

INTERVIEW WITH DAN MAZZUCHI  
MARQUETTE, MICHIGAN  
February 6, 2006

SUBJECT: UP Project. Also, U.P. Medical Education Program, U.P. Health Education Corp., U.P. Campus of M.S.U. College of Human Medicine.

#### START OF INTERVIEW

MAGNAGHI, RUSSELL M. (RMM): Interview with Dr. Dan Mazzuchi, Marquette, Michigan, February 6<sup>th</sup>, 2006. You are going to be talking about what is known as the UP Project. Ok, good morning Dan. What we like to do before we begin talking about the project is get a little of your background. Where were you originally, originally from, what was your educational background, and how did you end up in the Upper Peninsula?

Mazzuchi, Dan (DM): I was born in Washington DC in 1939. I spent most of my life there, except time away for college, at Holy Cross College in Massachusetts. I had Jesuits for 8 years, and then I went to George Washington University medical school. I did my internship residency in Internal Medicine and fellowship in kidney diseases there and then went into the navy. I was stationed in Jacksonville, Florida, from 1969-1971. My wife Connie and I had seven kids and we were looking to live in a small community in New England. She was from New England and my dad was from New England. New England was a second home for me. While we were looking I saw an ad for someone with my kind of training here in Marquette. We didn't know where it was, but I got on a plane flew up here and called her the same day and said this is where we're going. She said buy a house, so I bought a house and we came here without knowing a soul in May of 1973. I came to practice medicine but there was no medical education going on here at that time.

(RMM): Were you interested in medical education?

(DM): Yeah, in the way that all recent graduates are. You come out of university-based medicine programs and you are both the teacher and the taught all the time which I think all docs feel a loss for when they leave the university to go out and practice. When the news came that there was to be some medical education enterprise in Marquette, it was greeted by most of us with enthusiasm. We weren't sure how we'd be a part of it, but we wanted to be a part of it in any way we could.

(RMM): So let's talk about the UP Project. Could you maybe, as an introduction, explain a bit about it and then maybe get into it?

(DM): Yeah. These things are always interesting. It takes different kinds of people, dreamers, to invent things that are away from the mainstream in almost any field, certainly in education. Education has rules of all kinds. Medical education was established and standardized, fixed in its thinking. I'm a product of traditional medical education and there are many very wonderful things about that. But here were some people at Michigan State University who were iconoclasts, people who wanted to try something different and the notion that they had was that they could train a small number of students at a remote site without from the immediacy of the basic science environment and without traditional assets of a modern university. They would use teaching physicians and imported faculty and people who would drive up here or spend a week or whatever and orient training towards the needs of the region which in those days was seen almost exclusively as a primary care environment. The U.P. housed a lot of little hospitals and just a few hundred docs and it was by any definition understaffed and undermanned. So this was an area of need and a MSU land-grant institution said it was part of its responsibility to at least try programs that might help the man-power issues up here. So they concocted this scheme with the help of the state. They had gone to the state which had an interest in doing something for man-power up here. They had the money. They got a line item appropriation, unheard of today, no small measure, due to Dominic Jacobetti who was one of the most powerful people in the state. He controlled the state budget dollars. The money was not huge, but it wasn't insignificant either. When it started, half a million or more was made available to provide the resources for this educational experiment. It was to be an experiment, it was to be small, it was to involve ten students every other year chosen for their specific interest in rural medicine. The students would train in Escanaba in a specially designed primary care practice which was staffed by full-time people whose desire was to both practice and teach. Escanaba had been chosen through a competitive process involving multiple communities. I wasn't a part of the selection of that site so I can't comment further. It was in May of 1973 when I first heard of it. A private, non-profit corporation called the Upper Peninsula Health Education Corporation was set up in 1973. It was to have members at large only. No institutional representation was allowed although institutions saw to it that they were represented in various ways. It was to be the recipient of the line appropriation, not the university, a source of great contention in those days. But, it was thought that the ownership of the line by UPHEC would assure the program a little more added independence and survivability. The UPHEC board was chosen and they hired an executive director, a man by the name of Jack Van Tassel. Jack still lives in the community and he is a worthy person to talk to. He was involved in a lot of public policy in those days and was recruited. From one of the federal programs that had to do with shepherding health care resources and assuring primary care access. And then, things began to unfold rapidly. In 1974, there was a recruitment process for students and lo and behold, there were a lot of people interested. There needed to be a curriculum developed and basically, it didn't exist. The guy who was the youngest department chair of Michigan State's medical school, a guy named Ron Richards, who was chair of OMERAD, the Office of Medical Education and Research and Development was selected to develop the program. He decided to come up here himself and became the chief academic officer of the program and the point person for the recruitment and development of local faculty from Northern, Tech, Lake Superior, and wherever else they could be found, as well as

