

William E. Jacott, M.D.
Narrator

Dominique A. Tobbell, Ph.D.
Interviewer

**ACADEMIC HEALTH CENTER
ORAL HISTORY PROJECT**

UNIVERSITY OF MINNESOTA

ACADEMIC HEALTH CENTER ORAL HISTORY PROJECT

In 1970, the University of Minnesota's previously autonomous College of Pharmacy and School of Dentistry were reorganized, together with the Schools of Nursing, Medicine, and Public Health, and the University Hospitals, into a centrally organized and administered Academic Health Center (AHC). The university's College of Veterinary Medicine was also closely aligned with the AHC at this time, becoming formally incorporated into the AHC in 1985.

The development of the AHC made possible the coordination and integration of the education and training of the health care professions and was part of a national trend which saw academic health centers emerge as the dominant institution in American health care in the last third of the 20th century. AHCs became not only the primary sites of health care education, but also critical sites of health sciences research and health care delivery.

The University of Minnesota's Academic Health Center Oral History Project preserves the personal stories of key individuals who were involved with the formation of the university's Academic Health Center, served in leadership roles, or have specific insights into the institution's history. By bringing together a representative group of figures in the history of the University of Minnesota's AHC, this project provides compelling documentation of recent developments in the history of American health care education, practice, and policy.

Biographical Sketch

William Jacott was born and raised in Duluth, Minnesota. He earned his bachelor's degree in speech with a minor in political science from the University of Minnesota Duluth. He attended Medical School at the University of Minnesota Twin Cities, earning his M.D. in 1964. Dr. Jacott then completed an internship at St. Luke's Hospital in Duluth and subsequently entered general practice at Lakeside Medical Center in 1965. In 1974, Dr. Jacott became part of the newly created Medical School at the University of Minnesota Duluth as head of Family Medicine and director of the Duluth Family Practice residency. In 1978, Dr. Jacott returned to Lakeside Medical Center and private practice full time. Jacott's practice merged with the Duluth Clinic in 1980 and became the first family medicine group within the Clinic. Dr. Jacott became head of family medicine at the Duluth Clinic. In 1987, he was recruited to be assistant vice president for the health sciences at the University of Minnesota Twin Cities. He left this position but stayed on at the University, becoming interim and then permanent chair of the Department of Family Practice and Community Health in 1995. Over the course of his career, he held many prominent leadership positions in professional organizations, including his tenure on the Board of the American Medical Association. Dr. Jacott retired in 2004.

Interview Abstract

Dr. William Jacott begins part one of his interview by describing his educational experiences at the University of Minnesota Duluth (UMD) and the University of Minnesota Twin Cities (UMTC), his interest in medicine, and his early career. Dr. Jacott then reflects on his time in private practice; the establishment of the Medical School at the UMD; his growing role at the UMD Medical School; the Family Practice Program at UMTC; orienting student education and training toward family practice; relations between the UMD Medical School and other schools and hospitals; and his work with the State Legislature. Reflecting on his time as assistant vice president for the health sciences at UMTC, Dr. Jacott discusses the following: community outreach; his work as administrator in charge of Use of Animals in Research; setting up affiliation agreements for the professional schools in the health sciences; the role of nurse practitioners in family practice; his work with the various vice presidents of the Academic Health Center; and the threatened closure of the College of Veterinary Medicine and the Dental School.

Jacott begins part two of his interview by describing his experience with the Antilymphocyte Globulin litigation, the creation of the University Health System, the sale of University Hospital to Fairview, and the closure of the University Family Practice Program. He then discusses Ed Ciriacy's chairmanship of the Department of Family Practice and Community Health and his own chairmanship of the Department. The conversation then turns toward a discussion of Dr. Jacott's national leadership roles. He discusses his work for the American Medical Association as chairman of the Council on Medical Education and a member of the Board and his time on the Minnesota Board of Medical Practice, the Federation of State Medical Boards, and the Joint Commission Board of Commissioners. Dr. Jacott concludes the interview with his views on combining the position of Medical School dean and vice president of the AHC.

Interview with Doctor William E. Jacott, Part 1

Interviewed by Dominique Tobbell

**Interviewed for the Academic Health Center, University of Minnesota
Oral History Project**

Interviewed at Doctor William Jacott's Home

Interviewed on June 18, 2013

William E. Jacott - WJ
Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here with Doctor William Jacott. It is June 18, 2013, and we're at Doctor Jacott's home in Shoreview, Minnesota.

Thanks for meeting with me, today.

To get us started, can you tell me a bit about your background, where you were born and raised and where you did your education?

WJ: Yes. I was born in Duluth [Minnesota] and graduated from high school in Duluth—Duluth Central, which now does not exist. I went to UMD [University of Minnesota Duluth] for undergraduate and received a Bachelor of Arts [degree] in speech and a minor in political science. Then, I went into medicine.

DT: What led you to go into medicine?

WJ: When I was in high school, I worked for a locally owned drugstore in Duluth. Those were the days when the pharmacists would deliver all the drugs to the patients, particularly shut-ins and nursing homes, so I ended up doing all the deliveries. I really enjoyed the interaction with the patient. I didn't know any answers to their questions, but it was nice to interview the patients and talk to them about their problems, and not be in any hurry and getting paid fifty cents an hour for doing it. That got me into medicine.

I was actually at UMD in a pre-med curriculum the whole time. I felt strongly, and I do today, that communication is a very important part of medicine and, therefore, I took a speech major and a political science minor.

Then, I went on to the University of Minnesota Twin Cities to get my M.D. [Medical Doctor] degree in 1964.

DT: Can you talk about, perhaps, your experiences as a medical student?

WJ: The curriculum was pretty old fashioned and traditional. You had two years of basic science and two years of clinical science. There wasn't a lot of intermingling. You had to go through two years of laboratories and lectures before you got to see your first patient. Then, the last two years were excellent, a lot of clinical material in the Twin Cities with the two big general hospitals and Veteran's Hospital and the many, many private hospitals. They'd all participate. I think there's only one or two that don't have a medical student in their confines, at any given time.

DT: What was the atmosphere of the Medical School like at that time?

WJ: It was arrogant. It was a talk down atmosphere. You're a lowly medical student. The residents, on the whole—I'm generalizing—were arrogant to the students and the junior faculty were arrogant to the residents and the senior faculty hardly talked to anyone.

DT: This was the early 1960s. That was kind of the heyday of cardiac surgery at the University. Did that come through at all?

WJ: Well, that was a very positive thing: the idea that we had at the University of Minnesota giants in medicine. So it wasn't just cardiac surgery, which was a big piece, but it was neurology and pathology. These were nationally and internationally known people who had done some fantastic research, and the basic sciences, too.

For example, my obstetrics [O.B.] clerkship, I was able to take under Nicholas [Nicholson J.] Eastman who wrote the book [*Expectant Motherhood*] on obstetrics and was a professor, I believe from Johns Hopkins, on a sabbatical at Minnesota, and I was fortunate enough to take his O.B. course. I think that influenced my choice of practice in primary care a lot.

DT: Were there other notable faculty that stand out to you?

WJ: [C. Walton] Lillehei, of course. A.B. Baker, who was head of neurology. I'm probably missing a few. [Richard] Varco, surgery. [Owen H.] Wangenstein, surgery, of course. The building where I had my office is named after him and the maker of vodka.

DT: Oh, Phillips makes...?

WJ: That's [Jay] Phillips liquor.

DT: I didn't realize that. [chuckles] I knew he wasn't affiliated with medicine. I knew he donated a good chunk of change.

WJ: No. No. I don't know what we did for him, but we must have done something good.

[laughter]

WJ: Those are the faculty...and then the deans. It was a rare privilege for me, as a medical student, to get to know the administrative people in the dean's office as the assistant vice president [v.p.] for health sciences, a different interchange. So people like Bob [Robert] Howard, the dean, Neal Gault, who was a very good friend, and [H.] Mead Cavert were wonderful people, both as a student and as a colleague.

DT: After you graduated, did you complete your residency and internship?

WJ: No. I did an internship, interned at Saint Luke's in Duluth and, then, was recruited into private practice from right out of my internship. The family practice residencies did not exist when I graduated. That was not an alternative. It was G.P. [general practice]. I wanted to be a G.P. and, subsequently, an F.P. [family practice], so I didn't want to take a residency in anything else. So I went into practice.

DT: What led you to want to do general practice, family practice?

WJ: Again, it's my experience in the past working in the pharmacy and, also, having been cared for. I didn't have any major illnesses but the sports physicals and things from G.P.s. I liked obstetrics, but, on the other hand, I liked pediatrics, and I liked internal medicine, and so on. The only way to accomplish that is to go into family medicine.

DT: At that time, I know there was a lot of debate, at least maybe in the Minnesota Academy of General Practice but more in the American Academy of General Practice, about what general practice should be and whether it should be renamed family practice. Were you aware of those debates when you were first pursuing your career?

WJ: Not initially. Again, the arrogance in medicine came out. You had to be in practice three years before they'd let you be a member of the Academy. So during those three years, you had no interaction with the Academy. You didn't get the books, journals, nothing. All of a sudden, G.P. became F.P. It happened in the late 1960s, early 1970s. I became a delegate from Duluth to the Minnesota Academy of Family Physicians in the early 1970s. Then, I became aware of what was going on. I took my boards and became board certified and reluctantly dropped the G.P. and went into being an F.P.

