Interview with Daniel Mazzuchi
March 20, 2009
Marquette, MI
By Russell Magnaghi

START OF INTERVIEW

RMM (Russell M. Magnaghi): Interview with Dr. Daniel Mazzuchi, Marquette, Michigan, March 20th, 2009. Okay Dr. Mazzuchi, I start with my usual first question. Your birthdate?

DM (Dan Mazzuchi): May 10th 1939.

RMM: Okay, now could you give us a little background about yourself, where you grew up and were there any influences, directions that got you to move towards medicine?

DM: It's interesting, I was born and raised around Washington D.C., my dad was a lawyer there, he had gone to a catholic university. He's from an Italian immigrant family in the east coast. My mom was the daughter of an attorney who had become the dean of the law school at catholic university. They met there, got married and I was their first child. The idea of, I'm smiling because I can't help it, the idea of what you become is interesting and is different from family to family, but a lot of immigrant families in those days regardless of French, Italian, Germany, anybody from the European area, education was everything, so people who were very, very poor, who themselves had never been educated, made education of their children their entire reason for living. Because they felt and I think with a good deal of justification that education was the way up, so from the time I could remember my father and my mother always said to me, "Danny, you can be either a Doctor or a Lawyer, the end." So if you ask about influences I would have to say that, that message ringing in my ears was probably the greatest influence. I would like to believe that I had some of my own and I think that I did but certainly that kind of reinforcement, not only a lifelong plan but a no nonsense attitude towards education in general. If you came home, if anybody in my family came home with less than an A, you really had to explain yourself and life could be quite miserable for you if you didn't do that, so achievement in school was a must and that's the reason for it. They thought the whole future of your life was at stake if you didn't do well.

RM: So that was the influence and what university did you go to?

DM: I was trained in catholic schools, Fansiscan Nuns for eight years and Jesuit Priests for 8 years. Went to high school in Washington D.C. at Gonzaga high school there and then went on to Holy Cross college in western Massachusetts and then a relatively small place, famous for basketball, Bob Kuzie and other people have, but also famous for its pre-med program and when I got out of there I think I had had enough of catholic schools in general and I went to George Washington University in Washington D.C. and did my medical education there and then my residency in affiliated hospitals, D.C. General Hospital and the University Hospital and I did a fellowship in renal disease. One of the probably first hundred fellows in the country in renal disease and especially because renal disease was brand new then and

then I went into the Navy like everybody else went into the service in those days. Came out and wound up in Marquette by a whole bunch of accidental things that I don't even begin to understand and I have been here ever since.

RM: Was there one particular individual or something that got you to come to Marquette?

DM: No my wife and I had seven children and we were looking for a smaller community to raise them in. I had always planned to go back to Washington D.C. but the bigger my family got the more inhospitable I thought a large city environment would be. I planned to go to New England my wife was from New England, my dad was from New England, New England was my second home and just saw an ad in the New England Journal of Medicine for this place and I made a phone call, didn't know where it was, didn't know there was a U.P. Got on a plane and flew out here and thought to myself, man this looks like New England, feels like New England. A lot of the people who founded this place were from New England. The houses look like New England houses. Even some of the names there's a Clark University, and the Clark family is big here, Clark university of _____, they happened to be related I thought gee whiz and it was in December and there was lots of snow, it was fine to me. In those days there was no formal recruitment program at all. We took care of that ourselves and we didn't have any money and so buying one plane ticket was hard enough to ask because my wife couldn't come, so I made a tough phone call I said, "This is it I think." She said, "Okay, buy a house." And I did and we're still in the same house and I might leave that house but she never will, so it's just one of those accidents that worked out. It was a nice fit, the community needed what I did at that time. There was a women whose name was Sarah Hawes, I believe. She was a school teacher and in those days and she was dying of kidney disease. In those days there was no insurance for Renal Dialysis. The federal program to support people on renal dialysis came into effect right as I came here. HR1, it was the first bill considered by congress that year and basically provided for Dialysis. Subsequently the law was changed to provide for transplantation as well under the Medicare Act where it still resides and so this community as the same as many others in that regard. There was someone who known in the community and was dying and the cost of in-patient dialysis back then, 40 years ago was twenty five thousand dollars a year, lord knows what that would be in current dollars, it was an enormous amount of money, so there were relatively few people who could afford any kind of dialysis. Community fundraising was necessary to keep somebody alive. Charley Wright, who I know you've already spoken too and who was the Dean, if you ill, of the internal medicine group at that time somehow managed to get a machine and he hadn't been trained but he kind of taught himself he was an amazing person in that and many other regards, he was looking for somebody to take it over, obviously there were other people applying and so my task was to find a way, when I first came here, was to find a way to bring dialysis services to the community and I had to set up a dialysis unit but I had to do it in some sort of context. People had to be trained. The community had to understand what was going on. The hospital had to buy equipment. Nobody really knew what this stuff was. I remember having to go in front of the board of Trustees at the hospital to explain what these things were and I remember being quizzed, "Well you know is this something we would make money on or lose money on. I mean what's the cause?" Nobody new and above and beyond that transplantation services were coming into view, nobody knew anything about that .The idea of transplanting organs was then and is to me still now somewhat ghoulish. It's a ghoulish concept, it's something that people feel

