Interviewee:	**Hurt, Myra, Ph.D. (Associate Dean for Research and Graduate Programs, FSU College of Medicine**
Interviewer:	**Karen Thomas**
Date of interview:	**March 15, 2006**
Category:	**FSU College of Medicine**
Status:	**Open**
Tape location:	**Box #52 (3 tapes)**

[This is the first of three interviews]

Thomas: I'd just like to start by asking you to outline your career in medicine up to the time you came to FSU, and then tell me how you came to FSU and what you did with the program in medical sciences once you got here.

Hurt: Okay. Well, I got a biology degree as an undergraduate. I graduated from college a year early in 1968, and I went to college in 1965 in a small town in Arkansas. All of my female role models that were educated were nurses or teachers, and so I picked teacher. So I taught high school biology for six years in northwest Arkansas in a little town of 3,000, very rural. Students that were bused in from the mountains. Had an absolutely great time. I absolutely loved working with the students and wanted to — but I always knew I wanted to go on with my education and it was unclear to me exactly how. I got involved with the college I graduated from teaching the inquiry approach to teacher interns, and got picked by NSF (National Science Foundation) to be involved in some national activities on how to transform biology curriculum nationwide to teach the scientific inquiry approach. Anyway, ended up (long story short) in graduate school in the area of bacterial genetics at the University of Tennessee Health Sciences Center in Memphis and was a teaching assistant the entire time I was in school there. I taught micro labs to dental and medical students for four years. So that was my introduction to medical education. I taught in the medical curriculum in their first year and then a small infectious disease module in the second year. Was involved on the graduate council as the student representative with all the deans and department chairs, so got to know a little bit about how medical schools ran during that period of time. And then after graduate school, after I was nearing the end of my Ph.D. training, I married my husband who is a heart surgeon, and he was getting ready to go — had to do residency training. So we were, shall we say, fairly involved throughout the last two years of his medical school education, his clinical years. I don't realize that I was studying this, but I was learning a whole lot about how physicians are trained, and the time in which he was in medical school, the emphasis was on academics. Their academics got them in, it was very competitive, high GPAs, high MCATs, and academic performance was the whole deal. He picked as his surgery training Baylor College of Medicine, the DeBakey program there, which was probably one of the most inhumane training programs in the United States but also one of the highest prestige. I did my post-doc there in the Department of Cell and Molecular Biology, working with medical geneticists. I was a medical genetics trainee for five years. Two of the people I trained with are now in the National Academy. They're MDs that are just superb researchers, that identified the genes that were responsible for several important genetic diseases.

Anyway, during my husband's five years of general surgery, I got a really close-up look

at how — the continuum of medical education, I'll just leave it at that, and ended up — we went to Kansas, he had two years of chest there and I was a research assistant professor at the University of Kansas College of Medicine in the Department of Medicine. I worked with an oncologist during those two years, looking at some of the genetics behind particular cancers that she was studying.

We came to Tallahassee. He had a practice opportunity and I had determined that two-career — by that time I knew that a two career family was not a good package in terms of getting a job, but I was naive in that I believed that I could get one. Florida State looked like a good place for me. I had a former member of my Ph.D. committee was here, and it turned out that he was the director of the Program in Medical Sciences (PIMS). His name was Bob Reeves. I eventually made some contacts with a couple of people in the Department of Chemistry and the National Science Foundation funded a proposal of mine to work with Bill Marzluff in the Department of Chemistry to basically enhance my molecular biology training. I had become a medical geneticist, as it were, right at the time period where cloning and the power of molecular biology was transforming medical research. So the National Science Foundation funded me as a visiting professor at Florida State, even though I really wasn't visiting, I lived here, and they knew that. The rest, as they say, is history. That was 1987, and in 1989, I had just received news I was going to be funded by the National Institutes of Health as an independent investigator, I went to work for the Program in Medical Sciences as an assistant director. They were a person short, somebody was on sabbatical. I decided this would be interesting, and I did pre-med advising and became a part of the admission committee. I had also began to teach in the Biology Department. I was teaching undergraduate micro as an adjunct professor. It was during my first year with PIMS that I realized that I knew a lot about what it took to become a physician and what I thought was wrong with medical education and so forth. I had the great fortune that first year to study the medical admissions process with two old pros from UF. PIMS was obviously working with the University of Florida. We had a separate admissions process but their faculty, their head of admissions at UF, participated on the committee. And of course, our students transferred there after their first year. So they had a very vested interest in what students we admitted. So these two people basically taught me medical admissions. I, a very curious person, asked lots of questions and learned a whole lot from them. Our PIMS values are a little different, obviously, and the current College of Medicine look at admission of students in a more holistic way, I guess I would put it. But they taught me a great deal and I will be forever grateful. Hugh Hill was the Associate Dean for Student Affairs at UF for thirty years; he just died this past summer. And he was absolutely fabulous in terms of teaching me to trust my instincts and what to look for and what the red flags were and so forth in the admission process.

