse practitioner become a midwife as well or --

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Goldsmith: But the patient rising to a level of real health understanding is fabulous.

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Meeker: Well here's the rub and the controversy. And it particularly comes not necessarily from educating patients so they can engage in their own health care better but it comes from having nurses do more work and leveraging doctor time. I know a lot of doctors hear that as that means you're not going to need as many of us.

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Goldsmith: Right now again the biggest criticism I think of my idea would be, "Oliver, you're going to have the nurse take on things they can't do." The nurse practitioner, the general practitioner take on the internist, the internist become the -- it's up the scale. But we need to have evidence-based medicine to assure that doesn't happen, OK, because that's wrong. To have a nurse operate on me, nurse practitioner do my cataract operation. I don't think they can do that. OK but perhaps the nurse can do upper GI endoscopy, specially trained nurse. Others would say absolutely not. Let's let the evidence decide that, I'm open to that. There's yes and no. So but the idea of the economics, there won't be a need for as many of us, well what is this about? The number of us? Are we a profession trying to protect our turf, is it just economics? Of course it is to some degree. OK I recognize that. But that's not putting the patient first. That's not putting the economics first. Economics meaning of the patient. Cost of health care. So why have a doctor, why have me do a checkup on a 19-year-old woman who's pregnant and get 45 minutes to do it when a nurse can do it in 20 minutes?

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Meeker: Because if the nurse does it then Kaiser Permanente doesn't have to pay that doctor's salary anymore.

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Goldsmith: But that means we can lower our premiums and that benefits the patient. Again all of these have potential for distortion.

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Meeker: Being a young doctor and presenting these ideas, were you seen as an iconoclast in some ways?

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Goldsmith: Yes yes. We were, even our own doctors would say what you said. But they'd say it too. They'd say, "We're dermatologists, don't let them hire too many dermatologists. If they don't need us desperately they won't pay us more." So couldn't you say it there too? "Don't train too many historians. Keep few historians, we can charge more." You can say on any economic model. It's an economic principle. But that's fine but this is about something broader and that's the cost of health care and delivering quality. So if I can deliver effective medical care, measured effective medical care, to a population of 3 million patients with three doctors what the heck's so bad about that? If I can.

I can't. Why pack it the other way? That smells of -- what they call that? Featherbedding? Who knows the answer? Some doctors, they -- only a physician can do a physical examination. Oh baloney. Show me the evidence. I'm just trying to be evidence-based. I'm not -- because there are distortions. I've sometimes recommended things that were a little too far but it was in good faith trying to sort this out. So I don't think that's right. I think once you change the economics to salary, I remember one time I was being interviewed by some newscaster. He said, "Why would you, Dr. Goldsmith, a UCLA trained doctor, all this, join Kaiser Permanente, salaried position?" Same idea. OK. I said, "Aren't you on salary?" I said, "Aren't the Supreme Court Justices on salary?" Where'd this idea that salaried positions are held in contempt, they're second rate? I don't know where this came from but it's a beautiful myth. Our President of the United States is on salary. Why put him on a fee for service? Yeah but you know what I mean? To me it's laughable, one of the myths of American medicine. Fee for service engenders quality. And salary. But this whole idea of our medical group and changing the economics and giving people opportunity to do more and weighting it evidence-based is fantastic. It starts with the patient, making them more educated. Why do we have a handbook of self-help? How to take care of a bee sting. Self-help. It makes sense.

02-00:53:54

Meeker: And not to push this issue too far, indeed logically they are very good questions. But there's an institution that exists and there are in fact -- when you are training these nurse practitioners in the 1970s and 1980s there are doctors who -- I know this happened in northern California -- that felt as if their jobs were going to be threatened. How then do you deal with that very real institutional question?

02-00:54:25

Goldsmith: Leadership. There's plenty of work for doctors. One of the reasons for the shortages of doctors in the country is the expansion of things that need to be done with patients. You used to have just a general radiologist, now you have 150 radiologists doing things that never existed before. So there's plenty of additional things to do. Why lock the doctor into doing this kind of work when they can do this kind of work? In fact access is very poor and so the correct people aren't being seen. Because if doctors do trivia and stuff that can be done by a nurse practitioner, and nurse practitioners can do a lot more things than trivia, complicated stuff, they're not doing what they should be doing. So I'm very comfortable with this notion. And Kaiser was great because they pushed it.

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Meeker: To what extent were these questions asked of you and --

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Goldsmith: They were asked.

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Meeker: They were and was that the kind of response you would have made?

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Goldsmith: Yes and some doctors said, “I’m not going to participate. All this does is intensify my work.” But that’s what life’s about. We’re supposed to have intense complex work. This isn’t supposed to be featherbedding. Just because it started that way that you do 19-year-olds who are basically well, that’s not the way it should be. So we would talk about that. I felt very strongly that all of us would be involved in teaching the nurse practitioners because this is an organizational decision. So you joined the medical group, Martin, as a doctor, you can’t opt out, say, “I’m not going to.” Can you opt out on the number of patients to see a day? Can you opt out on hospital rounds? Can you opt out on following the formulary? No, you’re in Permanente. Part of the deal is you cooperate with the consensus decisions made by the organization. And I always was bothered by doctors in other medical centers around here said, “I’m not going to do nurse practitioners, I don’t work with nurse practitioners.” That’s trouble. What do you mean you don’t work with nurse practitioners. We all do, it’s part of new medicine. What do you mean I don’t use a stethoscope but everybody else does. We use stethoscopes. It’s the nature of medical care, that’s why our group is a group. We do things together. Go out and practice in Barstow if you don’t like it. I’m not speaking to you, Martin. But I would. But there’s where the but I mentioned earlier, the need to find doctors who can operate in a group model, you see what I mean, because if you have a choice of nurse practitioner, do you have a choice of everything? Where are the lines? Can you just say, “I use any medication I want, I’m a licensed physician in California?” Not in Permanente you can’t. You have to cooperate with our way of doing business. If you say, “Screw it I’ll do what I want, I’m a licensed physician,” well you better prove you’re right. Because that’s why you’re in a group practice. That’s the benefit of group practice. Can’t be a surgeon who says, “I just do one case a day,” can you? Obviously not. Can’t be a professor who says, “I just teach one class a year, that’s the way it is buddy.” I suppose there are some guys like that but it’s for that’s the decision by the chairman. That’s what you do. Well we have rules like that too. They’re very important for group practice. If you don’t like it -- I’m not being mean-spirited -- go practice by yourself. OK so we had to pay attention to he’s a nice doctor but doesn’t cooperate with anybody. I always felt management, successful leadership, brought those things about. It could be nurse practitioners, it could be our schedule, it could be we’re opening a new hospital. It could be all kinds of advances as a group. You cannot have people say, “I just don’t do that.” You can’t. That’s not your option inside of Permanente.

[End of Interview 2]

Interview #2: 07-19-2006

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03-00:00:15

Meeker: OK, just I don't know if this question is an aside or not but following up on this notion of convincing the members of the medical group that they are members of the medical group and therefore need to abide by the consensus standards of that medical group, whether it's formulary or nurse practitioners, to what degree did the employment contract evolve over the years that you were involved with the organization?

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Goldsmith: Yeah but let me just speak a moment that if you're going to have a successful group practice, its success depends on a certain set of behaviors as a group. That seems to me a given. But to set those and to see them expressed requires management and ultimately leadership to see them expressed. Otherwise it's a group practice in name only or it's falling far short of its potential. And I think that in our medical group we have never realized that to the degree to fulfill that. We recognized that we're all together and we're salaried, we have certain hourly expectations of performance. Full-time means a certain thing, and there's some general characteristics that from the get-go everybody knew. You call yourself Permanente, can't call yourself something else. But when you get into the practice of medicine and the need for standardization and doing things in a similar way, buying similar instruments, etc., our potential is tremendous. But to reach it requires good management, good leadership. So all of the things you're asking about should be expected and therefore you have to have good leadership. That's why most of the medical groups go sour. Now when it comes to the health employment contract I think when I was hired there was no employment contract. It was thank you, go upstairs, see patients. Perhaps there was something I signed, I don't remember.

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Meeker: But there was nothing that said, "These are the hours you're going to work, you're going to have to do one night a week?"

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Goldsmith: Well there's a handbook that says, "Generally speaking full-time is Monday through Friday or a half-day Saturday morning, office hours are generally 9:00 to 12:30," they're general things like that, yes, yes. Now when you use the word employment contract, in the last ten, 15 years because of the world we live in I think every Permanente doctor in southern California, perhaps everywhere, has a specific employment contract, very elaborate. It has the usual lawyer stuff in it. So but that doesn't deal with anything like specific hours. It probably says, "You will abide by the handbook designed by--"

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Meeker: Local management.

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Goldsmith: Yeah by the board of directors.

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Meeker: Does it have anything for instance that you are required to work with nurse practitioners?

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Goldsmith: No it would not. But it would probably say words to the effect of we expect you to abide by the general policies of the medical group and then there'd be hundreds of examples.

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Meeker: OK and so the notion of then good management which leads to recognition of leadership is that those policies are introduced in a way that facilitates coherence, a consensus.

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Goldsmith: Yes good management. Good leadership. And things like the program Vince Felitti espoused. Whatever one's individual points about small parts of it, the general idea that we're going to do this, that we're going to speak positively about it, that this is the group culture, is expected. But leadership has to lead people to get there. Use good management. So in the medical group at least in southern California, I think all over, we spent a lot of time thinking about how to get good managers, how to get good leadership. And I was interested in that topic and tried to play a role in developing that to make sure the group is getting better at expressing its potential as a group practice. All of these things fall into group practice. So the contract was minor. Employment contract was simply a minor legal requirement.

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Meeker: Well let's then talk more broadly about your moving into a management position.

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Goldsmith: Me?

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Meeker: Yeah. And the way that I see it and let me know if I'm missing any of the main steps but you were hired by Permanente in 1969 and then in 1979 you became chief of service at West LA.

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Goldsmith: Yes what happened was in the mid seventies I became the assistant chief of internal medicine at West LA. That was the first actual administrative job. I was thrilled. A very academic superior physician asked me -- who was the chief, his name was Dr. Ackerman -- to be his assistant. I was honored that this happened to me. I actually wasn't consciously thinking about these kinds of things. But by then, that experience and the board experience, I began to think of rising in the medical group or opportunity, OK, but I always felt very strongly you had to earn it and you had to earn it by successfully demonstrating something, like good management, in something, whether it's nurse practitioners, quality audits, or whatever activities you're managing. And so I was going to stay at Los Angeles Medical Center because I really liked it there and the department of internal medicine at West Los Angeles, closer to my home, was a very divisive department, and the leader wanted to step down. They had nobody that was successfully groomed or prepared and they came to me and actually asked me if I would join the department as chief of service. It's very unusual for physicians to transfer inside of Permanente, we're insular. You don't go from Oakland to San Francisco.

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Meeker: So even within a region.

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Goldsmith: No it's unusual. Very unusual. Very unusual. But because I knew some of the doctors at West LA and it was a close hospital it wasn't quite as unique as let's say going from Los Angeles to San Diego. That would have been even more unique. It happens now and again. So I went to West LA as the chief of internal medicine in 1979 and spent ten years there. Yes ten years, 1979 to 1989. As the chief of internal medicine. But I always -- I knew enough about management to know consensus, we all do the same things, some things you can vary, but some things, we all have to work with nurse practitioners, some can do a little more with nurse practitioners, but we all have to work with nurse practitioners. We all have to take the call. I found out to my horror some departments of internal medicine, if you didn't want to take the call you didn't have to.

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Meeker: Take the call meaning?

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Goldsmith: Work the weekends, work the overnights. There's certain rules like if you're over 55 you didn't have to work all night in the hospital. But I wanted everyone to do everything. The chief included. I have a sense of democratic we all do it. If you're ill you don't have to or something. But we all do it. You can do it more than I do but I can't opt out. That's part of the deal. I found out over Permanente we often didn't act like that. And I always felt it was a failure of management. Failure of leadership. You took the easy way out. You

let Dr. -- or Martin Meeker not take call on Sunday because he wanted to be home. What do you mean? He's a member of the department of internal medicine. Well he said I can hire a resident to do it. Well that's not the same. He's a member of the department. Make him do one Sunday a month. I found out people didn't do that. Bothered me a lot. But in my department I tried to make it uniform. Lots of those kinds of principles, we'll all do the same thing. I realized that physicians needed an evaluation. The culture of American doctors is no one sits down and says you're not -- here's where you're good and here's where you're weak. I instituted that. I felt in my department of internists I'm going to sit down with everyone. It doesn't presume that I'm a better doctor than you but I'm the chief and you're not and I'm going to sit down and tell you what people say about you. And I did that every year for a period of time.

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Meeker: What were the tools of evaluation?

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Goldsmith: We had very rough tools of evaluation. I would get patient complaints. I would ask colleagues. I would know your work schedule. I would hear from the administrator. We had some measurements of productivity. They were rough measures. But it's what we had. And I would try to make it this isn't science. I'm saying you equal four. But I would say, "Look what I think you do very well is the following but I think you could do more in this area." And I would actually say, "Do you understand me?" And I would write it down. And the next year I would say, "Martin do you remember what we talked about last year? I mentioned to you the complaints I get from nurses about you. I want to thank you. I haven't heard any complaints. Or Martin it's gotten worse." You see what I mean? So I would try to make elemental suggestions to people and then I would say, "What can I do better?" I meant it. Tell me how I can be a better chief and how I can help you. And I made notes of that. I tried to improve to some degree. So I instituted that in the department of medicine. And I was recognized as a fairly decent administrator. Paid attention to details, tried to get rid of doctors that weren't doing a good job. Tried to penalize someone if they weren't doing a good job. Tried to be fair. Tried to learn. Was difficult work because being a chief of service is very difficult in our group. But I tried to act as the chief of the department. And then so then I was recognized for it. In our medical group doctors don't like their chief, their boss. We don't use the term boss. We recognize superior if you're a better doctor. Like if I'm a professor and you're not you might look at me as earning my right. But just calling me chief, doctors don't like that too much. So we always have trouble finding managers, managerial physicians. But we find them. We have thousands of -- not -- hundreds. 25 departments in every medical center -- 12 departments. That's 500 doctors who are managers. Some are becoming good leaders. So those are some principles I believe. The one about nurse practitioners, we're all together. Certain expectations, certain performance evaluations. I believe in those things. Denying certain doctors

raises because of their performance, I believe in that. Hard to do. And when a doctor said, “You’re not going to do this to me I’ll take it to the board of directors because we’re a democratic group.” I said, “I think you should. I’m only doing what I think I can do. You have a right to say, ‘You’re not going to do that to me.’ Take it to the board of directors. But I can assure you if you take this issue to the board of directors I will give my side of the story. This isn’t going to be one-sided. Because I don’t think I’m doing this personally. You’re getting too many patient complaints. So we’ll go before the board of directors, you’ll tell them that Oliver took away $3,000 of your salary, you’ll say it’s not fair, I’ll give you as much time as you want. And then they’ll call upon me. And I’ll say, “Make a decision, you guys, am I doing this because I don’t like the person or am I doing it because it’s right?’” I always felt keep the light on these things. I think I’m right. Think that’s why they hired me as chief of service. Try to do the best I can with this. And that actually worked. With all the gray hairs and whatever else it generally most doctors did not feel I was personalizing at them and I also was very keyed in on recognizing the but we were talking about earlier. So when I saw a young doctor who was capable but, I acted early to get them out of here, because it’ll only get worse. If you’re 30 years old and don’t know how to talk to patients or behave with nurses you’re not going to learn at 40.

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Meeker: What is the period of time between hiring and partnership?

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Goldsmith: It was three years. Then it was two years. I think it’s back to three years. So I always felt completely comfortable that if you’re a bozo in your first year you’re not going to be fine when you’re 30, 35 or 40. Get them out early. Once they’re a partner it’s more difficult as it should be. But there are ways to deal with errant partners too and I always felt we should. You cannot overlook these things. Harder but do it.

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Meeker: So the power of doctors and I’ve had this conversation with others in these interviews before about perhaps the parallels between tenured professors and members of a partnership.

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Goldsmith: Let me just say many doctors and you’ll talk to some I’m sure who feel that we don’t have the wherewithal to deal with this.

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Meeker: The wherewithal.

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Goldsmith: In other words like a tenured professor, they can be as loony as they want for some reason. I don’t want to get into tenured professors but they can be as

loony as they want until they try to kill somebody, then you can get them out, OK, I actually think that's a myth inside of Permanente. I have always believed that if I approach this issue in a mature way as chief of service and do my work the right way with fairness and the patient first and evidence and documentation and graduated punishment if you will, it's a myth that I can't do anything. Because what I know through experience, that when you say to a doctor, "I'm reducing your salary $25 a month," one might say "Huh that's nothing." It ain't. It's considerable. And if this doesn't improve it's $100 and if it doesn't improve it's going to be $4,000. You get their attention, OK, because I'm not going to work next door to you in the office for $25 less, right, I'm going to put up a fight. I'm going to change my behavior. Or I'm going to fight you on it. Welcome, let's do it. Let's get the truth out. I'm done hiding. So I believe it's a myth that we can't go after doctors. Who are bad. I'm saying -- that's what the definition of a profession is. That you self-police yourself. That is one of the definitions of a profession. So we're actually hypocritical if we say we're the profession and we ignore some -- now we're not talking about stealing and incompetence and alcoholism, the backroom, those are pretty easy to get to. Sex with your patient, stuff that's so bad it's criminal, we're talking about behaviors of good care, OK, we have to look at those things, and I believe Permanente has gotten better on it. So I was trying to answer your question about group practice and leadership. And I believe if the chief is sincere and doesn't give this wishy-washy act, we can't do anything about anything around here, that's an excuse.

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Meeker: OK during this period of time in which you were chief of service, I see that you were director of something called the Health Evaluation Center.