[chuckles]

WJ: I'm not sure I felt the difference at the time.

DT: When you were a medical student and once you decided you wanted to go into general practice, did you find much support for that career path at the Medical School?

WJ: No. Not at all. I must have had a half a dozen professors, faculty members, and untold residents—there were no family practice residents—tell me, “You’re too smart to become a family physician.” Very common—not common anymore.

It was, again, very satisfying for me to become chairman of Family Medicine at the Twin Cities University and be colleagues with all the other chairmen to the point where they wanted me to be their vice chairman of the new practice group, UMP [University of Minnesota Physicians], mainly because I was the only one who had been in private practice with a large multispecialty clinic like the Duluth Clinic.

Your question is right on target. Back in those days, general practice was put down. Unfortunately, if they had a bad student, they wouldn’t say that at all. They’d say, “Go ahead and be in general practice.”

[chuckles]

WJ: But if you were a good student in their eyes, you were always discouraged.

DT: Did you have many classmates who also went into general practice?

WJ: Uhhh... Not really. There was a couple who actually became members of my faculty here at the U, but a lot of my good friends from our class are in other specialties.

DT: Was it an easy decision to go back to Duluth into private practice?

WJ: Yes. I enjoyed Duluth. My parents were still alive and living there, and my brother and his family, my whole family, so it was very comfortable. I knew a lot of people. It was also interesting to go into practice in this community where I had gone to college and high school and so on and have a number of individuals who were teachers or other forms of authority become patients of mine when I was in family practice in Duluth.

DT: You worked at Lakeside Medical Center?

WJ: Yes.

DT: What kind of practice was that?

WJ: It was really a four-person small group. A few of our members were coming and going. It wasn’t the same four for a long period of time, but it was, basically, a four-person practice. Then, eventually, in the early 1980s, we joined the Duluth Clinic and became the first family medicine group in the Duluth Clinic, actually, in 1980.

One of the things that I think motivated me to get involved in other activities other than private practice... In the late 1960s, I was practicing with two other doctors: Doctor Rodney Langseth and Doctor Henry [J.] Jeronimus. Doctor Jeronimus was diagnosed with Parkinson's [Disease] and the only way to get adequate treatment in those days was to get into a clinical study. The clinical study was for L-Dopa [Levodopa], which was the new drug for Parkinson's. But the study required that the patient live in Minneapolis. So he moved, got an apartment down here and left the practice and was there for six months. Then, when he finished, his Parkinson's had increased in its intensity, and he gradually faded out of practice.

Within the same period of time, Doctor Langseth was drafted to Vietnam under the doctor's draft. He was thirty-four years old. The doctor's draft went to thirty-five, and he got drafted and entered the Army as a lieutenant colonel, because of his years of practice. He was gone, so I spent two years running a three-man practice alone.

DT: Wow [whispered].

WJ: I got burned out. It was twenty-four-seven for two years. During that time, I delivered a hundred babies a year, because it was three times...you know, if each of us had thirty OBs a year. In fact, I had delivered so many babies that the Minnesota OB-GYN [Obstetrics-Gynecology] Society asked me to be a member.

DT: [chuckles]

WJ: I think I was the only family doctor in the Minnesota OB-GYN group, a nice group of people. They thought I must have been an obstetrician because I delivered so many.

But I burned out, and I think I was looking for other things.

It was about that time, around 1970, that we were planning a new medical school in Duluth. Bob [Robert E.] Carter, the new dean who I consider one of my mentors, asked me to be head of Family Medicine. It wasn't really a department, because it's a two-year school, and the clinical areas didn't have departments. So it was a section under the dean called Family Practice. I started at ten percent time with the Medical School and, then, it gradually ballooned into more, because I became program director of the Duluth Family Practice residency. I actually started that residency as the first program director and got it accredited and recruited residents, eight per year. That's been a real success.

DT: Going back a little bit... When you were in practice those first few years, how were your relationships with specialists in the community?

WJ: Very good. In Duluth, it was very good. There's always been a rift between Duluth Clinic, Saint Mary's [Hospital], and Saint Luke's [Hospitals] in Duluth. Duluth Clinic and Saint Mary's are now one unit along with Miller-Dwan [Hospital] and, then, there's Saint Luke's sitting over there with the private practice docs, non-Duluth clinic. But as a family doctor, you were wooed by both groups. So I never sensed any problem. There

were one or two arrogant people that think that family practice shouldn't exist, but that's true in any community. On the whole, my relationship with other specialty colleagues was very good.

DT: Did you have any contacts or referrals with the Twin Cities [University of Minnesota] Medical School?

WJ: Interestingly enough, not many. There might be some little niches, like cystic fibrosis, little niches where it's the only act in town. But, for some reason, Duluth, in those days, was primarily referring to Mayo [Clinic in Rochester, Minnesota].

DT: Okay. Why was that?

WJ: I think we had a lot of Mayo graduates in town from other specialties. [chuckles] Also, we had had some bad experiences with the University, lack of communication. Patients would be sent down to the Medical School for one problem, sent down maybe for heart disease, and then in the process of working them up, they found out they had gallstones, so they took out the gallbladder, which could have been done in Duluth. When those kinds of things happened, the word gets out, "You don't send to the U because you'll never get your patient back." With Mayo, they've had this slick tradition that the chief resident would call the family doctor, and the second-year resident would dictate a letter, and the chief of service would sign it, and you'd get all this information from them in the communication. If they said, "Oh, by the way, we found gallstones. You better take them out..." That didn't happen at the U. That was part of the arrogance that I sensed as a medical student.

DT: That's interesting. I kind of determined that there was competition for patients, that the Medical School was seeing more and more private patients at that time. It certainly sounds that that was the case.

WJ: Right.

DT: That's interesting.

Do you recall the debates about the need to establish a second medical school in Minnesota?

WJ: Oh, I do. I served on the Northern Minnesota Council for Medical Education, which was the group that really put together the Duluth school. There were two of us in family medicine on that committee: myself and Reino [H.] Puumala, who was an elderly G.P. from Cloquet. The two of us served on that and got it started. There was a competing group in Saint Paul that wanted to start a medical school. So when the year came to go to the Legislature for funding the Duluth program, with the support of the Duluth and the Iron Range legislators, we won out over Saint Paul and got the funding and became part of the University of Minnesota. That's how it happened.

DT: That was the Northern Association for Medical Education, that other group in Saint Paul. I interviewed Davitt Felder who led that Saint Paul group.

WJ: Yes. Obviously, we were not enemies, but we were adversaries.

[laughter]

WJ: I didn't know the group very well, but I did know they were lobbying for Saint Paul. It was tough for Duluth with three hundred doctors in the community to lobby against a group that had three thousand doctors in the community. But we did it. It's really thanks to the legislators from Duluth and the Iron Range.

DT: Did the Minnesota Academy of General Practice have any role in that?

WJ: Actually, they did. They endorsed UMD. It was about that time that the new chairman in the department was Doctor Ed [Edward] Ciriacy. He was very supportive of the Duluth program and not of the Saint Paul—although I shouldn't speak for him. But he, obviously, supported UMD. Being part of the University himself, he naturally would support a University program.

DT: I know Benjamin Fuller was the first chair of the Department of Family Practice.

WJ: That is correct.

DT: I read that there was some dissatisfaction among the Medical Academy of General Practice about his chairing the position, because he was an internist and not a general practitioner.

WJ: Right.

DT: Can you speak to that at all?

WJ: Yes, I can. The Minnesota Academy of Family Physicians actually passed a resolution of non-support of the chairman of family practice at the U. We had delegates from all over the state, and it was passed by a *huge* margin. I was at the Reference Committee that debated it. There wasn't much debate. Everyone that got up and spoke was upset that an internist was... You'd hear words like, "That's typical of the University. They're discouraging family medicine again." One of the most outspoken was Doctor Ed Ciriacy who became the second chairman, really, but the *long* time chairman of the department and built it to what it is now.

DT: Did the Academy seek support from the Legislature for its position about the way that family practice was being run at the Twin Cities campus?

WJ: Oh, yes. Yes. I wasn't part of that, because I was still a young practitioner at one of my first meetings. I think the leadership of the Minnesota Academy were over at the

Capitol a lot, letting them know that they were upset and actually going so far as to take away the funding of the department at the U. So it was the leaders of the Academy that pushed that.

DT: That certainly came through very clearly in the archival documents, that the Academy of General Practice had a lot of political sway in getting the department established at the Twin Cities campus and, then, yes, the situation with Fuller and Ciriacy.

WJ: Every major community in the state has family physicians and they know their legislator and probably in many communities, they are the legislator's doctor. So it's a good way to get in contact with the Legislature statewide.

DT: It seems like the actions of the Northern Minnesota Council for Medical Education and the Academy of General Practice...that there was a lot of concern about shortages of physicians in rural areas. At that time, Duluth wasn't as urban as it is now or as the Twin Cities are. Did you see that as a significant factor?

WJ: Well... Duluth actually was more urban in the past.

DT: Really?

WJ: They had a population of 125,000 people and were the second largest city in the state with a growing business in lumber and iron ore and wheat coming through the port. When the Saint Lawrence Seaway was opened up, foreign ships came into Duluth. It was a bustling community. It's actually degenerated.

DT: Okay.

