WILLIAM JACOTT

September 11, 1996

Dr. Fitzhugh Mullan,
interviewer

Mullan: Your date of birth?

Jacott: 7/4/38.

Mullan: We're sitting in Dr. Jacott's office at the Phillips Wangensten Building on the University of Minnesota.

Jacott: Owen Wangensten was the former chairman of surgery here.

Mullan: Is there not a procedure or something?

Jacott: Many. There was a Wangensten pump, and a Wangensten instrument, and so on. Phillips was a patient here who liked the university. You may be familiar with the Phillips Liquor Company that makes Phillips gin and Phillips vodka.

Mullan: So he put up the money, I gather, and commemorated Dr. Wangensten along the way.

Jacott: Yes.

Mullan: At any event, we're in the Phillips Wangensten Building at the University of Minnesota School of Medicine. It is the

eleventh of September 1996, a somewhat cloudier day than it was, early fall here in Minnesota.

Tell me a bit about yourself. Were you a Minnesotan to begin with?

Jacott: I'm a Minnesotan, born and raised in Duluth, went to high school in Duluth, college, University of Minnesota-Duluth, and then medical school at Minneapolis Medical School.

Mullan: Taking you back to Duluth to begin with, what was your family doing in Duluth? Were they long-term residents?

Jacott: My grandparents came over from Sweden in the early 1900s. A lot of Scandinavian people ended up for some reason in Minnesota, because, I think, the climate and the general condition was very similar to Scandinavia.

Mullan: What did they do?

Jacott: My grandfather was a stonemason, and grandmother was a homemaker.

Mullan: And your parents?

Jacott: My father was mostly in sales, and my mother was actually a professional woman, an executive secretary for a law firm and later for a mining company.

Mullan: What was it like growing up in Duluth? What was your family life like?

Jacott: It was wonderful except for the weather. But it was a good place to grow up. A lot of friendly people, very safe, very little crime, good educational program, and secondary education, and the University of Minnesota-Duluth is a very good institution of higher education. So this was a great place to be.

Mullan: Was family life good? This was war years, post war years, fifties going on sixties?

Jacott: Well, my father was in World War II, and so he was gone for about four years during my early childhood, then came back and, as I say, got involved in sales with Westinghouse Electric, and then later one of the television stations in Duluth. But it was fine growing up in Duluth, made a lot of friends that are still long-time friends and acquaintances. More importantly, coming back to Duluth to practice in the community where I was born and raised was an interesting experience, particularly when you acquired, and I did, a number of patients who were former high school colleagues, and college colleagues, and so on.

Mullan: You spent high school years and your college years in Duluth?

Jacott: Except for medical school.

Mullan: What was the university at Duluth like?

Jacott: It was a growing campus that was a broad liberal arts type of campus, but had a good record in science. But growing meaning that by the time I graduated, the size of the campus had almost doubled. It has continued to grow at the present time, although not quite at the same rate.

Mullan: Duluth is a port? Is that its principal economic reason for being?

Jacott: Duluth, the initial economy of it was a focus for iron ore mining and the lumber industry, both production and exportation. Then in the fifties, when the St. Lawrence Seaway was opened up, Duluth became an inland port for a lot of the ocean craft.

Mullan: The timber was shipped out. The iron ore was shipped out?

Jacott: The iron ore was shipped to Cleveland and Pittsburgh and places like that where it was refined and made into steel.

Mullan: Then the St. Lawrence Seaway, could be shipped anywhere in the world, I guess.

Jacott: Right. But the iron ore industry, like all industries, when they don't keep up with what's going on, gets into trouble. The mining went from a high-grade ore to a low-grade ore, which was not much in demand. So the iron ore industry really dried up until somebody here at the University of Minnesota invented taconite [phonetic]. Taconite is a pellet that is a highly concentrated form of iron ore. So then taconite processing plants developed in northern Minnesota, and they started producing that with the low-grade ore.

Mullan: They could extract it right there.

Jacott: Right. It kind of revived the industry. It's still doing fairly well. But the lumber industry has sort of slowed down as more and more forestry becomes protected. So that isn't a big thing. So now shipping and really tourism are two of the big elements that keep Duluth going, being sort of the focal point or the pivoting point to go up into the boundary waters. Duluth has a high tourism industry, particularly in the summer.

Mullan: Growing up, did you have encounters with physicians? Were there people in your family or elsewhere that were in medicine that had any influence on you in particular?

Jacott: Well, actually, there were a few, but the person who influenced me the most to go into what I would call to become a health care professional was a pharmacist. I worked in high

school for a pharmacist, and used to enjoy helping him fill his prescriptions, read the doctors' writing, and then delivering. We delivered almost all the prescriptions in those days. I particularly enjoyed getting into people's homes and delivering the prescriptions. We had several nursing homes that were accounts where we delivered prescriptions. People will talk to you as if you were a health professional, and I enjoyed that encounter and that interaction with the people in their own settings. I thought, too, it would be nice to go into general practice, and that's what I did.

Mullan: Did you have a general practitioner?

Jacott: I did, yes. My family doctor was a family practitioner, but who was a good role model and encouraged me to go into medical school, and to go into general, now family practice, but wasn't the major reason. Of course, there was nobody in our family that went into medicine.

Mullan: So when you went to the university at Duluth, did you have a sense you wanted to be a premed?

Jacott: No. I entered the university--at first I was going to play college football. I decided not to do that because I wanted to be in premed, and it conflicted with chemistry lab. Because I was recruited by the college to play football. I played a lot of high school football. So I dropped that and went into premed.

But at the same time I was working for a television station doing sports broadcasting. So I was torn between being a sportscaster, and I was actually doing play-by-play and sports shows, and everything else.

Mullan: This was during college?