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Goldsmith: Yes, I liked Vince Felitti. We were colleagues. We had different ways of looking at things but we basically believed in mass centers of screening. Morrie Collins kind of ideas. We each expressed it differently. Vince and I were very respectful toward each other. I happen to think a lot of him. I didn't always agree with his specific way. But it was more tactic than concept. And there's a certain at times a lethargy from my point of view inside the medical group. Hey come on let's get going, let's do this. So I took the leadership of that to just get it going. I like to sometimes just say, "Let's just do it." I think the mark of a good manager is hey let's just do it. But sometimes I can't get people to do it. Can't do everything. So I'll do it myself. So we did it.

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Meeker: What was it?

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Goldsmith: Well it was instead of a patient calling and being told it'll be three months to get a checkup we'd say the minute you call we're going to get you in within a week and start all the lab and start screening and a Vince approach. And you

may get your physical a month later, the actual hand touching physical. Or we'll try to do it when you're there. If you're 50 years old and you have some complaints we might get you in in a week but if you're 19 and you're well we'll get it all done. Mass medicine. Sacrificing personalized care. But what's better? Waiting three months for personalized care when you might be bleeding to death and have some ominous disease? I always felt get them in. It'll get personal when we get them hooked up to a doctor but get them in. They deserve this laboratory testing. They deserve that first screen. They deserve to say to a nurse practitioner or a nurse, "I'm bleeding into my urine. You want me to wait three months for personalized care?" Hell no. Get them in. So that's what we were -- and Vince was doing that too. In a very comprehensive way. I was doing it just in a get it going. That's what that director of health screening was, whatever the --

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Meeker: OK I see this started in 1979. Was this an early initiative of yours?

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Goldsmith: Well others were doing this too. I believed in it. I don't think it was necessarily -- it was not something I came up with. Vince was doing it. I think each -- some medical centers weren't doing it at all, to their embarrassment, because some of the old guard, same idea, what would they need us for as doctors if they do this, well, I find that comment -- your comment was accurate because that's what people say. Repulsive. There's so much work for doctors, it seems self-evident. I was just carrying it out, that one, multiphasic screening. I want patients to make a phone call or an inquiry and get seen. I can't always supply a board certified internist the moment you call but I got to supply something. That's the way I felt. Very pragmatic.

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Meeker: Was there any effort to use the data collected at the Health Evaluation Center for purposes other than the individual patient?

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Goldsmith: No, I always wanted someone to do that. But I did not have the time or propensity to take it on. That would have been great but it takes a grant and time, so forth. We were always so overwhelmed with patients, I couldn't get to it. So that was that ten-year period. By that time in the eighties I became what they call the coordinating chief of internal medicine. I don't know if that's on there. But there were 12 chiefs. Each medical center had a chief of internal medicine. But Dr. Murray, the medical director at the time, had a coordinating chief. So there was an internist who was in charge -- not in charge, but coordinated all of the other chiefs.

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Meeker: This was not the two-pronged approach that he developed with clinical and operations?

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Goldsmith: No that was his business development, very wise, which I continued. This was simply he wanted all of the internists or all the dermatologists or all the general surgeons to work together to spread best practices. So he had 12 chiefs of surgery, 12 chiefs of dermatology, in southern California. And you would have a coordinating chief so that was a more leadership opportunity for me to be that person.

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Meeker: What challenges were presented to you under those auspices?

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Goldsmith: Well at that time it was trying to get all of southern California's internists to do certain things together.

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Meeker: For example.

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Goldsmith: Work with nurse practitioners, multiphasic testing, well, a simpler one was let's each recognize an outstanding physician in our group. Let's each department -- the coordinating chief, I would try to get people to do things like performance evaluation. A little one. I think we should all select an outstanding physician in our department. And here's a typical thing someone said, "Well Oliver if we're going to do that we ought to get a gift to give him like $1,000 to make it meaningful." I said, "You're asking me to go to the Dr. Murrays of the world and say we need $12,000 to give this award, which means he's going to have to figure out how to give $400,000 because he's going to have chiefs everywhere. You're missing the point." When a department of peers selects someone as the outstanding internist of the year, that in itself is a very very special honor among physicians. You don't need to give them a gift. Give him a card, flowers, a plaque, I'd love to give him $1,000 but I disagree strongly that it undermines it, not giving him money. Pick me as the outstanding internist of the year. I'm honored, I'll go home to my family and say, "What an honor that my colleagues thought that about me," that'd be quite an achievement. So we got everyone to do that and every year at the internal medicine symposium they have someone stand up in each department so I'm told now, it may have evolved, and get internist of the year. I'm very proud of that. That's an example of good practice spread.

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Meeker: I also know during this period of time you spent some time at the executive program at Stanford University.

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Goldsmith: Yes. The medical group, correctly at the time, and subsequently even more, was trying to identify physicians for potential growth and opportunity. It's a

mixed bag in the medical group. The minute you say that you're interested in rising up administratively we don't want you. I used to say do you want someone who doesn't want it. Do you want someone who hates being a medical director? What good is that? You should select people who are interested in it. I openly said I was interested in it. So Dr. Murray -- well at the time, I don't know what year that was. Does it say there?

03-00:23:05

Meeker: '83 to '84.

03-00:23:07

Goldsmith: Well in '79 I actually was on the board and ran against Dr. Murray to be regional medical director. And I lost. But I made it to the finals. And I'm quite proud of that. I became visible to the entire medical group because I debated Dr. Murray.

03-00:23:22

Meeker: To what degree is it a candidacy that you run for an office?

03-00:23:25

Goldsmith: Just about, just about. The finalists go around to every medical center in front of hundreds of doctors and talk. And say why I'm the best guy. And there's about 50 candidates and then they eliminate, eliminate, eliminate.

03-00:23:40

Meeker: What was your platform as opposed to Dr. Murray?

03-00:23:43

Goldsmith: My platform was twofold. One was totally humorous, you can't trust anyone over 42, and I was 41, and doctors have a great sense of humor. They understood that completely. Except for some buffoons who said, "He's so self-serving, he's 41. Made the cutoff at 42." But it was a joke of course. The second was we need someone young and ambitious and interested in changing this group into a much more effective organization. OK it played very well in the medical group by popularity but at the end of the day the board makes its decision and they made the right decision, Dr. Murray was the correct person to choose. He had maturity. He had run one medical center. He's good. He knows what he's doing. And he led the medical group successfully for about I think 12 years or ten years. OK and I was his area medical director West LA. So after that he offered me the opportunity to go to the Stanford course to get some real academic training. So I went to that and profited from it.

03-00:24:42

Meeker: How early on was there a sense that you would be a serious contender for medical director?

03-00:24:47

Goldsmith: Well once I got to the finals in ‘79 I think I carried the emblem or epaulet or whatever they call the thing of someone who probably would try again because I was pretty young. It would not have been very helpful to me to get that job. Talk about going from I want to work from 9:00 to 5:00. My kids were young and it would have been colossal challenge for me. I don’t know whether I could have done it or not. I think I could have but would have been premature. So I already was recognized as one of the guys that was coming up in the groups. Whether I’d get to do it again I don’t know but I certainly continued to have opportunities given to me to be in administrative medicine.

03-00:25:28

Meeker: Well during that ten years you must have at least had in the back of your mind that this is a possibility I might run.

03-00:25:36

Goldsmith: Absolutely oh I talked about it.

03-00:25:36

Meeker: How then did that influence the way that you worked?

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Goldsmith: I wanted opportunity. I sought. If you -- for example to be the coordinator of internal medicine. I wanted that. I wanted whatever opportunity came up to demonstrate that I was capable of doing these things. So I’m sure I had -- I don’t know if I listed it but I had different opportunities given to me. But it was me, people knew Oliver wanted to be medical director. I had already run and lost. So I expressed it. And I was going to try again when the time came. And then the time came for Dr. Murray to select an area medical director at Sunset and it turned out that Sunset and West LA came up at the same time. I don’t know if he remembers this like I do but my memory’s better. He called me to be the medical director at Sunset. Because I was already reasonably established. Doctors tend to -- when they have two candidates for a job, the doctors, here’s how you get the job, in a lighthearted way, I hate this guy and I don’t like Oliver. So therefore I like Oliver. OK it’s not I love this guy and this guy’s good. It’s I hate this guy and I’m not sure I trust Oliver.

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Meeker: Lesser of two evils.

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Goldsmith: Yeah and I think that actually, it’s a play, but it’s not too far off from medicine. There’s no absolutely powerful popular person who does anything very strongly because it’s hard to find those kind of people. We’re all with our warts and stuff. So Murray wanted me to go to Sunset, which was our flagship, but I already was living close to home at West LA and I was already very well liked at West LA and I said, “Frank, I don’t want to go to Sunset. I

want to stay at West LA." He said, "Oh come on you got to go to Sunset, it's your opportunity. Maybe after that you'll become in my job." And again my querulous nature I think showed itself. I said, "Frank, the answer's no." He said, "What if you don't get to be medical director at West LA?" I said, "I'll take my chances, I like being a doctor." I said, "I'll tell you what, there's one man at Sunset I favor, he'll take the job." Said, "I don't know him that well." I said, "Trust me, he's very good. If he doesn't take the job send out an announcement that Oliver's taking the job. Don't even call me back. Because I'm a company man and you're stuck. You're in trouble. I'll take the job, I don't want it, I'd rather stay here. But you are stuck." While he was calling this other fellow I had his phone number and I said, "John you've got to take the job at Sunset. It's a fantastic opportunity, which he did." He appointed him that job. And he came to West LA and he found out what I knew he'd find out, that I was well liked by the doctors. He appointed me the area medical director. It all worked out. So I was one of Dr. Murray's area medical directors. Four, five years later then it was clear I was going to try for the last job. And there was that opportunity where he retired and I took that position. That got me through '93 -- '92.

03-00:28:47

Meeker: I don't mean this question to be too challenging or something but the way in which this is described, especially when you have this ten-year period of time when Murray is the medical director and you've already run for this position and it was anticipated you would run for it again, I just think about the analogy to political life in which somebody is announced themselves as interested in a position and the original reason that they often want to run for something is ideas and ideology but then in the process of trying to achieve that position so they can realize those ideas, politics intervenes. And which really means being confronted by all sorts of challenges that may challenge your ideas. So in politics for instance it's special interest money making you change your ideas. I wonder what sort of challenges -- and I think the one you just told is probably an example. Maybe there are some other challenges you were presented with.

03-00:29:52

Goldsmith: Can I repeat that back to you to see if I got it? In other words you and everyone else know that you want to be medical director the second time. Don't you begin to conduct your political life to curry favor, to curry support, years down the road, by taking stances which ultimately look like you're being politic. Am I trying to say that correctly? And you in fact undermine your credibility at the end of the day, or you strengthen it, but you certainly make enough enemies that you've taken strong stances.

03-00:30:30

Meeker: Actually less -- whether you undermine or establish your credibility, you might -- the point is that you might undermine your own personal beliefs.

03-00:30:39

Goldsmith: Yeah either you undermine the support or you undermine who you are. Or you become a typical politician in the most negative sense of the word. Am I saying that correctly? Well I think that some people do. Maybe I did to a degree. I'm sure it operates on different themes. I suppose it would be fair to say that at times I wondered about that. If you support nurse practitioners what about us. Do you always stand up and support more money for the doctors. Or do you start to say, "Look we got to be reasonable this year, there's a budget problem, we can't always ask for money for ourselves, we might lose votes." I'm trying to take stances to show you that. Now I freely say that these things enter my mind because I'm thinking. But on the other hand you have to understand something I believe about our doctors who I know -- I knew pretty well. Foremost I think they want to understand where you're at on things. Well first place they want to like you. Back up from content. I believe doctors, I believe this is in my book I said this, I believe doctors, maybe all people, but certainly let me apply it to Permanente doctors, I think I have some expertise, will adhere to someone they like. And will not adhere. So for example I believe that if I don't like your idea I might start saying, "Well I think Martin's making some money off this himself or he wants to be chief or he wants to be dean." OK so you, Oliver, have to overcome that by who you are, open. I disagree with you. I think we have to modulate our income this year. I'm no pussycat, I'm not afraid to stand up. But I think we have to be realistic. At least you know where I stand. You see? So I think physicians in our medical group they have to first like you, which equals trust, which equals your ego is not dominant, which equals you're listening to them and your behavior is a rather model behavior. Because they'll find the fault in you. If you begin to equate yourself as the best doctor or the all-powerful chief. Or you begin not to listen to them or whatever the hell it is or worse. Take positions just to curry favor. They'll see. So they have to -- once they have that positive attitude toward you which I generally was able to maintain, not by everybody, then when you took stances as long as you tried to explain yourself. I know we disagree, Martin, but this is my belief, and here's my evidence for it. I respect that you don't agree with me but this is where I'm at. And I think if you think about it enough you might change your mind. You might. Or you'll say, "Martin you've convinced me, I'm changing my mind. Because I think you're right, I'm wrong." People love that. And so -- as long as being honest. Well I can go both ways. Sometimes I could say, "I'm not going to change my mind, Martin, you're completely all wet. And let's talk about it more." But sometimes I'd say, "I think you're right, I've been thinking about it. I'm not afraid to change my mind." So taking positions on things, at least in the medical group, didn't necessarily weaken your stance. At least I know where Oliver's at. At least I know he wants to be medical director. OK I'm not going to get up there and say some stupid thing like I don't want to be president. I do. But I took the next step and said, "What do you want, a guy that refuses to be president, a guy that says, 'I hate committees?' What do you think being medical director is? You go to

committee meetings. Do you want to hire a guy that says, 'I'll never stop seeing patients? All day long?' When's he going to be medical director?" And on and on and on. I make jokes, jokes -- humor takes you closer to the people. I would say, "If you don't want doctors to manage you do you want me to have the health plan manage you?" OK how's that for a good one? No we want you. So the answer to your question is effective management or maybe leadership can get you there. I never felt that I was getting compromised by that. Because I tried to take my views. Sometimes they say, "I don't know, which view, let's take a vote," but not always take a vote. You can't always take a vote in the medical group. There are times you got to say, "This is what I think we should do and I don't care if you like it or not like it. You have to do it." So you have to choose. I took a course at that Stanford, course at Stanford, where the OE person, one of those tests, are you passive, are you aggressive, are you whatever you are, and I was kidding around, I said, "Did I win?" Just for fun. And the fellow said to me, "Oliver it's not a matter of the right answers." I knew that. He said, "It's," and this is very profound, "it's a matter of the right attributes at the right time." For example there are times for me in management to be very passive. To listen. To go along with the crowd. To take a vote. To say, "Whatever you guys want to do we'll do." There are times for me to say, "I don't care what anyone thinks, we're doing this." I used to say, "Over my dead body." But that gave people an opportunity. But you have to choose the time. And the reason this is so important is we generally do this out of our own personality. I tend to be a directive person so I'm telling you what to do. Well there are many instances you shouldn't be a directive person but that's where you're comfortable. Or passive. Or I always tell the truth. Well that's a blunderbuss. Timing is everything in truth. OK, but some people are comfortable thing, one thing you hear from me is the truth. And I refuse to kid myself. My wife and I kid around saying, "You mean from Oliver you don't hear the truth?" So the test -- that experience at Stanford taught me to try to apply the right -- sometimes you need to be just a tough ass and I don't want to hear any more guff from anybody. But not all the time. And on and on and on. So that's what I mean. I've been very interested in these characteristics.

03-00:37:01

Meeker: Well speaking of these characteristics do you recall what your outcome was on that personality test?

03-00:37:08

Goldsmith: No but I think I took it again a couple more times. I think I'm a mixture. Yeah people who meet me generally say, "He's the social butterfly, he likes to go to cocktail parties, he likes to talk to people, he's constantly --"

03-00:37:23

Meeker: An extrovert.

03-00:37:24

Goldsmith: Extrovert. But I think the actual testing shows a mixture. If you ask me what I am myself, I'm certainly that. But if you ask my wife she'd say, "He likes to hide away and read poetry and do his music."

03-00:37:42

Meeker: I've noticed on that test, I've taken it a few times, and it's always used --

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Goldsmith: Did it get you in one way, another, did it --

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Meeker: Actually it's been fairly consistent. I took it once in high school and then I just took it recently. Try to figure out what to do with my life and I think it was pretty much the same, which I found --

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Goldsmith: Were there mixed elements in it? Or were you pretty much a characteristic period?

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Meeker: I think two of them were mixed and then two of them were very --

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Goldsmith: My other problem is I don't like to take those tests. So I finish first.

03-00:38:16

Meeker: I noticed one of the things that when I take them I think, "OK is this really who I am or is this who I want to be?"

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Goldsmith: Exactly, gets mixed up.

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Meeker: Yeah and that has to do with the extrovert thing. I like to think of myself as an extrovert but I know that my behavior says that maybe I'm not that much.

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Goldsmith: Whatever it is, I do think that applying the right characteristic to the right problem is important. And jumping ahead, when I became the -- I don't know if this is still germane, but when I became the regional medical director, there were significant group of people who said, "Oliver's not capable of this job." And what they meant by it I think was, "He's not strong." I believe that would be what they said. He's weak.

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Meeker: When you say regional do you mean the area associate medical director or the southern California?

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Goldsmith: When I went for the second time to be the regional director and successfully achieved the job I humbly believe that it was a combination of, "I can't stand this guy, maybe he's going to be able to do it, despite I'm a little worried he's strong enough," and then other people saying, "Oliver's not strong enough, we'll take this guy and stuff like that." It's a composite. And so soon after I became the regional medical director, where you're supposed to be tough and strong, that is part of the deal, we embarked on some policies that turned out to be rather difficult and unsuccessful but did require my being strong. And for example we set out to close Kaiser Hospitals. And that was a very turbulent era. We set out to deal with Kaiser Health Plan. It became a bunch of -- I could bury this for 12 years -- a bunch of nutcakes in my view on certain ideas which I'll get into. So my strengths came out to my own satisfaction. I saw I had it. I had what it takes. For that job.

03-00:40:12

Meeker: Well I definitely want to get into some of the stuff and I think that -- let's see. We've probably got about another 20 minutes. So we'll certainly have to save the vast majority of that for tomorrow. I'm wondering if you can maybe just offer from your perspective how it was then that you were elected to become medical chief or medical director.