WJ: Wrong word. Not degenerated but it actually has decreased in its urban activity and the population is now about 85,000. A lot of people grow up in Duluth and, then, leave. So Duluth has a high Medicare population, and they're struggling to get back in urban success. But all around Duluth were rural communities that needed doctors.

DT: As I understand it, the Duluth Medical School was set up primarily to prepare physicians for primary care. Do I have that right?

WJ: No. The original legislation that passed authorizing the establishment of the school stated—I'm paraphrasing now—it was to prepare young men and women to enter family practice, not primary care. We constantly were reminding the legislators of that and other people that that's what it was, and that's what it has accomplished.

So my job as the first head of Family Medicine was to develop a curriculum that would attract people to it. Therefore, I developed the first-year preceptorship and the second-year preceptorship in rural communities. That's been very successful.

DT: It seems like, given that was the priority or the mandate of the Duluth Medical School, for you to, then, be the chair of that first Family Practice Department was an essential, crucial role that you played within the Medical School.

WJ: Yes. Yes, I feel very good about that.

DT: Were there specific strategies that the school and you as the chair of that department used to ensure that you were attracting students that would go into family practice?

WJ: Yes, all the way from the Admissions Committee to the dean's office to the actual student's exposure them self was all geared for that. Now, they obviously got a good background in the basic sciences. A wonderful basic science faculty was recruited. But even in that faculty, they were strong supporters of family medicine. You know, it's hard to give a biochemistry lecture and include family medicine, but they found ways of doing it. So everywhere the student turned... But in the *selection* process, we learned very quickly that students from small communities who had the support of their spouse or significant other were the best ones to recruit into the Medical School. [chuckles] They were more likely to return.

DT: Yes. Even if you get people through the family practice program, still getting them to go back to those small communities could be a challenge.

WJ: That's right.

DT: The preceptorship that you set up for the first- and second-year students...that sounds like the main way that the students had contact with family practice or general practice physicians. That was their main clinical contact in those first years?

WJ: Mainly. Some of the basic scientists would invite family docs to come in and give case histories to support pharmacology or anatomy or something else. They would find ways to interdigitate the clinical. But, basically, the preceptorships, we set up so they would go a half a day a month in the first year to a family physician in the Duluth/Superior area. In the second year, we set it up—the University was still on the quarter system—so toward the end of the quarter when they finished exams and everything, they would go and spend three days with a rural family physician who was either in Minnesota, Northwestern Wisconsin, or even Michigan. We snuck into Michigan.

[laughter]

WJ: I personally went out and interviewed all the family doctors and told them what their responsibilities would be.

We had some help with federal grant writing.

Actually, I'm rambling...

DT: No, this is perfect.

WJ: The office of the vice president for health sciences at the U was very helpful to me, a young G.P. who had never written a grant. They were very helpful in helping us write grants to support the rural preceptorship. Because it was kind of a unique program throughout the country, there wasn't a lot of competition, so we got some good grants to support that.

We had twenty-four students in each class, in those days, so we needed twenty-four rural locations where they could go and spend three days, sometimes staying in the hospital but, often, staying in the home of the family doctor and, then, tailing that doctor wherever they went. It was wonderful experience.

DT: Did you have any difficulty recruiting those preceptors?

WJ: Not at all. I had probably one or two decline. I had gotten to know a lot of the docs all around, and I think for me to personally go out and meet doctor-to-doctor and tell them what the experience is, it's hard for them to say, "No."

DT: It was presumably in their interest, too, depending on how near they were to retirement.

WJ: They can recruit, right. I would make that point clear.

DT: Who were the primary funding agencies that you received grants from?

WJ: HRSA was probably the most common. What is it? Health Services Research Act, I guess [Health Resources and Services Administration]. I don't recall any others, but there probably were others.

DT: It seems that in the 1970s, there was possibly a lot more support when it began being termed primary care and including those internists, pediatricians.

WJ: Peds, yes.

DT: There seemed to be a lot of support for family practice.

WJ: Yes, there was. Again, the director of HRSA was a family practice physician during the times I was writing the grants.

[chuckles]

WJ: So I got to know him quite well.

DT: What was his name?

WJ: I've forgotten.

DT: I can find that out.

During this time, how were relationships between the Twin Cities campus and the Duluth campus as you were setting up these programs.

WJ: They were very good as far as Family Medicine was concerned from the U. Ciriacy was very supportive. He would come up maybe once a month, once every other month, and visit with us and consult. The relationships with the other departments were kind of spotty. Once the students finished their two years in Duluth, they all transferred down to here. It was with mixed feelings. It took quite a while to accept the Duluth students. They were thought of as being less academically suited and probably not recruitable into their specialty. They were just not highly thought of. They figured that it was a self-study school and didn't really understand. Most importantly, they didn't try to understand the school. Those faculty members that would go from the U up to visit the school and maybe give a lecture to the Duluth community suddenly found themselves getting referrals and breaking that barrier.

I don't know if Ted [Theodore R.] Thompson [died July 28, 2013] is somebody you're interviewing, but...

DT: No.

WJ: ...he's a good example of someone that early on realized that. Ted is a neonatologist at the U, and he's also in the dean's office.

DT: Right. I've actually had a good number of communications with him about students.

WJ: Ted was one of the early ones that came up and buried the hatchet, so to speak, and was very helpful.

DT: Do you have a sense of those students that then went to the Twin Cities for their clinical two years...what kind of rate of return there was for them to go back and do residencies in family practice once they graduated?

WJ: I don't know the numbers, but it was the highest in the nation. We really did succeed in our goal in getting them to enter not only family practice but rural family practice. Jim [James G.] Boulger has all that stuff. I don't know if you're going to interview him but he's got all of that. Jim sort of took over when I left. He took over the preceptorship program, and he maintains all the data.

DT: I'll definitely try to talk to him.

Was there any discussion about turning the Duluth campus into a four-year school?

WJ: All the time. All the time, but every time we did a study of the Duluth community to turn it into a four-years, we came up with the same conclusion: there wasn't enough clinical material to support it. It might have worked if we stayed at twenty-four, but we didn't. Now, they're, what, forty-nine, fifty students a year [the Duluth campus admits sixty Medical School students each year]. There just isn't enough *and* the constant battle between Saint Mary's and Saint Luke's didn't help.

DT: Why was there so much antagonism between Saint Luke's and Saint Mary's and why did it persist?

WJ: To some degree, it was arrogance on the part of Duluth Clinic doctors looking out at anybody that's not in our clinic is inferior. But, it was also the same thing that happened between Duluth and the University referrals. If you'd refer something to the Duluth Clinic, the same old story: a heart patient would get his gallbladder taken out. All you need is a half a dozen cases like that, and the word gets out, and you don't do it. So off they go to Mayo. [chuckles]

DT: Did relations with the Mayo Clinic change at all once the Duluth Medical School was set up?

WJ: Uhhh... No. Well, there's never been a formal relationship, but you're saying referrals?

DT: Yes, referrals.

WJ: I don't really know. I think it's probably stayed about the same, but the number of referrals to the U has increased as students come from Duluth, take their two years here and, then, go out into practice somewhere. They develop more respect and more relationships and, then, refer to the U directly. I would even see some of those concerns when I was department head ten years ago. There was still reluctance to refer to the U...somebody from Starbuck [Minnesota] referring to Mayo instead of to the U.

DT: The Mayo Medical School opened the same year the Duluth Medical School opened.

WJ: Yes.

DT: In the discussions to get the Duluth Medical School established, was there any kind of concern or discussion about the fact that Mayo was also setting up a medical school?

WJ: No, because Mayo, right from the beginning, said they wanted to be a national and international school. They've pretty much stuck with that. Some years, it's a little different. It seems their class was forty and of that forty, maybe five would be from

Minnesota. So they weren't competing for the students, so there wasn't that concern. I never saw anybody concerned about that because they sort of do their own thing.

DT: As I understand it, the University had agreements with [the University of] North Dakota and [the University of] South Dakota to take their medical students and train them. Did you ever get any of those students at the Duluth campus or were they completing their two years in the Dakotas, their first two years?

WJ: That didn't last very long. Both North and South Dakota were two-year schools. It seems to me the agreement was with the U. It seems to me, it was the opposite of Duluth. They would take their basic sciences at the U and, then, go out to Sioux Falls and Grand Forks for their clinical years. Then, both of those schools became four-year.

DT: Yes.

WJ: Again, it's because they had the adequate amount of clinical material. The Fargo Clinic is huge. The number of docs in Sioux Falls is significant, so they had plenty opportunity for clinical. And in the case of the Dakotas, there's no other school in each state. Each state has one school and that's it. So they've got the whole state for clinical material. That's the way it worked. I had forgotten about that. Then, they got their own four-year school.

DT: That makes sense. Thank you. I've asked several people about that relationship, but haven't had such a full response as you've provided.

[chuckles]

WJ: I've been all around.

[chuckles]

DT: As I understand it, you chaired the department at Duluth until 1978 and, then, you returned to private practice full time?

WJ: I actually was program director of the residency from 1974 to 1978. I got it going, and it was very successful.

My old group came to me and said, "You know, we're going to recruit another doc who's going to take over your old practice unless you come back and join us." I had to do it, because I really missed practice. I would see people at the supermarket or the gas station that were former patients, and they would say, "How do we get at you?" They couldn't. So that's when I went back.