Jacott: During college, yes. So I ended up with a bachelor's degree in speech, a minor in political science, and enough premed credits to go to medical school. But it's been a good background for me, because I was one of the first ones to come into this medical school without a science major. In those days, if you didn't major in biology or chemistry, you weren't worth anything.

Mullan: Yes, and I gather here there was a very strong emphasis on that.

Jacott: Very strong emphasis.

Mullan: A lot of requirements.

Jacott: But I got in with a speech major and a political science minor. I think it's probably in my nature as I've evolved into AMA [American Medical Association] and other activities.

Mullan: What was it like coming to both Minneapolis and medical school?

Jacott: Having been in Duluth all my life, it was a scary period. We all remember our first week or so of medical school, and our first experience with a patient, and our first experience with clinicians in a ward, and so on and so forth. My first internal medicine clerkship was at the old Minneapolis General Hospital.

Mullan: That preceded Hennipen County?

Jacott: Yes. That's the same thing, but it was called Minneapolis General. Those were the days when as a student you had to be there at six, seven in the morning, to draw the bloods from all the patients, and every patient had fifty CCs of blood drawn every day, whether they needed it or not. There were no disposable needles or syringes; it was all the glass, steel-type stuff which you hoped were clean, and you hoped you didn't get contaminated those were not experiences that I think need to be repeated, and that we have gotten way beyond now in medical education.

Mullan: So which years were you in medical school?

Jacott: '60 to '64.

Mullan: And between pre-clinical and clinical years, was there a difference in your mind as to what you liked or felt better about?

Jacott: Well, once I got into medical school, I was committed into moving into general practice, and I stuck with that.

Mullan: You had that idea pretty much going in?

Jacott: That was my idea going in and I stuck with it going out. I had a number of professors who, which they do, come up to me and say, "You're too good to go into general practice. You should go into my specialty," whatever it happened to be. We got very little support at this institution, and it's true for many of the big academic health centers for general family practice. You got very little support if you were going into that profession.

Mullan: That was what many consider the low point for family practice. I mean, the old GPs were kind of dying out and family medicine as a residency level discipline really hadn't been born formal yet.

Jacott: Hadn't started. See, this was '64, and the Millis [phonetic] Report was '69. That's what really triggered the advent--

Mullan: If you can recall back to those days and erase all of the developments of all these years, what were you thinking? Did you have a sense that the GP was going to continue in America?

Or was it on its way out and you were grabbing onto the tail of something that was sinking?

Jacott: I'm always optimistic. I always look at the bright side of things. I didn't know that we were going to evolve into family practice, but I really felt that there was a need. All you had to do was be in general practice one day and you knew there was a need, and that people are always going to want that kind of contact, that kind of relationship, that kind of care, regardless of what you call it or what the encounter involves. I never felt that I would be in a dying breed. I did feel that there were a lot of my senior colleagues in general practice that were outdated and burned out, but I could see those few of us that did go through that as a group that met together and interacted together and had a chance to interchange ideas. One of those individuals was the person responsible for recruiting me to a group in Duluth. He's a physician who actually went to school with my older brother. So I knew him. He actually came down when I was in medical school and said, "Why don't you join our practice?"

Mullan: In Duluth?

Jacott: In Duluth.

Mullan: What was his name?

Jacott: Rod Langseth. He's still in practice. He'll probably retire in a couple of years, but he's a very good family physician, and was a colleague of mine for twenty years.

Mullan: So as you went on through clinging, holding to the notion you wanted to be a family doc, what did you do when you graduated?

Jacott: I took an internship in Duluth.

Mullan: Rotating?

Jacott: A rotating internship at St. Luke's Hospital in Duluth. As you know, at that time there were no residencies, so I couldn't go. I couldn't take a residency. Actually, Canada had a few general practice two-year programs at that time, but they didn't look very good. They looked as though they just took the first year and repeated it in the second year, and there were no goals or objectives. If one year is good, two years is better. That wasn't my philosophy. So I took the one-year rotating internship, and it was a good internship. I felt very confident if somebody came into my office with chest pain. But the first wart that came in, I had no idea what to do with it. That's just the way it was. [Laughter]

Mullan: Hard to get all that in in one year.

Jacott: That's right. So you learned from your colleagues. I don't know how people in those days who went into solo practice could do it.

Mullan: You joined after one year this group of Dr. Langseth?

Jacott: After the one year, I went with Dr. Langseth and we had a senior partner, and then we very quickly became a four-person group. That's kind of the way it was until I left that group in '74. So I was really there about eight or nine years in a small group practice. Then in '74 I became the full-time program director of a Duluth family practice residency.

Mullan: Those must have been interesting years in terms of the development. Actually, let me ask one question. Your medical school classmates, did anyone else go into general practice at that point?

Jacott: Yes, actually, quite a few did.

Mullan: There was a tradition here of that happening?

Jacott: Yes. Minnesota, even though the faculty hasn't necessarily promoted it, has always had that because we've had such a strong academy, the presence of the Academy of General, and now, Family Practice. They've been a very active group and

good role models, and have encouraged a lot of people to go into that. I think that's what did it.

Mullan: So you're not alone.

Jacott: No.

Mullan: Was Paul Eneboe in your class?

Jacott: Yes.

Mullan: I interviewed Paul a couple of weeks ago up in Homer.

Jacott: He's in Montana, I think, or he used to be.

Mullan: He was from Montana.

Jacott: Oh, he's from Montana.

Mullan: He's been in Homer, Alaska, since 1968.

Jacott: Is he in family practice?

Mullan: Absolutely.

Jacott: He is. Oh, good. Wonderful guy.

Mullan: Wonderful guy. He's held down health care. Homer's a town southwest of Anchorage out on the Kenai Peninsula. He was the only physician in a town of about 5,000 four or five years. Now the town's maybe 8,000, 10,000. It's got ten physicians. He's got a little help.