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Goldsmith: You mean what accounted for it?

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Meeker: Well for instance how did you campaign, how did you --

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Goldsmith: First place I'm good on my feet. I can speak well. I'm a public persona. I know how to make a lighthearted self-deprecating remark. Like a politician OK. I know how to engage with people and be respectful toward comments. The opponent I had was more a businessman, more official, less personable, and tended to be a little bit more secretive person.

03-00:41:08

Meeker: Can you remind me who that was?

03-00:41:08

Goldsmith: Dr. Goldstein. Just his persona, OK, he was a finance guy, etc. And so my campaign was based on at the time just my intuitive thinking. I'll campaign as -- certainly I've had the experience. There was no question. He was more the corporate guy all the time. Appointed to jobs rather than getting management,

he was not a people manager. People knew that. He was brilliant. But he wasn't a people manager. So I made the point that this is about people management. I had the experience of people management. Which was incontrovertible. Secondly I was a clinician. So I came out of the ranks of clinical doctors. He hadn't practiced in ten or 15 years. That was simply my trying to distinguish our characteristics. Obviously appealed to -- I pointed out that I'm a primary care doctor. Why? There's more primary care doctors. You know what I mean? In the medical group. That I both was hospital-based, because I was a gastroenterologist, and a primary care. These were true. I thought they were right to say. That I had generally been successful wherever I went. Two medical centers. Because I had been. So I pointed out rather evident I thought true statements. And then in the presentations I had the good skills to keep people feeling good about me. I knew more people than he did. Even though he had been in the corporate office so many years. I had been so many different opportunities, more people knew me. And at the end of the day he was more disliked than I was. I wasn't disliked. Whatever my negative characteristics were weren't sufficient. And I was trusted. I generally had been trusted. Tell me something in confidence, I generally keep it in confidence. So that combination was my campaign.

03-00:42:51

Meeker: What was your clinical practice like during the years in which you were at West LA?

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Goldsmith: Chief of medicine, I had an active practice. Probably a little smaller than some of the others but I made a very big point about equal workload.

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Meeker: So was it about half time that you were seeing patients?

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Goldsmith: No I saw -- well whatever it was I don't recall. Could have been six tenths, seven tenths. But in the eyes of the department I think they felt Oliver's pulling his load. I took the call. I always made sure I was in the emergency room, took the overnight call, sometimes did a little more than I should because I tried to be sure that no one would say, "Yeah he comes up with these ideas but he didn't do it." I thought it was very important to be perceived really as doing the work.

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Meeker: Well that's interesting because a lot of the physicians I've spoken with who've gone into administrative roles, there is this reluctance to give up the clinical side of their practice but there's also an understanding that you just can't do both well.

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Goldsmith: Well both are -- no, it's clear to me. You cannot be an effective manager, leader in the medical group, without seeing patients. Now at some point, maybe regional medical director, no one expects you to see patients. But that cut happens way up here. Way up here. The current medical director of Permanente in southern California once in a while sees patients. I still see patients. Half day a week. At Inglewood Kaiser. I'll tell you that story. Maybe I'll tell you now. When I was the area medical director of West LA I did not see patients. Perhaps I could have a little bit. But I didn't. Whatever the reasons are. When I was chief I had an active practice. But it is the kiss of death for leaders to rise up in the organization and stop seeing patients early. Kiss of death. If you want to rise up in Permanente keep seeing patients. First place --

03-00:44:46

Meeker: So for instance that happened with Irving Goldstein.

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Goldsmith: Stopped seeing patients early on. Kiss of death. Many. Now on the other hand, to say I'm going to be a leader, a manager, and I'm not going to give up any of my patients, that's a joke, how are you going to get to all these meetings you have to go to? Not have meetings? You're not an administrator if you don't go to meetings, OK, so you have to see patients but the more important part about it is from a political standpoint in the eyes of the doctors you're a doctor. And from the leadership standpoint from the eyes of the doctors you understand. That you can only see so many patients, do so many things, etc. I used to have an expression that came right out of my practice as an internist. There are so many little things a doctor has to do today so if a guy like you -- let's put you in a category as a bureaucrat. Came and he said, "Oliver I need you to do one more thing in the office. Write down if they smoke or don't smoke." Maybe I picked something that's so important I should do it, but let me just pick on that one. Martin, I'm not doing one more 15-second activity because you think it's right because I don't have time anymore. You don't have time to do that? Of course not. I've got 95 other things to write down. In 15 minutes. You only get that understanding when you're in the pit yourself and by the way the doctors know you're in the pits when you say that. Because it may sound good, that's why we're automating our medical records. I can't do it anymore. Smokes, bathes, brushes his teeth, wears his seatbelt, you know what I mean, doesn't eat eggs. God knows, what the hell you want from me. So get in the trenches with the doctors. They want that. Plus in their eyes you're going to be a medical leader. Now at some point you just can't. But get out early kiss of death. It means you really didn't want to be a doctor, I think. I don't care what anyone says. A lot of us are doctors because we really like being a doctor, it works for us. But some people are carrying the title of doctor but really in their deepest inner core there's something in there that didn't really ripen. Doctors understand that I feel. You can make it to the top in the organization and be one of those doctors but it's a whole lot harder.

We want to see one of our own. I actually believe this completely. So for example this job I have, I'm the president of this company, when the guy I was negotiating with, I retired for two years, I was working half-day a week at Kaiser in Inglewood. Seeing patients, urgent care. My colleague said, "You're the senior medical director, retiring? Doing urgent care? In Inglewood? That's like nothing." It's everything. It's everything. It's so much fun I can't believe it. I'm learning the health record, the electronic medical record, stimulating, I won't get Alzheimer's early, but more importantly I like being with the patients. I even see some of my old patients. They're 90 years old now. OK when this fellow hired me I said, "You want me to be president of the company, I'll take it full-time but every Tuesday afternoon I go over to Kaiser and work as a doctor." Said, "What? You can't do that and be president of a nationwide company." I said, "Well then don't hire me. That's the deal. I'm going to go out as a doctor. Not as a president of a company." I like this but that's not -- I'm going out as a doctor. That's important in Permanente. It's great. OK is that where we're at?

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Meeker: One more question.

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Goldsmith: Yeah no take your -- we're doing fine, Martin.

03-00:48:36

Meeker: And that is well you've answered it to a certain degree just now. By describing your commitment as a doctor first and foremost and how that had appeal to other doctors. So I think -- and correct me if I'm wrong but it sounds like perhaps one of your main agenda items or platform notes upon becoming medical director was to ensure that there was a doctor in that position. And you knew that --

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Goldsmith: Yes the medical group needs a practicing physician. Now I stopped practicing for ten years. So somebody'd say, "Well what do you make of that."

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Meeker: But it's like this existential category as being a doctor and something that perhaps you felt like your opponent wasn't.

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Goldsmith: Yes and by the way that goes all the way back to the beginning. The medical group and the health plan. And I remember my opponent, we became quite good friends, he took great umbrage at this, when I said, "Look you have -- the health plan has a businessman," this guy was a prototype businessman, don't think he ever smiled in his entire life. Good person. I said, "Now you're going to have this other fellow, you're going to have two businessmen," I said, "Where is the practicing physician?" That was powerful. OK that was

Reaganesque if you will, OK, and he took great exception to it. But it was too late, the damage was done. That was a political fight so I took it, I took it all the way. Played the game.

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Meeker: What were your other agenda items?

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Goldsmith: As medical director? As regional medical director? Well, that wasn't an agenda item, that was just the qualifications for the job. And well it was to empathize with the primary care physician, the physicians. To understand always keep them in mind. Ask of them things. Push them. Push them hard. But never forget they're in there seeing patients and how difficult that is. Whatever the specialty. That was very important to me. My second agenda was -- well actually primary care was the biggest challenge of the medical group, above surgical challenges and pediatric -- try to work harder on primary care. Terms of staffing, terms of doctors, in terms of understanding. My third was accountability. In other words you have to decide -- you can't just be salaried, we're all the same. You have to have some doctors get more for something. It can't be fee for service because I don't believe in that, that's too easily disturbed and manipulated. But it has to be something and what are little somethings? Well one is hours worked, we already had that, if I work more hours than you, I work every weekend, I should make more money than you. No one would argue with that. I'd think.

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Meeker: But there was an equality in hours worked, was there not?

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Goldsmith: No, but one is just time, if you're working one weekend a month and I'm working three I don't think anybody would be reluctant to see me make more money than you. Or vice versa. Two, do patients like me? So my big accomplishment was to carry Dr. Murray's work about rewarding doctors for their patients' evaluations. So we developed -- he developed, or somebody developed something called MAPs, member assessment of physicians, and so each six months we recorded patients' views of us and if you scored above a certain number you got your raise. But if you didn't you didn't get a raise. Try that one on. Sorry, Martin, you're not getting a raise this year. Why? Your patient scores were low. We'll give you video training. We'll have you work with actors. We'll do something to help you. But you're not getting the money till you get that score up. That was an achievement that took place during my time. Very proud.

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Meeker: But that's probably not something that you ran on.

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Goldsmith: Well it was under the rubric of accountability. Let's find ways to measure what's good. Three was actual measures. We're going to actually measure productivity. And so forth. And we never could get successful measures. So it failed. But even that I was open. I said, "We're never going to do this until we get everyone, especially the people measuring, to trust the numbers." Because you can't measure doctors on numbers they don't believe. The doctors came to believe the patients' numbers.

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Meeker: Why did the productivity fail?

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Goldsmith: Well because we never found an underlying trustworthy number.

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Meeker: What were some of the numbers tried?

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Goldsmith: Well like number of surgeries per day, per year. Number of patients seen per timeframe. It was just during my tenure we never found credible numbers.

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Meeker: So the exceptions in most cases proved the rule.

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Goldsmith: Yeah we just couldn't get there. Do objective tests.

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Meeker: In a subjective world.

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Goldsmith: Yes so I ran on accountability. I believe I ran on we're going to be an equal partnership to the health plan. We'll get to that. That we're going to be a business. Murray had started that. Now that was his medical ops and clinical. He gets credit for that. But I carried it, continued to carry it. As strongly as he did. I felt very comfortable with that notion of his that we're a business. So a business means you have measurements, you have costs, you run a budget. You work hard, you make the budget even, otherwise it's a joke. So I continued to do that and actually the guy that ran against me, Dr. Goldstein, was my chief of operations and was very effective at that.

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Meeker: So you kept him in the same position.

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Goldsmith: Oh yeah it was just two guys wrestling with each other. Became very close colleagues and friends. So he ran that part and so those were the -- primary care, accountability, think like a doctor, strong with the health plan, and business.

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Meeker: Why was primary care an issue?

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Goldsmith: Because in the last two decades specialization has become so dominant that the day-to-day life of the primary care doctor is probably more difficult than anyone else's. The adult primary care doctor.

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Meeker: When you say difficult?

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Goldsmith: Chronic disease. People's expectations. People bringing in Internet articles. People not accepting death and dying. People wanting to be healthy without doing everything it takes to get there. Give me the newest medicine. I saw it on TV. Dealing with the public in that sense. It's hard, hard work. I'm in urgent care just seeing patients in urgent care. It's easy. Because I'm not their doctor. I'm just seeing them for their illness. Let me help you. Which I like doing. But when you take care of patients day in and day out and they call you back and they say, "The medicine didn't help, I'm still in pain," "Let me give you something else," "I'm still in pain, I need medicine, I need a referral to two specialties, I like to be seen within a week, and you know it might be three weeks, please call the other doctors and get me in early, you're my friend," that's hard work. Wife calls, "How come my husband's still in pain, how come you didn't call me back yesterday, that's damn hard work for a doctor." People don't love their doctors as much as they used to, I don't think.

03-00:55:42

Meeker: Tomorrow we'll talk more about what you did in each of these areas. So let's --

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Goldsmith: Wrap it up?

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Meeker: Yeah let's stop there now.

[End of Interview 3]

Interview #2: 07-20-2006

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04-00:00:30

Meeker: All right well let's get started. This is the second day of interview, Tape 4, Martin Meeker interviewing Oliver Goldsmith. And we concluded yesterday by talking about your candidacy for regional medical director. And your agenda for action really. So I think that what we should start out with then is that from what I understand shortly after your term began there were a whole series of pretty monumental challenges that you were faced with. Some of them acts of God such as the earthquake, the Northridge earthquake, that happened at that point in time.

04-00:01:18

Goldsmith: Tell you about it, tell you about it, January 17th.

04-00:01:20

Meeker: And some of them historical, contextual issues about falling membership, questions about how high doctor pay needs to be and so forth. So I guess what I want to do is invite you to discuss a few of these challenges, the ones that perhaps you think are most important, and then describe how you approached the challenges.

04-00:01:47

Goldsmith: Thank you. They play into the history. Actually I'm going to just go these as they come to my mind. There may be four or five but they're not necessarily weighted the first one's most important. Because the one I want to just say, which I don't think is the most important, was one of my temperaments, one of my tones, is I think sometimes maybe like anybody, something's new, I always think other people know more than I do, like I was saying in medical school you move along to get better in what you're doing. And so I've always approached things with a sense of great deal of respect and maybe a little bit of intimidation that others are ahead of the curve and I'm not, OK, and that applied when I started my new job because the people that were in the senior leadership always seemed to me rather majestic senior people. And I just ran a medical center or a department so I had the sense of will I be successful in that new role with those people who seem to know so much.

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Meeker: When you say those people at this point are you speaking primarily about medical group or health plan as well?

04-00:02:52

Goldsmith: Well I'm talking about for sure health plan. The man was Hugh Jones. He was the regional manager of southern California. And certainly with the health plan Dr. Lawrence, various executives in the central office who I knew very

slightly. Hello at best. Senior leaders of the medical group. Dr. Caulfield was the medical director of northern California at the time. But anybody of that level, OK, even people who'd been in the corporate office of the medical group for many years who are now seeing this newcomer come in. Including the person that I beat for the job, Dr. Goldstein. A sense of can I make this work after all of this. He said things about me, I said things about him that were political. Can we make it work? But that was the least of the concerns. It was more with the health plan and senior people. And so if you start out there's something -- let's start with the medical group. My understanding as an area medical director for many years had been that the medical directors, regional medical directors, had never really formed a good team. They weren't a strong cohesive group of people working together. They were each individual strong leaders and they had their own priorities, their own medical group. Each medical group is independent. They had to look after their own medical group. And they didn't necessarily take positions that weren't parochial. I understand this because I too have taken many parochial positions because I'm elected to represent my medical group. But there was one Kaiser Health Plan. And you understand the many medical groups. Furthermore, the strength of the organization was California. That's the powerhouse. The rest is peripheral in a sense. No one liked to be reminded of that but it's true. And so the two medical groups didn't always function well together and this is probably -- now known in history but it actually transcends the two medical groups. It's California, what I learned is if you're in California you think the brains are in northern California and we're the agricultural center. Like the year 1100. You're in the 20th century. And so if you're with Bank of America I've been told the brains are up there and they have peripheral people down here in southern California. So there's a lot of that that plays out. And the humorous part of it, which I always capture and I've made many jokes about this is if you notice, the medical group in northern California's called The Permanente Medical Group. And the joke that Oliver coined, that I hope lives on after me, is that I resent this, this is funny, I hope it's funny to people, why should they get the The? But they got it, they're called TPMG. And so I used to always say to them, "When our membership exceeds yours I'm going to break into the building and take your T off and take it home and I assure you guys I am serious." It was always meant with a lighthearted laugh.

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Meeker: And then they would have to put NC in front of their --

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Goldsmith: I don't care what they put in front of it but they're not going to get the The. And Robbie and Harry and I, we're all good friends, we're all trusting friends. But it was a good joke like baseball teams. And so our membership would go up a little bit and I'd say, "It's getting close, you guys." But they continued to exceed us in membership. Just the other day one of my friends called me and said, "It looks like in a certain period of time we might exceed them." And I said, "Well get the The." So it's become an in culture.

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Meeker: Well more than simply just representing a regional feud or competition was it indicative of a competition, perhaps a friendly competition?

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Goldsmith: Well it was competition because people in management and senior leadership are competitive. I can't help but think if I do better or if I get some recognition if there's a joint commission survey or whatever government inspection and southern California is here, *Consumer Magazine* rates southern California Kaiser number one in the country and they're number two well there you are, OK, I want them to be number two. I don't want them to be number 11.

04-00:07:13

Meeker: That begs the question then.

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Goldsmith: That was that but that was friendly.