Michigan State. Together they developed a primary care curriculum. The basic assumption was that a person who wanted to be a physician in a primary care environment could learn whatever he needed to learn by working side-by-side with practicing physicians in a primary care setting, and basically by apprenticing themselves. An old fashion notion, one that characterizes the way medicine was learned back in a different century. Prior to the Flexner Report, that was the way many medical schools operated, but this was a novel idea in a modern age. Even though the program was small, it flew in the face of everything that traditional medical education demanded. This caused a lot of folks to come up here and look at accreditation issues and so forth. Students were doing well, they had the students take the same departmental exams that were required on campus and they all did fine. It's sort of disconcerting to certain people, but they did. Proving I think more than anything it's kind of hard to stop an intelligent person with motivation. Curriculum has its place, but a motivated person will learn, with or in spite of it. A lot of our students were among the most aggressive learners you could find. The biggest mistake that the founding fathers of this experimental program made according to them, and certainly upon reflection I would have to agree with it, is that they were so iconoclastic that they took a position strongly against students being measured by national standards. The students then had to take state exams for their license, which they all did and they all passed and they did fine. But meanwhile, as the program went on, it had no standard database. No national standard database to point to, to say our students do what everybody else does. Which in fact they well could have done, but they didn't. They set themselves up for and put themselves into a deep hole. By the time I became really involved with its administration, in 1978, MSU was forced to relocate the first two years of this program back to campus or lose the accreditation of the entire medical school. So of course they did. The idea of teaching basic science so far away from campus was a novel one and one that most of us, myself included, felt was risky beyond necessity. I used to think in terms of an automobile accident. Our faculty was as thin as thin can get. So many of us thought it was fine and it wouldn't impede the real purposes of the program at all, which it hasn't. But it was looked upon as a defeat for some of the people who thought up the program. Some left, some were disillusioned, others stayed. The program recruited new people. It had had a good deal of success locally and began to grow. Then it's name evolved, it was the UP Project initially and then became the UP Program, and when I took over in 1978, I had been a teacher in the program, I taught a section on renal disease, I had been a member of the board and done whatever I could to support it. It was great fun to think of the richness of the medical practice, which had been lent in part by – there were students who were here to teach and everyone else thought that teaching made us better because we read more and it added to our professional enjoyment of our lives. Even though, it took time and time was something we didn't have tons of because we were short handed. There weren't many of us in those days. When I came here in 1973, I was the 35<sup>th</sup> or so doctor in town, and we have almost three hundred now. If you want to take a look at it that way, it's hard to remember how it was.

(RMM): I think at that time, if I remember right, there was like, one entomologist?