DT: Were you able to see any patients while you were at Duluth?

WJ: I did, one half day a week, which is not much.

DT: Yes.

WJ: They were all former patients from Lakeside that followed me down there. Gradually, that dropped off because I'm not available the rest of the time. What good is a doctor that you can only see or talk to half a day a week? I would take phone calls during the week, but it was filtered.

DT: It seems like it must have been... Given the priority you placed on the patients from the very beginning of your career to, then, be away from patient care.

WJ: It was. I missed it.

As soon as I got back to Lakeside in 1978, I began negotiations with the Duluth Clinic to merge our group with them. One of the main reasons we did that is overhead. Our overhead was sixty percent. It dropped to forty percent when we joined the Duluth Clinic.

DT: Were there any challenges that followed from that merger?

WJ: Oh, yes. The non-Duluth Clinic doctors were madder than heck. Several were classmates...internal medicine and surgery. I went years without speaking to them. [laughter]

WJ: They got a lot of referrals from our group and, all of sudden, we were in the Duluth Clinic, and we referred to Duluth Clinic doctors. It's a normal progression.

DT: So the Lakeside Clinic Medical Center had gone from four physicians...and, then, the Duluth Clinic, how big a practice was that?

WJ: They had about two hundred, at that time.

DT: Wow [whispered].

WJ: So it was a large, multispecialty group practice. Now, they're even bigger. I don't even know what they are now. Of course, they've acquired more family practice groups around northeastern Minnesota and northern Wisconsin.

DT: Were there any downsides to joining with the Duluth Clinic?

WJ: The only downside was loss of friendship with some of the specialists. It was a wonderful group to practice with. I enjoyed large group practice, and I became head of family medicine at the Duluth Clinic.

[chuckles]

WJ: I enjoyed that very much.

DT: I just want to go back briefly to setting up the residency program. I realize we kind of moved past that. Were there any particular challenges or obstacles to setting up that residency program at Duluth?

WJ: There were a lot of challenges, you know. The funding of the program had to come in the appropriation that went to the University, so it was under the Board of Regents. It was difficult to do that, because the vice president of the health sciences really controlled the legislative request.

Senator Sam [Samuel George] Solon was a very good friend of mine. He was a senator from Duluth, state senator. I went to Sam and said, "Sam, we need to get the money for the residency." Sam gathered together the Duluth legislators and talked about it. Sam took me into the governor's office and, we sat down with Tom Kelm, who was the chief of staff for the governor—Wendell Anderson was the governor who later became a regent on the Board of Regents—and explained what a family practice residency was and how we were going to contribute physicians to rural communities that needed one desperately and so on and so forth. They got the message.

So when the senate hearing occurred at the State Legislature, Senator Norbert [P.] Arnold from the Pengilly [Minnesota] area was chairman of the Senate Finance Committee. Tom Kelm had written a letter that Governor Anderson signed saying that x number of dollars had to be set aside for the Duluth program *out of* the University request. So Senator Arnold convened the Senate Finance Committee. I was sitting there with Lyle French, who was the vice president, and Dave [David] Preston, who was his associate, and the deans were all there, the whole gang. Norbert Arnold [said], "I have a letter from the Governor. Let me read it to the committee." It said x number...I don't remember the figure. By our standards today, it wasn't very much, but, then, it was. He said, "It must be set aside *out of* the University request for the Duluth Family Practice Residency. Having said that, that's a done deal. Let's go on with rest of the meeting." That's the way it worked.

DT: That's amazing.

WJ: You asked for challenges. That was an interesting challenge.

The other challenge was making sure that we got Duluth Clinic and Saint Luke's clinicians in an equal way so that they could all benefit from having residents see their patients.

Then, the other challenge was to develop a curriculum that could be done in three hospitals with one program. That was Saint Mary's, Saint Luke's, and Miller-Dwan in Duluth. We did that.

Of course, lesser challenges... We had to have an accredited program. We couldn't receive funding and everything else without being accredited. So I went through the accreditation process and got it accredited through the Residency Review Committee and the ACGME [Accreditation Council for Graduate Medical Education].

DT: Was that a fairly straightforward process?

WJ: It went well, yes. It went well. They send out a surveyor to survey the place.

[laughter] I'll tell you a good story about that. He wanted to see all the hospitals and the Family Practice Center that we built. So we were walking through Saint Mary's. Having been a Lakeside Clinic doctor, most of my patients went to Saint Luke's. So I wasn't that familiar with Saint Mary's. Walking down the hall, the surveyor said, "Where's the library? I'd like to go look at the library at Saint Mary's." I didn't have a clue. But I looked up—we happened to be on the right floor—and there was a sign that said, "Library, this way." I brought him to the library. It was the first time I'd ever been in it.

DT: [laughter] Good placement of the sign.

It's really amazing to me that the history of family practice in Minnesota has had so much to do with the political influence that family physicians have been able to muster because of their relations with the state legislators.

WJ: Exactly. Exactly.

DT: As I understand it, even setting up the Department of Family Practice in the Twin Cities campus became a line item in the Medical School budget, that there was always money set aside for that family practice.

WJ: Correct. That was another example of the influence of family medicine on the legislators. Boy, did the other departments want to get at the line item.

DT: Yes, I can imagine.

WJ: That was one of my challenges when I became chairman down here is to maintain that funding.

DT: Given the priority then that family practice was given within the Medical School thanks to the Legislature, did that change the attitude that other faculty had towards family practice?

WJ: Yes. It really did. I sensed no arrogance, no animosity when I would go to the meeting of the department heads down here or the clinical chiefs. We were all colleagues. I felt very much a part of it. Like I said, they elected me the vice chairman of their new practice group, because of my experience in large group practices.

DT: What were your responsibilities as vice chairman of the practice group?

WJ: I chaired the Human Resources Committee. We established all of the benefits for employees of UMP and put that together. The chairman was Roby [C.] Thompson [Junior]. He was busy himself, so, frequently, when he wasn't there, I ran the meeting. Also, whenever important issues came up, and we had special meetings, I always was part of that group.

DT: What led to your appointment as assistant vice president for the health sciences in 1987?

WJ: That's interesting. It's not something I went after. In fact, I didn't even know there was a position like that. I had gotten to know Neal Vanselow, who was the vice president of the health sciences. I had gotten to know him quite well because the Minnesota Medical Association had asked if I'd be their representative at Neal's health sciences advisory committee. The advisory committee was something Neal had set up with community input.

[brief interruption]

WJ: Because I was serving on the Health Science Advisory Committee, I got to know the players and they got to know me. At the time—this was in the mid 1980s—I was chairman of the AMA's [American Medical Association] Council on Medical Education, which is a very prestigious group. It's had an impact on education since 1910. So I was chairman of that group, and I was president of the Federation of State Medical Boards, which is the oversight body for all the state licensing boards. Being in those positions is a whole other story and it has nothing to do with the University.

DT: But, it's still interesting.

WJ: Yes.

Neal recognized my national prominence. He called me in the fall of 1986 and said, "I've got this position that I'm looking for, and I think you'd be perfect for it because a lot of it has to do with community outreach." He didn't explain a lot. There were a few surprises when I got there, but basically it sounded like the kind of position I would be interested in. I was working hard in private practice and starting to get a little burned out even being in the Duluth Clinic. So the timing was right. I had all these national responsibilities with two major groups. So I went down and interviewed for the position. There were only two or three others that interviewed for it. The interview was a tough experience, because you'd go all day with a bunch of different people, the department heads and administrators, everybody. He called and said, "I'd like you to take that position effective March 1987." Judy and I spent one weekend talking about it and decided to do it. We had basically been living in Duluth all of our lives, and this meant moving to Minneapolis. I'll never regret it. It was a wonderful opportunity. So we moved down in 1987 and have been here ever since.

DT: You said that you were primarily involved in community outreach. What did that look like? What were your responsibilities?

WJ: The affiliation agreements with all the hospitals of which there are thirty-seven in the Twin Cities area... There has to be a legal agreement to put residents in those hospitals, medical students and pharmacy and nursing because that's the Academic Health Center. So I did affiliation. At any activities that occurred at these various places, I would represent the vice president, like annual staff meetings and award ceremonies.

I was on the podium for the opening of the new Veterans [Administration] Hospital, because I had written the agreement with them, and I knew all the people. That was an exciting thing. I don't know if you've ever seen that hospital, but it's a magnificent facility.

DT: Yes.

WJ: Neal, in his responsibility as the vice president, just like Frank [Cerra] was, had so many internal responsibilities, constantly meeting with deans and representing us at the Board of Regents. That was the vice president's job. They didn't have a chance to do all the community stuff, which is so critical to the University to have good relationships. It was what I love to do. That was the primary...

The surprise responsibility was I became the administrator in charge of the Use of Animals in Research.

DT: How did that come about?

WJ: It was transferred. I think the vice president for Academic Affairs had previously been responsible for the Use of Animals in Research. Somebody said, "It makes more sense, since they're all used the by the health sciences, to put it under the vice president of health science. So that had happened just short of my arrival. So here Neal is given this new responsibility. I know where it's going to go.

[laughter]

WJ: And that's what he did. I actually enjoyed it. We got our labs accredited. We made sure that we did alternative use of animals as much as possible. Ninety percent of the animals used in research now are either rats or mice, which nobody seems to feel too sorry about. The use of chimpanzees, and cats, and dogs has decreased markedly. So we got accredited.