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Meeker: It begs the question who are your main competitors. Is it within the Kaiser system that you --

04-00:07:21

Goldsmith: Well sometimes you couldn't tell but we weren't competing against each other because we're not in the same geography. We're just competing to be best. To be the The. OK this is just warm friendly relationships with a little bite to it. Where it sometimes undermined us is the two Californias couldn't get together on a uniform position because of the past history. And Dr. Murray himself would say of Dr. Sams and I, "I don't know what those guys are thinking," and I can't imagine what Dr. Sams said about Dr. Murray. But that kind of fratricidal tension if you will or brother – fratricidal (fraternal?) -- brotherly tension OK breaks it apart. Because we needed a uniform face to the health plan. So one of my goals you asked me was to say, "I got to get people to function as a team." And I can say Harry Caulfield and I and Robbie subsequently, but certainly at the start Harry and I, became very good friends. We worked behind closed doors. I'll share with you some historical points. That were tremendously good feeling and I think helped a lot. And then Robbie and I continued that. But there was still trying to overcome our separateness. So that was one. The second was the health plan manager in southern California, he and I, Hugh Jones, was a rather stiff businessman of high values, high integrity, but stiff person. Very religious person. If you were in the jazz world as I grew up in one would not call him hip. OK and on and on. And so it was a challenge to work out that. I remember he didn't drink. My wife and I have an occasional cocktail. I remember going to a first meeting and this had come after there was an interchange some years ago where Mr. Jones, bless his heart, was espousing the vision -- typical corporate health plan kind of thing, the vision, vision of caring for one another. And I

got stuck in an elevator in Los Angeles in a Kaiser building. I was frightened to death. And upon escaping from this complicated thing, it was an hour or two in an -- wasn't an hour, half-hour in an elevator, which is enough to scare the hell out of you, into the fresh air, I wrote an email. Said, "Dear Mr. Jones why don't you spend some time on our elevators and not so much on the vision." Or something like that. It wasn't the worst statement in the world but something like that. And he sent back an equally offensive remark. "It's time you studied the vision a little more." OK versus what anyone would say I thought with common sense. "I'm sorry that this happened to you. It's very sad that this happened to you and 20 other people." OK it's why to this day I try to not go into elevators where there's 20 people. Because this happens in life. But the point was that now I was meeting him after that background noise and he probably remembered that. It was probably six years before. So whatever contribution I made to that, it was certainly understandable what had happened to me. Nothing had happened to him in an elevator. So we sat down one day and my wife, we were in Atlanta. And my wife orders a mint julep. She likes the indigenous drink. So I said, "I'll have one too." To my chagrin he orders one. I said, "Oh my God, my wife is getting me into a life of sin here. Or getting him into a life of sin." And so the drink arrives and I didn't know. I'm talking. And to him and his wife. They're very nice people. And he starts to drink his drink I guess to show me he's relaxed and my wife notices that her drink and his drink has dirt in it because the mint leaves. He's already drunk half of it. My wife gets the waiter and says, "Will you take these drinks back, they're dirty." He's already drunk his. Just a break -- but my wife helped me break the ice. And we became good colleagues, friends, his wife and I went out to dinner. And we overcame that. First time I met him I said, "Hugh, let's go for a walk. Let's get to know each other." This is the way I work. OK, now during his reign we had some troubles but I'll tell you about that in a moment. So the second was to get on the same page as the health plan. These are people relationships, how important they are to move forward. I think I understand people relationships and how important they are to accomplishing goals as much as anybody inside of Kaiser Permanente. I'll just say that flatfootedly. Whether I accomplish it or not anybody else can judge. But I certainly understand seemingly more than others where trust, building relationships, is so darn important to accomplish goals. And I think leadership at the end of the day as I may have said yesterday is getting people to like you or whatever that better word is than like. They will follow you. They hate your bloody guts, they don't trust you, you got a long way to go. Even though you carry the title of I'm the boss. So that was the second one with Mr. Jones and the health plan. Then there was the national health plan and we'll get into what was going on in the organization. So and then just becoming successful in the medical group with the difficult issues politically that you face with the many many doctors and disciplines. So that's the pause. Then came the very very difficult issues which were going on in California of the competition, managed care. Kaiser was slipping. Everybody knows the history. Managed care light came in, was seemingly acting like we acted. And what happened it

seems to me we had this loose relationship of the medical groups, the Permanente not federation but the Permanente something, I can't remember the name for it, the predecessor to the federation. And the health plan nationally was shaken up by what was happening. And where we were in the past not acting in the appropriate business manner, the health plan tried to take on a more businesslike stance. Nothing wrong with that, but they went far beyond that in my view. The realistic part was we're getting competition, we have regions that are not performing, Kansas, Texas, east coast, where is it -- New Hampshire -- not New Hampshire but Hartford, Connecticut, and I think it was called east. But whatever it was we had underperforming regions and even in our better regions, California, we were beginning to flatten our membership. Now a lot of it was due to just the economy and the cycle of insurance and all. But there were new factors, companies like Family Health Plan, southern California, growing, different medical groups, etc., OK, and our service reputation and our performance was average, OK. But what happened is the health plan went too far. And they were led by David Lawrence, who was a physician, but frankly, and this is something physicians all know, you can carry the title of physician but you're not a physician in here. And Dave is not a physician in here, bless his heart. He never really saw patients as a physician. He saw them as a medical student and intern. His recollection of patient care is trivialized by that. He doesn't really understand deeply the physician mind. Of course he would disagree with me for sure. But in the eyes of most physicians that there's a certain something, OK, and so he I believe was the central reason that we went astray. Now I'll say that on tape. He himself, he's a very very capable man, like we all are, in certain things. He understood the marketplace change. He knew we had to make steps to change. But he took some wrong directions. And he could influence certain people in a profound way, like his board of directors. He had charisma. I'm supposed to have charisma, whatever the hell that is. He has it. Big hands. Cheekbones. I used to -- and that's -- a number of the health plan people were like that. If you look back over history. Henry Kaiser may have had charisma but he didn't have the looks. He was just a roly-poly big guy. But Dave had -- if God gave me what he gave Dave, cheekbones and this, I'd probably be President of the United States. I say that as a kidding around, just so your history will record that. But he went to excess two directions. One was he was so alarmed at the marketplace that he brought in the executioners, McKinsey, which will be in the history.

04-00:16:52

Meeker: Why do you call them the executioners?

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Goldsmith: Because McKinsey is widely known for a company that comes in and applies the same formula, screw the unions, screw the -- identify your cost centers, cut, cut, cut, and run it centrally, concentrate the power. They're a bunch of bozos, at least in terms of their understanding of health care as I know health care. I didn't know at the time. This is in retrospect, OK. They're extremely

expensive. I'll give you some examples of what they do. They also manipulate the chief executive. It's an absolute part of their business. I'll give you examples. One is a rather harsh one. They take a person like Dave Lawrence who's paying them because he's the CEO of Kaiser Health Plan. And they make sure he's more successful than ever. It's called manipulation.

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Meeker: He's more successful in what way?

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Goldsmith: They put him in different opportunities.

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Meeker: Elaborate please.

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Goldsmith: Well like they give him opportunities to be on different boards. Or they make sure he's getting more ego flattering. In turn he keeps using them. I believe this happened. Can I give specifics? No, I can't. Who cares?

04-00:18:05

Meeker: But these things also sometimes result in higher salary.

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Goldsmith: His own salary? No, not his own salary.

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Meeker: Not from Kaiser Permanente but from what I understand service on certain corporate boards pays, right?

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Goldsmith: Oh he did very well for himself. Not only money but fame, fortune, ego-stroking, things that he liked. They make sure it happens. I'll give you my specific example. A specific example about McKinsey. I can't give you specific examples of Dave because I know a lot of the things he got into but I always wondered about them and once I figured out McKinsey then I realized that it all came from that. Different boards and all that kind of stuff. So he was duped by them but he liked it. OK now give you my example.

04-00:18:52

Meeker: Let me just ask one more question about that.

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Goldsmith: He failed in my view by the way. I feel he took us in the wrong direction.

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Meeker: But in being duped and of course this is going to be a speculative response on your part, there are the real things that they can give, memberships on prestigious boards of directors and so forth. But what is it about his role in the health plan that you think that they were trying to cultivate in his mind?

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Goldsmith: Well I think they were trying to cultivate in his mind that he and his small group can take charge of this whole operation, change the dynamics, break the relationship with the group that ran the organization, that he no longer would have to be just the inspiration and the external model and the spokesman of our values and the leader, but he could become with his people the decision-makers and run the damn thing from there, which they tried to do. And break the historical relationship and flatter it. But it was all through flattering him to what he could do.

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Meeker: So to a certain extent --

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Goldsmith: Inside the medical group. Inside the health plan. Now they did some good in this. They helped us with a marketing plan. It's not that McKinsey comes in with nothing. They gave us marketing ideas. Lots of different substantive ideas which I bought. Some correctly, some incorrectly. They brought value. But I'm talking about their relationship with him.

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Meeker: Do you recall when they were brought in?

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Goldsmith: Well I was entering in '93, '94, so they must have been coming in around then. And this was -- a guy like me who's mainly been a doctor with a little bit of management, this was a new experience. So when I --

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Meeker: Of course you weren't consulted or people like yourself were not consulted.

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Goldsmith: Well I think Murray was probably consulted. Yeah but they weren't asked is it OK. They were just brought in.

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Meeker: Because it was a health plan thing.

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Goldsmith: Yeah it was a health plan thing. And generally we cooperated and OK we'll try it and there were misgivings and all but I endorsed it, I said, "OK. What do

I know about McKinsey?" Well I'll give you an example. The inside McKinsey guy calls me and says, "Oliver by the way we see that you're in Boston, you're going back to Los Angeles. Why don't you get the flight, let us fly you there on the J&J airplane?" J&J Johnson & Johnson airplane? Boy guy like me who's had a paper route. I'll go for it, I'll take the flight. OK save some money, meet the CEO of J&J, what's wrong with that? OK. Good night's sleep. I don't know if this is a good idea. I don't know enough about -- I'm not even in the job yet. I was in that year of training before you become the medical director. I don't know this is a good idea. Bernie, I don't think I can make it, my schedule got screwed up, tell the CEO I appreciate the offer. A month later I'm telling Mr. Jones, the health plan executive or what have you, he says -- he was such a straight arrow guy, he says, "You went?" He was criticizing me. I said, "Hugh my point of the story is I didn't go. I did say yes." He had a mind like you say let's rob a bank and then the next day you say, "I had a drink, I'm not going to rob the bank." Ridiculous. He says, "You did it, Martin, you robbed the bank." I didn't rob the bank. It crossed my mind to have the bank robbed. For fun. My friend talked me into it. He thought that equals crime, that was his notion in life, it's your thoughts that are sins. I think this about Hugh. Have good thoughts. He doesn't understand that mind can have thoughts that's separate, personal. But he was astonished that I did this. Did it.

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Meeker: That you had considered it.

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Goldsmith: Well he thought -- yeah I said, "Hugh what's wrong with you?" That's an example of manipulation. OK they know how to do that in McKinsey. In fact the guy managing it said, "Oliver we expect to be your advisor." And I said, "That's just what you'll be. You'll give me advice, I'll do what I think is right." No, no, that's not the way with McKinsey. You pay so much money for our services, we expect to be right there with you helping you and doing it. And I said, "I don't know where you get this from, Bernie, but I don't have anybody like that." They actually said that to me. Well they got to Dave.

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Meeker: How were they trying to influence you? Do you remember anything specific that they tried to --

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Goldsmith: When I say influence, they were recommending. But they thought the recommendation equaled do. Close Kaiser Hospitals. Break with the unions. Create different kinds of delivery systems. I don't know that it was just them.

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Meeker: So substantial changes.

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Goldsmith: They were breaking the way Kaiser Permanente did it. They say that the integrated model -- by the way, many people were thinking this, not just them, and by the time I'm finished with work, the reason you bring in a consultant is not that you need their brains, you need them to recommend things you already know but you can't get done. A lot of people say that about consultants. Guys that lead these big companies know all this stuff. They bring in some fancy consultant to tell people that's what the consultant said to do. The guys that run General Motors know the answers, OK.

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Meeker: Second opinion.

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Goldsmith: Yeah. It's like let me get a second opinion. So the point of it is that they came in and they recommended things that Dave already wanted to do probably, which was change the model. And change the model was much more profound than the marketplace and the changes. He wanted to break the delivery system because frankly I feel strongly that because of this physician quote he really didn't have faith in the model. I don't believe he really in his heart trusted the model himself. Himself in his deepest sense.

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Meeker: When you talk about the model that can be --

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Goldsmith: The model is Kaiser Permanente the closed integrated practice. What Kaiser Permanente has been for 50 years, a partnership, an exclusive marriage, of the two owners, and I use the word as a metaphor. I mentioned this yesterday. He gave up on it. And he gave up on people like me and pretty much everybody else. OK he probably gave up on anybody except himself, I'm not sure he had much of a self-confidence either. But he certainly didn't have confidence in the medical group. Maybe a few people, mostly sycophants who would say yes to him. OK he liked people that said yes to him, didn't like people that said no. OK definitely didn't like that. And so that started a chain of events which led to a crisis for me. Because I had agreed to close Kaiser Hospitals. In my brain I thought it was the right thing to do. What could I do? It wasn't because of McKinsey or Jones or anybody else. I thought it was the right thing to do. I was wrong about it. But I went at it energetically. I think most people on the health plan side felt Oliver was trying. There were sometimes doubts that I was trying, that I was secretly trying to suppress this. I remember one time Mr. Jones was very upset with me. I said, "What's the matter, Hugh, your tone has changed." Went out to dinner. I had to always work the relationship because he was psychologically unable to really maturely be open with people. He said, "I don't trust you, you're trying to keep one of the hospitals open or something." And I said, "I'm never going to change your mind because you're the kind of guy that forms these opinions. But you got

wrong information. So I'm going to tell you you're all -- you're wrong. But I know you're going to leave this dinner thinking that. But I feel sorry for someone like you who draws a conclusion that I was dishonest and secretive when in fact I wasn't." OK I'm comfortable enough to say yeah I was and I apologize or I'm not apologizing. But in this instance he was completely wrong. OK and so there's a reaction formation I think is the old psychiatric term where you -- I'm thinking evil toward you so I figure you're evil toward me. It's actually me thinking evil toward you. I think he had some of these primitive emotional reactions. Good person by the way. So in the midst of all of this, trying to do some of the ideas like health plan had of closing hospitals, fighting with the unions and stuff, which I thought was correct, to get the marketplace response, here they go and announce they're creating these -- what do they call -- divisions? The California division. 1996 or 7. They fire Jones. Here's this guy that I have developed a good B relationship with, this health plan executive.

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Meeker: When you say California divisions I'm a little confused.

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Goldsmith: Instead of regions northern and southern California.

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Meeker: Medical service areas? Is that -- something different.

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Goldsmith: No, no, I'm going to get there. We were endorsing that. Stay with this. We had X number of regions, Hawaii is a region, northern California, southern California. They announced in one fell swoop, what year you can look up. '95, '96. I was still a rather new regional medical director. That Jones was fired by them. Well it's their right to do that. But summarily fired. Tearfully escorted out of the office. Now this -- I may tell you things about this man but never dishonesty or anything like this. Humiliated. He cried at his farewell. Because he identified with health care. He's never been able to talk to me again. I've called him to say, "Hello." He can't even return the phone call. He's so emotionally bereft because of this. I don't think at me but I'm part of it. It almost killed him. They summarily fired my partner. And brought in the henchman. I call that man Barnaby. He's a guy way over his head brought in to do the tough things that Lawrence wanted him to do because he's a tough -- fancies himself a strong-minded willful person. Inarticulate and ill at ease with people and basically doesn't like people. But a very -- appears to be a strong -- humiliates people who report to him in front of people. Does stuff that tarnished his reputation. He used to be the business manager of the Permanente Medical Group, southern California, not The. Can't use the The. And so they bring in Barnaby as some COO of the whole thing, all over California. And he's everything. He's like the second in command of the organization of the health plan. He reports to Lawrence. And he's the kingpin.

And he was impossible to work with. He didn't like me. I didn't like him. But he was so difficult, OK, that he now was the partner to Caulfield and me. And Caulfield, great guy, could never say, "Let's argue." Harry wanted smooth operations. So he would sit with Barnaby and they'd talk about baseball games. And I would say to myself, "What am I sitting here in a partnership with -- it's time to get to difficult things. I'm tired of this talking, I'm not going to go to this anymore. I need a partner in southern California." So we -- Harry and I both started to complain. So they broke apart the relationship and they created some cockamamie thing called not service -- yeah service areas. Six of them in southern California. Six or seven in northern California. And there were 24 across the country. So they completely changed the model of the organization according to probably McKinsey. Where there was 24 of these service areas reporting to Barnaby the czar. And so if you were a service area guy in southern California, let's say San Diego, instead of reporting to Pasadena you report up to Barnaby. 24 health plan managers.

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Meeker: Divide and conquer strategy?

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Goldsmith: Yeah so they got them going. But they forgot there's six medical groups. There's two -- basically California. There's two big medical groups in California. We don't report like that. So they completely ignored that trying to break it down. So in fact the first thing that ever happened in my administrative decisions, Jones came to me and said, "We're creating service areas." I said, "Sounds good. I want you to have one medical director in charge of a service area." One medical director would have been in charge of let's say West LA and LA instead of two medical directors. Sounds simple but if you understand the culture of the medical group you can't do that very easily. Very --

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Meeker: It's so center-focused, right?

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Goldsmith: It's so center-focused. It's our culture. So I said, "We're not going to do that." He said, "What do you mean?" I said, "I thought we're fact-based. I thought we're performance-based. We're not theoretical-based. Come back and see me in a year if we're not performing well and recommend that. And we'll see what happens. But I'm not going to do it." Of course Harry didn't do it either. So gradually their idea wasn't being very well accepted. Service areas they created. It was their legal right. But it wasn't the matter of legal or authority to do stuff. They did it without consensus. And partnership. And that's what Barnaby, he wanted consensus, which meant --

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Meeker: I'll do it.

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Goldsmith: -- do it his way.

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Meeker: Well it seems to me --

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Goldsmith: But there was a design by the health plan board to break the medical group into small parts and it culminated -- this is very relevant if you will -- so we were working with McKinsey, good -- nice people, they weren't bad people to talk -- in fact they're very polished people. OK very smooth people, very effective people. They dress with great suits, they know how to go to the best restaurants and spend $500 for four people with wines, they know how to do that. Because the nonprofit's paying the bill by the way. I can imagine what Lawrence authorized, OK. Shameful. Nonprofit. What they came up with -- I lost my train of thought. So I'm going to keep going. The service areas. McKinsey. Lost my train of thought there, Martin.

04-00:33:18

Meeker: You were discussing basically the problems of the service areas and how through the service areas the health plan was trying to impose --

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Goldsmith: Trying to break up the medical group. Oh thank you so they were helping, McKinsey was helping the Mid-Atlantic, separate from us. They were helping all over the place. Some medical centers, some regions accepted them more than others. Some less. They were very involved in Mid-Atlantic and a document came to my attention and the attention of a few leaders. By now I was getting to be two or three years in office. And was really stressed out with all this and distrustful of anything the health plan said. And the document said -- someone has this page. We need to create more foment and distrust and trouble in each medical group so it breaks apart. I'm paraphrasing. Now I'm not -- that's fact. It said that.