(DM): Most of us here were the first persons in whatever we did. I was one of six interns but I was the first person to have ever trained in kidney disease. This other guy was the first person who was the first cardiologist. The first pulmonologist, they were all the first ones ever here. So it was pretty raw. On the other hand, people were very well trained and they all came to build. I think medical education, at least in part, some of the medical educational opportunities were the result of this program. And we practiced medicine, they were positive assets for recruitment and retention, as well doctor-doctors, another nature of them. I had been recruited, I tried to build a residency program here in family practice. While this medical school stuff was going on in the early 70's, I did it from the position of senior staff over there. Got interest but couldn't quite pull it off. And then the Kellogg Foundation which was heavily invested in this medical school program came up with a grant. I got called into Ron Richards office one day and he said if you want to do this thing, you need to take a leave of practice. I want you full time. I went home and had nightmares about it. I told my wife and she thought I was crazy. Probably, I was. I recruited somebody to take my practice, I thought I would be coming back in a couple of years. They gave me a pencil and a piece of paper and said write a residency. I had no idea what to do, I had the money and the desire and I just got in my car and drove all over the darn place and looked at what other people had done. I got a small group of people together here, put a curriculum together, built an office, recruited some people, and tried to get out of the way. That venture had gone on, we recruited somebody and we were ready to roll with that. Then I got a call from Ron to go into his office and he said he was leaving and that I would take his place. I talked to the Dean of the medical school, I had never been down there before. I said ok, but I mean, I wanted certain things changed and I wanted the title of Assistant Dean so that this place could be a community campus, one of 6, Michigan State already have five other community campuses. They were involved in traditional medical education. Michigan State had always been a community based medical school. That is to say it never had a Michigan State University hospital in which Michigan State students were trained in. It used existing community hospitals. So that all the students were in Michigan, all the MDs in the MD school I'm talking about now. The college of human medicine. That's another story, but the first medical school of Michigan State was the pet-vet school, so when the MD school came along, they call it the College of Human Medicine to distinguish it from the College of Veterinary Medicine. And then the college of Osteopathic Medicine, so it led to a salad of acronyms. CHM. Anyway, it had been a community based medical school, but all the other communities were places where medical education, residency education, had a footing for a generation or more. They were all traditional and all within an hour of campus. Saginaw, Kalamazoo. This place was four hundred miles away and tiny. Ok, so I said that sounds like fun and I did that and the ideas of going back to practice evaporated. I think about that a lot, it was never planned, these things sort of just happen. I have loved everything I've done. People say, don't you miss it? And I'd say yes, I wish I could do both. Today you probably could but back in those days there was no system you could plug into for a little bit. You were all or none. So I left practice and I went to work for Michigan State University.

(RMM): So you actually practiced here for about five years?

(DM): Five years, yeah. Independent practice, I saw patients within the system, the medical education system for a while. More and more I became an administrator. I became the community dean for this campus. It had grown enough and it survived the accreditation problems of the early design in the program. Interest in it had grown and its acceptance had grown on campus. The majority of people of campus probably thought we'll also do a little of this endeavor, it went from ten students from every other year, to six students per year, to eight students per year, which it still is, 8 students per year. Which I understand at present they are trying to make it grow some. We could have grown accept we never wanted to get to the point of where we overwhelm the faculty here. Most faculty work for next to nothing. You can't take volunteer faculty for granted, you have to be careful about that. In terms of interest in the program, it far outstrips the available seats. And students of the years have done well as measured by anything. They all take national boards now and they all take department exams. If they aren't the best on campus, they are the next best, I mean, best in the system. It's, I say I don't think that's a reflection on us, I think that's a reflection on the kind of students we attract. They are bright people and highly motivated and they get in an environment like this where they get so much personal attention, they thrive in it. Done very, very well.

(RMM): So after you took over then, the program stayed? Basically how it's continued to the present day?

(DM): No. It's gone through an awful lot of change. It's evolved like you might have not expected. You know, it's coming on being thirty years old. These are the things that have happened. A program that was originally centered in Escanaba, as it grew and as the demands on the program grew and the system in Marquette grew, it grew from this little group of thirty people, to now, two hundred and some odd docs here, and from mostly primary care to some specialty to basically now a tertiary care system, all these resources became available, more faculty became available, and therefore the educational venue began to change. Then Escanaba, which was the umbilical cord for the program, without Escanaba, the program wouldn't have gotten off the ground. Rather slowly, things began moving towards Marquette.

(RMM): Why did they select Escanaba?

(DM): They were looking for a primary care center originally to build the program in and the community of Marquette wasn't interested in doing that. They didn't consider themselves a primary care place primarily, but virtually all the other communities in the U.P. did. There was just a very aggressive group of young family docs in Escanaba that said by god we want this here and they went after it and they got it. It's good that they did because I don't think the program could have gotten off the ground without them.