simultaneously elated about and reticent about because you're talking about some pretty basic things now. Most donations in those days were cadaver donors that had to be matched. There was no social service ability of anybody here to deal with that or anywhere else for that matter. These things were brand new, so I remember I needed to hook up with something. We just couldn't be whatever we were going to be sort of hanging out there. We had to be part of something because we needed training, we needed education, we needed consultation, we needed all kinds of stuff. I remember getting into my car and driving all over and making a million phone calls and finding out if there was anybody anywhere in Wisconsin or Michigan that we could hook up with and basically the answer was no. Nobody wanted us, we were too far away. The world was too busy and we were too tiny an esoteric place and finally I found a regional kidney disease center in Minneapolis and they were willing. There was a pioneering guy there named Shapeero, Dr. Shapeero a spectacular person. He had developed, he was in Minneapolis and he had developed a way to try and bring together people from smaller communities. He went all over the Dakotas and had people like us, very much like us, smaller communities, isolated but trying to bring these new services in and he had designed a team, a support team, wonderful people, social workers, all kinds of physicians in the field, people to train people, a communications system, a continuing education system and so forth and we hooked up with them and one of the absolutely wonderful outcomes of that was that we could get transplantation services here and by that I mean we, they had a transplant team on call 24 hours a day. If we had somebody who wanted to donate an organ who was dying or who was dead, you know about to die. We could call them and they would fly a team in here and they would go to the operating room. They would harvest a kidney or two kidneys and if there was a match, a genetic match I got first dibs for one of my patients so that was the quid pro quo and it was wonderful. It cut the wait time down enormously for us where otherwise it might have been prohibitively long. There was then and there still is now more demand for transplanted kidneys than there is time or availability of organs, so there are a lot of people who are on dialysis who die waiting for transplantation and life on dialysis is at best unpleasant and certainly risky. The kidney machines are life saving things but they don't correct a disease they simply allow a person to live, so whatever disease process is present that has caused your kidneys to fail, continues on its merry way and the disease processes that are pertinent to this discussion are relatively common diabetes, high blood pressure, coronary artery disease, but there are many other kinds of diseases that have systemic component to them so people who are ill remain ill form their basic disorder, though the life saving function that the kidney provides is taking over by the machine in terms of regulating water balance, getting rid of protein waste, regulating electrolytes and so forth, so its an unpleasant way to hang on. Some people adapt to it readily and some people certainly do not and of course there are many, many factors that relate to that age and just the kind of disease you got and other diseases and other complicating illnesses of which there are, obviously, quite many. Anyway, so having availability of transplantation was spectacular and also having the ability to send nurses and business people all that stuff to Minneapolis every year or whatever, more often, for continuing education and so forth, it was great. In those days the hospital had just merged and we had space because we had two places, what is now the Jacobetti Veterans center as I'm sure you know, was Marquette General Hospital South and the dialysis unit, my dialysis unit I call it that because I still feel some type of ownership over it was housed there. Just basically as you come in the front door off to the left just before you get to the patient care areas. I had a four bed unit or something like that. Some of the people who were, well certainly one of the people who was very much involved as a nurse