The AMA appointed me to the accrediting body, so I actually served on the National Accrediting Body for the Use of Animals in Research. I don't think any other family physician in the world has done that.

[chuckles]

DT: It's not an obvious place for a family physician to be.

WJ: No.

DT: Did you encounter any protests in your new responsibilities around the use of animals?

WJ: After I served as chair of the AMA Council on Medical Education, I got elected to the AMA Board and served nine years as a trustee of the AMA. I became the AMA's lead person on Use of Animals in Research. So I testified in Congress on several occasions.

Also, the animal rights people were pretty vocal during that time. That was in the 1980s—actually in the 1990s. That's when P.E.T.A. [People for the Ethical Treatment of Animals] had been declared a terrorist group. I don't know if they still are considered that by the F.B.I. [Federal Bureau of Investigation], but they were at that time, because they were bombing laboratories, and killing people, and everything else. I was sent to the National Press Club in Washington, D.C., and we had a news conference on the Use of Animals in Research telling everybody how it's done humanely and all of the things that are...

Well, I got a death threat after that from P.E.T.A. They actually put a bunch of literature in our mailbox. We lived in North Oaks. The AMA paid for a security system in our home, so it wasn't taken lightly. I had training by the F.B.I. on how to deal with terrorists and how to deal with death threats. I was a jogger at the time. I was told, "You don't jog the same route every day. Take different routes so that people can't predict where you're going to be," and all kinds of things like that.

DT: That must have been a scary time.

WJ: It was. We got a couple of packages at home that we couldn't identify. We called the Ramsey County sheriff to come and open them up for us. We were told, "Any unidentifiable could be a letter bomb."

DT: That must be very difficult and not something that you would expect as a family physician, to be in the line of fire.

WJ: Not in there.

DT: Going back to the other responsibilities you had as assistant v.p. in setting up these affiliations with hospitals... Given that your experience up to that point had been with physicians and now you were responsible for also setting up those affiliation agreements for the nurses, pharmacists, dentists, and what not, did that present any challenges?

WJ: No, I loved it. As a family physician, I considered all of those areas colleagues anyway. At the Lakeside Medical Center, we had an agreement for our physical building that was the four doctors, the two pharmacists, and the one dentist, and one nurse practitioner [P.A]. So we already had done that back in the 1960s. I was very familiar and had a great respect for all the other areas. I was not too sure what the School of Public Health was, because they've got kind of a variety of stuff. Even the College of Veterinary Medicine, I was familiar with because of my activity in the Use of Animals in Research. I frequently was asked by Neal or Bill [William R.] Brody to represent them at various activities, graduation ceremonies and so on. I loved it. I enjoyed doing that.

DT: You just mentioned nurse practitioners and that reminds me... Given that you were working in family practice at the time that nurse practitioners emerge as a new kind of clinical professional, what were your experiences of and the attitudes about nurse practitioners as a new kind of healthcare provider?

WJ: As long as they stayed in their scope of practice, I think they were great. As I say, way back in the 1960s, we had one in our office who was considered a colleague. I didn't have the same threatened feeling that a lot of family docs had about nurse practitioners. But some of them want to do more than they're actually trained to do or write prescriptions when they haven't had a lot of pharmacology. That I don't agree with.

DT: What's your sense of the role that nurse practitioners have played in rural health care?

WJ: Oh, it's tremendous, a tremendous role, and a tremendous help. Working side by side with the physician and the physician's assistant makes a good healthcare team.

DT: It's important to ask about those physician assistants then, as well. They emerged around the same time as nurse practitioners.

WJ: But not at the U. It was quite a long time before we had a program for training P.A.s. Then, we developed our affiliation with Augsburg College. I don't know if it's still around. That's a good program.

DT: Yes, it's still in operation.

Can you talk about the other assistants and associate v.p.s that you worked with?

WJ: [Villis "Vik"] Vikmanis... Did you interview him?

DT: On Friday, I'll be...

WJ: Say, "Hello," to the old buzzard.

DT: I will do.

WJ: He retired before I did.

[laughter]

WJ: I worked very closely with Vik, because, of course, Vik had the State Legislature. That was his big baby. His animal research area was parking, so he got the State Legislature and parking.

DT: [chuckles]

WJ: It couldn't be a worse... Frequently, he and I would confer about political strategy. I worked very closely with him. He was really a good guy to work with.

DT: I imagine you had a lot of perspective to share, given your experience with the Legislature.

WJ: Yes, and, occasionally, I would go with him, but not too often.

Neal had actually asked me to be liaison to the federal legislative group, so I got to know Dave Durenberger and Rudy Boschwitz and Bruce Vento, all of the state legislators. Jim Ramstad is still a very good friend. So that was another area that I worked in.

Cherie Perlmutter was the associate v.p., and she was extremely helpful. There isn't anything about the University that she doesn't know. Nothing. Absolutely nothing got by her.

[chuckles]

DT: I'm, fortunately, going to interview her at the end of this month and I'm very excited. I said this to her, "Every single person I've interviewed said, 'You must talk to Cherie.'"

WJ: Yes, oh, yes. She's a wonderful person and, just as I say, knew all the resources. She was the one that helped me write my grants when I was up in Duluth.

DT: That's wonderful.

WJ: So it was Vik and Cherie. Neal Gault was there for a while as sort of a special consultant whenever the vice president needed a former dean who knows everybody else. It was nice working with Neal.

DT: How about the other vice presidents once Neal Vanselow stepped down? Robert [Andy] Anderson.

WJ: It was really a scramble for a while. Actually, I was so busy at the national scene that I sort of lost track of everything. At one point, they brought in the dean of Dentistry, Dick [Richard] Elzay, to be v.p. Then, Cherie was v.p. for a while. Andy Anderson came in, and he lasted only a couple years. I don't remember the dates, but there was a period of time when it was unstable leadership, in my opinion. I enjoyed working with Bill Brody. Then, when he left to go to Johns Hopkins, from that point until we brought in Frank, to me, it was unstable.

DT: In 1987, there was an Advisory Taskforce on Planning that recommended the closing of the School of Dentistry and the College of Veterinary Medicine. Do you recall that?

WJ: I do.

DT: Can you talk about why that came about?

WJ: Well, I think it was University politics...clearly, University politics. They just figured they could get a big chunk of funding that was going to those two schools.

That was an interesting thing, because Neal asked me to mobilize as much political power as I could, which I'm good at doing. One of the amazing groups that we called upon to help us was the local undertakers.

DT: Hmmm.

WJ: We have a program of mortuary science. Almost a hundred percent were trained in our program of mortuary science, because it's one of the few around, and it's at a big university. They were probably as helpful as any group in lobbying the legislators because every county that's represented in the Legislature has an undertaker and every undertaker is a University graduate. They mobilized and did more lobbying than any group. All of a sudden, the Legislature got the message, and they said, "You're not going to close those schools." But we all worked hard on that. We all lobbied to maintain those two schools. We really united.

DT: So it was a serious threat?

WJ: It was a serious threat. It's like the University goes through... They just finished some sort of study, and they're going to do some things. They always do that. It seems like every five years, there's a study that comes out with some recommendations that nobody is happy with. That's what was recommended but it looked like it might be on the table for the Board of Regents and that would have been a reality.

DT: I've heard that farmers in the state were also quite important in terms of lobbying to save Veterinary Medicine.

WJ: Yes, very much so. That's what I say: it was a statewide effort and everybody worked together. There was nobody that didn't work on that. That was a *major* priority. We would have lost two schools, the College of Veterinary Medicine and the Dental School.

DT: It seems shocking to think of that now.

WJ: I'd forgotten about that. I'm glad you brought that up. We had many, many meetings on that issue.

[End of Part 1 of the Interview]

Transcribed by Beverly Hermes

Hermes Transcribing & Research Service
12617 Fairgreen Avenue, St. Paul, Minnesota, 55124
952-953-0730 bhermes1@aol.com

Interview with Doctor William E. Jacott, Part 2

Interviewed by Dominique Tobbell

**Interviewed for the Academic Health Center, University of Minnesota
Oral History Project**

Interviewed at Doctor William Jacott's Home

Interviewed on June 26, 2013

William E. Jacott - WJ

Dominique Tobbell - DT

DT: This is Dominique Tobbell. I'm here, again, with Doctor William Jacott. It is June 26, 2013, and we're at Doctor Jacott's home.

So we left off about half way through your tenure as assistant vice president. One of the things I wanted to ask you about was the situation that transpired with Doctor John Najarian and the ALG [Antilymphocyte Globulin]. Being that you were in the vice president's office at that time, what are your recollections of that event?

WJ: I wasn't involved in the details of the issue, but it clearly was on our agenda a lot. The ALG situation was unfortunate. In my opinion, I think Doctor Najarian delegated to some of his staff people the responsibility to get that drug approved, and it just didn't happen. When you're head of a department, the buck stops with you. [chuckles] I always felt—this is a personal opinion—that the General Counsel of the University had some sort of bone to pick with Doctor Najarian and made an example of him on an issue that was full of technicalities.

To show you how the medical staff felt about Doctor Najarian... As you know the University stripped him of his Regents professor title, but the University could not determine hospital privileges at the University Hospital. So the medical staff of the Hospital still kept Doctor Najarian as a staff member of the Hospital so he could do surgery, he could teach residents, and he could do research. So what he lost was the Regents professor and head of the department.