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Meeker: Who authored that?

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Goldsmith: A local McKinsey person, you know how you do these documents, I'll do a study of your organization.

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Meeker: White paper or --

04-00:34:25

Goldsmith: White paper. And so a young MBA, some idiot, puts this in there, helping the McKinsey, and it demonstrated once and for all where they were at. This was

truly a negative act toward the medical groups. Now when I saw that it was like a revelation of infidelity. It was a heinous crime in the culture of our organization, OK, and I said, “That’s it, I am not going to be in any -- no Permanente doctor or administrator will be in the room with a McKinsey person. We’re not going to participate. We’re separate entities. If there’s a McKinsey person in the room my orders are every administrator leaves the room who works for Permanente.” That’s really sad. So McKinsey actually sent -- try this on for historical interest -- when we said this, of course the word got back to health plan that Oliver was being difficult, OK, overreacting to something that a young MBA wrote into the document. You couldn’t refute that it was there, it was there. Oliver said that. They sent the general manager of McKinsey out to see me. OK now this would be the ultimate polished guy. Probably a wonderful man. Because you don’t get to the height of an organization like that without real human polish. And we talked. And I showed him the statements and this and that. And when he was done I said, “I can see you don’t really get it. It’s amazing. You can sit here with me and not understand the way I feel. And I guess that’s just what’s happened to you in your McKinsey world. So thank you for visiting. Thank you and goodbye.” Out of touch with the medical group culture. Totally indoctrinated by Lawrence. Two other episodes, this was really sad. Firing Jones. They took another one of Jones’s best friends, a man named Ed Carlson who was in charge of the southern California hospitals, and he was a very good trustworthy person. He was on a secret committee to plan all this stuff. And I used to say to him, “Ed, I don’t pry and I don’t expect you to tell me secrets. Because you have to keep secrets. But here you are going up to Oakland to work with those guys to destroy your relationship with us. You can’t tell me about it but I know what’s happening. And you and I are working on the most difficult thing in southern California, potentially closing hospitals.” I said, “How’s that for trust?” He just looked at me like I don’t want to reveal my emotions. I said, “I understand, Ed, but I just want you to know we know something’s happening. Something terrible.” So they were doing all this stuff like we’re going to be businessmen. I remember one time going around the room with these -- by then we had the KPPG or some group or enclave at the top that -- the Kaiser Permanente Partnership Group, Lawrence and four or five health plan persons, and they had Caulfield and I and so forth. And I’ll tell you about the federation. Am I going in the right direction now? And we go around the room and say what’s important to you and I say something about some of the people and relationships and Dave says, “It’s all about business.” Typical, like we’re children, we only know doctoring and medicine and the big boys know the real stuff. This is a joke among us, OK, no politics on the health plan side. We’re all business. It’s a joke. And so it was terrible, the distrust. So the medical group then -- Dave wanted us to do this. Dave wanted us to form a more cohesive medical group. Again he was correct there. When I rail against him it’s not that every idea, he wanted us to respond to the marketplace, he wanted Permanente to be more cohesive, and he even felt maybe there should be one medical group. I think he felt that. Could never

happen but. We formed then the federation. Al Weiland and I and Harry Caulfield and a few other people. There were five of us who were on the executive committee of this newly formed federation. Our avowed purpose was to create a cohesive response, not one medical group, but a cohesive group of medical groups called a federation who could respond. And we needed to find a point person to be that executive leader.

04-00:39:08

Meeker: It seems to me that Lawrence wouldn't have wanted this to happen. He seemed to be more invested in splitting it up and fragmenting the medical group as opposed to --

04-00:39:19

Goldsmith: Yes and I don't have an explanation for that. I think Dave had some foresight there. You can have a mixture of views. He was certainly -- his history had been embedded in the organization. He'd been a medical director in Oregon. I don't remember all his biography but he'd been on both sides of the house. He understood team. Wrote a book about teams delivering care. So he was a man of some paradoxes. I characterize him in a way that's not particularly favorable but like everybody he had characteristics that even swing the other way. So he supported this. To the point that when we -- jumping ahead -- selected Dr. Crosson, and I'd like to get to that in our history, we said, "Dave you're going to put us on the 27th floor of the Ordway Building," you've been there, Martin. And we had said in our mind if he says, "No, you'll be on the 25th floor," we're moving to San Francisco. And we were quite intent about that. I'll tell you some of the other verbal wars.

04-00:40:20

Meeker: OK but I want to just rewind a little bit, explore this, there's lot we have to go back through about this. This notion of Lawrence both approving of a federation and also interested in fragmentation. And it reminds me of the marriage metaphor that you talked about. And sometimes in advance of divorce the person who is seeking the divorce in advance of seeking the divorce will try to make the spouse more independent.

04-00:40:54

Goldsmith: Independent?

04-00:40:54

Meeker: Independent so the divorce will be easier. And after looking at this period of time it seems to me that it would be a reasonable supposition to make that there was a move within the health plan to really seek a divorce between the medical group and the health plan.

04-00:41:13

Goldsmith: Yeah and let me comment on that. I actually -- the breaking apart divorce I don't really think they envisioned. Perhaps they did. I never thought that. I

think it was more they run the show and we get our act together. I think Dave wanted cohesiveness from a very good reason, he wanted a standardization in clinical behavior that represented all these groups doing similar things. Working effectively on drug formularies, etc. Helping each other. So in that sense he wanted cohesion when he had these autonomous medical groups. So in that sense he was paradoxically hoping we'd come together. I don't think politically he wanted to see us that strong up against him. He couldn't possibly have wanted that.

04-00:42:01

Meeker: Well if he was truly taking a businessperson's approach, wouldn't it make sense that he would attempt to cultivate or seek competitors to the Permanente Medical Group?

04-00:42:10

Goldsmith: Well he did. He did. But not in the way of breaking the relationship. And here's what happened there in my view. He began to explore probably with McKinsey offering other medical options for Kaiser members. So and this could have been actually appropriate. Because let's say in North Carolina you couldn't attract to the Permanente -- maybe if you offered them Duke or UNC or somebody or someone in Hartford, you could say if you like Kaiser you can now choose doctors in your community. Sounds good. It sounds good. If you price it higher, it is one stream of thought. But if you price it the same you begin to pit this one against this one. I'll see which doctor I like, which delivery system, you see what I mean? So I'll go to this one or go to this one. Well this creates a tremendous instability in both sides but private medicine's already so unstable it's just another ball into their house. Ours would be very unstable. So we made very clear that we're married, you can't go outside the marriage. Now we could see some role for pricing, you don't want to see me, Martin, you have Kaiser, go spend another $200 and go down the street. Perhaps there's some way to work that through. I don't like it but -- do you hear? Well that was their plan all over the country. So it's not breaking us apart but making us run faster to deliver quality and price that people would attract to us. They kept the patient, still a Kaiser patient. But it threw off the whole relationship. Misunderstood the whole alignment of the two of us going forth together to solve our problems. Because outside doctors aren't going to give a damn for this plan. I remember going to the Kaiser Health Plan board, which Dave had completely hypnotized, I mean hypnotized, the man had Jamestown charisma. He did. I think they would have taken the cyanide in my view. They had guys there that would say his words. He had a tremendous ability with some. But these guys, he had them completely I believe hypnotized. We went in there one day, many times, to speak to the board, to warn them of these things. Politely. Talking. And I remember saying to them, "I cannot believe you have 10,000 doctors in this country devoted to the insurance plan." More than any other. No private doctor gives a damn about Aetna. Devoted to Kaiser Health Plan. "How can you put that in jeopardy?" Thank you, child, for sharing, and we left. We all spoke. I don't think it had

any impact on these people. They were completely hypnotized. So it really got bad. In fact we made a midnight flight to Nashville, Tennessee, I think it's public, to contact this screwy company called Phycor, P-H-Y-C-O-R, that was a health care delivery bunch getting rich in the private world who wanted to take over managing us. And we thought let's talk to these guys just in case. We used to call a nuclear scenario. Nuclear war. And this never came up to my knowledge in formal presentations but it certainly came up in discussions with health plan that you will advertise if you like Kaiser you can see any doctor. Sounds good. What do you think we're going to do, we're going to advertise if you liked Permanente you can have us through Aetna. Through Blue Cross. To which the health plan says, "How could you guys do that? You're in our offices. You're in our buildings." To which we said, "We'll leave your buildings. You own thousands of medical offices. They'll be empty." Where are you going to get the money? There's plenty of investors that'll support an organized medical care system. So at the end of the day both sides will be bloodied. The end of Kaiser Permanente, one of the most noble experiments in health care in the world. Challenged as we are. Both sides will be bloodied. We'll never recover. That was our discussion.

04-00:46:33

Meeker: Was there ever a Cuban Missile Crisis moment where people's hands were on the button?

04-00:46:40

Goldsmith: Not that I know of. There may be one in other people's views but the closest I think it was was when Jay went to Lawrence to say, "We need to be on the 27th floor." And there may have been some -- when we threw out McKinsey and said, "We're not going to work with them." They could have pushed a further button. But so the sad thing about it was all this attention to dealing with the marriage when the important thing was to raise the children so to speak if we had to carry this thing too far. We had real business problems. Should we close our hospitals? How do you deal with unions? How do we improve the service? How do we control hospital days? How do we do better on cost? How do we improve our image? There were 100 things that could overwhelm us. But all we did was argue on this stuff. And then of course it would be -- one time Barnaby and I had an offsite with our teams and we had hired some psychologist to try to help us get better and he was another one of these guys that was inarticulate and couldn't deal with feelings and all that. And he gets up one day, I'll never forget, he says, "I can't deal with you, Oliver," he starts to walk out of the room.

04-00:47:44

Meeker: Barnaby or the psychologist?

04-00:47:46

Goldsmith: Barnaby. Barnaby -- the psychologist was watching this. And I knew Barnaby from when he was in the medical group and I never had any trouble with him

then. He was a nice gruff kind of a guy. I said, “Dick, get your body back here and sit down, you don’t have the authority to walk out of the room on me. It doesn’t matter that you don’t like me. A lot of people don’t like me. It doesn’t matter. You have to deal with me. I represent the medical group. So get back down here.” He’s all red in the face. Sat back down and grudgingly finished the day. Nothing good came of it. So that was -- whatever those years were, ‘95, 6, leading up to around ‘97. It was a very very difficult period. It was a difficult period for me professionally although it did two things for me very nicely personally which I’ll tell you. But it was a very big waste of time, all this crap. For example the word California division is gone, there’s no California division, they’re regions. OK MSAs are about as shaky as you could imagine. The 50 people that were pictured on the health plan side that were the health plan leadership, there’s an X through almost every face. They’re all gone, they came and went. They had no staying power. They either fired them or they left on their own. Because it all fell apart. So and then what happened, so the challenges for me as a young man, young regional medical director, were facing this terrible distrust that I felt toward the health plan. Disliking some of their policies, trying to carry out others. And all the rest. What it did on the positive side for me and three things, I said two, one is it illustrated to me personally something that I thought I had in prior life, overcoming some adversity. Because this was adversity. That I can get my way through this with these people and demonstrate my ability to manage the situation. Try and hold off on the word leadership. Secondly the medical group, which had always been in itself a place of guys sending emails pissed off, angry at each other, just doctor life, the life of doctors when they’re not with patients, suddenly lined up and said, “We support Oliver.” So suddenly I was the commanding officer and could get things done more swiftly, even a pay reduction. Try getting a pay reduction of your professors, OK, the dean would be executed, all right, we were able to take, absorb, with great difficulty, a pay reduction. It’s not something doctors, any profession, anyone does. That doesn’t reflect poorly on doctors. No one can do this. We were able to do it. I was able to lead the way and get reelected. Successful leadership out in the world is doing something that people don’t want done. It’s being Reagan and saying, “I’m going to reduce taxes, how many people will follow me,” ain’t leadership. He was a leader in other ways but that’s not an example of leadership. Raising taxes successfully could be. OK so I was able to succeed with the medical group in the medical group’s eyes with the things I was trying to do because now they became the enemy and I became the commanding general so to speak. So and then the third thing it did is it brought the medical groups together. Because Harry and I and Al Weiland and all this became even closer. By then we had selected Dr. Crosson. And I want to make sure I get that in the history books. So now we’re poised to confront the future. The health plan was the problem, not the external environment. We had to get the health plan settled first. Because they were so off base. A short distraction if your tape’s still working, who would be the medical director, the executive medical director? Well, fortunately for Dr. Weiland, we went

around the room, I don't think I was particularly a good candidate to be it, I didn't actually want it, I don't think Dr. Weiland wanted it. Dr. Caulfield wanted it. And he was our senior man. TPM -- The. TPMG. Senior guy, he'd had pretty much every experience in the world. Good friend of mine. I felt that he was the right guy. I was the chairman of the executive committee. So it was my decision to carry the message. It was our decision to decide. And Dr. Weiland felt Dr. Crosson was a good choice. Now I believe this is the history I remember. I think if Al was here -- we're good friends -- he'd say, "Oh no you have it wrong." So there may be some variation here. But sincerely from my standpoint I thought Caulfield would probably be suitable, I was a little worried about his inability to confront Barnaby and punch him in the nose so to speak.

04-00:52:51

Meeker: Crosson?

04-00:52:51

Goldsmith: Yeah. No, I was a little concerned about Caulfield's seeming inability to get tough and get mad and say, "Goddarn it," and put these guys to where they needed to go, at least verbally. But I thought he was suitable. I knew Crosson slightly. Weiland suggested I reconsider and think of Crosson.

04-00:53:15

Meeker: What position had Crosson been --

04-00:53:16

Goldsmith: Second in command in TPMG and he's a gruff guy himself. Stoic, you'll meet him, if you don't know him. Hard to figure out what he thinks. I knew him slightly, just socially. And Weiland convinced me -- I needed moderate convincing but not complete because I had some concerns about Harry. The difficult thing was who's going to tell Harry, well we took our little executive committee vote and it was clear Caulfield did not have support. Crosson was the man and I supported Crosson. Not at the start. I think Al thinks he went to Caulfield to tell him. I believe I did. I know I did. We selected Crosson. Harry Caulfield is such a unique and good person that when I went to him as I remember and said, "Harry we did not choose you, we chose Jay, your second in command," Harry said, "If that's the wish everybody has I support Jay." Shook my hand. Never mentioned it again. Harry Caulfield's very unique guy. It went on and Jay was the perfect person. First place he is a great Permanente -- he's a great person. And he's a wonderful physician. He's a pediatrician so I've never seen him as a doctor. I wouldn't choose him. I would for my kids. His wife's a great person. But he also has a great interest in policy, intellect, thinking about things. Plus as a negotiator he's phlegmatic, you can't always read him. He's not like Oliver, all over the place, OK, even his close colleagues like me say, "Jay, what are you thinking, do you agree with me, do you not agree, are you mad at me?" He's got a funny kind of a face. So he was perfect and he struggled to deal with Lawrence. Never successfully because

no one could deal with Lawrence unless you worked for him and said, “Yes.” OK but he was tough and he got us together, period. Now we had the fractured health plan trying to do all this divisive stuff. The screwed up environment outside competing with us where we were losing our way. We needed to make rational decisions. Terribly difficult problems. We were coming together as a medical group. The health plan was all over the place with their fancy ideas. Lawrence was off getting fame and fortune through McKinsey, OK, and all of this stuff. And not much was being accomplished. Then the crisis happened.

04-00:55:50

Meeker: And we’re going to stop right there.

04-00:55:53

Goldsmith: And the crisis is a good one to talk about.

[End of Interview 4]

Interview #2: 07-20-2006

Begin Audio File 5 goldsmith_oliver5 07-20-2006.mp3

05-00:00:00

Meeker: OK let's do it.

05-00:00:13

Goldsmith: OK so here we are with all these problems in the community, all these problems inside the organization and all these problems with the health plan. And that was a sad period of time. With some people by the way in both sides of the house but certainly I can tell you in the health plan that didn't seem to have the capacity to grasp this. Then came the financial crisis, which was the storm that began the cleansing.

05-00:00:49

Meeker: In 1997.

05-00:00:49

Goldsmith: 6, 7. And I can tell you that the crisis happened in a variety of ways. But I think I can tell you the broad two. One is when you run a large company or maybe a small company or maybe even a family or maybe even one person's finances if you lower your revenue or your income you better be able to lower your expenses. Simple as that. And McKinsey and health plan and Oliver and most or all of the medical directors had endorsed an intellectual descent of the premium, the revenue. In order to compete. But instead of doing it thoughtfully each year at the time and seeing how we're doing it was an intellectual disciplined step to do every year for five years. And it assumed that you could bring the costs down commensurate with that.

05-00:02:15

Meeker: And it sounds like there was also an assumption that the membership would grow because of the decrease --

05-00:02:23

Goldsmith: Yeah and you'd see success. Fact, I used to ask, "If I have to close hospitals how big could the membership get so I don't have to do this?" Because it was painful to try to close a hospital. Painful for everybody. The community, the unions, the governor, the mayors, churches, everybody. Closing hospitals is pretty hard to do.

05-00:02:40

Meeker: Closing hospitals meant significant layoffs?

05-00:02:46

Goldsmith: Layoffs, foreign for our doctors to go to different hospitals.

05-00:02:51

Meeker: So the physicians in the medical group would generally be reassigned but --

05-00:02:54

Goldsmith: Extremely upset about it. They wouldn't be reassigned, they wouldn't lose their jobs, they'd have to go to the other hospital to practice. They like practicing in Kaiser Hospitals in California. We weren't going to close all our hospitals. But I used to ask, "How big do we have to grow?" They said, "Four million." I used to make a joke always, well let's sell the plan in China, when they all sign up then they'll figure out later in English what hospital they go to is in California. But the number was 4 million.

05-00:03:19

Meeker: The health plan at this point was about 3 million in southern California.