Jacott: Oh, he's in good shape then.

Mullan: Yes. So you left, spend eight years thereabouts in practice, after which there was a family practice program?

Jacott: I started it. I started it because, as you recall, the rotating internship disappeared in 1975. Duluth had this long, strong tradition, the two hospitals, of rotating internships. They didn't want a gap, so we all got together and developed a residency, and I was appointed its first program director. Got it started, was full time there for four years, then went back with the same group that I left, and spent three years in that group, but very quickly saw health care changing, and health care delivery changing, and the economics of health care changing, and so initiated discussions with the Duluth Clinic, which is a large multi-specialty clinic, and we became the first family practice group to merge with the Duluth Clinic.

Mullan: This was in 19--

Jacott: '81.

Mullan: Let's go back and pick up a little bit. First, you made a comment before that was very interesting, what it was like to go back to your home town and practice. Develop that a little, if you would.

Jacott: Sure. I thought it was very satisfying to do that, and got a lot of positives out of that. To have people that you went to high school and college, and neighbors, and everything have enough confidence in you to choose you as their family doctor was a real positive thing. So you really get to know your patients, and a lot of them become good friends, and yet, it is a challenge when you do that to be objective and to not let bias or emotional feelings enter into any of your decision-making.

Mullan: Give me an example what kinds of problems would present themselves in that regard.

Jacott: If you had seen somebody that you're doing business with, you don't want to get into the point where you would treat them differently than another patient that you didn't have anything to do with, differently by saying, "Well, he looks like he's all right, I don't have to do a rectal exam on him, but all these other people, they're going to get that." That type of thing. There is a tendency to think in those terms, that I don't want to do anything to make this individual uncomfortable because he or she has been so good to me. I didn't fall into that.

Mullan: That's a hazard.

Jacott: But that's a hazard that you could do.

Mullan: How about privacy issues of confidentiality in a small town?

Jacott: I never found that to be a problem, because I never brought any of those issues home. I kept them very close. So I really never ran into that. At times you ran into situations where you were examining someone that you may have taken to the high school prom, and you were a little bit uncomfortable about that. But even that, you get so you're in your professional setting and mold, and you just approach everybody in the same way, with the same objectivity, and you can learn to live with it. Initially, those were the kind of things that I had to deal with, until you get enough experience to be comfortable.

Mullan: Those were fertile years for the laying of the first tracks for family medicine--I'm mixing a metaphor there--seeds were planted for the new discipline of family medicine, or the reborn discipline. How did that play out in terms of both your own satisfactions, dissatisfactions with the practice, based on your one-year of training, and what then was going on in the larger political and academic context to make family practice come onto the scene?

Jacott: Well, it was interesting. Initially, a lot of us felt that it was unnecessary to have a three-year residency to become a specialist in family practice, let alone take a board exam and become board-certified. I think as many of us began to look into it more, and particularly as I went further into medical education and family practice residency training, it became clear that this was very important, that the amount of knowledge and technology and skills and experience that's needed can't possibly be delivered in one year, and that we had to have a specialty and not just a discipline, and the specialty had to have certain minimal standards. One of those benchmarks was board certification and recertification. It was very difficult for many general practitioners to buy in on that.

Mullan: Was there a struggle on the local level between perhaps the older practitioners who didn't buy this new three-year train, board preparation, etc., and some of the newer folks?

Jacott: Big-time generation gap, and very frequently, a group that has maybe two or three older, differently-trained physicians, when they recruit a residency-trained physician, unless there was a second residency-trained physician, that individual didn't last very long in many groups.

Mullan: Dissatisfaction on both sides?

Jacott: On both sides. The three-year residency-trained physician was trained in a totally different way and practiced in a totally different way.

Mullan: How would you characterize that?

Jacott: I think probably knew a lot more of sophisticated evaluation of patients, either through laboratory, X-ray, or whatever, and had a tendency to do more of that before making a decision about treatment. So that same philosophy then carried over into amount of prescribing. I think the older physicians tended to prescribe more. The younger physicians would hold off and wait for test X and test Y and test Z, before they would prescribe.

Mullan: So the younger ones might be more rigorous in terms of diagnostic workup, but more fastidious in terms of prescribing.

Jacott: Right.

Mullan: Whereas the inverse was true of the older ones.

Jacott: Right. But there's a compromise there, because after you get enough experience and you see a certain condition, you don't need the laboratory backup to make a decision about that, because you've seen enough of them that you know that's what it is, and the chances of you missing something are pretty remote.

So there is a compromise that you get to eventually. Eventually, the younger physicians would get to a point where they would say, well, he or she really knew what they were talking about without ordering tests X, Y and Z.

Mullan: So by 1974 there was enough impetus, given the closing down of the rotating internship to really start a residency in Duluth?

Jacott: Yes.

Mullan: Tell me about those four years. What was that like for you to step out of--

Jacott: Well, it was very interesting to do it in your own town where you've got a big practice. I ended up seeing my own patients privately one day a week, and then being involved with the program either administratively or teaching four days or longer a week. On the other hand, because I knew all the players, whether it be the hospital directors or the medical staff, it was easy to mobilize help and have everybody working together on it. It still has that feeling up in Duluth, but it was the only residency program that's based in Duluth. Everybody sort of was involved in it.

Mullan: How large a program was it when you got it started?

Jacott: It started with eight residents per year, and I recruited six second-year residents, people who'd had a rotating internship. So I started the program with fourteen residents.

Mullan: Over those years, how did it fare? Were you satisfied with the developments?

Jacott: Oh, very much so.

Mullan: What kind of folks were you getting, and how did they [unclear]?

Jacott: We got very topnotch people. In the matching program, very seldom went past twenty on our list to get our eight people. That's continuing today. It's a very popular program.