(RMM): Now at that time was sort of paralleling development, Marquette was developing the medical community from thirty and they developed the medical center.

(DM): Yeah all these things were happening at the same time. Marquette had decided collectively, it's hard to speak of Marquette as a single person obviously, there are all kinds of people involved in this and there was a consensus that was easily gotten to and sometimes not. But by and large, it decided to make itself into a referral center, a specialty community to grow around specialties, many of which were just developing. Other communities had decided to do other things. Mostly to involve themselves in primary care, generalists by and large. So, things began to change, educational venues were far greater up here, and in some respects it was the people in Escanaba just said they can't and they were limited in their numbers. They really couldn't provide the numbers we needed, sometimes departments on campus just said we can't do this down there anymore, you got to move it. So it was a combination of opportunity of push and pull within the system and long and short of it was things began moving up here. At one time the Escanaba group got up to around thirty people and the total budget got up to a million bucks and most of it was tied up in running a health care system. Which in part became an anachronism. As growth continued in the community, the health care system we had built really was not needed as much as before. As the dollars in the state became more and more competitive and we went through a period in the late 80s from then until now, state dollars have become harder and harder to come by. We were put under the same squeeze that everyone else was. We redefined the relationship between the university and UP Health Education Corporation and redefined the outfit, and the corporation itself. A new partnership evolved in Marquette General and St. Francis Hospital and the community at large. I had been recruited to campuses as an Associate Dean of Medical Schools in charge of all the communities. So I sat down there from that vantage point and helped redefine some of these arrangements. A couple guys came in and took my place up here. Doug Shirk, Tom Griffin. Tom was a northern faculty member and was one of the original teachers in this program. Anyway, those things continued, and I stayed down state three years, I came back here, took the program over and redefined the corporate arrangements again. And one thing led to another. Long and short of that, over time the program moved completely here. The operations in Escanaba were closed, the practice was closed. Both for monetary reasons and we weren't needed there and the original notions of which the program had built, the whole apprenticeship and things had changed more towards the more traditional ways of things based in this hospital, which looks an awful lot like a University hospital without the university system. But in terms of patient mix, and the kinds of educational opportunities, especially orientation, etc, looks very much like a university hospital. And then to make up for the absence of this wonderful environment which had been created in Escanaba for primary care teaching, we looked out in the communities across the UP and saw all kinds of changing for students to learn side by side with practitioners, primary care guys, almost all intending practices, some of them our own graduates. We developed a series of two month long primary care experiences, late in the training of our students which had become the most favorite thing that these students do and one of the real pluses that they look at when they try to recruit them. They look at these opportunities as not only unusual for them, particularly if they are from the UP, or if they have notions about coming to the UP ultimately...

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(RMM): Ok.

(DM): State dollars, you try to pay it off, and it adds. Now in today, you have a UP Health Education Corporation, whose office is now at Marquette General Hospital, they had been everywhere, they had been at Northern, they are currently anchored at Marquette General. You have a family practice residency program, which had originally been invented by the UP Health Education Corporation. Run by us and given over to the hospital which ran it separate from us. Now brought back into the UP Health Education umbrella so that graduate medical education are all government run and part of the same administrative system, and the administrative efficiencies are there and the learning opportunities are greater cause these things are together and there are far less competition for people's time because these two programs are really one program now. The administrative reality now is that the UPHEC is a partnership exclusive between Marquette General Hospital and Michigan State University. Their board of directors represent both institutions and that's all. The at-large nature of things has disappeared so it's morphed into this new, fairly traditional system of a health care system and a medical school to provide two full years all of the clinical education for all of the students who are now on the UP campus and who are recruited only from the pool of students who have already been accepted to the Michigan State University College of Human Medicine Science who want to come to this campus here. We take only people who wish to be here and there are more of them than we have slots so it's a competitive process that goes even after the competitive process for medical school which involves onsite interviews, a host of criteria that are designed to help make the program successful in its output. To put people more often than not in their primary care. Or into specialty areas like psychiatry that are needed in more rural environments. And to put them into the UP or into the state after they finish their residency or the states like it. The states need docs that have those kinds of credentials and experience. I don't have the data on my fingertips but the last I looked, by any measure, very, very successful at doing that. I mean, national averages are helpful guides to look at and we are well above that. A larger number of our students have stayed here, than any national norm. Even more than Michigan State in general go into primary care. So it's been a very, very successful program in that respect. And from my point of view, it's been very successful in maintaining an environment of inquiry and reading and scholarship and so forth among the medical community. Certainly, then, had it not been here in the first place, we are nowhere near isolated as the place might have become as you well know the UP is proud of its isolation. But you know, when it gets down to information, it's not a good idea.