He's a good man.

DT: Yes. I was fortunate to interview him last year, I believe, such an important figure within transplant medicine and the University's history.

WJ: Internationally.

DT: Yes. Did you get the sense from the others in the Office the Vice President that they would have shared your opinion about the General Counsel?

WJ: Yes, I think so. In fact, Andy Anderson resigned because of that issue.

DT: David Brown also resigned as dean, at the same time I think, or around that time.

WJ: Yes, I'm not sure of the circumstances around his leaving. That may have been a factor but not all of the issues.

DT: What's your sense of how the situation with ALG impacted the Academic Health Center as a whole?

WJ: It was a black eye for a while, but I don't think it made a huge long-term impact. I think everybody realized that the paperwork hadn't been done. I don't even know if it's still been done yet.

[laughter]

WJ: ALG has certainly helped a lot of patients.

DT: Yes.

Another thing—I think we you were still vice president at that time—the University Health System was created, joining together the hospitals and the University of Minnesota clinical associates or University of Minnesota Physicians [UMP].

WJ: UMP.

DT: UMP. Do you know what the rationale was for joining those two together?

WJ: It's more efficient and it becomes, then, a large group multispecialty practice. I think we're learning in medicine all over the country that if you merge a couple large organizations, you have a more efficient operation with a lower overhead and a better chance at marketing and so on. It's just good business.

DT: You, of course, had had that experience earlier in your career with Lakeside [Medical Center, Duluth, Minnesota].

WJ: Right.

DT: Was there general support for the creation of this system or was there any opposition to it?

WJ: Oh, there were a number of departments and department heads that were opposed to it. They liked the so-called silo system. So they came kind of kicking and screaming into the group. [chuckles] But that's to be expected. We had the same thing at the Duluth Clinic with certain departments. The surgeons said, "We're not going to support psychiatry," and so on. The same thing happened here, but it wasn't major. We didn't have people leaving or defecting or picketing or doing anything else. It just happened.

DT: Do you recall which departments were particularly resistant?

WJ: Ummm... No.

DT: Once the system was created, do you feel it changed the culture of the Academic Health Center at all or the Medical School or the Hospital?

WJ: I really think it did. You saw more collegiality among the medical staff, you know. Right away, Fairview put in medical staff lunchroom, so the medical staff from all specialties could meet there. I was there one or two days a week sitting with other colleagues in other specialties. A wonderful atmosphere was developed, and I think continues.

DT: You mention Fairview. Were you involved at all in the decision-making around selling the University Hospital to Fairview?

WJ: No, I had nothing to do with it, because I had only been head a month, and I was in Washington, D.C. when the news broke at an AMA [American Medical Association] meeting. I got these frantic calls from my faculty saying, "Come home! Come home!" [chuckles] The merger in our case meant that we had two separate residency programs in the same hospital. That didn't make a lot of sense. I eventually closed the University Family Practice program, and we maintained the Riverside Family Practice program, which is still there today.

DT: What led you to that decision to close the University one rather than Fairview one?

WJ: There were multiple factors, but the University program, when it first started, was the kind of program that was emphasizing a lot of research and they didn't have a good patient base, a good mix of patients for learning. As a result, they did poorly in the match and sometimes didn't fill and sometimes didn't get, necessarily, the top students. There were a lot of factors that led me to believe that I clearly couldn't have two residencies in the same place.

DT: With the University residency program, why was there such difficulty getting a diverse and substantial enough patient population?

WJ: Well, it goes back to why we in Duluth didn't refer to the University. Family practice was thought of as a second-class citizen and family practice had never been at the University Hospital until that program started. We didn't help it any by not having

the strongest students. So the faculty from other departments were saying, “I don’t want them messing with my patients.” Then, the word gets out and you continue to have poor matching. Once you get that reputation, it’s very difficult to change it.

DT: So Fairview’s residency program had a better reputation at that point?

WJ: The Riverside program was the University program at Fairview. It wasn’t Fairview’s program.

DT: Okay.

WJ: Clearly, they had a marvelous case mix for their patients. They had a wonderful clinic, the old Smiley’s Pharmacy, across the [Mississippi] River. They had a solid faculty and they used the Fairview Saint Mary’s Hospital campus as opposed to the University campus, which was not used to or very accepting of having family medicine residents in the house. That’s all changed, but it was that way, so it just didn’t work.

DT: Were there any particular challenges for the department once that merger happened aside from the residency program?

WJ: When I got back from Washington and made an assessment of the chaos... [chuckles] That was a big deal. Fairview basically bought the hospital and the parking ramp. We hadn’t merged with those groups at that point, so they were now the owners. Knowing that we in Family Medicine had an ax in the fire... I was appointed to the transition team and got to be right there when all the decisions were made, which was very helpful.

DT: You mentioned that your faculty contacted you in alarm when the merger happened. What was your sense of the faculty’s feelings toward the merger?

WJ: They didn’t like it. The Riverside faculty didn’t like it, because they, all of a sudden, went from being a community hospital program to a university hospital program. The stigma in family medicine is clear. In recruitment, many of the top students want to go to a community program and one where there are no other residencies, particularly primary care residencies where you’re fighting over patients.

DT: Yes, that’s interesting that you bring that up about the different primary care residencies. Can you elaborate on that at all, that kind of competition that the different departments might experience or the different residencies might experience?

WJ: The internal medicine, pediatrics, and family medicine, basically, when it comes to general medicine are doing the same thing with their patients, so they’re competing for the same kind of patient. The surgical residencies definitely like family medicine, because we refer a ton to them, so it’s that competition. If you have patients show up in the emergency room that don’t have a doctor, how do you assign the doctor for that patient? The politics of working that out, taking calls within the hospital, having your

own teaching station in the hospital where you put your own patients and, then, you make teaching rounds on them everyday, all of those things are important and in all of those things there's competition for the unit.

DT: Did you get a sense of how patients would make their choice about what kind of primary care physician they would see?

WJ: Not really.

DT: In terms of the residency, in addition to being based at the hospital, how many opportunities are there for the residents to work in outpatient settings?

WJ: It's required. By the time they're a third-year resident, they have to spend four days a week in the clinic. They've finished a lot of their in-hospital rotations. So they might be spending three days in their own clinic seeing their own patients and, then, one day in a specialty setting and another in the hospital. So they, clearly, get a lot of outpatient experience.

[telephone rings – break in the interview – brief extraneous conversation follows]

DT: Let's backtrack a little bit. What led to you being appointed chair of the Department of Family Practice and Community Health?

WJ: Again, I was at an AMA meeting in October 18, 1995. I got a phone call from Frank Cerra. They called me out of the meeting. This was a meeting of the AMA Board and I was sitting at the Board table, and they came and said, "You have an urgent call. The person on the line wants to wait." I thought now what? [chuckles] So I went and got the call, and Frank said, "I fired Ed [Edward] Ciriacy. Would you be the interim head of the department?" It was that quick. I said, "Well, I haven't given it much thought. I would, yes, under the circumstances." Then, he proceeded to explain why he fired Ed and so on. I had to just leave the AMA meeting, jump on a plane, and come back.

The next day, we had a meeting with the faculty, but good old Frank was on his way to Italy...

[chuckles]

WJ: ...on a vacation that he had long since planned. So he wasn't there when I met with the faculty. The v.p. [vice president] for health science, Bill [William R.] Brody, came with me. Of course, Ed Ciriacy was at the meeting. It was a very difficult faculty meeting, at the time, especially because Brody and I didn't have anything to do with Ed being fired, but we were the scapegoats at the time. The faculty got over it quite quickly. I was quite pleased how I was accepted.

DT: Frank was Medical School dean, at the point?

WJ: He was Medical School dean.

Less than a year later, Bill Brody made his announcement that he was going to Johns Hopkins [University] to be the president. The Board of Regents without a search pulled Frank from the deanship and made him the vice president. Then, I think it was Al [Alfred] Michael...

DT: Yes.

WJ: ...ended up being the dean of the Medical School. That was when the two jobs were split.

DT: Can you say why Ed Ciriacy was fired?

WJ: He had dismissed a faculty member at Methodist [Hospital] and had done it, apparently, without much of a fair hearing. Frank Cerra was contacted by the Methodist people and given their side of the story, and he got Ed's side of the story. Frank concluded that Ed should rehire this individual, that there weren't enough grounds to fire him or dismiss him. Ed said, "No, I won't do it." Frank said, "If you don't do it, you're fired." That's the way it happened.

DT: Ed Ciriacy had been chair of the department for quite a number of years.

WJ: He was the pioneer chair and a marvelous visionary and a wonderful family doctor. That was a tough situation because he built that department into one of the largest in the country and one of the most productive and particularly one that saw many of its students and residents going into rural family practice.

DT: What role did the Rural Physician Associate Program [RPAP] play in that placement?

WJ: I think it played a strong role. Unfortunately, Ed Ciriacy did not get along with Jack Verby who was the director of RPAP. Because of that, I don't think maximum use was made of the two programs working together. The two heads didn't get along. Jack Verby went to the dean's office and said, "I can't report to the head of Family Medicine, because we don't get along." So the dean's office said that basically the Rural Physician Associate Program would report directly to the dean's office. When I took over as department head, I was kind of surprised. Where's RPAP? It was going right to the dean's office, so they wouldn't have to deal with the two heads.