Mullan: Mostly from Minnesota?

Jacott: Well, most. But we've got from the region. We rarely would get someone from out of the region for that kind of a program.

Mullan: Was it hard to craft a curriculum? What was it like when this hadn't existed before, you hadn't done it, and you were going to put together a program for three years of this education? Was it obvious what you would do, or did you cross-walk with others, or how did you decide what to do?

Jacott: Well, you'd do it in a variety of ways. You certainly have minimum requirements according to the special requirements for training to follow. So you've got to follow those and pull those in. But there's a number of areas that in the early days of the program were shorter, the principles of practice management, principles of medical liability, and biomedical ethics. Those kind of things probably are learned by chance more than by direction. On the other hand, surgery, OB, pediatrics, and internal medicine are probably the strong centerpiece to start with.

Mullan: Stick to the basics.

Jacott: Then you evolve into that, and eventually, you get your program to the point where you're even doing primary care research. But none of that happens all at one time. I obtained, also, outside consultation from the American Academy and others, to come in and look at what we were doing objectively and help us develop the program. As you know, family practice has been taking a leadership role in helping to develop programs.

Mullan: Sure. Taking this a little bit out of sequence, I realize, but if you walk through the developments that led to the development of the medical school at Duluth, did they stem from the family practice residency?

Jacott: No. Actually, it was a parallel course. The medical school in Duluth was the vision of a few of the administrative leaders at UMD, University of Minnesota-Duluth, and some of the medical staff at Duluth. They said, at a time when nationally we were being told we need more doctors and we need more general doctors, "Let's build a school in Duluth and train family physicians, and make that the goal." So we formed a committee. I was on the original committee that formed the medical school in Duluth.

Mullan: What year was this?

Jacott: '69. Somewhere in there. '68, '69. The Northern Minnesota Educational Council. That group expanded to put people from business, and some of the politicians, and others on there, former regents of the university and so on, got our act together, went down to the legislature and, actually, were competing with an outfit in St. Paul that was also trying to develop another medical school in the Twin Cities, and we got the funding to get it started. One of the first things we did is recruit a dean to get things going. The first dean in Duluth was Bob Carter, a pediatrician, who was one of my role models, and the person that really got me involved in medical education. I mean, I was on that committee because I was a young general practitioner in Duluth, but had no experience in medical education. Then when we recruited the new dean, and I got to know him, he called me up one day and said, "How would you like to be chairman of family

practice in our medical school?" I said, "Well, what does it involve?" He said, "Ten percent time," which is a half a day a week.

So I would go up to the medical school, which was the old elementary school on campus. We took over the old grade school. I would sit in there a half a day a week and create curriculum for family practice out of a total vacuum, because there wasn't any. But the program that I developed back in 1970 is still what they use today in Duluth, which got first-year medical students into physicians' offices.

Mullan: The program was a four-year program in Duluth to begin with?

Jacott: No, two.

Mullan: First two, then they went to--

Jacott: Still. Still the same.

Mullan: So it's the first two years in Duluth.

Jacott: First two years in Duluth.

Mullan: The basic sciences, then they come to Minneapolis for their clinical years.

Jacott: Right. But basic science with a heavy emphasis on clinical correlation and clinical experience and exposure. So in the first year, medical students every other week would spend a half a day in a physician's office just following he or she around in whatever they do. First-year student. And you could see them grow. The first week they were there, they had been in anatomy three weeks. They didn't know what end of the stethoscope to use. By the end of that year, they had had their physical diagnosis course and they were learning. They could apply what they were learning by coming out into the office.

Then in the second year, we developed three three-day experiences with a rural family physician. So each of our second-year students--it was a quarter system, fall, winter, and spring quarter--for three days, each student went out and spent that three-day period with a rural family physician. They still do that.

Mullan: Then this is 1970, the program started?

Jacott: Well, the first students came in '72. The dean came in '70.

Mullan: The size of that program over the years has remained constant?

Jacott: No. It started out with twenty-four students in a class, and it is now up to fifty in a class.

Mullan: I gather its track record for both rural practice and primary care practice has been quite good.

Jacott: It leads the nation.

Mullan: Do you know roughly what those figures are?

Jacott: It's more than 60 percent of the students who have gone through that school have gone into family practice, not primary care, but family practice. Close to 80 percent have gone into primary care. Of those that have chosen primary care, probably half of them are in smaller communities.

Mullan: Most in Minnesota, or do they spread out?

Jacott: Mostly Minnesota, but Wisconsin, Iowa, Dakotas.

Mullan: Why has the university not turned their head when they come to the big city, which is so often the story, taking rural kids, bringing them to the big city, they learn the ways medically and socially and don't go back, whereas this program seems to have been able to either recruit or develop within their recruits a staying power for the primary care in rural areas?

Jacott: That's a question that I don't think we can really answer clearly, except in the admissions process, they've tried to identify those students who would be most likely to go into

family practice, regardless of what external influence they have. I think the early and frequent exposure and the positive presence of family practice and primary care have been big factors in that. Certainly, a number of them will come down here from Duluth--transfer down. They all can transfer. They don't have to reapply or anything else, assuming they meet all the requirements up there. But some of them come down here and get involved in pathology and radiology and so on, but not very many. So what keeps them from getting knocked off track during their junior or senior year is not totally clear, except for the previous exposure and selection process that they've had.

Of course, this department down here does everything we can to enhance that, so when Duluth students come down, we welcome them. Many of us are their advisors. We have a large department here, and I would say that the people on our faculty, the bulk of those people, are advisors to most of the Duluth students. So then they have a family physician advising them.

Mullan: Let's pick up your story. You're back in practice.

Jacott: Got back into practice, and then negotiated to have our small group merge with the Duluth Clinic. Spent the next eight years with the Duluth Clinic, again, as chairman of family practice.