05-00:03:23

Goldsmith: And I used to say, "How many would it take so I don't have to go through this painful process?" Which the medical group had accepted. In other words, another example of trying to manage the thing or lead the thing was I got the medical group in southern California to reluctantly agree. If Oliver says we close the hospital we're going to close it. That was quite an accomplishment. I admit freely it didn't work, it failed. There were many snafus and intellectually it was flawed. At least I think it was flawed. But I bought it. I owned it. So did everyone else but when failure happens there's an expression. Failure is an orphan. Failure is not an orphan. I made a mistake on that one big time. Not one other person in my team or in the health plan has ever said to me that they too made that mistake. You'd think it was Oliver alone. Huh. That's a good one. The financial crisis happened because of that. Adopting the McKinsey ignorance. Cut, cut, cut, cut, cut and buy on the margin, buy on the margin, different hospitals, misunderstanding you don't buy on the margin. Do you understand that? In other words since hospitals have empty beds they'll sell you the fringe beds cheap. The problem is we don't do things in fringe beds. We need 70 percent of the hospital. So --

05-00:04:51

Meeker: So as an example of a site this was happening, the effort to close LA medical center and then transfer to Saint Vincent's?

05-00:04:57

Goldsmith: I announced we're closing Sunset. Announced that --

05-00:05:02

Meeker: That's the LA medical center, correct?

05-00:05:02

Goldsmith: Yes. 450 doctors. That's when I used the expression, over my dead body, and then I stopped using that expression. Then I found out due to completely

clumsy work that there was no emergency room at Saint Vincent's. And once I said, "You can't have a hospital that Kaiser uses without an emergency room." And I was so upset with the people investigating this, health plan and medical group. When they started to figure out how to build an emergency room there the economics fell apart. But that was only a sideshow. The fiasco there.

05-00:05:42

Meeker: What was the main event?

05-00:05:44

Goldsmith: The main event was the intellectual descent of the premiums. On the microcosm -- this was happening all over the country. This was Kaiser march stepping along. In my own experience in southern California I remember as clearly as if it was yesterday Barnaby, the man I couldn't work with, we could be in the same room together, we could talk, but it was so charged. Saying, "We're going to lower the premiums." This could have been the third year. If I came in in '94 I must have participated in '95 lowering the premiums, '96 lowering the premiums, this was the third year of five. And I remember saying to Dick Barnaby, "Dick, I'm very uneasy with continuing to do this. I don't know that we can get the costs down." OK these are union contracts. Just for starters.

05-00:06:40

Meeker: Well there's the getting the costs down, there's also increasing the membership. Had there been --

05-00:06:44

Goldsmith: We're trying to increase the membership but the feeling was you can't increase the membership without lowering the premiums. People will come follow price. McKinsey believes people will follow price. Lower the price, they'll come.

05-00:06:58

Meeker: But it sounds like at this point in time every effort to lower the price was maybe too late to attract the bargain-seeking consumers…

05-00:07:10

Goldsmith: No, no, it was just --

05-00:07:10

Meeker: …who had already found somewhere else that was cheaper?

05-00:07:12

Goldsmith: No they weren't really leaving in droves yet. It was just flattening the membership.

05-00:07:15

Meeker: Flattening but this model required an increase of members.

05-00:07:19

Goldsmith: Well there's a general increase of a couple percentage a year to keep it managed. You don't want it to grow too fast because you don't have the facilities. But you certainly don't want it to go down. But we were flat, maybe losing a little membership. OK and thinking that it was the competition taking them away for price, whatever the reasons was, the economy and our lack of good service and our price was too high. It was a combination of thoughts. But certainly we were not lowering the costs commensurate with lowering the premium. And on that specific day I said to Barnaby, "Dick, I'm very uneasy with this." I turned to my finance people and said, "Are we getting our budgetary needs met?" Because remember, the premium is distributed to the medical group to pay the salaries and the costs. And I got the signal yes. We'll be OK. Now my finance guy let me down on that one. Because he thought, Dr. Goldstein, that he was answering me -- he was answering me from the medical group's narrow standpoint. But he's a broad thinker. He should have said, "Dick, we shouldn't agree with this because it's not going to work overall." Because he understood these things. But he signaled to me incorrectly we can live within this budget. That very day I went to a gentleman named Pete Palarito who was my business manager, also involved in budget, who worked for Dr. Goldstein and me. And said, "Pete, I think I've agreed to something that's going to come back and kill us." I remember saying it. I agreed to it. Not trying to shift. Again failure is an orphan. I don't hear anyone else talking like this. I'm a genius because I learned from these mistakes. So I went into the room there and said, "We got a big problem here." Within a month, Martin, maybe within six weeks, the next month's -- or the budgetary revelations kept coming forward what it was costing us, whatever, that we were losing our shirt. And that things were going to get worse next year. And we didn't set the premium. Because once you set the premium you can't change it. Like if you just as simple as this. You say I can live on $30,000 a year and you're making $60,000 and if you're wrong you just took the job for $30,000.

05-00:09:45

Meeker: It's like tuition on an annual cycle.

05-00:09:48

Goldsmith: Yeah you're stuck. There's nothing you can do. Tuition. You can't change the tuition, say there's an additional $2,000 charge for every student, we've got some untoward expenses, OK. You're set for a year. Then all over Kaiser Permanente the losses mounted.

05-00:10:08

Meeker: Why did the breaking point happen then?

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Goldsmith: Because in my view the health plan leading the premium setting but the medical group acquiescing made the fatal mistake -- almost fatal -- of thinking they could achieve cost reductions. I think I can lose 20 pounds in a month. So I'll promise you my home if I don't get there.

05-00:10:31

Meeker: So continuing that analogy they were able to lose ten pounds in the first two weeks but then that was all you could lose.

05-00:10:38

Goldsmith: Exactly, the first two years. We kept up the first couple years but it became more and more difficult. And then the public was saying -- we thought cutting premiums would be greeted with -- I thought. I don't want to say we. I thought reducing the cost of health care would be an achievement recognized by the community, the newspapers, the *Los Angeles Times*. But in fact it was equated to managed care cheapening health care. So now if you couldn't get an appointment at Kaiser you didn't just say, "Kaiser sucks," you said, "it's because those guys are cutting costs." You don't say, "I'm glad they lowered the premiums." It's a little hard to get an appointment. I wonder if there's a relationship. You said, "Those guys are cutting costs. And that's why I can't get a doctor." Cutting quality.

05-00:11:28

Meeker: Well there was also the discourse circulating at this point in time post 1993 and attempts at health care reform and the big question was choice.

05-00:11:39

Goldsmith: Managed care.

05-00:11:39

Meeker: Well the reason that health care reform never happens in the United States, at least the way this is presented, is there's this like bugaboo of choice. The people want to have choice.

05-00:11:47

Goldsmith: Yes so you're taking away my choice by pushing me into managed care. In a sense they're saying, "I don't want to go this way for a lower premium." Or conversely lower the premium and let me have choice. Let me do anything I want. Well it's typical American public. I want. It's why surveys are such a joke on television. Because you ask how you ask the question. But certainly dampening the premiums did not make us attractive. Every time there was something that went wrong inside of Kaiser Permanente people said, "Those guys are cutting costs, cutting premiums, cutting costs." It just got all mixed up in the public's mind. It'd be like my saying to you, and I've used this example. Martin, "I'm going to take you out for dinner to a really -- I want to -- it's your birthday. I got a discount restaurant. They're knocking 20 percent

off the price OK if we go between 5:00 and 7:00." OK what are you thinking when I say that, I thought you were taking me out for my birthday. You're taking me to some discount restaurant; I got to go between 5:00 and 7:00. It could be that it's actually a great restaurant. It could be that I'm not thinking mean-spiritedly. But OK so we were getting hit by all sides. The *Los Angeles Times*. Everybody. Every time there was an incident. Cutting costs. The unions hated us. They were planting these things in the papers. And the *Los Angeles Times*, there's a famous statement by -- I remember this, think Adlai Stevenson said, "The newspapers are a fantastic source of information but they can't separate the facts from the chaff or the wheat from the chaff," or something like that. They always are off base by a cycle. So everything was going wrong. But mostly the drop in the revenues. The net income. Dying. Suddenly Lawrence was no longer the fair-haired boy. Because you can't run a corporation losing hundreds of millions of dollars across the country. It wasn't just Oliver's error in southern California or Barnaby's stupidity in northern California with Caulfield. It was everywhere. So this was a national decision they'd made. Acquiesced by the medical groups, OK, I don't say --

05-00:14:15

Meeker: And this decision originated with McKinsey you think.

05-00:14:18

Goldsmith: I believe so. Well it was -- McKinsey recommended it but they didn't execute it. They're just an external body that goes on and makes their $50 million, $100 million from Kaiser and goes on to something else. But Lawrence and the board of health plan adopted it. They endorsed it. They're to blame. So are the medical groups for accepting it. We all -- we could have said, "No." It's their legal authority to set the premium by the way. So at the end of the day they could have said, "We're doing this anyways." But I can tell you people like me thought it was the right thing to do. Big mistake. To blindly endorse a five-year strategy without looking, sniffing around every year to be sure you're on the right track. Why, then Lawrence was completely identified as the leader of a corporation that's going broke. Because in the business world that I'm in, probably any, it doesn't matter how good your last year was. Reason being a medical director was hard on me was every -- didn't matter how good I performed, I ran the marathon in 48 minutes, yeah but Oliver you're running this one and you're five minutes behind everybody else. We had a great year last year financially. Yeah but the first two months of this year are terrible. It's only a matter of time before it catches up. So you never can sit back on your laurels and Lawrence then was identified, because he wasn't a finance guy and he didn't really have good judgment in people and he just had charisma, whatever that is, and no -- and he was sensitive to the marketplace but he didn't know how to move ahead. So he was basically by his board and a few members of the board, I don't know who, but it was obvious you had to do something. His policy and his leadership was now he'd lost all of the trust of everybody in the medical group side. Many in the health

plan side. But his point was it's about performance. That's what Dave tried to say he believed in. Remember the point? It's about performance.

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Meeker: What did that mean?

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Goldsmith: He tried to emulate a businessman. Martin, it's about your performance, not how you say you're good, not how you are going to try things. Bottom line. What's the bottom line? Now in health care bottom line is of course important but a variety of components are important. All have to be in place. Dave knows that but now he was identified as the man presiding over a bottom line that was red. Terribly red. The biggest losses Kaiser Health Plan had ever experienced. Well if you can take pride in being the leader when you're doing well you got to take it when it's not doing well. So at that point the board basically made him into what we thought was going to be a eunuch. What they said was Dave is going to be involved in external meaning talk. Public. Boards. Press. Discussions. Because that's what he was actually skillful at. OK but he wasn't going to be in charge of running the organization. And they brought in Dale -- I'm thinking of -- I know him very well. Dale -- just blanking on his last name. But he became the chief operating officer. OK and that was a chapter that was very exciting in retrospect. And very dynamic. Now Dale. Crandall. C-R-A-N-D-A-L-L. Dale Crandall is a businessman and a good person and a person driven.

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Meeker: Where'd he come from?

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Goldsmith: He had been with some shipping industry as a CEO and he was from San Francisco and he'd also been with Price Waterhouse. I think he had a financial background. And he was a businessman. And he enjoyed coming into the organization to right size it. To get it right. He came in at first with a lot of cuckoo ideas that he would bring from the business world that were repulsive to most of us like you guys don't have any incentive, we need to put 30 percent of your income at risk for performance. That's a typical business idea, 30 percent of your performance at risk. And we said, "Dale it's never," -- I remember saying to him, "Dale I know you don't understand this, I know you think I'm copping out, what you mean is 30 percent of my current income at risk. That's what you really mean. You don't mean 30 percent of additional money. I'll take it. Secondly you have no idea what the press is going to say when they learn that doctors made $50-100,000 in profit based on their performance. You have no clue," which he didn't. "But you also have no clue that this ain't going to happen. OK but you use it as your mechanism, you think that's what -- you think." I remember saying to him. He's a very good person, he could listen to this. He didn't – "You think that doctors get out of bed in the morning because they want to make 30-50 percent more money as a

bonus. That's not why doctors should get up in the morning," and they don't. Sure, like everybody else they want to make more money, but that's ridiculous. "Furthermore it's not going to happen. And furthermore, if you think about it, Dale, who makes such profits? Stockbrokers. Guys that sit at screens all day. It's not going to happen." He gave up. Dale was a quick learner. So what we said to Dale in 1997, 8, we meaning Jay and the leading medical directors, is, "We all have a crisis. Financial crisis. Let's work effectively together to lower our expenses, to raise the premiums, to get our act together." Which he then led that. And Dale actually I think gets credit for rebuilding the trust of the medical directors and the program as the COO to get us back on our feet. And he took us through several years of return to recovery. We closed Texas, we closed east coast, we closed Kansas, North Carolina. We began to take better care of our patients. We began to get our hospital act together. The hospital strategy had already failed. Miserably failed. Lawrence's strategy which I endorsed. Failed.

05-00:21:07

Meeker: The closing of hospitals.

05-00:21:07

Goldsmith: Closing of hospitals had failed. The membership began to go up. The economy turned around. We began to trust each other. And the Kaiser Permanente partnership got back together. And that led to Lawrence ultimately retiring. Which we were relieved at. It got so bad -- and this should be known in history -- it is said, I believe it's true, that Vohs, who was the values leader before Lawrence, stopped coming to his own dinner honoring him, the Vohs dinner. Which is true, he stopped coming. I know this is a fact because I went to those dinners. He was so unhappy with what the health plan had done and Lawrence's behavior that he stopped coming to these dinners. He's now in his late seventies, eighties. And he was one of the fellows I knew slightly. I stood in awe of him. Before I left the organization I was at one of the Vohs dinners and Vohs attended. George Halverson invited Vohs to the dinner and he came because we recovered. Moving ahead, should I stop? Or should I go? Do you have more questions to --

05-00:22:18

Meeker: I don't know, it seems like you're getting called.

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Goldsmith: Oh OK can we pause?

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Meeker: OK so if I recall correctly you were about to discuss the formation of the federation.

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Goldsmith: Well no the federation was formed around ‘95, ‘96. I just got a look at the history of that and that came about because as I say there was a mixture of there was a need on our part, there was some support to do it from the health plan, and there were forces to which we were responding. So we had that in place. We had an excellent leader in Dr. Crosson. The health plan now brought in Mr. Crandall, who as a quick study began to learn that dealing in health care is different from other industries, and he began to recognize to get the crisis under control he needed to partner with the physicians and address the costs, etc., the service. Because it is commonly known that the physician’s pen so to speak results in I think 70-80 percent of the expenditures for health care. And that’s true. The ordering of things, the staying in the hospital, the admitting to a hospital, medications, etc. The physician launches the expenditure. So we formed committees, we built trust, we argued, we disagreed, and we moved forward, culminating in the recovery around ‘98, 9, etc. And that recovery was internal. We recovered our trust. We recovered financially. We recovered growthwise.

05-00:24:05

Meeker: From the vantage point of Los Angeles, or rather southern California, it might be helpful if you could provide a few examples of how that turnaround happened.

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Goldsmith: Yes so once we began to raise the rate, the premium, it was actually tolerated in the market. In other words we did not -- our membership began to grow or at least right size or at least stabilize. Our reputation improved. As we raised our rate. People didn’t knock us as much for trying to be cheap oddly enough. But another thing happened outside. The competitive forces faltered. So it was not just us against the environment. The environment was against us. And competitors went out of business. FHP, a large competitor, complex managed care organizations in southern California didn’t do very well. And so the idea that the external world could compete with us favorably, which they had been for a year or two or three, disappeared. They were not.

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Meeker: From your vantage point what was the flaw in FHP?

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Goldsmith: I think they lacked geographic expansion, they didn’t have probably the capital borrowing. And I think internally they did not have the culture that was needed to have a prosperous medical group that could take care of variety of patients. They were probably very much dependent on external consultants. They couldn’t bring stuff in house. They were locked into one or two areas of southern California so they couldn’t develop the marketplace, variety of other things. Probably had their own internal politics I don’t know about. So in southern California we raised our rate. The membership improved. Stabilized.

The health plan finally acquiesced in bringing a local leader here. So we no longer had the division. We kept the name but we always used to laugh at it. They brought down a health plan executive for southern California. They brought in a very trustworthy person to run their division, Mr. Pettingell, Dick Pettingell, and he tried very hard to work with us effectively, which he did, and we're back to our partnership. He understood our need for an executive in southern California so he brought us a man named Richard Cordova. I actually helped recruit him. Good person. He and I worked together in southern California. And so we restored the traditional partnership between the health plan and the medical group in southern California, in northern California, and nationally. With Jay Crosson and Mr. Crandall and Dr. Lawrence to a degree. So that partnership was restored. The board turned around and knew their errors. Never admitted them. But came to their insights. And it culminated in the partnership expressing itself on the selection of Mr. Halverson. So I'm already up to that point. So faltering external forces, better economy, etc.

05-00:27:13

Meeker: Before we move along from Lawrence, he was moved into a more honorific position. Did he ever become chastened? Did he ever admit what might have been the error of his ways? Or?

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Goldsmith: He could not help but know it. He was moved to a different responsibility. I think I've heard him at times give some clue that he did. I don't think he got close to the core of it. The core of it I think would be painful. But I think he knew certain errors of business, like I'm admitting certain errors of business. I think he admitted certain errors. But I think he saw them more as errors. So I don't know.

05-00:28:07

Meeker: Speaking of core, this question about where he erred, you brought up several things. The paying too much attention to the high-paid consultants, not paying close enough attention to income versus expenses. But also I think more fundamentally rupturing this marriage, right, between the health plan and the medical group over the years. And that one in particular has been described to me as a Kaiser core value, something that is in the DNA of the organization.

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Goldsmith: Absolutely.

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Meeker: There are other points though that are described as a Kaiser core value. And I wonder looking back at Lawrence's term the degree to which those other core values also were challenged and the degree to which those challenges were either seen as illegitimate, like the problem with the divorce between the two, or they were seen as legitimate. So prepayment for instance. That seems a

Kaiser core value. To what degree was that challenged under Lawrence's tenure?