and an aid in those days you're going to be talking to and that's Margarete Turner, that's where my friendship with Margarete began. I'm sure she has lots of memories about that and there are lots of people whose faces I can still see. There is one young women in this community who I still run into who was dialyzed then who was in terrible, terrible shape and is in the community now having been successfully transplanted after being on dialysis for many years and got pregnant, named her baby after me I'll never forget.

RMM: Dan or Mazzuchi?

DM: (Laughter). Anyway, yeah those were very interesting days. It brings up another interesting and honestly I think an important thing. As I said, I referred to the concept of transplantation as ghoulish, my term perhaps others don't feel that way but it is. I mean it's certainly an invasive thing and it is fraught with potential religious and ethical hazards. The process by which living organs are attained from one individual and given to another, there is much debate about what is death and how is death defined. That debate continues to this present day, because the concept was what it wasn't because it was certain, relatively very new concept for this community. In anticipation for it I thought it would be best somehow to have an open ended honest straightforward discussion about what we had hopes for and what we planned to do with the religious community of Marquette and to get there questions on the table and their concerns out there. I still remember Carl Hammerstrum who was here and was my colleague and partner, fellow internist had everybody over to his house. We invited every clergy man in town and we had a ham and a roast beef and some pot and some beer and some stuff and we sat there. I don't remember how many there must have been at least 20 of them that showed up. We sat there and put everything out there and talked and listened and talked and form that initial meeting others came about and a friendship was built between several of us and many of the clergy all denominations and a working plan was put in place so that whenever a person had come into the intensive care unit with, let's say a brain injury or something from which there was to be no hope of recovery and where organ transplantation was something the family desired or wanted to at least discuss. I promised I would never be involved in that discussion until after the clergy men, their own clergy men had gone in and discussed the possibility with them and then and only if they had desires after that discussion to have their loved one provide organs, then I would discuss how that might be done otherwise we wouldn't go. We kept that up for all the time I was involved in it. It also led to a discussion, a general discussion of the history of religions, various and sundry religions and medicine and how Christianity and or Judaism and or Islam and or Buddhism had considered medical principals and how culturally the peoples who practiced these religions respond to death, to pain, to suffering, to dilemmas to moral dilemmas. That led to a lot of other things. It led to a course that we taught to medical students who were here. It led to a wonderful, truly wonderful what I will call road show. Mike Coin representing Christianity, Chris Ahmad representing Islam, Aaron Schoemack representing Judaism talking about the history and the feelings and the culture of medicine in those various religions, took rotaries, took community groups all over town, there were a lot of things that came out of it that were interesting and unique, I think, in many ways and that I remember with fondness.

RMM: So you avoided a conflict, a religious medical confrontation.

DM: We didn't have any confrontations at all. I would like to think that was for a couple of reasons, but certainly one of those reasons that we had set that up and we never pushed, we never got in anybody's face or anything like that. We always had the clergy men involved first. I mean it was important to people, many people want to have their loved ones organs reused. In these days we have our own desires in those regards. We have directives that we carry with us, I have one in my pocket, legally in the state of Michigan you can do that, but in those days this was a relatively new thing and you must, I mean it's a fearful thing. Death is a fearful thing, especially traumatic death, especially sudden traumatic death and people need information and trust and that's not something that is readily available in some fresh, aggressive nephrologist passing down the hall and jumping into somebody's room and asking for somebody's kidney. It has to come from sober inflection and contemplation, religious belief, cultural belief, with the information given in a very supportive way and what better way than by your own family physician and by your clergy.

RM: Now you were involved in the program, did you have additional positions to mend and could you just kind of talk a little about the progression of the program?