Mullan: This is a large multi-specialty?

Jacott: About 180 doctors, all specialties. It was interesting, because, as you know, today that's what most groups are doing. Very few small family practice groups that are not joining in some network of some sort. We decided to do it back in the early eighties for all of the benefits of group practice. Then in 1987, I was recruited to come down here, but not in family practice. I was appointed the assistant vice president for the health sciences--it's now called the provost, but it's the same thing--to work with the vice president of health science in that office. Twenty-five percent of my time was with this department, so I stayed in the clinic one day a week to see patients and teach residents.

Mullan: As somebody who's been in Duluth all of their professional career, what's it like? What were you thinking? Was there a desire to move to a bigger state?

Jacott: Well, actually not. I was called by the vice president. At that same time I had become increasingly active in the American Medical Association. At the time I was recruited to come down here, I was chairman of the AMA's Council on Medical Education. I was on the LCME, which accredits all the medical schools, and I was the president of the Federation of State Medical Boards. So I was holding those positions and became really quite visible within the state as an individual. It was because of that I think I was recruited to come down here, and

because a lot of what I did was external relations and outreach and affiliations and those types of things.

So I wasn't planning on leaving Duluth, but I had gotten so involved in all of this activity, that it really was very interesting, that actually the vice president called me, I think on a Thursday, and my wife and I spent that weekend talking about it, and on Monday I called them and said I'd be interested in coming down. It was that fast.

Mullan: Let's drop back and pick up the AMA story. You had gotten involved originally on the state level?

Jacott: In 1974 I became an alternate delegate to the AMA from Minnesota. Then working my way up, I became a delegate. Then as a delegate, my focus, because of my background, was on medical education. The AMA, like the medical schools, wanted to recognize family practice in sort of a token way. So the Council on Medical Education, they always wanted to have one family physician on just to make sure that they had that representation. That's not true today, but that's the way it was then. So in the early eighties they had identified somebody for the Council on Medical Education, who at the last minute withdrew. So they started calling around, looking at who was a member of the House of Delegates, and they found me. So they said, "Do you want to run for the Council on Medical Education?" I did that in 1981.

Mullan: I'm going to turn the tape over.

[Begin Tape 1, Side 2]

Mullan: This is Bill Jacott, tape one, side two continued.

So in 1981, you ran.

Jacott: So in '81 I got elected to the AMA Council on Medical Education, and then worked my way up to be chairman of that.

Also, in 1974, because I was so active politically in the state, in order to get funding for both our medical school and our residency, I had a lot of visibility with our legislators. There came an opening on the Board of Medical Practice in this state, and several of our state legislators submitted my name to the governor, and the governor's office called and asked if I wanted to serve on the Board of Medical Practice, which I did for eleven years.

Mullan: Starting in what year?

Jacott: '74. During that time then you tend to get involved with the Federation of State Medical Boards, which is sort of the national group. You're probably familiar with that bunch, Jim Wynn [phonetic] and company. So I got on that board in the early eighties. So here I am on the Council on Medical Education and the Federation Board at the same time. It turned that I became chairman of the Council and president of the Federation during the same period of time, which was an interesting experience. It

was at that time that the university down here called and said, "Do you want to come down and join us?"

Mullan: So you had the extraordinary experience of being active on the university side, on the organized medicine side, and on the Federation side, simultaneously.

Jacott: Right.

Mullan: Not too many people have three feet to put in three camps.

Jacott: No. No, not at all.

Mullan: How was it?

Jacott: Oh, it was an interesting, fascinating experience, very good learning experience, and I think it gave me a depth of knowledge of all aspects of medical education, health care, and health care delivery, and probably accreditation that has been invaluable.

Mullan: Taking those three channels, those three organizational points of purchase, tell me a bit about each as you experienced some strengths and weaknesses, that is, academic medicine from the front office to major university medical school, Federation

of State Boards and its oversight of state functioning licensure, etc., and finally, the medical education, AMA.

Jacott: Well, academic medicine has been a group that has been very slow to respond to a very rapidly changing health care environment, and were beginning to wake up only because of competition and draining and decreasing resources. That's what's really driven change within us. We need to even move more rapidly than we are, but we've got the problem of trying to compete in patient care and still maintain our mission of education and research. That's difficult, and I'm not sure we've really solved that one.

Mullan: The university here is always cited as an example of an academic institution that's gotten into deeper trouble, or its troubles surfaced earlier, than others.

Jacott: But yet it's one that is struggling now to make that change. So we're changing our eighteen departments into one group practice, and with my background coming out of group practice and private practice, I've been playing a major role in that activity. At the same time, we are merging with a big health care system in the Twin Cities, the Fairview System. So that Fairview will take over the operation of our hospital and clinics, and we will be part of a private health care system, but still maintain our education and research mission. I think those two moves are going to allow us to survive.

Mullan: Just to follow through this theme of academic medicine in a changing medical, economic environment, is it fair to surmise, as I've heard surmised, that the university has gotten in deeper, higher risk than many others, and if so, why has that been? We talked a little bit about it in terms of engineering.

Jacott: We have gotten in faster. I don't know if it's deeper, but it's faster, and the reason is because of the Twin Cities health care environment and the high penetration of managed care in this area. We're probably at 80 to 85 percent managed care, and very little of the old fee for service. What fee for service there is is discounted fee for service. So we've just been in an environment where these changes have occurred more rapidly.

Mullan: What has that meant? What is inclement for an academic medical center about an environmental that's heavily managed?

Jacott: If you have situations where patients don't have a choice and where physicians don't have a choice of where they can refer their patients, then very quickly the pool of patients available for education and research are not there. That's really what it amounts to.

Mullan: Has that happened in terms of census?