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Goldsmith: I don't think -- the multiple core values I don't think he got into those kinds of things. I think it was more relationships and the core mission to work together. I think he began to forget that however we fell short, which we did, the concept that an organized system of health care can approach the monumental problems of health care better than a random dispersed system, he forgot that. Give you an example. The ability of a medical group of thousands of doctors to decide what's the appropriate medication for a condition and carry it out 99 percent of the time is powerful. No one I think except someone that doesn't know health care would forget that. I think he began to forget that. He may say he didn't. But you have to support that. If you believe it you have to do the things to support it. He lost track of that. So words began to lose, walk your talk was gone. So but prepayment, capitation, we have abandoned capitation to some degree in that we've had copays. So it wasn't a matter of moving ahead to certain things like that. People like me and others were distressed that we went from copays of $2 to copays of $50. But I didn't know which way to turn. I'd rather not charge a $50, but we couldn't do it in the premium. So he didn't abandon all of the principles of -- the failings that he had was I think his own persona was being fed more than the organization. I know for a fact from insiders of the health plan that almost everything they scurried around to do was to promote David Lawrence. That was an astonishing revelation in the organization, OK, if true. I believe it was.

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Meeker: But that alone doesn't account for the massive problems of 1997, does it?

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Goldsmith: Well it could if you then relate that to bringing in McKinsey. McKinsey feeding you. Making decisions that McKinsey endorsed, not confronting them, trying to foment troubles in the medical group because McKinsey supported that. Breaking up the medical group, seeing those doctors as a problem because you basically don't trust doctors. It was rampant. And then I think so if you had to put -- there's no one -- could have happened to anybody but certainly happened swiftly under his command. Recognized by Vohs, recognized by others. Everybody he had in office is gone. It was pretty rampant. So but it was still the physicians were to blame, they weren't getting their act together, I was making mistakes in terms of certain things, I'm old-fashioned, I believe in the values of the organization deeply, I don't want to see them tampered with, I actually would go so far as to say -- and this should be history because if Kaiser Permanente goes under, which it could, it'll have to go under as it is. With our core strengths that we can't surmount. Because that is Kaiser Permanente. It sounds stunning to say it but I believe we are who we are. The medical group health plan parity in decision-making, you change that, you can call it Kaiser Permanente but it ain't. And I believe it

will affect patient care and our values and our history and our future. And maybe we're doing that now with increasing copays but I don't know what else to do but charge 50 bucks sometimes because people come in, we need the premium. We need the money.

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Meeker: What about the nonprofit model?

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Goldsmith: He tampered with that. I believe there were secret studies to see if we should convert to a for-profit.

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Meeker: Would you consider that a core value?

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Goldsmith: Absolutely. People say the medical groups are for profit, well, it's true in a legal sense. Corporation or for-profit. But our driving model is not to do that. It just happens to be our legal status. But for the health plan to change to a for-profit, that puts it in the same camp as United, Maguire making $1.8 billion, it's unbelievable that they would let themselves be publicly humiliated. Legally if it's permissible. They had the stupid executive committee chairman of United say publicly, "We were a little uneasy about the compensation of Mr. Maguire, Dr. Maguire, at $1.8 billion, but we were afraid to approach him because we thought he might think we were criticizing him." We had a good laugh around my dinner table at that one. Because I said to my kids lower me from $1.8 to $1.4 billion, I'll try to adjust. He should have led that adjustment. The CEO Maguire. But he probably is no different from other people.

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Meeker: That brings up a question that's really not any of my lists but I've noticed in the course of doing these interviews and going to a lot of homes of leaders of Kaiser Permanente just as a personal aside they're much more modest than I would have expected.

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Goldsmith: But we've attracted a rather -- we attract a group of people, myself included, who while they want success and they want the trappings of success and they want the -- I don't play golf but the golf course, it has a little more balance to it I hope in the eyes of a public than let's say people who are in the for-profit world. Not always by the way. You can be in the for-profit world, you can be a fee for service doctor like we said yesterday. But I think the system distorts things. I think they looked into that. I would allege probably he probably made a fortune doing it but they must have reared back their heads from the abyss when they thought about that. McKinsey must have told him to do that. In my opinion.

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Meeker: Well, yeah sure, they probably said to him that in order to be respected you have to have a higher salary.

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Goldsmith: Yeah well who knows what they said. But I think that's a minor part of it because it never happened, it never surfaced for discussions, and it was always kept under wraps. But in answer to your question, Dr. Lawrence and the board of directors did not abandon other principles. They continued to want to work with the medical group, but a very different kind of relationship. They considered prepaid health care important. Preventive health. Empirical medicine based on fact, science, controlling expenses, patient-centered approach. There was never any de-emphasis of that. And I think things like Lawrence himself led the effect to try to have a good relationship with unions. I agreed with him on that. Labor. He was always -- in the history of Kaiser Permanente we've always been culturally sensitive. We pride ourselves on that. I think you were going to talk to me about it. But I think Dr. Lawrence had always been involved in culturally sensitive diverse care way ahead -- as had Henry Kaiser. So in many ways Dave carried the tradition forward in an exemplary way. Not with the medical groups.

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Meeker: Institutionally how was he finally ushered out of the organization?

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Goldsmith: Well I think he -- I don't know exactly but a year or two before -- well when he was at retirement or took a little early retirement, it was depicted as a retirement sort of time. I think it was. He was over the hill. Well if you're going to be in those positions you have to endure people saying that about you. He was through. He'd lost his impact on the physicians. You can't have a health plan executive that can't influence the physicians. He can influence his people around him but he lost that opportunity, very sad. But it happened, he was over the hill. So he retired. And then to show the degree to which we have returned to unity, I'm sorry, Mr. Garcia, Dan Garcia, the health plan board, approached the executive committee of the federation to participate in the interviews for the CEO, which you may be familiar with, that we did.

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Meeker: No.

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Goldsmith: Oh. Well Mr. Garcia was the chairman of the executive committee, he was a businessman, lawyer in southern California on the board of Kaiser Health Plan. Always had a good relationship with him. We don't have any -- speaking as a physician leader, I don't think we have any hesitation about a strong-willed direct business relationship. I think that's what we need from our health plan. They're our partner. If they go down the tubes we go down

the tubes. No one doubts that we are part of the health plan. In fact when the health plan was in trouble I rallied the doctors by saying, “Guess what happens to the Permanente Medical Group if health plan fails?” So don’t call me a commie sympathizer by working hard with the health plan or a right-wing conservative businessman. We need them, they need us, it’s mutual, it’s marriage. Dan approached us, me for sure -- I can give you the personal side. And said, “I want you guys to help me decide who to recommend to the board of health plan.” I remember -- and I know Dan would hear this correctly -- I said, “Dan, thank you, but you guys make the decision. But my own view is you should find out first if a guy like Oliver is going to say they’ve chosen an idiot. A dithering idiot. You can choose who you want, it’s your authority, we don’t ask you to choose our leadership. But when you choose this person wouldn’t it be interesting to know if Oliver’s going to stand up and say, ‘I can’t believe they chose a jerk?’ Then choose him, because that’s your right. But I’m going to say it if you did.” He went so far as to -- well he heard us and he said, “Oliver, I’d like you to participate in interviewing the finalists.” I said, “That’s very very -- that’s really great.” Which we did. There were interviews of the finalists. I don’t know if it’s still confidential who the finalists are but --

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Meeker: Well maybe you can just tell me how many of them were --

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Goldsmith: We interviewed two people. I know I did. Now whether there were others before that, I don’t think they needed us to interview people they weren’t going to even consider themselves, but they had two finalists for the job. One was Mr. Halverson. And one, his name is escaping me, but it’s probably public record. A physician. And we interviewed both. I’ll never forget. It was a video interview. In other words we weren’t up in San Francisco or Oakland. And Dan said to us, “Who did you like?” And I remember saying -- because I speak up – “Dan, you don’t need to ask that. We have huddled, we have conferred, we think both are suitable candidates. That’s what we wanted from you. We think if you choose this one or that one you have demonstrated -- first place you’ve demonstrated what you said.” He was a man that did what he said. That’s what we wanted. Both are capable. He said, “No no no I bet you have a preference or I wonder if you have a preference.” I said, “Well I don’t want to put you in that position of I choose A and you want B. We can live with it.” But he pushed. He actually pushed us. Said, “Who do you prefer?” We told him. And the health plan chose who we preferred.

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Meeker: Was there any question that the main candidates were ever going to be -- I’m not putting this correctly. They were both insiders to Kaiser Permanente.

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Goldsmith: Both were outsiders.

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Meeker: They were both outsiders. Where did Halverson come from?

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Goldsmith: Well Halverson was the CEO of a Minnesota plan called HealthPartners for many many years.

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Meeker: Well this is a very new development then for Kaiser Permanente.

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Goldsmith: Yes, I cannot recall in my brief review of the history anybody from outside. But both candidates were from outside. And so but it was clear to us that there -- well Crandall wanted the job. He was an insider. But he'd only been with Kaiser two years. And Crandall would have been a difficult choice, as much as we admired him. He was not from health care. The CEO of Kaiser Health Plan has to have something to do with health care. And not just a bring in a guy from --

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Meeker: An MBA.

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Goldsmith: The shipping industry. That would have been a big mistake. As effective as he was. Pettingell wanted the job. He was this California division president. Hospital person. I'm sure others inside the health plan wanted the job. But none of them warranted even minor consideration. So they were stuck. They would never choose someone from the medical group. Someone asked should they have. Well, probably not at the end of the day. Because you need expertise on both sides. So if you had someone that talented, like a Jay Crosson, to qualify for the job, then you lose him on the medical side. And it's a partnership. So why not complement the strengths? And while Jay is very terrific, his persona is not a warm leader persona. So guy like me would have been a mistake. It's flattering because I would not have known all the health plan stuff. So you need a health -- that's the point. It's Kaiser Permanente. Two people with expertise differently that combines together and goes forward. You see, so Dave Lawrence when the health plan picked him, they picked a physician, they didn't pick a businessman. And that got us into big trouble among other things. So both were outsiders. Halverson's question to me was, "I don't want this job, Oliver, if it's full of conflict and arguments." Because everyone knew we were fighting. By that time we weren't fighting that much by the way. But I said, "George," I remember saying, "George, I really don't think there's much fight left to fight over because we've been working together much better since Dale came on board." And he said, "Fine, I like that, I'll take the job" -- I mean he subsequently got the job. And I don't think we fight with George at all. What else?

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Meeker: Let's see here.

05-00:44:37

Goldsmith: We also missed an opportunity to expand. If Kaiser Permanente is so good, you guys who think this way, why don't you expand? I know you closed, but you can expand and close at the same time. Can close in Kansas and open in Chicago. And I felt very strongly that we were missing an opportunity to go east young man. In fact I coined the term. Go east young man. Instead of going west young man, 19th century or whatever, I felt go east. Contiguous east. Vegas, Las Vegas. If you go to Las Vegas there's thousands and thousands of people who were Kaiser members who retired there. It's a service industry state. It's unionized. It's waitresses and regular people, all with health care. It was perfect for us. Run it out of California. But because Kaiser had had such a nervous breakdown with its financial crisis, no one would touch it with ten-foot pole. Dave used to say, "Until we got our act together." An organization never really gets its act together. They're always pursuing other goals. Now it's late in the game. There's rumors that we might be looking into that but I wanted to go right across and set up a small medical group and build our own hospital and start from scratch. But we now have plenty of money to do it by the way.

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Meeker: But the market there is saturated?

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Goldsmith: No, I think we could enter there right -- we'd take some losses for the first few years. A lot of politics in the state of Nevada, maybe we could -- but I think we could do it. I've always felt we can do it.

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Meeker: Rather jump over to --

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Goldsmith: Chicago.

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Meeker: Chicago or Ohio, Colorado. Colorado's more contiguous I suppose.

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Goldsmith: We're there. We're already there. Go west. Go east.

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Meeker: But attempt to maintain those --

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Goldsmith: Yeah but Nevada you could say, “Oh it’s California.” Could run your specialists there. You could do all kinds of things to undermine the usual opposition. We’re in Bakersfield. Go up the 10, go up the 15 I mean, north, go through Tahoe, lots of opportunity. Someday we will. That’s it.

05-00:47:03

Meeker: Now let’s see. There are some other issues that I want to cover. One of them being the labor management partnership. And again this comes to a head around 1997 as well. When there was the delayed opening of the Baldwin Park facility.

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Goldsmith: Yes I was very much involved in the breakfast at which the lights went on.

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Meeker: OK describe that please.

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Goldsmith: Well first place the labor management partnership and the opening of Baldwin Park are related but a little bit --

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Meeker: I guess I was going to ask you to tell the story of the labor management partnership in the context of --

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Goldsmith: OK first in 1994, ‘95, certainly in southern California, I don’t remember the rest of the country, we had labor war with the unions because we were carrying out the cost reduction of the McKinsey plan in the first two years to reduce salaries of nurses and staff. Dietary workers, everybody. OK and we won. In a simple short term. We beat the unions. OK they took pay cuts. If they did strike, and I don’t remember they striked, they didn’t have much impact. This is not northern California, this is southern California. And that was the first two years. Of course we were bloodied from it, etc. And out of that came some people on the Kaiser Health Plan board who said there’s a better way. And they created the labor management partnership. And they got the AFL-CIO and the fellows there to agree to move forward. And I thought it was a good idea. I think a lot of things are good ideas. Especially teamwork and working together. And so I was asked by the Permanente medical groups, who were very skeptical, to join in as a senior member of the labor management partnership representing the Permanente medical groups to a degree, OK, so out of that came the national labor management partnership with Pete Dechico, who you’ll probably interview. And various people. Dick Pettingell. Dale Crandall. Dave Lawrence. Picture taking, all kinds of stuff like that. And we thought there’s a better way. So did the unions. And so we moved forward. Now one of the initial elements of the labor management

partnership was joint management of a hospital. If you could do that that'd be pretty good. Now by that I mean the nursing union people would run it and so would the health plan and medical group. So in Barnaby's mind he began to see -- we can say this, KP Labor, KPL. That there were three legs to the stool.

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Meeker: And that frightened him?

05-00:49:49

Goldsmith: No he liked that. We used to say that's never going to happen because unions aren't the same as the medical group. And he'd say ah the medical groups are just a bunch of unions anyways. That's the way Kaiser would sometimes dismiss us. OK, but we don't have the same operating principles. As voluntarily taking a pay reduction, which we did in '96. We didn't negotiate with the health plan to do this, we did it ourselves. Because we thought it was the right thing to do. The unions in southern California, throughout the -- it's impossible to do that. Impossible. Show me a union that has voluntarily taken a pay reduction. I used to say that to Pete Dechico. You're never going to be KPL. But we can have darn good relationships, work together. One element of it was self-managing a hospital. Labor and Kaiser Permanente. So one morning I was having breakfast with Lawrence, because he would periodically circle around to try to patch up relationships with people and we'd have breakfast or something. And our hospital in Baldwin Park was built but not opened, and it was ridiculed how wasteful we are, this nonprofit, they're not businessmen, they'll build a hospital for millions and millions of dollars, they don't open it. So I remember that morning at breakfast Dave said to me, "What would you do?" This, we were talking about the labor management partnership. I said, "Dave, I got a great idea. Open Baldwin Park as a green fields project." That green fields is the term that I believe green something or other, green pasture, green field, in the union to try and experiment with management somewhere else. Like Saturn plant is in Tennessee, so open a new car style not in the old way in Detroit where the unions and management hate each other. But go to Tennessee and do it. Get a fresh start. So I saw -- let's have a fresh start with labor and management in Baldwin Park. Plus it met my goal, which was to get the hospital open. I'd do anything to open the hospital. Because meanwhile the medical group said, "We need the hospital, we want to go there." But the health plan wouldn't open it. Dave liked the idea. We all liked the idea. We opened it within a year. We tried co-management and one of the pivotal components of the labor management partnership didn't work. From labor's standpoint as well as ours. It was a very mature good thing that that happened. Both sides learned we can't do this. We can do other things well but we can't do that. That's the relationship of the green fields --

05-00:52:27

Meeker: Can you describe what was to be unique about the Baldwin Park facility?

05-00:52:30

Goldsmith: Yes, specifically that the management of the hospital was going to be shared between Kaiser, Permanente and labor leaders. It's putting the prisoners inside of the -- managing the prison if -- that's such a stupid -- that's not a good metaphor, I take it back. It's putting the workers in charge. A social idea that the workers care as much about the bottom line as anybody else, put their people in charge, they'll make it work.

05-00:53:00

Meeker: Were these labor leaders Permanente employees or health plan employees?

05-00:53:04

Goldsmith: Oh yeah, oh yeah. They were union people that worked in the hospital. But it didn't work because the minute they became managers or managing their own fellow workers resented it. Be like take the teacher, put him in charge. The minute he's in charge he's not one of us. He has to make difficult decisions. It didn't work. But it was a learning. It was OK, it wasn't a bad thing. It got rid of this naiveté because both sides thought it might work. I thought it might work. I wasn't sure. Had my doubts. But it didn't work.

05-00:53:35

Meeker: What would have been the goal of sharing management?

05-00:53:38

Goldsmith: Well, the outcome all sides wanted to be better care. Happier patients, happier nurses. If my nurse is managing me maybe I'm willing to see six patients, take care of six patients in bed rather than five, better productivity, better outcomes, less accidents, less absenteeism and everything else. It didn't happen. We didn't get a chance to try it because it failed. The management. The union recognized that. So but the labor management partnership I supported. But as I went along in it, just to get that, I began to fret that it wasn't expressing itself, it wasn't working out. And now all of the hoopla we had, expectations we set upon it, I'm disappointed.

05-00:54:27

Meeker: What expectations?

05-00:54:32

Goldsmith: We wanted to see for example absenteeism go down. We didn't see it. I concluded that the expectations we put around the labor management partnership fell so far short of what they could deliver and what they thought they could deliver. They were decent people, but at the end they get -- here's an interesting thing. They get elected by their union people. So do we in the medical group. But their election depends on more benefits coming to them than our medical group leadership in my view. It fell short. Can you hold that for --

[End of Interview 5]

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06-00:00:00

Meeker: OK go ahead.