(RMM): I think when we were talking earlier the other day about this, you said what percentage of the physicians now have come through this school?

(DM): Yeah, it's about 10-15% of all practicing docs in the UP are graduates of this program or the residency or both. In the best of worlds we would be involved in more kinds of residency

training than just family practice, it limits us. But really the size of the institution sort of prevents us from doing that. Now on the other hand, we look for opportunities to provide advanced training in some other specialties. We probably don't have enough research to build a residency in general research or a residency in neural surgery or a residency in general medicine or in pediatrics, but we do have the opportunity to provide rotations in special areas of those things. We have done so in psychiatry a couple of times. The hospital and UPHEC has worked out special arrangements for people to be recruited into psychiatry programs on campus and then allowed to spend the last full year of that in a special rotation up here as an overall part of their education and also to provide them with an easy transition from their residency training into practice as easily as we can. We keep looking for opportunities like that. It's one of the nice things about having the kind of administrative intermediary that UPHEC has become. It can not only work for institutions, it can, has, and does apply for grants. It has set up special programs at the AHAC administration at the Area Health Administration Corporation, the federal money they had in place now. All kinds of things that they have done and opportunities they have had before them for implementing their service and for involving themselves in institutions in research. Bringing people together is one of the things they will be most successful for, that is, sharing research between the hospital, the university, Michigan State, and others. Those that run the program now are very much interested in that. And they have a good bit of experience now and a legacy and they are reasonably well funded, and the same kind of problems of all higher level institutions have had in initiating that in the last ten years. They are well managed and well positioned to remain a force for good in medical education and service here in the UP.

(RMM): So when we look at the hospital and the way it's grown and so on, and something associated with the medical school and so on, can we say we have a branch of the medical school?

(DM): We definitely do. We have a community campus here. Which is tried and true, it's survived 30 years, highly productive, it's small, it's well integrated, it's the educational arm, not the exclusive, but a major one, and when you take a look at job opportunities and educational opportunities and help in health related fields, boy oh boy, that's where it is. Whether it's the school of radiology, or medical school, or the clinical opportunities there. Gee whiz, there is an educational engine there in health. One of the things that UPHEC did early on after I left was having an arrangement with the pharmacy school at Farris. So, we have people training in pharmacy here and pharmacies are terribly under-represented, believe it or not as a profession, nationwide. Why I couldn't say because there are all kinds of opportunities now. There are all kinds of educational venture there now that has a home. There is a sense of Marquette General Hospital as an educational environment and a hospitable one. Whether it is for the medical students from Northern or from Michigan State, there is a place for them to go and hang out, like they belong somewhere. I think people lose track of the importance of it because it doesn't blow its horn enough. It has to kind of re-establish itself with a new audience every year, gets a new audience and people to look at, it's relatively small. Like a lot of educational things, I think it's a little egg-head, nerdy. People don't brush up against it very



often unless they have a kid or someone they know who happens to be going through the program and all of a sudden it becomes real.

(RMM): When we first talked about doing this interview, I was pretty much ignorant as to the element of the program. Listening to this, well I knew it started years ago, but now I know it has morphed into an institution.

(DM): It used to have a public relations person, it used to do a lot more in communities, but you know it didn't get broke, but they had to make some decisions about what to do with dollars as dollars became shorter. The other thing too is it's not an independent entity as it once was. Now it's much more integrated into the Marquette General Hospital. It's changed its flag.