DT: Did you change that? Did that arrangement get changed?

WJ: I started the groundwork to change it. Before I became department head, I had actually been appointed by the dean to be part of a team to study the RPAP program and make a recommendation to the dean. We gradually integrated and, now, it's totally integrated within the department, but it took quite a bit of time.

DT: When did Jack Verby step down?

WJ: I don't remember. He stepped down before Ed was fired. I know that. There was a lineup of people when I got to be interim head, and Jack Verby was one of the first to come in and say how happy he was that I was there.

[laughter]

DT: Why do you think there was so much conflict between...?

WJ: I never knew. I don't know. Both individuals are sharp, articulate, outspoken people. I suppose there was something that happened in the past and neither one was going to budge.

DT: It seems a shame because my sense is that both were committed to getting rural physicians out.

WJ: They were both ultimately pioneers in family medicine.

DT: I know the Pharmacy School established a similar program for pharmacists, so it seems RPAP was a model within the health sciences.

WJ: It was a national model. Jack Verby, in his last two years as head, was actually traveling around the country, at the country's invitation, to tell them all about RPAP. It was a unique model and is now being copied all over the country, maybe not for nine months but in some manner.

DT: So that originated at the University of Minnesota?

WJ: Yes.

DT: That's what I thought.

WJ: That was a gem.

DT: Yet one more of the significant innovations that came out of the health sciences at Minnesota.

WJ: Exactly. Yes. And it became a good recruitment tool, because if the RPAP student had a good experience, went into rural Minnesota, they're going to refer to UMP physicians. It's a winner.

DT: What kind of leadership style did Ed Ciriacy have?

WJ: He was, on the whole, a good leader. He recruited a good faculty. If somebody crossed him and didn't follow exactly what he wanted done, he was not very tolerant of that. That was the kind of situation that got him fired. But he was innovative, futuristic, and set up a very good program. He also was an isolationist and did not want to integrate. He was very opposed to UMP's formation. He did not want to integrate or work closely with other departments, for a whole lot of reasons. You know some of the other departments wanted to get at our money. I can understand why he was concerned, but it didn't accomplish much to kind of isolate.

I remember once Roby Thompson told me, "Where did all these wonderful faculty members come from, all of a sudden?" I said, "They've been there for years, but Ed didn't turn them loose within the department or within the entire Medical School." They were unknown, and they were gems.

DT: What were the relationships like between the department and physicians practicing out in the community?

WJ: They were quite good. They were good when I came, and they were good when I left. [chuckles] I think we improved on it because we did a lot of outreach with physicians. That's a natural thing with family medicine because of your colleagues within the academy, the Minnesota Academy of Family Physicians. I felt that it was important, for example, to attend the Minnesota Academy Board meetings and give a report at each meeting on what's going on at the University. Those kinds of things became very important.

DT: It seems like first with Ed Ciriacy who had practiced in Ely [Minnesota] and then yourself having an extensive career practicing as a family physician would foster those excellent relations.

WJ: It really did. Then, my AMA activities also generated a lot of interaction with other specialties. It wasn't just family medicine.

DT: You mentioned that it was, perhaps, a bit of a challenge when you first arrived as interim chair. What about during your tenure? What do you see as the major challenges that you experienced?

WJ: I think first is funding, to make sure that we had adequate funding for our programs. I think second is to integrate the department within the Medical School. And, third was to set up a line of communication between my faculty and staff. I think those are the main challenges. There are everyday challenges for individual issues, but, basically, that was it.

DT: In terms of the funding, given that the department was a line item in the budget, did you have to go to the Legislature each year?

WJ: Yes. I made sure of that and, fortunately, I had the background of knowing many of the legislators and people in the Governor's office. So we were able to maintain that funding. In fact, Al Michael appointed me co-chair of the Medical School's legislative committee. The other chair was [G.] Scott Giebink from Pediatrics who, unfortunately, died [August 29, 2003] at a very young age [age fifty-nine] from a heart attack. Scott and I would go to the Legislature together and visit many of the key people on behalf of the whole Medical School, not just our own departments.

DT: Did you work closely with Vik [Villis] Vikmanis?

WJ: Well, I had done that in the vice president's office but not so much as a department head. We'd, obviously, see Vik over at the Legislature, and he would give us feedback on people. He was very helpful, but it wasn't as much as when I was in the v.p. office. I never did return to the v.p. office. I went from department head to Family Practice faculty part time. While I was department head, it took me a while to unload some of my v.p. responsibilities, particularly the Use of Animals in Research.

[chuckles]

WJ: Nobody else wanted to get that one, so I had that for a while afterwards.

DT: You mentioned that one of the challenges was setting up better communication between the faculty and staff. Can you elaborate on what those communications difficulties had been?

WJ: I don't think there were difficulties. I think there's a lot of issues that occur within the department. Ed Ciriacy was not real transparent. So when we had a monthly faculty meeting, in my report would be everything that I had done in the last month to the faculty so they knew what was going on. I also set up an executive faculty committee that met once a month, two weeks apart from the general faculty meeting and made sure we communicated. I also set up a line of communication with the Family Practice program at [University of Minnesota] Duluth, and Hennepin [County Medical Center], and [Saint Paul-] Ramsey [Hospital], and to some degree United's [Hospital] program, and to some degree Saint Cloud's [Family Medicine] program. Those were all different. A lot of those have become University... I wanted to be sure we communicated, so we would meet quarterly with the family practice groups of the state, with the exception of Mayo [Clinic, Rochester, Minnesota]. They sort of sing their own tune.

DT: In addition to the challenges, what do you see as the major achievements during your tenure?

WJ: Well, I think it was recruitment of residents. We continued to be one of the leaders in the nation in recruiting residents. We had fifty first-year residents among seven programs, so we had to recruit a lot of people. You don't just get all of those out of the University of Minnesota. There's a lot of competition for residents, not only within our own programs but within the ones I just mentioned within the state, plus the borders.

You're competing with La Crosse with the Gundersen Clinic. You're competing with Eau Claire with the Mayo Clinic [Health System], Sioux Falls with the University of South Dakota, and so on. If you take those all into account that is probably over two hundred medical students that those programs collectively had to recruit.

We won the Gold Award from the American Academy [of Family Physicians] on several occasions because we had more than twenty-five percent of the University of Minnesota graduating medical students who went into family practice. We got the Gold plaque. I went and accepted it. I would have with me somebody from UMD [University of Minnesota Duluth] because those students were transfers from UMD. So UMD was always represented when we got the award.

I think that's one thing, and maintaining the funding is another.

One thing I'm very proud of is our research, the research that we were able to generate, research grants and research projects. We became listed as one of the top ten research family medicine practice departments in the country. We actually, at one time, got into the top five.

DT: Were there specific areas that the department's research focused on?

WJ: Oh, it was all over the map from smoking cessation to residents doing procedural activities. We had a core of women faculty who were interested in women's health and did their research in women's health issues. Then, of course, the program in human sexuality was in our department and they had tremendous research efforts in that group. It was all in that area. They began to get the so-called RO1 grants, which were unheard of in family medicine.

DT: I'm glad that you brought up the program in human sexuality, because I wanted to ask you about that. I know this was before your tenure as department chair... Earlier in the 1990s, there had been allegations made against the program regarding patient privacy and mental abuse of patients. Can you speak to that at all?

WJ: I never saw anything like that. I think that had all been in the past. I never got a complaint. I never heard a thing about it, really. I know some of the leaders of that program in the past became unacceptable for a variety of reasons, but I never had to deal with that. Eli Coleman was head of the program the whole time, and he and I worked very closely together and very well. In fact, I would go to make a quarterly visit for a full day at the program and Eli had lined up an agenda where all of his faculty would come in and sort of tell me what they were doing, and what their research is, and talk about the patients, and so on. It was a good opportunity. They had never had that opportunity. It's a strong program.

DT: Yes. Eli Coleman is of national, and I think even international stature.

WJ: Oh, he is. He's always getting elected to some position somewhere with some organization I've never heard of.

[chuckles]

DT: Do you have any more observations to share regarding your experience as chair of the Department of Family Practice?

WJ: I think we've covered it quite well.

During that time, I continued to act as a preceptor in the Family Practice clinics, and I would rotate among all seven of our clinics a half a day a week when I could. So I still maintained a little touch of patient care. I was glad to do that.

I was there almost six years as the chairman. When Al Michael hired me, I had agreed to serve at least five years. It took a year to do the national search for my position when I became chairman. There were two or three other candidates for it and, finally, about a year or a year and a half into my tenure as interim, I was officially made head of the department. But I counted the first year as part of my five years, but I ended up six years anyway. I went in and met with Al Michael and said, "Al, my time is up. I'd like to bail out."

What I did after they had a successful search and found Mac [Macaran] Baird is I went half time as a faculty member. In particular, I was chairman of the Joint Commission [Board of Commissioners] during that last... Then, I became a consultant to the Joint Commission. I took advantage of what's called the Phased Retirement Program.

So I went into that program. I took it for three years at fifty percent time the first year and twenty-five percent the last two. It worked out very well. By June of 2004, I was done.

DT: I'd like to now use the last bit of time that we have to turn attention to your national leadership roles. I wonder if you might talk first about your experience as chair of the AMA Council on Medical Education.