Jacott: Oh, sure, the census is down in the hospital, and the out-patient visits are down. Well, it's a gradual slope in the

downward direction, to the point where we're probably at about 60 percent of previous activity.

The other problem is that the Twin Cities probably has a thousand more hospital beds than it needs. So somewhere those have got to disappear, and there's got to be a lever. Now more and more care is carried on in the out-patient setting anyway.

Mullan: Has there been a similar diminution in out-patient visits at the university complex?

Jacott: There have in some areas. We in family practice have not seen one. But one of the things that we did in this department was we developed our own HMO, which is a Medicaid managed care product. The whole reason we did that was to have more patients for our training programs.

Mullan: That's the U-Care MN System?

Jacott: Yes.

Mullan: As you've seen the growth of managed care from all sides of town here, and functioning, as I understand it, is in a not-for-profit environment, as in by law, I gather.

Jacott: Only state in the union.

Mullan: Right. What has been the level of interest and delivery on the part of the managed care organizations in terms of education? Are they doing it? Are they talking about it? Are they doing it? Are they doing much of it?

Jacott: Some are doing it, most are not excited about funding it, and many are beginning to develop quotas for the physicians, which really eliminates the ability of a physician to have a student or a resident. Not so much a resident, but a student. Because they can't fulfill their quota.

But on the other hand, of course, our HMO in this department is dedicated to education and research. So there's sort of an exception, but the other nine HMOs in Minnesota, it's variable. Some have made a significant commitment to education and research, and actually have developed, like Health Partners has developed an educational research foundation. You probably learned about that.

Mullan: Talk about that. I was not clear how functional it was.

Jacott: Well, it's just getting up and going. But we have representation on the board, and we hope that it will be functional. At least it's there.

Mullan: Yes. I ask this not just to probe or biopsy Minneapolis, but since you're so far downstream from where everybody else is headed, do you have hope that an environment

which is heavily managed care will developed some kind of *modus vivendi* with the established university teaching system to continue to provide or play its part in providing education on that?

Jacott: Yes, I do. I do. I see that. Well, I see that with the Fairview merging. There's a lot of excitement within their system about education and research, and then actually having more involvement. I see it with some of the other systems in town also, but there are those who are in it for the bottom line, and the bottom line doesn't support the education and research.

Mullan: That would seem to me what's so key about what's going on here, because to the extent you have some protection and some buffer, given the not-for-profit nature of these institutions, it would seem that you have an organism here in which education could be moved out into the managed care organizations and delivery settings, whereas an environment where you've got some who are marching to a not-for-profit drum, but others who are marching distinctly to a for-profit drum, and are not going to be education or research, then you're going to have an environment in which everybody can sink to the lowest denominator, which is a non-academic, non-teaching, non-research, and that will create problems.

Jacott: Yes. I don't think our medical student education and resident education is probably 50 percent out-sourced right now, beyond the established academic health center.

Mullan: Off campus?

Jacott: Yes, and we haven't seen that change all that much in the last five years. Of course, in family practice, we've been much more than that. But a lot of the other disciplines, they're out there, too.

Mullan: It's not rapidly moving up. You're not going to 60, 70, 80 percent.

Jacott: No. Well, but I'm not sure that we want to do that. There's a certain core that needs to be here.

Mullan: In terms of your role, in going back on the personal side within academia, this is your second time as interim chair of the department?

Jacott: No, this is the first time I've been interim chair of this department. I was chair of the department in the Duluth school early on. But that was really not even a department, that was a section, because it was a basic science school.

Mullan: Then you came to the assistant vice chancellor role here.

Jacott: Right.

Mullan: And you occupied that between 1987 and 1995.

Jacott: '95. So a year in October I will be here.

Mullan: Right. [unclear] to the chairmanship here.

Jacott: Right.

Mullan: How's that been?

Jacott: It's been great. It's been great. I started in general family practice, and I started my career in medical education and family practice education, and now I'm back in it managing one of the largest family practice departments in the country.

Mullan: How large is it?

Jacott: We have an annual budget of $25 million, nearly seventy full-time faculty, 150 residents, and counting our HMO, 400 employees.

Mullan: How many different sites?

Jacott: We have seven clinics, plus we manage the program in human sexuality, which has its own clinic. We really manage eight clinics.

Mullan: Impressive operation.

Jacott: Yes.

Mullan: In terms of your life as an academic administrator, both in the chancellor's office or the vice chancellor's office and here, how do you feel about that? Is that a new development? Do you feel torn?

Jacott: No. I'm enjoying it very much, and I feel this would be a great way to finish my career as a health professional.

Mullan: You won't miss the twenty-four-hour, seven-days-a-week clinical--

Jacott: No, and I'm still in clinic one day a week. So I'm still in direct patient contact. I delivered probably 1,500 babies in my career, so I don't miss obstetrics. I paid my dues.

Mullan: Let's then go back and pick up the AMA organized medicine theme.

Jacott: That was interesting, because I was sitting at a nurses' station at a hospital in Duluth minding my own business writing on a chart, when the president of our local county society came up and said, "You're just the person I'm looking for. I'd like you to be the local arrangements chairman for the state medical meeting."

I said, "Well, what does that mean?"

"Nothing," he said. "The staff does everything."

I said, "All right. Put my name down."

It turned out I had to do a lot, and when you're done, in Minnesota, in those days when you were local arrangements chairman for the state meeting, as a bonus for doing that, they made you the second vice president of the state Medical Association. Therefore, you had a seat on the board of directors of the State Medical Association. So I became second vice president, went to the board meetings. One of the board meetings I was at, one of the AMA alternate delegates announced that he had to resign because one of his partners left him and he couldn't get away for the meetings and so on. So they looked around the room to see who were they going to appoint as an AMA officers delegate, and there I was. So I got appointed an AMA alternate. I had never been to an AMA meeting. I'm not even sure I was a member of AMA at that time. I probably was, because I always felt it was important to be a member.