DM: I'm smiling because I worked really hard and so did my colleagues to try and get somebody else to come in. We had a steady stream of young guys coming out of fellowships and I just couldn't get anybody, so all of us were quite busy. In those days there were fewer than 40 Doc's in town and there's over 250 now but back in those days and there were more people and we were swamped. I counted my charts off in my first year of practice, I had over 2500 full time patients of my own after one year of practice, which is an enormous amount. I mean in those days too, I was trained as a nephrologist but I was trained first as an Internist and so we did internal medicine and methodology, internal medicine and ____. Nobody did pure specialty work in those days, so we had huge loads that we were on call frequently and of course I was the only nephrologist so I was on call for kidney disease, every single day and every single night for as long as I was here. I'm not trying to imply that my phone rang for renal problems every night and every day but you couldn't get away from it, nobody else knew and it wasn't until, oh gosh, I think it was five years before I was able to get somebody.

RM: Now you came in?

DM: '73.

RM: So you did produce all of these, this whole program and so on and then at work and then-

DM: Please let me say I had enormous backup from my colleagues, I don't recall, I mean in retrospect it was imperfect but in my memory I don't recall ever being in such a uniquely supportive group of people. The internist that I practiced with from the ____ were good. I mean all of us, they had their agendas too, GI was just beginning, cardiology was just beginning, this was the beginning of all medical specialties and the development of technology made specialties particular. I trained from the time of zero technology, there wasn't any. The only technology that was available to us was an EKG machine and an X-Ray, there wasn't anything else and so cardiology, GI, all those things, all those specialties now are defined by the technology. The technology allows you to not only invade but also to accumulate data that simply wasn't available to us and so you can call it what you will, I mean I think of it in very fond terms, but I

have delusions, it was very primitive with what we were trained in. It was pretty primitive and so the time period that we are talking about, in the seventies especially, seventies, late seventies, even into the early eighties was developmental for medical specialties, because technology was just basically coming on. I told the story many times but when I trained at George Washington University Hospital and I did my fellowship with renal disease. We used a **cult**, Dr. Cult just died, just a couple months ago, but we used a cult twin coil dialyzer on an old washed up looking dialysis machine. The serial number on it was 002. At Kennedy or even earlier than that, so yea I was at the very, very beginning of medicine.

RMM: So when you were going to school, training, was there any discussion that something was on the horizon, something's out there or you were still trained in the old without this?

DM: We were trained with what we knew, what people knew. Obviously there were people, a transplantation was a possibility, a little possibility. The things that we see in our lives now 35, 40 years downstream that we take for granted and stuff – they weren't even thought up. I think it's, in terms of, you can look at modern life in many ways and I think the commonest way people look at it, especially young people is that the information is available, the information age, how to use information, how to use computers, people take that for granted. It's still a foreign concept to people of my generation. We adapt to it and learn how to use it and, you know, depending on who you're talking to a more or less rudimentary way and to me I think of it as a language that I have a small vocabulary in. When I look at my grandchildren, it's just part of their life, just something they learn and that they intuit and none of that stuff existed. You can get very precise about invasive methodologies of medicine and for us old people it just blows our minds, you know, to see the kinds of invasive radiographic techniques for example that are available now and that we do. Cardiac Cat Labs. The skill sets that were necessary for people of my generation were information gathering from knowledge of the Natural History of Disease, that is to say, understanding from the experience and writings of others. What disease processes looked like, smelled like, the very earliest drawings, or their presence in human beings and what they developed into left untreated. Being able to identify that, that combination of looking, listening, touching, feeling, using senses, the cussing, I could still percuss a lung, but I don't all those things are completely irrelevant. You couldn't plug something in to get a bunch of data so you had to have a sense of how things were and then be able to assess it using your senses.

