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START OF INTERVIEW

MA: You arrived in Marquette approximately when?

DM (Daniel Mazzuchi): I, my wife and seven kids moved here in May of I973.

MA: You were on the medical staff as an active medical staff member until approximately when?

DM: I was in private practice through I978. I kept active privileges for quite a number of years. I don't remember exactly when because I saw a lot of patients in association with the students and the residency program at that time. And I don't remember exactly when I took courtesy privileges but I think it was probably when I left here in the mid-80's to go downstate to become associate dean of the medical school. And I've had some type of courtesy privileges ever since.

MA: You retired from MSU medical school in what role and when?

DM: I came back here to be CEO of the U.P. Health Education Corporation and retired two years ago... that is, in the late spring, early summer of 200I.

MA: Can you also just give me today's date?

DM: If I can remember I think it's the 29th. Yeah it is.

MA: January 29, 2003.

MA: Can you describe what the medical community was like when you arrived in Marquette?

DM: As I recall I was the 32nd physician on staff. The medical community was small, cohesive, very well trained, a mixture of middle aged and younger folks. It's hard to imagine me as a

young person, but I was a young person then. Its togetherness I think was one of its principle attractions to me.

MA: And at that time how many hospitals were in Marquette and what were they?

DM: There were two hospitals although the decision to merge the two had already been made. At the time I came on staff, you only had to go through one credentialing process for both hospitals. Both emergency rooms were still open. Care units were still operating at the old St. Mary's but they were on their way out.

MA: Can you tell me what services were provided at St. Mary's at that time in general terms?

DM: It's hard for me to be precise. I think in those days they still ran the emergency room, physical medicine/rehabilitation, inpatient psychiatry and then shortly thereafter, once I got it started the dialysis unit. I think the surgery suite and the general medicine wards had already closed and had been transferred to St. Luke's or what became Marquette General.

MA: What was your personal perception of the climate, the medical climate in Marquette around the time of the merger?

DM: It was exciting. It's what attracted me. I mean, we knew no one here. We had no contact before this with anybody in Michigan, let alone Marquette. And Marquette was an unusual place. I had looked all over the East Coast and Marquette was unusual in that it was a group, albeit small, of very well trained and very cohesive individuals. People who had a lot of dreams and a lot of close working arrangements. So it was an exciting place to be. They were looking hard for people with skills that were not represented here and that was a novel thing. I had looked at communities that I liked where I might had been the fifth or sixth nephrologist, even back in those days. And here I was the first one in and a lot of the people who they were recruiting at that time were in similar circumstances, the first one in whatever field they were hoping to practice in. It was very, very exciting. It was a building time, a time of a lot of thinking out loud about what might happen here in the future.

MA: You mentioned there were a lot of dreams. What kind of dreams were articulated at that time?

DM: They all had to do with building and they all had to do with trying to implement a decision to become a specialty community. And I have to say, a lot of credit goes to people who were here in the years before those of us in that particular wave of recruitment joined them. For two things, one is to merge the hospitals, I can't imagine us having been able to do anything trying to run two small hospitals in this community. So putting us all together in a way that forced everybody in the medical community to cooperate with one another around one hospital institution was a very, very necessary first step. But overlapping that decision was another decision made by, I will call them our "founding fathers" for lack of a better term. But certainly Charlie Wright and Matt Bennett and old Dan Hombogen and Jack Kublin and others. I mean,

they... Hank Barsch... they decided that this would be a specialty-based community. That may not seem like such a big deal but it was a HUGE deal back then. Because every other community in the U.P. and most of the communities in the Midwest for that matter were based and developed around primary care, not specialty medicine. In the jargon of the docs at the time, it was either a GP town or a specialty town and GP towns could have specialists in them, especially those that lent themselves to general practice; ENT, or orthopedics, an obstetrician here or there. But in this community the decision was made to have board certified, trained specialists, even in the primary care fields; internal medicine, pediatrics and the like, as the basis of care. And actually when those people put together the Marquette Medical Center and you were required to be a part of the medical center, you were required to have board certification. There were some people grandfathered in but basically board certified specialists were what they were looking for and it was a critical decision, I mean the whole community developed as it did I think because of that one decision made back then.

MA: What's your recollection of how the medical staff interacted with the Board of Trustees that was formed from the merger of the two hospitals at that time?