So I started going to AMA meetings, and that's how that career started. Then I went on through all the chairs up through the council on Med Ed, and then had a number of people say, "You

know, you really ought to run for the board. You've got a background that's different from a lot of people who are on the board, and you could add a lot to it." So I thought about it and had a lot of encouragement. In '89 I ran for the AMA board and was elected. Then I've been re-elected twice, so I'm in my third term.

Mullan: What is running for the AMA board like?

Jacott: It's a very political process. There are 450 members of the House of Delegates that vote for you, and you have to get a majority of those to vote for you. So you do that in a variety of ways. You have people campaigning for you; you make phone calls during the year; you write letters; you go to the meeting; you give speeches;, you talk to people; you give away boxes of Wheaties; you do anything you can to be elected. But a lot of how you're elected, I think, has to do with how people see you, and how you present yourself, and what you stand for, and what your experience has been. I've seen very few losers elected to the AMA board. The people who have had all those qualities.

Mullan: As an experience going through just, again, the election process, is it substantive in the sense of issues that are topical? Or how much is it substantive? How much is it student government where you've got to be on the right side and know the right people?

Jacott: It's a little of each. You've got to know the right people, and have not rubbed the right people the wrong way. But setting that aside, and assuming that that's okay, then you really also have to know the issues. Many of the caucuses and states will spend a great deal of time questioning you on them and getting your views.

Mullan: How have you been seeing those as a primary care physician, or, specifically, a family physician, and also as an academic? Those are both issues that are not mainline statements I don't think to the AMA board. Am I correct?

Jacott: No, it hasn't--I've been almost the only one that comes from academia, although now there's more. There's five of us now in family practice on the AMA board. So there's more and more primary care.

Mullan: Does this represent a resurgence? I mean, if you're going back eighteen years ago would it have been?

Jacott: Yes, fifteen years ago there probably would have been one or two, but there always have been pretty good representation. When you think back, I mean, you go back to the days of Bill Rial, who was Speaker of the House, and then President of AMA, I don't know if you knew him, but people like that, those are all family docs.

Mullan: Family medicine's not been neglected.

Jacott: No, family medicine hasn't, but academia has. So that's the one component that I bring and the one place where they look to me for comment and expertise. But also I bring several other dimensions. I bring group practice instead of solo practice. I bring credentialling and accreditation, which I've had vast experience in, and credentialling, including credentialling in individual such as the state license, and credentialling in medical school. Then I also bring in experience in managed care.

Mullan: One presumes that you think these experience has been valuable, since you stood for election again, and devoted time.

Jacott: It has. It's been an exciting experience. As I got busier here at the university, I've had to make decisions about higher office in AMA. Actually, my state association wanted to nominate me for president this last June, and I declined. Several of the last presidents have spent 200 days on the road each year, and I couldn't do that and be chairman of this department and work here at the university. It isn't like a one-year commitment. You're president-elect, and president, and past president, all of which you have a lot of responsibility.

So I think that's something that we in organized medicine have to figure out. Traditionally, many of the people who have been president have done it as the last thing in their career and

then retire, because if you don't retire, you come home and you've got nothing to come home to. So it is a tough responsibility. I didn't know at the time I made the decision not to run for president that I was going to be chairman of this department. But I was so busy in the provost's office, that I just decided that I couldn't do it. I couldn't be president and work here at the university.

Mullan: AMA, obviously, over the years, comes in for a lot of criticism from various sectors, but let me cite some of the common issues, and my interest would be to hear you respond from not so much the inside, but from the perspective of a leadership person, in that the organization has been conservative and out of touch with, or not as in touch with, certain patient interests that they might have been [unclear] trade union, that it hasn't appealed to young physicians, and that [unclear] has fallen below 50 percent of AMA members, that it has been stodgy on certain issues, perhaps even hypocritical in the sense that it espouses certain things, but backing congressmen, not espousing, tobacco being one. As you function from the inside, how do those commentaries play?

Jacott: Well, first of all, I think you need to recognize that AMA has changed a lot in the last ten years, and we've gone from the good old boys' club in the smoke-filled room to a diverse organization that does have a lot of the important public health and patient care issues in the forefront. So I don't have any

problem when people criticize some of the things in the past, because it's true, but yet it isn't the case today. It's easy to cite all kinds of reasons why that isn't true.

Now, the membership is a difficult problem, because we do have less than 50 percent of physicians in this country are members, but the problem is that they can benefit from the AMA without joining. People can get the journal; they can get the AMA news; they can benefit from our lobbying in Congress; they can benefit from everything we do; and they don't have to pay. So we don't have that hook that brings people in as members, other than saying, "I really should join, because they're doing a lot of good things on my behalf and on behalf of my patients." Times are getting tough for a lot of physicians, and their income is going down, and AMA state and county dues is more than $1,000 a year. So doctors are looking at that very seriously just from the cost. If they can get the same benefits without it, then they can take that $1,000 and go to a CME thing, or buy a home computer, or something else. As you know, a lot of health systems and clinics now are giving an allowance to their doctors, and under that allowance they put travel, computers, CME, and dues, and you know what comes out in the bottom.

Mullan: As you characterize the organization changing, or moving ahead, what sort of environment do you find the board and the leadership? How would you characterize it?

Jacott: Well, I think the word is "diverse," because we've had young physicians, women physicians, African-American physicians, international medical graduates, all of whom are sitting members of the AMA board right now. That wouldn't have been true ten or fifteen years ago. We will elect our first woman president next June. We just had our first African-American president finish his term, who is now elected to the board of trustees of USUHS, Uniform Service University. So there has been a big change, and we continue to see that. We still are influenced by the solo fee-for-service physician who wants it to stay that way forever, but their influence is not anywhere near what it used to be.