Anyway, in 1991 I had been working for PIMS about a year and a half when half of our students that were in the second year at UF, had just finished the second year at UF, failed the national board Step 1, which is the first step of the licensure exam for all physicians in the United States. It's a three part exam and you have to pass it to practice, to be licensed. So this was in what I call the second era of PIMS, at the end of the second era of PIMS. PIMS was funded in its first era by a National Institutes of Health grant to expand medical education, and there was lots of money and lots of resources. What happened when that grant ran out was that the then dean of Arts and Sciences (his name was Werner Baum) really didn't have much interest in the program, didn't throw a lot of resources in its direction. The state took up the funding, but it was basically

under-equipped and underfunded.

At the same time, in that second era, the national applicant pool for medical students declined. PIMS had a restricted applicant pool during the first two eras, which was that they could only accept students from FSU and FAMU directly. In the '80s, they added UWF, the University of West Florida. Then the UF admissions chair would flesh out the class, and sometimes that number of applications would be fifty for thirty slots, or less. And so the admissions chair from UF would flesh it out with people that weren't quite good enough to start in Gainesville but were good enough for PIMS; that's kind of the way they explained it to me.

Most of those people are practicing medicine now and they made great doctors. But these were people that came from under, some of them, from rural and underserved backgrounds, both medically and educationally. They had a program that was taught by professors in chemistry, biology, and psychology, and those faculty were teaching the course that they wanted to teach in their department and there was no accountability to a medical agenda, if you will, the objectives. What did these kids need to go on in their education? The thing that I observed as a naive person who really didn't know why I was looking at all this but I could see it, was the accountability was in Gainesville and it all happened here for those kids that were here. So when the students performed so poorly, and the performance had been declining for about five years — in the early years of PIMS, our students' academics matched the students at UF even though the curriculum was quite different. Our accreditation came through UF, and so when UF was up for re-accreditation, obviously PIMS was a part of that. Well, UF became concerned when our students failed that this was a liability for them in the re-accreditation process that was coming in about another year. So they called our university — the then director and our provost – the dean (Larry Abele was dean then) — to go to Gainesville to meet with them to discuss the future of PIMS. In truth, UF didn't want PIMS. It had been a way of increasing their class size when they didn't have space to do it on their own campus. It was a way to get money, leverage money from NIH during the five years of the grant. But as everyone knows, there's an intense rivalry between UF and FSU, and at the heart of it is (as disgusting as it is to say) is football. I came up against that time and again during my about twelve years with PIMS. But anyway, at that time point, UF really would have liked, I think, for PIMS to die.

So the then provost of FSU was Bob Glidden, and he invited the leadership of the College of Medicine, a survey team, a site visit team, if you will, to come to Tallahassee and visit him. It was like September of 1991, I believe, and visit the program so that we could make some decisions. Now I'm an assistant director at that point; I was the third in the peck order. The dean at that time was Larry Abele, who had been chairman of Biology before that. So we went over to visit with Larry. Now some of this — I'm going to tell you my side of the story, and eventually others may want to clean it up. But this is what happened.

The then dean, Larry Abele, asked Bob Reeves, as director of PIMS, and myself and a man named Warren Schoenfisch – he was associate director of the program and had been for probably ten years, to come meet with him and present a report, a briefing report so that we could brief the provost before these visitors arrived from Gainesville. Basically the brief would be as to the status of the program. So I had been kind of barking at everybody's heels for about a year and a half – how does this work, why do we do this, why don't we do that, this kind of — that's just the way I am; I like to understand things and what are the relationships and what's important here. And I'd already made a lot of observations about "hmmm, some of this doesn't seem to be

working perhaps the way it should." Anyway, in terms of how our curriculum worked, in terms of how our admission process worked, et cetera.