DM: Well, you know my recollections are scattered somewhat because the Board grew and evolved and the medical staff grew and evolved. It's really hard to take one static view. The cast of characters was constantly changing, things were happening fast. By and large though I would have to say there was a relationship that was friendly but a bit distant and certainly competitive. There was a strong sense of togetherness in those early days and often the feeling in the medical staff was that the people who had the responsibility of running the hospital really didn't understand our world. And I'm sure we didn't understand theirs either. I think that set up a lot of tension and also it set up the need for various kinds of information exchanges. It happened with a certain degree of regularity especially as new technologies were being introduced into the hospital. The specialists were being recruited in those days exclusively by the staff, the hospital had no interest in recruitment of non-hospital based medical specialties whatsoever. Didn't fund them, didn't look for them, didn't do anything. So the medical staff, I have to say, in the early days at least was led dynamically by the group of internal medicine guys that I was associated with who basically put the dollars in and pushed hard to get it done. Of course they were looking largely for medical sub-specialists. And there were a lot of things especially technology that the guys who they were recruiting were quite used to because they had just come from residencies and fellowships in larger metropolitan areas. These were medical services that were not known here. Services that required not only specialist physicians, but required hospital employed staff, nurses, technicians, etc...and these services had to be designed by doctors and frankly had to be sold to people who were on the hospital board but who were basically unschooled in that stuff and who had no experience with it and had no way to make decisions really except by their willingness to trust what the medical staff was telling them. I can think in particular of efforts made by Matt Bennett and Jack Kublin and some of his colleagues to bring Mayo Clinic folks in here to talk about the need in modem hospitals to have ICU and CCU complexes. I can think of a presentation I made to the Board of Trustees about the need to have dialysis equipment even if it wasn't moneymaking. It was a close vote. I can think of quite a number of things; the need to develop an invasive cardiology

service which was a decision made by the medical staff and held firmly. It took quite a long while to convince people to hire those docs or to build cath units, cath labs, things like that. So, you know, a long, long, series of information exchanges some of them quite contentious. But, you know, all you got to do is look around you now to know that things worked out. But yeah, it was, I think gentlemanly for the most part, but I'd say a competitive and a contentious relationship.

MA: What's your perception of the evolution and it's been an on-going changing process and the dynamic of change itself. It's my perception as a relative newcomer, I6 years ago, that there has been an atmosphere of embracing change. How accurate is that perception and how recent or how long-standing is that?

DM: You know as I say it's difficult and perhaps hazardous to look backward as I'm trying to do here now and to look at a freeze frame of time and then characterize it because these things were quite fluid. I mean I think it's fair to say what I said about the medical staff in those early days in the 70s being the leaders. They certainly were even with the contentiousness I referred to. I mean, today it's been the hospital who has taken the lead in recruitment and funded it and looked beyond its borders at its little empire of clinics and services around the U.P. and put money into the purchase of practices, I mean all kinds of things. It sees itself today in a very, very different way from what it was able to see a generation ago. So then that evolution has been gradual, and it's hard, it's like watching your child grow, it's hard to get a freeze-frame and accurately portray it. But, on the other hand, I think once the hospital and medical community woke up in the middle 80s and found itself actually being a referral center full of modem specialties, the die was cast. From that particular point on, the nature of the competition that the hospital and the medical community were in had changed. We were no longer competing with other communities in the Upper Peninsula for patients. We were competing with other referral centers. And, in order to stay alive and do well and prosper we had to do just as good a job with providing services and care and providing communication with referring physicians, etc. as all those other places did. And that became quite evident to everyone. Certainly to the doctors whose livelihoods depended upon that, but certainly also to hospital administration and to hospital personnel at all levels. By that time and any doubt about what we would become was over. And there was doubt, I mean it's hard to remember that there was quite a bit of uncertainty and quite a bit of contention back in the 70s and early 80s, not about whether there should be specialists here, not about whether this should be a specialty community, but whether the intention of this place should be directed to citizens in and around the community of Marquette or to a much wider audience. That was major source of contention within the community and within the hospital community and in the medical staff. Because many people regardless of their field of endeavor felt that they already had plenty to do just trying to take care of people who lived here and they were right about that. Certainly in those early days we docs were fewer in number and the population was greater and we were all terribly, terribly busy. For some them, it seemed unconscionable to try to increase the number of people we were taking care of because they were already swamped. And so, the philosophical or intellectual battle was fought around that particular issue and the battle was over by the

middle 80s. I mean by then this hospital had started to market itself as a medical center. I remember the signs first going up that said Regional Medical Center. A term that had been used elsewhere for quite sometime, but around here was unheard of and when that sign went up it was kind of the end of the battle. From then on we looked hard for people at all levels, not just in the medical staff, but the entire complexity of the hospital support systems changed completely. Education became a critical part of that because education was the funnel whereby both the hospital and the medical staff could get the technically trained people to carry out this work. The hospital's education programs now are quite diverse. The affiliation with Michigan State, the establishment of the medical school campus, the establishment of the residency, the school of radiography, the program with nursing and on and on. All that stuff became an integral part of this place because the decision had been made, intellectually, functionally and every other way that this place was going to be forevermore a multi-tiered, highly integrated tertiary care medical facility.