Mullan: Is managed care something the AMA is dealing with?

Jacott: AMA is not anti-managed care, even though many of the physicians are. We deal with it and feel that it's important that those who are involved in managed care need to be part of that process, and we need to be concerned about that. We developed the so-called Patient Protection Act, which was proposed and dealt with a lot of the managed care issues, the gag ruling, the full disclosure, due process, etc., particularly full disclosure to the patients. So we've spent a great deal of time on those issues, and I've gotten those issues to rise to the surface before the policymakers.

Mullan: In terms of the future of organized medicine, do you see the AMA continuing to play a role? It's been argued by others at

groups such as the AAMC, and perhaps the ACP, and the American Association of Physician Executives, and others are playing more prominent roles, and AMA less so.

Jacott: I think the AMA will continue. I think that kind of an organization is needed. Even if we went away, I think someone would reinvent us in some form. But I think we need to be more cognizant of these other groups and their needs, and we need to find ways of working together to avoid duplication. One of the things we did in the last couple of years, the so-called Federation Study, which was a way of trying to bring it together, many of us feel we didn't go far enough, but hopefully we will be able to find ways where all of organized medicine can work together towards our common goals, and not have everybody going off in their own direction and protecting their turf.

Mullan: What about the specialist-generalist schisms in the country?

Jacott: Well, that's one of the toughest things we deal with, because we can't take a stand on one side or the other. The primary care physicians are finally sitting back and saying, "It's about time we've been recognized, both in compensation and in quality, and those specialists who had been"--I'm the messenger here--"who have been ripping off the system, it's about time they took a cut in pay." Those are the issues we have to

deal with as an organization that supposedly represents all physicians.

Mullan: That must be very tough.

Jacott: That's a hard one.

Mullan: How about the IMGs [International Medical Graduates]? They have clearly staked out the AMA as an important representative group or place to make a stand. How does that play out? Is that seen as reasonable, or are they seen as very self-serving?

Jacott: The IMGs play an important role in membership, and in membership in our House of Delegates, and are in the process of forming their own section within our house. But there are some delicate issues there, because when you get into funding of graduate medical education, you get into some tough IMG issues. Should the federal government be funding slots that are occupied by non-citizen, international medical graduates? Those areas we have to be very careful, because we want to be fair. So we have tried to do whatever we can to involve the IMG and make sure that we also recognize their concerns and their problems.

Mullan: Where is Bill Jacott headed? What between these many hats that you're wearing and have worn very respectably--

Jacott: I'm a family physician, and I intend to, if I can, become chairman of this department, not just the interim chairman but chairman, and finish my career as chairman of this department. I will finish as an AMA trustee in two years, and I'm ineligible to run for re-election. I don't plan on going any further within the AMA.

I have been a commissioner to the Joint Commission. I will probably be elected vice chairman of the Joint Commission in a week, and if that in fact happens, then in two years I will be the chairman of the Joint Commission. That will be a very interesting way, in addition to being chairman of this department, to finish my career in both education and organized medicine and accreditation. So those are my plans, and beyond that is retirement.

Mullan: Tell me a bit about family.

Jacott: Well, that was probably the main reason I didn't run for AMA president, was because we have a very close family. We have three children who live here in the Twin Cities. One is married, and we have a grandson who just came less than a year ago, October. We have a son who's getting married in December of this year, and a daughter who's getting married next year. Those are our kids. They all live in the Twin Cities. We're very close with them, and with all the activity going on, with those kids, our grandson, and their significant others, if I were running

around the country more than I am, I would miss out on an awful lot of family. So that means a great deal to me.

My wife, she gets mad when I introduce her as my first wife, but she is, and we've been married thirty-three years.

Mullan: What does she do?

Jacott: She's a homemaker. She was a nurse. Met her when I was in medical school. She was in nurses' training here. We got married when I was still in medical school. She worked as a nurse on and off, but mostly she's a homemaker. Volunteers at the University Hospital.

Mullan: She, I presume, has been pretty supportive of your work?

Jacott: Yes, very much so. Very much so. And very often travels with me when we go, because the kids are all grown up and we don't have to worry about that.

Mullan: We've touched a lot of things, and your career has touched a lot of things. Is there anything that we haven't touched on that you'd like to get on the record or comment on?

Jacott: I can't think of anything. The Joint Commission was the one piece that I felt I wanted to slip that in. But otherwise, I can't think of anything else that's of relevance to what you're trying to do.

Mullan: The thing that's so interesting about what you've done, I didn't have any sense of the scope of organizational involvement, but you have played leadership roles in such a set of national organizations having to do with medicine, while at the same time keeping your feet on the ground as a generalist practitioner. To have all these national appointments would be tough to do, but certainly most people who do them would wander off into the imperium of organizational politics and activities, but you seem to have kept rooted in practice. You've done that, I presume, purposefully.

Jacott: Yes.

Mullan: Why?

Jacott: I like Minnesota, for one thing. Obviously, as you suggest, I've had opportunities to leave. But I enjoy living here in Minnesota, and I visited a lot of other places where I know I wouldn't want to live. So that's a big part of it. But the other is I've always felt it's important to maintain my roots, and that's what I've indicated, I'm a family physician, and I need to keep that as the centerpiece in what I do.

Mullan: Is that intellectual or spiritual or financial? How would you characterize what it is that makes you want to go to clinic once a week at the least?

Jacott: Oh, I think it's important in all of my positions, that I maintain my reality and credibility as a physician, because most of what I'm doing and where I am is because I am a physician first. So when I sit down with the other clinical department heads, and they know I'm still seeing patients, it gives me more credibility. But it's also the personal satisfaction of seeing patients.

Mullan: I think maybe that's a good place to end.

Jacott: Yes, I think that's fine.

Mullan: Thank you.

[End of interview]