06-00:00:08

Goldsmith: Well again it was a great experiment. Perhaps in retrospect we could have muted the expectations a little more and tried to accomplish some more limited objectives. But we certainly accomplished labor peace for the last five years or six. And that's important. Now some would say we paid too much for it but I'm not so sure. I'm not so sure. Health care, people earn more in health care. And I'm not so sure. But I wish some of the targeted improvements we sought had come forth. And at the end of the day I began to feel the union did go into the backroom and look more toward their self-interest more often. And even Mr. Dechico, who was a straight arrow guy, what he said he did, he was having trouble with some of the traditional union workers. So like most things it wasn't as much a pure labor partnership on their side of the house. They couldn't get their act together. So that combined with the demands for improvement which they couldn't deliver on, sometimes the resentment of our managers to the absenteeism, we fell far short of the expectations. Would I do it again? Probably yes. It was better than war. And they're good people. And maybe over a 50-year period or 30-year period it'll mature even more. My own view is there's probably been a de-emphasis of it in the Kaiser system since I left. Not because of me. I believe that people just got worn out trying to make it work and they may still use the term but it's more we're trying to get along better and do things together.

06-00:02:01

Meeker: Before we move on I do want to talk to you about the culturally competent care issue. But looking back upon what we've talked about, particularly during your period as regional medical director for southern California, is there anything else that you'd like to expand upon or feel like we've missed out on so far?

06-00:02:29

Goldsmith: Well I like to think just a self-reflection that it was a very turbulent period, which it was, and that I played a role in keeping us focused on our values. We made advances. I think I instilled in the group a continued effort to do the right thing. That leadership is very important, good management. Leadership

of physicians very important doing difficult things, and not always in the physicians' interest. Making a decision, sometimes wrong, is important. Being liked can succeed but you need to be somewhat -- have good relationships with people by your character is important. And reinstilling the same values, the traditional -- I like to see myself in the continuum of leaders and managers and people who are at the top of the organization. Is that I feel great that my decade, fifth decade Permanente's history, I think I fit into the tradition. And that tradition I think is such a wonderful tradition that I'm glad that it held together during that time and we did so much good. Plus I did fulfill some of the things of measurements, trying to move forward to hold people accountable for their behaviors. So I like that. We succeeded. I think I gave a good name to Kaiser Permanente. That's all. But that captures it.

06-00:04:12

Meeker: OK, speaking of accountability and evidence-based practices, one of the points that Frank Murray made in the interview was he talked a lot about his notion of the idea of living up to the health maintenance organization. Really engaging in evidence-based practices. And he said that one of the main things that he did, aside from thinking about this and making this an issue, was bringing on this consultant, David Eddy. Are you familiar with him? Did you have much interaction with him?

06-00:04:51

Goldsmith: As the regional medical director I had modest interaction with him. Visits once in a while. But Frank did bring him on.

06-00:04:59

Meeker: OK so do you think that your role was really just continuing to facilitate his work in context?

06-00:05:06

Goldsmith: I don't think I was as much of a champion as Frank was. So I think Frank was here, I was here, in terms of -- I supported it, David wasn't a personable guy, appear much. I think by the time I got into office the shortcoming was certainly not David, it was the measurements. To do everything he wanted required an electronic world, as I look back. And we simply didn't have an electronic world. We still don't. We're implementing it. So Frank was certainly ahead of his time in championing that fulfillment, but I think Frank himself would say we didn't yet have the instruments to automatically do it. So by the time I got in we were still talking, we're getting some measurements, but I think another decade from now that will look more exciting in its expression than it is now.

06-00:06:06

Meeker: Well, the circumstances were much different in northwest region simply because of the centralized record-keeping system. Patient records that then had to be driven around to various campuses. And it made it much less likely

that there would be a record accompanying a patient than in the northern California or southern California model.

06-00:06:26

Goldsmith: We had problems with that too. They got stuck in the chutes. Did you know that? There were chutes like tunnels. Charts were so thick. The medical record is dying. The paper medical record is pretty much moribund.

06-00:06:40

Meeker: Did you feel like you wanted to have an initiative about developing an electronic medical record?

06-00:06:46

Goldsmith: Oh I was one of the fervent supporters of continuing to do it. We funded it. I wasn't the leader in it but I was supportive of it. Kaiser Permanente made many many errors in what they spent their money on but so did most corporations I'm told. And we went through our build our own, work with IBM, all these things failed, and now we're in the midst of one that I think is very likely to succeed, Health Connect. I'm learning it as a physician. I'm the luckiest guy in the world on that because I was one of the members of the leadership that approved the choice of Epic Health Connect and now I would venture to say I'm the only one of them who is going to use it. I am being trained in Health Connect. Did you know that?

06-00:07:38

Meeker: Oh I didn't. Well I know that it's being implemented right now.

06-00:07:41

Goldsmith: This secure ID is from Kaiser Permanente, which allows me to access the internal system to practice using Health Connect. So I'm now on the frontlines using it. I'm not using yet. We're trained in it. But we go live September 15th I think at Inglewood offices. I'm very excited.

06-00:08:00

Meeker: Do you have any thoughts about it so far?

06-00:08:04

Goldsmith: Just that it's a major step forward in the history of medicine. I feel like I'm participating in something that will be taken for granted 20 years from now by young doctors. It's great. I'm participating in the scientific information advance. It's like someone's giving me a stethoscope.

06-00:08:28

Meeker: Moving on, you were chair of the Kaiser Permanente National Diversity Council. Can you explain what that was, when it was formed, what kind of work it did?

06-00:08:36

Goldsmith: Yes well the National Diversity Council had been in place I believe many years. Whether it had been functioning all of our career, we were always an organization advancing the cause. What happened specifically to get my -- I've not been a person particularly involved in that subject personally or professionally. But Ron Knox, who is the vice president for this in HR who was in charge of that, was trying to create some new initiatives in 19 let's say 97 or 96. I don't remember the year. Perhaps 2000. I don't remember. And he was -- I met with him once just in a routine capacity. And I said, "Ron, you'll never get traction on diversity issues to the degree you want unless you involve the medical group much more directly." Because it had always been a health plan-led activity. And Ron said, "Why don't you be the national chair?" I said, "Well I will." Not because of anything but just I did say that. So I took the national diversity chairmanship position. Which I believe I was the first physician but I'm not positive. I was certainly the first one with a lot of visibility to do it. I don't think a California medical director had ever done it. I just took it as something interesting to do and learn about. I'm interested in languages, you live in southern California, exposed to different populations. And I was curious to see what would happen. Plus I had what I brought to it from a thinking, my own thinking standpoint was we had always talked about diversity and health in Kaiser as let's say -- when it first started it was legalistic, EEO, government-required, you have a contract with the federal government, you have to hire minorities.

06-00:10:38

Meeker: Affirmative action programs.

06-00:10:40

Goldsmith: Affirmative action programs. Well I don't -- affirmative action applies to the hiring place like schools, but you have to have certain paper trails of fairness and minorities and so forth. That was the driving issue. Now Kaiser had always tried to do the right thing. But the operating thing was get the lawyers involved, EEO, do the right thing. The second phase of it got into it's a good business opportunity. If we get everyone speaking Spanish we'll get Spanish-speaking clientele, it's a good business. Like how to sell Coca-Cola, beba Coca-Cola, drink Coca-Cola, OK. Those two lures did not work for me. What worked for me was clinically being effective. Because I do believe deeply in a clinician is only as good as his or her ability to impact the patient. So you can speak in English about what to do and if the patient leaves the room completely clueless what you said what impact do you have? So I began to conceive of diversity as to extend your clinical effectiveness. I also knew that that would suck in the clinical side of the organization because clinicians want to be effective. So I brought to it -- then I said, "Well we should measure what we do." Everybody says they're for diversity but let's measure it. And then we came up with ideas like -- and I think I thought of these ideas -- let's see if we can take care of diseases in minorities and measure and become centers of excellence. And Ron and I both liked that. And so we set up -- I think northern

California may have already had one -- excuse me. So we did centers of excellence like sickle cell at West LA you may have heard of. We said, “Let’s see if we can become scientifically better at caring for African Americans with sickle cell disease.” I think they were already doing something like this in northern California with Chinese immigrants. Then we set up Armenian clinic at Glendale. Armenian-speaking. It’s a population. I think we’ve done a lot of these. And I was very proud of that. And I think I got the medical group to be more involved in diversity rather than lip service. Not to say they don’t care about it but there are actually measurements. How many Armenian doctors do you have, how many women, how many this, how many that. And I made some wonderful mistakes that were educational and I turned them to advantages in diversity.

06-00:13:24

Meeker: For instance?

06-00:13:26

Goldsmith: Well this is a good one. Again you learn by -- I am what I am. So I get involved and we set up a -- I always felt the health plan is so bogged down in their stuff, I’ll set up simultaneously a Permanente diversity committee. Do the national, but that was already hung up in tensions between people and Ron and I had tensions. And different tensions. He didn’t think I understood things. And I didn’t think he understood things. And so there were tensions OK but if I set it up in the medical group I could get things going faster. Because after all I’m in charge. So I set up a committee. I sat there one night, said OK, “I’ll have an African American, a woman, Chinese person,” I don’t know what. I forgot a gay person. OK I actually didn’t think of it. Now whether I didn’t think of it because I’m whatever I am I didn’t think of it. That’s all. So the committee meets for the first time and they’re all bothered by this. As if I meant something mean-spirited. Well maybe I did in some theoretical sense, he’s insensitive to gays, but I certainly didn’t know I meant that. Finally one of my gay colleagues sat me down and like sits me down, says, “I have to tell you something very difficult.” I said, “What did I do, what did I do?” And he says, “You know that you don’t have a gay person on the committee.” I said, “Now that I think of it, made a mistake. Let’s do it.” He said, “Well you’ve known about this for months. The committee’s been talking about it.” I said, “What a bunch of yokels you all folks are. Why didn’t someone tell me, what’s the big deal?” It doesn’t matter what it meant, it meant do it. So I began to say to people “You cannot be involved in diversity issues without making a fool of yourself.” And I actually believe this. You cannot get involved in this topic without making some mistake. Because that’s what mistakes were made over history. You’re part of history. You’re part of humanity. If it’s not toward this one it’s toward that one. OK.

06-00:15:44

Meeker: Well diversity categories are historical entities. They change over time.

06-00:15:48

Goldsmith: Yeah it's all over the place. And so I could give you countless examples of this. But the funny part about it was no one said something to me. And I think they actually left a chair vacant. If I remember, when I was invited to the committee to respond to this, they were symbolically -- and I said, "That's so fascinating." I said, "I'm at a level of this thing that you people aren't at." I'm laughing because why didn't you get to me early, why did it have to become a thing with me? In the Jewish religion we have a chair for Elijah when we celebrate the Passover, like a vacant chair. I tried to make it lighthearted. I guess some felt I had wronged them. I apologized. I said, "All right let's move on." But that's something I learned, and I would often say publicly in the diversity world or topic you can't do this without -- it happens all the time. We say to a person, "You don't speak English, bring your relative," guy takes a day off of work. And then you say you can't come in the room here, who are you, man took a day off from work to be with his wife. If that isn't culturally incompetent I don't know what is. OK and on and on and on OK so that was funny. So I tried to bring the clinical Oliver to it. I always felt there's like character of Oliver, all right, let's move on, made a mistake, don't get so hung up in it, let's move on. Most of the time I could do that. Sometimes it got so difficult in the diversity world that I actually found it very very disappointing to me.

06-00:17:18

Meeker: For example?

06-00:17:19

Goldsmith: Well for example there was an issue at the national level about a Martin Luther King holiday. Right or wrong. And that's a national issue by the way. It's a national debate. And I felt that my view was wait a second, if we have another holiday on a workday you deny patients care. Because Martin Luther King holiday would occur on a Tuesday or Monday. You close the clinic like Christmas. And how do patients get access? Any kind of patient, African American patients and everybody else. Plus if you work it's double pay and it becomes another holiday. And cynically I don't think many people -- majority of people -- take it as a holiday to go to affirm the greatness of Martin Luther King. OK I think it becomes a holiday. Just like everything else is. And so I was opposed to it. Well I thought it was being interpreted as racist or ignorant. And that hurt me. And it led to tensions. And I know that Ron didn't like that. I don't know if he felt that way but he certainly was disappointed. Well I was disappointed. And others on the committee were saying well is there a Cesar Chavez holiday and just it gets -- goes off. Why do we celebrate Christmas? As if I designed that one. Or George Washington's birthday over Martin Luther King. It becomes just a complex argument. But I was trying to stay at the delivery system level. And there were different ideas that were possible to solve this. But it led to such tensions that there was a counselor brought in to deal with it with me and Ron. Because we were both trying to carry out our goal. And when the counselor entered into this I was profoundly disappointed

in the counselor, who I did not think performed like a professional -- not a bad person but that person just didn't seem to frame the issue correctly that there's two people trying to work through this. I began to feel this is two people working on me. And that's not the way counseling should be. And I had entered into it in a good spirit but I suddenly found that this is not going to be counseling, this is going to be judgmental. And it ended in I retired mentally from the National Diversity Committee quickly and fortunately my time was up so I stepped down. And Ron was relieved too. He was very disappointed at the end, at the end. Not to say we weren't trying to do good work together. This just was what it was.

06-00:20:06

Meeker: Did you ever think that the National Diversity Committee in addressing something like a public holiday was overstepping its bounds, when reality in the context of Kaiser Permanente it should have been focusing more on cultural competency in care and clinical issues?

06-00:20:23

Goldsmith: They did, no, they did. They did. The problem was I think first place a national committee to deal with operational issues is a challenge because you have these regions. So it's already difficult to translate. Ron wasn't the master of working all of this. And so and people knew that about him. His heart was in the right place certainly. He was trying to carry out his responsibilities. But in the tactics I think he fell short. But in interactions with people it became difficult. I think the health plan knew that. But we did good work together. Some of the work we did well but it ended both of us professionally saying farewell. Fortunately I was ending my career so I was able to step down but I found it burdensome after that. It wasn't fresh. It wasn't -- like the example I gave with the gay, the chair, that was -- hurt me momentarily but it was never in the spirit of meanness. It never got racist or deep character disorder on Oliver's part alleged to me. Just learning and stumbling and getting to know each other and that kind of thing. Versus I thought it was getting deep-seated at the national level and frustrating. Finally but I was close to retirement so I said, "I don't think I need this in my life, I'm not able to do much here and just walk away from it." And I walked away from it with no hesitation at all.

06-00:21:58

Meeker: Maybe we should wrap up today. I would like to get you to describe what it was like to go back to clinical practice after --

06-00:22:08

Goldsmith: Thank you, nice topic to end on. During my tenure as medical director for ten years I tried to see patients at the beginning but lost my ability or intent or desire or whatever because of everything. Stopped. Two to three years before I retired, I realized, more looking after myself, that in retirement it'd be nice to have something that I do regularly. I have a lot of interests, I wasn't worried about being bored, but I thought some attachment to the organization.

You start off in Permanente and health plan thinking you'll retire to be a consultant. Everybody will use you. But the thing you learn very -- every medical director has learned this. The day you retire you're out. You're retired. You're not the wise man they bring in, OK. Don't delude yourself, I say to myself and to others, into thinking this. Whether you're retiring as a physician or an administrator you're out. Let the young take over. I don't even believe the old guys should hang around, OK, so I said to myself, "I think I'll try to be useful if they need somebody as an urgent care doctor, not as a gastroenterologist," which I was, not as a hospital-based internist. Just helping out. So I began to retrain two years before. In Inglewood urgent care where they needed some help on Tuesday afternoon and they still do. And so I said, "Can I work a half-day a week?" They said, "Great, we need you Tuesday -- can only work Tuesday afternoon, that's when we need you." So I retrained and I had a doctor proctor me. Because it is said that older doctors begin to lose their skills. It's actually true. But if the older doctor begins to see lesser ill patients you offset that. Like the revenue and the cost. So I generally don't see extremely ill people. I think I recognize when they're ill but I don't care for them. Get them to the hospital. So I had a doctor proctor me, review me. And it was a very lighthearted thing. I thought, "How am I going to go in the room there as an older physician and explain to Martin that another young doctor has to review me? What am I going to say?" So I came up with the idea of -- well my son said, "Dad tell them you just got out of San Quentin." I said, "That's not a good idea." I said, "I'll tell them that a young doctor reviews me because I'm working in a different clinic. And every time you change clinics someone has to review you." So I saw 20 patients. The eldest patient I saw until she started laughing at me. I said, "Why are you laughing?" She said, "Because I know you, I'm a retired nurse from Kaiser Sunset in the ICU, we were buddies." We each gave each other a big hug. Was in her eighties. And so I now see patients a half-day a week roughly. And I thoroughly enjoy, like most doctors, seeing patients, learning the Health Connect, I mentioned that. Helping them medically, looking up things, using my skills. Having the patients say the classic statement inside of Kaiser, we all know what it means, it's, "Are you new here?" Which means, "I like you and I wonder if you could be my doctor." That's a code, are you new here or. I wanted a doctor. And establishing that rapport and natural relationship with patients has always been something I like, find myself feeling good about, they feel good about it. So I do that a half-day a week until the time comes. And the time comes is interesting because older doctors used to say to me, "You tell me, Oliver, if I'm not functioning up to snuff." And I said, "I promise I will." And I remember one of the most esteemed physicians, I had to sit him down and say, "Morrie, you're not practicing up to snuff." And he was so full of resentment he forgot that he had told m. and I told the young doctor that manages the operation, who I hired, I said, "When my time comes will you sit down and tell me, I can guarantee you I'll take it with difficulty. I'll be upset. I hope I know before that happens." I said, "Promise me you'll sit me down and if I

get mad at you give a big smile. Because at the end of the meeting I'll smile. But I just got to work through this, OK." Let's stop, I'll get emotional.

06-00:26:33

Meeker: All right.

[End of Interview 6]