WJ: That was a wonderful opportunity. I had become an alternate delegate to the AMA House of Delegates and, then, a delegate, eventually. My focus, obviously because of my background, was medical education. I actually was approached by the chairman of that council at one point saying, "Why don't you run for our council?" I did, and I got elected. It's not an appointed position. So I got elected and, eventually, became chair, the first family physician to ever be chair of the council. I really enjoyed that. That gave me the opportunity to branch out into other educational activities.

I was then appointed to the Accreditation Council for Continuing Medical Education, the so-called ACCME. I was also appointed to the LCME, which is the Liaison Committee for Medical Education and is *the* committee that accredits all of our medical schools.

There, I had a unique opportunity in the name of family medicine. I was on a subcommittee studying the Structure and Function Document, which is what accreditation is based on. Our subcommittee, with a little coaching from me, recommended to the LCME that one of the paragraphs in there include family medicine as a required clerkship for all schools. That now is in the Structure and Function Document.

DT: That's really significant.

WJ: That was a big move. Now there's still about eighteen schools that don't have a department of family medicine. [chuckles] So it's pretty hard to require a clerkship. But the LCME sort of overlooks Harvard [University] and Johns Hopkins [University] and all those that don't have one.

On the Council on Med Ed, I got a chance to meet a lot of national leaders who became very good friends, the president of the National Board of Medical Examiners and the president of the American Board of Medical Specialties, and so on. It was really the council that gave me a platform to run for the AMA Board. The AMA Board was full of mostly socioeconomic legislative types worrying about physician payment and other issues and didn't have much representation from medical education. So I, then, was elected to the board after serving eight years on the council.

DT: What years were you on the council?

WJ: Nineteen eighty-one to 1989. It was in June of 1989 that I was elected to the AMA board. I actually still had one year left on the council at that time, but timing is everything when you're doing an election, and it was the right time to run.

DT: It really does seem significant that as a family physician you were able to have such a national presence and that must have done a lot for family medicine in the U.S.

WJ: I believe that's true, that a lot of my colleagues recognized that.

DT: In general, was there a lot of support for you and family medicine on the council and then on the Board of Trustees?

WJ: Yes. Yes, there was. But, again, it's a matter of not being provincial and being collegial and communicating. I think that's the important thing. I think I'm able to do that.

DT: Can you reflect on your experience on the AMA Board of Trustees, and what were some of the topics that the board was dealing with?

WJ: They right away had me be the lead person on the Use of Animals in Research. [laughter] But, also, I was the point person on medical education. I was the only one that was a medical educator at the time I got elected. At the same time, I had been on the

Council on Medical Education, I was on the Board of the Federation of State Medical Boards, so licensure and credentialing became another important issue.

I was the only veteran on the board. I remember one specifically. I was asked to testify at the Armed Forces Subcommittee of the United States House on whether or not chiropractors should become [commissioned] officers in the Armed Forces. Naturally, the AMA was opposed to that. I got sent to Washington to oppose that. Half the members of the House committee had their friendly chiropractor. [laughter] So that was a tough experience. I also got involved with meeting with the Department of Veteran's Affairs and things like that.

DT: It's interesting that you note that you were the only medical educator on the Board of Trustees during your time there—or at least when you began.

WJ: Initially. We finally got a couple more toward the end of my time and by that I mean people that are full time. Almost all the physicians on the board were teaching medical students or residents. That's just a given, but they weren't doing it full time.

DT: I know from the AMA's history, and just in general in the history of medicine, that there have classically been tensions between the academic physicians and fulltime practitioners. Did you see any of those tensions?

WJ: I actually saw more in specialty societies. The Academy was a classic example, the American Academy of Family Physicians [AAFP]. Many times, they would hold an election for members of their board and the bottom line campaign issue by the non-academician was, I'm a real doctor and these guys are just educators. That came out *strongly* within the Academy. There was some of that at the AMA, but that's gradually diffused. Everybody is sooner or later involved in education, and they realize it's important. The AMA in 1978 welcomed medical school deans into their House of Delegates. The Medical School Section was created. I was at that initial meeting. It was a marvelous thing to see deans of medical schools welcomed into the AMA and wanting even to come. There are still a lot of deans that wouldn't come on a bet. Organized medicine has found a way to integrate a lot of different things.

DT: I see that you were president of the Minnesota Board of Family Practice at some point. Is that correct?

WJ: Not Family Practice, the Minnesota Board of Medical Practice.

DT: Oh, okay.

WJ: In other words, the licensure board. It was from that position that I got elected to the Federation of State Medical Boards.

DT: Were there any notable events that characterized your experience on the Minnesota Board?

WJ: There were a lot of events that had to do with individual physicians and inappropriate behavior and inappropriate practice. That was a lot of what we did. We licensed and relicensed physicians, but that was pretty much a staff function. What we were doing is handling medical discipline and issues where there had been sexual contact or inappropriate prescribing or continual malpractice cases and so on. That was an ongoing activity.

There was one thing that we did when I was president of the Federation of State Medical Boards. We developed a Model Medical Practice Act so that the states can use that as a model as they approach their legislators to develop and enhance the Medical Practice Act of their individual states. That was a good thing because they then did a better job on disciplining physicians that were getting out of line.

DT: Did you have a sense of whether those disciplinary issues were fairly stable or increased or declined?

WJ: I think we got better at identifying problems and taking action, so, actually, the number of actions taken increased, but so did the number of doctors. So when people cite statistics, you know, they always criticize the medical boards because they aren't disciplining enough doctors, but, in fact, they are disciplining more than they used, but it's just that there are more doctors.

DT: You were on the Joint Commission Board of Commissioners. Is that right?

WJ: Yes.

DT: What does that have responsibility for? What does that commission do?

WJ: We accredit all the hospitals in the United States and, now, in thirty countries around the world. Probably ten years ago, maybe more than that, if you went to Paris and had to go to a hospital, there were no accredited hospitals in the entire country of France. So we went over to Paris and met with them and gave them guidance and they now accredit their hospitals. If somebody wanted to make some money, they could buy a building, call it a hospital, and say, "Come on in." No standards of care or quality.

DT: That's interesting. I didn't really appreciate that not every country then accredits its hospitals.

WJ: The Joint Commission has been a consultant to many countries who have developed their own accrediting bodies. But when I was involved with all of that back in the 1990s, that wasn't the case. I was surprised at that, too. Great Britain had accrediting and Canada had a good program.

DT: I'm relieved that Britain had that, because I was in Britain at that time. [chuckles] With Canada and Britain having nationalized health systems, it seems like it would be in the government's best interest to have that accreditation being done.

WJ: Right. And Ireland, the same thing.

DT: Are there any other national committees that you served on that you would like to comment about?

WJ: I think those are the main ones. As a result of being on the AMA Board, I got on a bunch of other committees and so on, but they were all related to what we've talked about. I think the AMA Board, the Joint Commission Board, the Federation Board, and the Council on Med Ed are the big heavy hitters.

I did get appointed by the AMA to be a member of the AAALAC Board, the American Association of the Accreditation of Laboratory Animal Care. I eventually became chairman of that board, which is the national body that accredits all research facilities that use animals in the country. That was a unique experience for a family doctor.

DT: I bet. It strikes me that you were probably in a minority on each of these boards as a family physician.

WJ: Yes. The Association of American Medical Colleges, AAMC, had a representative also, and he was a physician, but I think he was a neurosurgeon or something. He wasn't in primary care. Otherwise, the board members of AAALAC were primarily veterinarians.

DT: That's what I imagine. You said, when you gave up your assistant v.p. position, it was the lab animals piece that you had difficulty handing off. I'm surprised that it wasn't one of the veterinary faculty that would take that on.

WJ: Well, actually, I had hired Cynthia S. Gillett. She's still the director of Research Animal Resources at the U. She's doing a good job. So I don't think the v.p. office has a whole lot to do there, because she's doing an excellent job.

DT: Do you have any final comments you'd like to make about the history of Family Practice, the Medical School, and the Academic Health Center?

WJ: Yes. I just have one and that is I'm very disappointed that the dean and the vice president are one person. I think that's not a good move for a whole lot of reasons.

DT: Can you elaborate on that?

WJ: Well, I think, first of all, it's too much for one person. Secondly, to have the dean of the Medical School as the vice president with the other six schools. I just think the deans ought to be separate from the vice president. The two operations are different.

DT: I find it interesting that when the Academic Health Center was set up in 1970, it was explicitly to undermine those hierarchies that existed within the institution regarding the Medical School and the other health science schools.

WJ: And hierarchies within the whole University, in Academic Affairs, and compete with big units.

DT: A lot of people have expressed that same disappointment.

WJ: Yes.

DT: You've been fascinating to talk to and you shared a lot of really invaluable insight. So I appreciate your taking the time.

WJ: I've enjoyed it.

DT: Thank you.

WJ: I look forward to the final product, whatever that may be.

DT: Yes. I will be sending you a transcript of the two interviews for you to review. Once you're satisfied with that, we'll then make a final version and you'll get a hard copy for yourself.

WJ: Good.

DT: Thank you.

WJ: You're entirely welcome.

[End of the Interview]

Transcribed by Beverly Hermes

Hermes Transcribing & Research Service
12617 Fairgreen Avenue, St. Paul, Minnesota, 55124
952-953-0730 bhermes1@aol.com