So anyway, Bob Reeves prepared a report on the history of the program to that point in time. So this included the first year in which Paul Elliott was the director. Those were the NIH funded years. Then the transition year where Robley Light from Chemistry was the acting director while they recruited a director, and that's when then they hired Robert Reeves. He was director for about the next ten years, and we were in the last year of that when all of this occurred. And Bob is a very wonderful guy. He is great with students. I have a lot of respect for him. But he was in an unbearable position. He had been director during the time when the dean of the college, Werner Baum, never approved his requests. He was not in control of the curriculum in that the Biology Department chairman decided who taught courses, and if those people weren't teaching the course that the students needed, well, that was really not a part of the equation. It was out of his control. And the national admissions pool had slumped. And then he would go to Gainesville and he — you have to do combat with those guys. That's how they live. You have to be able to argue and confront, and aggression is not one of his strong points. So all that is by way of explaining how we had gotten to where we were. He didn't have the support he needed, both academically and financially, and he didn't have the necessary personal skills to deal with it, and I'm not sure it would have even helped. So he was a victim of the time he was in, basically, is the way I see it.

So anyway, he prepared this history of the program and we were in the basement of Montgomery Gym. You couldn't recruit good students because you had to take them in through the back doors by a trash bin; it all smelled of formaldehyde. It was a miracle that the program had survived. And the bottom line I'll get to before I tell the rest of this story is that at the heart of all this, the design of this program, was thirty years ahead of its time. And all I did was re-institute all of the original design and the original values, and we are where we are today. So it had been allowed to decline through lack of interest and through hostility from Gainesville, et cetera. And just plain bad timing, because the national applicant pool slumped.

So anyway, Warren Schoenfisch prepared the second part of this briefing report, so there was the history and the second part were the problems. And he identified what he thought were the problems, and they included our bad facility and — I can't remember. I have this document somewhere.

Thomas: I want to see it.

Hurt: There was a part three. Now, I wasn't involved in evolving this document because again I was not really a part of the core here. I'd been allowed to — basically I was running the admissions process to the extent I could, but I didn't have control of pretty key elements of it, like who was interviewed and so forth. But anyway, I tagged along because that's just who I am. So the third part was solutions, and this part of the document was completely blank. So I even asked, I believe before we went over, and I can't remember what I was told — now this is all happening in a rapid time frame, they'd gone to Gainesville and it was a very bad meeting apparently. I wanted to go but was not allowed to go. I would love to have been in that meeting because there was a key piece of our history there.

Anyway, we go over to Dean Abele's office. At that time the Dean of Arts and Sciences

was housed in the basement of the new science library. We sat down and he (Bob Reeves) hands the briefing report to Larry Abele. And I saw Larry Abele, and he saw the third part, which was blank. And I think we were dead on arrival. But anyway. So he let Bob get started. Bob went through the history of the program and Warren told him the problems. And he looks at the third page and he goes, "What's this?" "Well, we need to develop some solutions." And he says, "You don't have anything here." And Bob said, "Well, no." And Larry Abele stood up and he went to the door and he put his hand on the door handle, and he said, "I have to be somewhere else." And I looked at him — and I hadn't said a word this whole meeting. I'm just this blond adjunct professor that's working basically part time for PIMS. I said, "Larry, if I understand you correctly, you would like to see some solutions here." He said, "Yes!" And he goes out and he slams the door. And Bob Reeves to this day says to me, "You know, I never understood why Larry acted like that."

So anyway, I took them back over to our basement and I said, "We have to come up with some solutions or we're dead." And I started grilling them, asking, "Why do you think this is a problem? What's the solution to that?" I did two two-hour sessions, one that afternoon and one the next afternoon with both of these guys. And they were not — I mean, Warren in particular was not my biggest fan. But I made them tell me. And they knew what was necessary. So Larry's secretary called and told us to be back, it was like two days later or something like that. So anyway, in the time frame I had, I had two meetings with them, I got this information, and I produced this five page report that had the history, had our — what are the problems and what are the solutions. What do we need to do to fix this.