RMM: So is that when you go to the doctor and they would tap on your-

DM: That's true, I could still do that. I mean I would have to do kidney biopsies on people, without anything, blind. I'd remember doing liver biopsies and you would have to percuss the ___ of the liver you had to be right. You didn't go sticking needles into, you know, it is so different, it is so incredibly different now. Thank God, I mean, you know, on the other hand. See I don't know how relevant, probably isn't relevant at all, but those kind of history gathering talents on physical examination skills were something to marvel at. We used to go to Grand Rounds my first time at University at Washington D.C. and there was a cardiologist there who would, who could listen **au scope** a heart and _____ because they had developed in his mind so completely he could draw the EKG and could measure intervals. His name was Bachloharvy, he was a very famous man. But, he could listen, he could hear and draw sounds to the hundredth of seconds, incredible, absolutely incredible. Just using his hears. I mean

so what, today you plug someone in, oh that data comes through you and you don't need to listen to anything but I say, part of the nostalgia is that all groups of people regardless of your trade or your skill, yesterday how things used to be, what the challenges used to be, what you had to do to overcome them. I think that it's true certainly that it's related to technology. Information for that matter, you know most of these things get erased by time, irrelevance disappears and what you're left with is a bunch of old guys that know how things used to be. It's kind of interesting but that's all it is, it dies when something else happens at work.

RMM: Now could you tell us a little bit about your perceptions of the medical community in Marquette when you arrived here?

DM: Yea well, I think probably the most important reason, there were several reasons but the most important reason I think that rubbed off was, at least in my estimation of quality, was the people who were here and the sense that they needed to develop and grow, that's why people were being recruited here. They were basically looking, this is the internal medicine group by the way they were doing this on their own. For that I credit the ones that were here before me, they had a notion that they needed to grow and develop and they made it their business to try and do that and they were all very well trained people. There was very little of any turnover, people weren't coming and leaving. They were coming and staying and so, yea, I think without question that was the major reason other reasons had to do with the community, it was a wonderful place to be, the school system was spectacular, again, it might be worse now. I look at the public school system here and the challenges it faces, especially the monetary ones. I do worry because I feel that quality has already been infringed upon. I think that if it that is so and if it continues to be this way that people are going to suffer and I fear that. Anyway, that was certainly one. The beauty of the place and the availability of recreation, were one of those things, but yeah the quality of medicine was the influence. People were good and there were very, very, few home grown guys and so they were bringing in people from other places and you know I've always felt that a place that is able to attract, I'll speak for medicine. I'm sure this is true in other professions as well, because the issue is ideas. The more insular a group is, the less likely it is to be available, or to avail its self with other ideas. So bringing a doctor in from this place and that place and this place and that place, I mean, we were all talking to each other. John English one of my colleagues that started the Friday Clinical Conference as a continuing education methodology, all of us, all of the docs we all went to all of that. We talked to each other about what we had learned training and what we took an interest for and we referenced the latest journals and research topics and stuff and gee whiz this was not University of Michigan but this was good and the idea was to stay as alert to what was happening in medicine as possible. Now here again, the amount of information, the information base of that day was a peanut by comparison to the information base of today. You can't possibly stay on top, I can't possibly stay on top of the information base of medicine today, you have to narrow your focus enormously to be up to date with medicine today . Back then you still could, it was getting difficult, but I mean we could know, we were all trained to deliver babies, we were all trained to look at tonsils, we were all trained to treat depression. When women came to us we did pelvic exams, we did pap smears, we did all this stuff, you know, we were trained as generalist with specialty interests and training on top of that.

RMM: So today a physician would be like?

DM: Well if you get trained as a family physician and thank god people do that. There are general internists and general pediatricians and so forth, but I mean if you were an -ologist of one or the other, the likeliness is you're going to be an -ologist and nothing else.

RMM: So you're not going to be able to _____.

DM: No you're not going to be trained very well for that and it's one of the problems that people have and it wouldn't be I suppose if there were a sufficient number of people going into general medicine, but there are not. So finding generalist, people who want to be generalist gets harder and harder and harder. They don't make as much money as the specialists do; sometimes they make a tiny fraction as the specialists do. Sometimes they make a tiny fraction of what the specialists do and they are overwhelmed, the demand for their services are far greater than the numbers that they got. For recruitment you talk to anybody in the hospital studying today they are all being recruited and I'll tell you how hard it is to find generalist positions. That's one of the great advantages that this place has is this, for lack of a better term, doctor factory. Its part in parcel of the soul of this place now, thank god, which is we train medical students here. We train nursing, we train family practice residents and many other kinds of technologists and so forth and the graduates of all of those programs in context of this discussion graduates of the medical school and the graduates of business schools in large numbers come back to the U.P., thank god. We would be in enormous trouble. The health education corporation was started back in the early 70's and the residency program which was started 1978. More than a hundred of the graduates of those two programs physicians have come to practice in the U.P. which that's about one in five well approximately graduates of that program, that's a tremendous impact.