MA: That's another that I'd like to talk to you a little bit more about is your prospective as an educator and maybe you've already covered it. But is there anything else about the link between teaching and development and the hospital's role that you feel is really key that we didn't talk about it?

DM: Well, there again those things have a natural history. I can say unequivocally that there were very few people in the hospital and on the medical staff who looked at education at a time when they were swimming in patient-care responsibilities that they could barely keep up with. There were a few of us on the medical staff who really desperately wanted to put together a teaching role for the institution. Most of us had come directly from major universities, where teaching was a major part of our responsibility and a major factor in our enjoyment of our professional lives as physicians. So to not be able to have students and residents around was kind of an unhappy circumstance. I think the hospital administration saw medical student education as something that doctors did and they weren't particularly interested in stopping that, but they weren't particularly interested in having it develop either. That certainly has changed enormously and I think all you have to do is look around now. We just got finished building a new relationship with Michigan State. I think current hospital leadership looks at education at all levels as a major part of the hospital's ethos and also I think looks at it as a kind of validation of this place as a regional medical center. It's one of the things that regional medical centers do. It's not only a responsibility that they take on themselves but it's an attribute of regional medical centers that basically lets the public see that there are high quality services here. High enough so that it is the kind of place where people ought to be taught about these things. And I think that's true whether we're talking about the school of radiography or nursing or medical students or residents or anybody else. There are enormous numbers of people who are trained in the technological aspects of what this institution does. I've spoken with many of them who come right out of high school, get into training here, learn how to operate some of these very challenging technical pieces of equipment and basically could take that skill with them anywhere they wanted to go. The fact that we keep so many of them here I think is to our great credit. So as I say, education although it started with a small number of us, I think has grown to the point now where the average person on the medical

staff looks forward to participating, maybe not in a huge way, but in a material way to them, in the education of these people. And some of them look forward to it as a principal part of their professional life and enjoyment. The hospital has supported it with dollars and time and people.

MA: The acquisition of the residency program in ‘84 really fits with the timeline you were talking about with the mid-80's and I'm not sure at what point we actually achieved federal designation as regional referral center, but I'm guessing it was around that time.

DM: Yeah. The residency has a very interesting history. And it's personal for me, I mean the residency – I wrote the program, so that's my baby. It is the norm if you're going to get involved in the education of physicians that you start with residency education. That's the way it has always evolved and then ultimately it may well be that medical student education is grafted on to that. Here we've done it in the reverse. We got outside dollars, and again, this was done virtually without hospital participation. I mean obviously the hospital had to allow the residency program to be placed here and it was made aware of the fact that it could get federal dollars for the presence of the residence program, which it has capitalized on quite nicely and it has turned into a very proper support system for medical education in this place. And so, to say that the hospital role wasn't important would be misleading. The hospital's role is critical; it had to provide a home for the residency program. But you know, it kind of did so with "okay, let's see how it goes."

MA: Do you remember...I know that the hospital acquired the residency program back in ‘84, but it had been in operation for what, 4 years prior to that?

DM: The Residency started in I978. In those days UPHEC was not the hospital partnership that it is today. UPHEC was a private, nonprofit corporation that had hospital participation, university participation, but really was much more remote from the kind of intimate relationship it has with the hospital at this particular time. Although it has its own history, which I won't go in to, that's a topic for another discussion. But, it kind of was a wait-and-see kind of thing. Then it did well, for a number of reasons we already talked about; the validity of education, the fun, the professional satisfaction and all that. You know one of the reasons we started that program, at least one of the reasons I had, was to try to develop some type of central receiving system for this hospital. At that time there was none. You could not get anybody to see a doctor in this place off the street. There was no way. A person's only entry point into this hospital was through a private practitioner's office, if they were willing to see the patient. And, for example, we had lost half of our obstetrics patients in those days. They were all gone to other hospitals because no one could or would see a new patient. They just closed their practices and that was that. My phone and the phone of every doctor in town was ringing from people, "Could you please do anything to help me get in to see any doctor?" And there was nothing. The emergency room was swamped. And so the idea of having a patient care system that at least could be the entry point for people was so overwhelmingly necessary (to me) that the idea of building a residency around that became an even more compelling possibility. I thought if we do nothing else, we should at least do that. Well, it was the evolution, the development and the

success of that patient care system that finally opened the hospital's eyes to say, "By god this is something we need." And so, we sold the residency program to the hospital for $1.

END OF INTERVIEW