So we're in the PIMS office and the two guys look at it, Bob and Warren both flip through this. We're literally minutes before going over there. So we're walking from Montgomery over to Larry's office, and Warren says, "Now Bob and I will present this report." And this is the first time — I was a good little white girl who knew her place up until a certain point in my life, and I always bowed down to authority figures. But I said to them, "No, I wrote it, I'm going to present it." So we get over there, we sit down, I give a copy to Larry, I go through it with him, and he goes, "Great. Let's go take this to the provost." So we went, we present it to the provost, and he said, "This is great!" And what it was, was how we would expand our admissions pool to include any resident of the state and would have to convince UF to let us do that; that we'd ask the legislature to give us money to build some new space and to get some new faculty lines that we could recruit; that we would work with UF to make sure that our curriculum was in line, et cetera, et cetera. Oh, and the other piece of it that was new was an outreach program. We would develop an outreach program to specifically African Americans as well as rural white kids to try to develop a qualified applicant pool from under-represented areas. So we go and we present it to the provost and he says, "This is fine." And the guys from UF show up the next day. So it was their current senior associate dean for education Bob Watson and his associate dean for medical education Lynn Romrell. Both of them are still in those positions. They had with them the former dean of the College of Medicine, Manny Suter, who was dean of the College of Medicine in Gainesville when PIMS was formed in the '60s. He was currently at UF at that time to help them with their self study for the re-accreditation process. And the fourth person was the director of their AHEC program for north Florida that's oriented towards the rural and under-served, and that was Ocie Harris. So those four people came up and they came to our little conference room in the basement of Montgomery Gym and I hit them right between the eyes right

out of the box. I could see that Lynn Romrell had brought this big stack of boards, scores, and comparisons to show us all these things, and I said, "We know we need to fix some things around here. Let's go through it." So I just went right through the report with them, and they're like stunned. And we admitted, these are the things and this is what we're going to do to fix them and we went up and we talked to the provost and he invited them to come up for a retreat. They came up in October, we had a retreat, and at some point during this process it became clear to me that Bob Reeves had been wanting to not be director any more and they had not allowed him basically to resign. Somewhere along this path, I told him that I thought that now was the time, because I was afraid that something worse might happen if not. So he resigned effective August of 1992. So I became basically the director in January of '91 in terms of all external relationships with Gainesville, with the legislature, with the provost, et cetera. And he did the day to day operation of the program until August when I became director in 1992. So then in the next year we put into motion the plan that we — I had to go to Gainesville with — Larry Abele went with me and convinced the executive committee of the College of Medicine that we could become an AMCAS (American Medical College Application Service) school and recruit from the whole state applicant pool and that we would be competing for some of the same students, but there were plenty for both of us. And I actually managed to convince them. There was some opposition but they came around. The thing I didn't know that happened then until a couple years later was that the day that we met with Larry Abele in which he got up and left the meeting because he was angry that there were no solutions, this was during the recession in the early '90s when universities were having to give back money that had been allocated by the legislature. The provost had asked all of the deans to prepare a list of programs and departments that weren't performing, because they were going to potentially have to kill some programs to be able to operate the university if they gave back money. And that day when he walked out, he put PIMS on that list. And so I didn't realize until some time later that for a period of about a month we came very close to not existing any more. And thank goodness we survived.

Thomas: You've given me some very interesting quotes and I want to go back to a few and asked you to expand on them. You described the residency program at the DeBakey Institute?

Hurt: Baylor College of Medicine (Debakey's general surgery residence program).

Thomas: The most inhumane in the country?

Hurt: It was one of them.

Thomas: Inhumane to the residents in its overall philosophy, do you think?

Hurt: Yes. They had a philosophy there which was quite common, and frankly probably still survives at places, that they had one you call a "pyramid." They admitted more first year residents than they could use in the final year. The whole reason for that was to weed out the sheep from the goats. The ideal product from that program, as near as I could tell, was someone who could stand in the ER of the murder capital of the United States, which was what Houston was, that had over 300 cases of major trauma every twenty-four hours, see everything bad that

could happen to a human being, either caused accidently or by themselves or by others, and have absolutely no emotion and act with cold precision to do what had to be done. Now that's what you want under those circumstances, but how you get there is by stripping away methodically all of the compassion, the concern and warmth, because those things are obstacles. So it made it very difficult for someone like my husband, who can be a cold-hearted, ruthless surgeon, but deeply cares about his patients. So that was a very hard program to survive, as you might imagine. He had the worst part of that — they cannot do this any more, they've been disallowed — every resident that went through general surgery at Baylor when my husband was there had to live in DeBakey's ICU. So this was an intensive care unit that handled fifty to sixty immediately post-op heart patients that had just had surgery. They (the residents) had to live there twenty-four hours a day for two months. They could not leave the floor. They were the only physician there. They were primarily responsible for everything that was happening in those patients' care. Now you may not know this, but when you have open heart surgery, they have messed with your chemistry big time. All your fluids, your ionic balance, everything is totally — has to be normalized. Okay. Your chest has been cut open, there's all of the problems, infection, healing, et cetera. So it was a very intense — in the first few weeks he was there, he did not sleep for four days one time. And that was part of the experience.