RMM: Now do you find that in today's world, is outside of the program you have sort of a native, you know, a local cabaret of young people that go into medicine and then stay?

DM: Very much so, more now than before. That's a large member due to the time. Northern Michigan University has a lot to do with that, the pre-med program at Northern has been cultivated with the specific desire to facilitate careers in medicine, but also at least at the outset, this isn't so anymore. At the outset there was a cultural amphetamine to careers in medicine, which had to do with expectation. When I first came here, there were fewer than two a year, two or three students a year going into medicine out of Northern. Many of the young people that I met in those days had this kind of, "I'm not good enough to do that, I'm just really not. Plus you would have to leave here and I don't want to leave here." I think we have all heard stories about, some of them humorous, some of them not so humorous in my view about the kind of wonderful place this is but it's in solidarity, at least back in the day and this kind of below the bridge, I can't go below the bridge and that was certainly true here. That's long gone and as people have come back and as expectations have risen I think the culture of this place has changed quite considerably and there are a significant number now of second generation physicians here and I think people here think of themselves in a much more mobile and global way than young people ever did before.

RMM: We won't go into it because you've done an interview about the medical school, cooperation and so on, maybe just kind of coming out of your practice, what was the transition from your practice? How did you get into the…?

DM: Damn if I know. People from Michigan State had come up to present U.P. Medical Society a program of medical education they wanted to start here and I have to say I remember being at that meeting and I remember thinking boy is this weird. I mean that's weird, this was a non-traditional medical education program that envisioned training medical students here in the U.P. for four years, I thought that's crazy but at the same time I thought that's great. I mean it's wonderful to have medical students and I mean it's wonderful beyond that to get the docs who are here whom many of them are recent graduates back into a teaching mode. The ancient Greeks had three points of view of medicine – teacher, priest, and healer. In my view medicine has an awful lot to do innately with teaching and I think most of the docs that I know, who I trained with, would have been frustrated by not being able to at least in part teach and so I thought it added to the 'whatever' it was, however weird it was. It added immensely to the professional environment and would in and of itself act positively as a recruitment tool if there were people to teach, there are people who want to teach, they would be interested in coming here and as it turned out all those things were true. Not just for here, they are true everywhere, but with that in mind then there were a handful of us, once the program was started, which it was started in Escanaba. There were a handful of us here, a tiny handful, who wanted to teach and were willing to get into our cars and drive down to Escanaba and teach. We were asked to teach in a format with which we were not familiar, we were asked to teach in a problem-oriented way and an integrated way, so at the same time we're all discussing a disease we discuss the basic science, the clinical science, and the social science of those diseases all at the same time, in a group discussion. So you looked at the anatomy, the pertinent anatomy, the pertinent biochemistry, the pertinent clinical aspects of diabetes for example. Then my job was to teach renal disease. That's where it started and I got sucked into it, so did a few of us. I loved it. It was very much fun and you could feel the value of it. The program changed, as you said we won't go into that, and it became a two year program like all the other community campus in the MSU system. I can't believe that the program has been here now 35 years, incredible. It has done a great amount of work, a great amount of good work, lots of results for people and for the community and I'm sure most people don't know anything about it and it's done a lot for medicine in general all over the U.P. There are people all over the U.P. now who teach our students. Many of them are former students who have come back. So I got involved in it, more and more and then I got involved, I had always wanted a residency program here and I wasn't the only one. There were many people who wanted it and I had been chief of staff here and tried to get a cooperative venture together among community hospitals to support the residency program and I failed. I couldn't do it, couldn't get people to work together. Irritated me no end, disillusioned me and anyway, along comes, here's the guy who runs the U.P. program and has really good working ties and relationships with the Kellogs foundation. He called me one day, he said, "Here's your residency program. We just got a grant of a million dollars." Imagine that now, a million dollars, back in those days, from the Kellogs foundation to do it. Said, "I need you fulltime." I said, "I'm practicing." Said, "Well you got to decide that." I left practice for what I thought was a year and I never went back. One thing led to another, I mean these are things that just happen to you, you know. So, I wound up I wrote the residency program and got it all set up for