(RMM): The recent agreement there, northern and some sort of agreement with the hospital to work on science or the sciences department here, they are talking about having me and sixteen members of the Northern Faculty attending a meeting. Is that part of it?

(DM): Yeah, it's all part of it.

(RMM): So it's just enriching things there.

(DM): Yeah. The guy that's running it now, Dave Louma, has a wonderful vision for the program and is a very capable person and he has an additional benefit an insider in the MGH health system, he came out of their residency program and had some administrative responsibilities. He's well known inside Marquette General. And he also, since he started up five years now, last year he got the Outstanding Faculty Award for Michigan State. He's become well known and accepted as a colleague from his peer group. And he's been honored for it, for his work. So he has to walk in a couple of different worlds. He walks both in this University environment and this community campus 400 miles away with equal prestige. In that sense, he's able to be a bridge, a catalyst, an effective administrator and bring these things together. There's much more that can be done and my hope is will be done as long as there are people like him and people in the administration who value for whatever reason, altruistic or self, who value the program or its output. Right now, in the United States, and certainly in Michigan, and certainly in the Upper Peninsula, having well trained native-born physicians is a big-time priority. We'll take well-trained physicians native-born or not, but the idea of having someone, recruiting them from high school, interesting kids from the U.P. in high school who might not have thought they have the opportunity, which is another huge part of this. If they can see it in their own backyard, they can think of it. One of the great things that pre-med advisory here at Northern has done over the years is try to convince people to come to Northern and that their ambitions can be whatever they want them to be. They don't have to be constricted by any fat or geography. Gee, when I first started here, good lord, listening to the students here and the idea of going below the bridge for some of them was overwhelming, an anxiety producing thing. Going to medical school was unheard of. It's important that they see it. Northern is known for many things, one is pre-professional programs. Which has been a couple

generations old now. They are very, very good. They put people and kids in college right smack in the middle of the health care system. Whether they want to be doctors, dentists, osteopaths, or technicians, hell, they can go right across the street here to a clinical environment and a willing person to find that if what they do, what the professionals do, is really what they want to aspire too. It all comes together.

(RMM): I'm just surprised because like you say, you don't have the PR person, and the community and myself don't realize or appreciate what we have up here.

(DM): I don't know how to make it so or make it different. A little education chain where everybody follows to get places is so personal and parochial, it's sort of hidden off the path. People don't brush up against it unless they want to be part of it. That speaks a little bit to the fact that our culture doesn't honor or respect education as much as it should.

(RMM): But I wonder if these articles, the Sunday articles, the community news.

(DM): There are big PR departments all over. Years ago we had television specials on this – "A day in the life of one of these people". It was twenty years ago or more. There was a lot of stuff in the paper and it's been done so these people don't come back to it. Or the people who did it lose track of it and so it needs to be rediscovered all the time. I'd love to see some public attention paid to it. I think it's so unique, not in itself, but here, an environment like this. It takes really special folks to make it survive, and to be excellent all the time. It takes a lot of work to do that. A lot of money. The per student cost of programs like this is higher because the student numbers are smaller. How much higher I don't know anymore, it's been studied to death. The payoff is spectacular for a place like this.

(RMM): Now are there similar programs around the county? Are there many of them? Limited in number?

(DM): My knowledge base isn't as good as it used to be. But yeah, there are similar programs out there. When Michigan State was first put together was pretty weird, the whole idea of community based programs was new. Now I'd say a third to a half of all the medical schools have some type of community base to them. Some are small, some are quite large. There have been programs, many of them with grant funding or federally funded design to look at the special needs of rural environments. One that springs mostly to mind is the WAMI program out on the west coast, Washington, Alaska, Montana, Idaho. Very extensive which has experiences that have such as this, there was one in Minnesota over many years that did the same thing. There was a new medical school in Georgia that did the same thing. There was one in Florida that has started that has some of the same sorts of notions in mind. I don't know enough to comment on them anymore, but yes, there have been many, many programs started that have this kind of thing in mind, but still, they are a minority institution.

(RMM): I think that answers all my questions, thank you.

(DM): You're welcome.