Marquette General Hospital. I mean how to write a residency program that's another thing. I got in my car and drove all over place. Went to everybody else who had already done it because I didn't know what the hell I was supposed to do and I had the enthusiastic support of a lot of people, gee whiz. Guys that said, "You sit down and write a curriculum." "How do you do that?" Anyway, we got it down and then one day I got a telephone call from campus that said, "Come on down and be our Associate Dean." I went down there and was the Associate Dean of the medical school for three years and, you know, toyed with the idea of moving on and staying in that. I thought, "You know what? I don't want to do this." I came back, after three years I came back here and became Chief Executive Officer of the Health Education Corporation and that's what I did until I retired. I mean, you know, totally unplanned things that happen to you, you just don't know. I smile about it now but some of it, my wife wasn't smiling, I'll tell you.

RMM: So you said at one point you were chief of staff in the hospital. Could you talk a little bit about your connections with the hospital?

DM: Well there weren't that many of us. There were a whole lot of guys here, I don't know what the list would look like, but probably would look an awful lot like the list of docs you're going to interview. I mean we took turns doing those kinds of things, the chief of staff was a volunteer position, it took an enormous amount of time. Most people don't want that, but it was important, everybody had their own reasons for doing it, it was important to me because it was important that the medical community and the medical practitioners had a voice in the hospital government system and at least that voice could be used for good communication. So much was happening, so much, I mean so many new things all at once, it was a struggle just to keep the information base up for the people who were charged with making decisions, the Board of Directors or the Board of Trustees for the hospital. I thought we needed a full time Chief of Staff and a full time Chief Medical Officer back then and that was 1970 something and we just got our first full time Chief Medical Officer this year. We're one of the last hospitals of this complexity or size in the state of Michigan to do that. There's lots of reasons for that, that's beyond this discussion, but anyway we finally do have one and I'm still cheering. I still have a letter that I wrote, I think that the Board asked me to do that after I got off. I said, "Gee whiz." So much was expected of the person as a volunteer, it ate so much into your practice time and the days were long enough as it was. Plus the world was getting very complex and the world of medical governance was and still was, it was getting very complex. We were growing and we were growing basically in the medical center. We put offices over by the high school, which wasn't the hospital, we weren't integrated and there were lots of people who didn't want us to be integrated and there were lots of people who did, it was a division of opinion there. We weren't sure what we were going to be, there were a small group of us, myself included who really wanted us to be a clinic, you know, a little Mayo clinic. There were a larger group of people, and I think probably still are, who wanted much more a separation between the private practicing positions. There are tons of issues.

RMD: Now, was the, you know, as and listening to your comments and then those of Dr. Wright yesterday there was on the Marquette medicine scene, there was this constant struggle to get positions and new techniques and all this was happening at the same time. Was this occurring in a large city as well, in a large setting Milwaukee, Chicago or something, you didn't have to worry about the personnel

coming in, they were there, so you just had to deal with, they sort of had attractiveness of the urban setting Chicago?

DM: Yeah, all these models that we were looking at and wondering aloud which of them we might become, were in existence. It was then, it is to a certain degree now, but I think probably to a lesser degree except in certain specialties, it was quite difficult to recruit, to get people who we wanted with the kinds of training and skills, fluency and new technology and so forth to leave the classic settings for those things and come, take a flyer, to come to this evolving, growing, little mini-medical center, to cast their lot with us. Especially, those who might in other settings be supportive for a while, maybe for a while, underwritten, we had no way to do that. We had, matter of fact, we had a contravening philosophy, prevalent that felt if you can't make it on your own to hell with you, you can't come here this is an entrepreneurial enterprise and you know its none of our business, no matter how bad we need you, if you can't make it on your own you can't make it to hell with you go someplace else. As opposed to we're a developing growing medical center and we need all the services, not just some and we have to take whatever steps we can to both attract, sustain and develop those services here, whatever it takes and there's a lot of attitudes in between those two extremes and we had them all, so we had no developmentally and organizationally we had no one single concept and that basic spectrum of ideas exists today. It hasn't changed very much. Things have changed, there are hospital employed physicians now, which is again something taken for granted but back in those days was unheard of, although it was true elsewhere. Obviously if you are familiar with the Midwest you know the Mayo clinic. Everybody knows the Mayo clinic and the model that it has and the kind of cooperative enterprise that is, probably you know the Marshfield clinic too and you know the University of Michigan and you know all these things, but those models back in my day and perhaps today, I don't know, but in my day were considered for someplace else no for here and yet many of the people who were bringing here were from places like that, kind of interesting and a dynamic that made for a fairly complete political spectrum because politics, if you use the word politics to reflect ideas, certainly there were clashing ideas involved, although I must say for the most part those varying ideologies about independence and cooperation and so forth were spoken always in a gentlemanly fashion, there was no warfare that I could recall, some more tense moments than others, but for the most part no.

RMM: Is there anything that we didn't cover that you would like to add?

DM: Oh probably a million things, you know I don't know my mind wonders. The purpose of this discussion is to talk about the early days and so I think, I hope that's what I've been addressing. The richness of this experience I just can't tell you. I think when you talk to people of my era, there was so much to be done and so few people to do it. That virtually all of us, did things or participated in things that today would be impossible, I mean there'd be someone around to do that and so I think a lot about this and get nostalgic about it. I have really nothing but good feelings about it. It was a wonderful experience, imperfect, human but wonderful and very complete and anytime I drive by this place, which is almost every day I think backwards and I remember what was here and it's no accident, you know, what we have here now, but still for a place like Marquette, Michigan is an incredible feat, I mean it really is. It's still not perfect and it still has problems in it and right now it's got big problems because of money and politics and everything else but it is incredible that it's here and I pray to god that it

continues to be here because the ease of access to medical care that exists in this community is absolutely unparallel, people here don't realize, I don't know how they could, it's just what they're used to.

RMD: Could you and I don't want to put you on the spot here but-

DM: Sure you do.

RMD: Since you're on the committee just get your comments about the oral interview project that we have started here.

DM: Well as you know this is, the whole issue is a particular interest to me. Maybe that's because I'm one of the older people myself and I have my own sense of nostalgia and history and I value it and I don't want it to be lost. I think the people who are here now and who will be here in the future will at the very least have an interesting story to listen to, if they have the time or inclination to listen to interviews like this. The cast of characters involved were fascinating and I think quite productive. It's also a way, I think, for people to validate their experience. To come in and remember out loud and to walk away, as I know way, from this interview today with a sense of, "Oh gee, that was not only fun, but maybe it was, maybe it was an important story to tell." And I think the last thing is, there's only as I know you know, there's only a small window in time and history to gather this stuff because people die, they move on, their brains get soggy and then the stories gone and so I think this is a really great thing to do and the time is right. I know you've interviewed people from the 50's, 60's, and now the 70's and so forth and that's some of the early, early days of this enterprise now known as Marquette General Hospital, the story of the 80's and 90's and on into the 2000's is going to be, not only equally important, but I'm sure even more complex and interesting to listen too, but I'm awfully glad we could concentrate on the early years before that story gets lost. There are very, very few people here now who know anything about it and it's not only interesting but I think, I know you agree, I think understanding the past helps you understand the future and prepare for the future, so maybe there is something even more important in it then to the listening and telling of story for simple nostalgia.

RMM: Okay, very good, thank you.

DM: You're welcome.