Thomas: Which leads me to the next — you clearly became interested in, as you put it, what was wrong with medical education. You were very closely involved with but had not gone through an MD program yourself. Do you think that's actually an advantage?

Hurt: Yes. I do think it's an advantage. Every physician that I know, every — well, I don't want to overstate that — most people are products of their raising, so to speak. Okay, so every physician that is over — let's say over forty-five years old in this country — that was educated in the '70s and early '80s — and in fact today at some of the most outstanding places in this country, the medical student is picked for their academics, they are educated in an environment in which they are not treated with compassion, they are treated as though they are inferior. It is a whole part of the clinical training program in the residencies that the top resident dumps on all the other residents down the chain, and then once a week they meet with their attending physicians and are told how they haven't gotten this information or they haven't done this and that they're, you know, in others words not very good.

Thomas: Sounds like a fraternity hazing.

Hurt: Yes. At Baylor they had — and Baylor's not unusual — they had a weekly morbidity and mortality conference where all the cases were examined, where people died. And this is what you want, right? But what they did was they used those for whipping sessions, to whip the residents. And these were done by the attendings who drew the fat salaries and stayed at home and didn't come in and who billed for services on the residents' backs. The government has come down on that really hard in the last ten years. But this is how it existed. So there are any number of books out there that have been written by residents that survived this sort of training. And so the fact that I was exposed to the continuum of medical education, both as a participant and by close exposure to my husband's life, and the ability to meet his colleagues, his faculty, the staff all

involved and so forth, and I was an outsider, I wasn't an insider. So I don't have anything vested in this. Because fraternity members that are hazed, that's part of the deal and now once you're a member, it's your turn, right? So I think it was actually a good thing that I was outside the club, so to speak.

Thomas: Have you ever found that difficult to gain credibility or be listened to by MDs that you work with or have worked under?

Hurt: Yeah. I mean, yeah, I've come in contact with — you know, the last ten years is really — well, let's go back to about 1993 when I began to really agitate with the guys at UF over a different kind of training program. Yeah, I think they were kind of paternalistic at times, but the thing I had going for me was that I was from Venus and they were from Mars, so to speak. I mean, they didn't know what to do with me. I was this blond female that was always calling and asking them questions and they didn't know how to deal with me. And it was a great advantage, I guess. And the other thing was, you know, I really did grow up outside the box. I didn't know what the box was. And that was a great asset in terms of dealing with these guys. I would go down and talk to the dean at Gainesville, and I had been at Baylor, which I don't know if you know this or not, but Baylor's the big leagues, okay? So I had seen the real big dogs; I had actually had meals with the really big dogs. So when I went to Gainesville, I was like, "Oh, yeah." Anyway, I wasn't intimidated by them but I knew how to deal with them. I knew what their values were and so forth. And so I would put on all my jewelry and et cetera. I'm not kidding you. I would wear power colors because I knew that that's not what women are supposed to do when they're in a professional arena. And it actually worked. They actually did not know what to think. So that usually meant that I got a real answer out of them.

So I spent four years rebuilding our relationship with them. I went down every other Tuesday morning. Got in my car at 4:30 in the morning and drove to Gainesville to go to the curriculum committee meeting, became acquaintances with all of the people that were representatives of the departments. I served on the subcommittees and built some real relationships. I instituted a yearly retreat between our first year faculty and their first year faculty. We got to know each other; the faculty got to know each other. And that's a real female approach to things, but it's also in all the leadership books if you look at them. So anyway, it worked very well. And inside of four years, our students were performing better than their students. The fourth year after — well, it was the third year, I think, after I became director — every single one of our students passed Step 1 and two of the kids in the UF side of the class failed. Actually it was such a big deal, I was on vacation with my family in Glacier National Park and Bob Watson called me from Gainesville on my cell phone to tell me that. It was a fun day. And it wasn't rocket science, really.

I haven't talked to you yet about the internal obstacles. I guess what I want to say is that it turned out that dealing with the people at UF was more straightforward than dealing with the people inside FSU. The Program (PIMS) had been viewed as a way to get faculty members by the departments in the science area; they didn't have any — all they had to do was provide staffing for a course and there were no rewards possible, the way the program had been funded. The evaluation structure for faculty was all in the home departments; the program director had no authority to say, you know, "Professor So and So stinks. This is a bad course and the kids are

doing very poorly on this section of the boards." So changing that was extremely difficult. In fact, I got some of my biggest scars on my back over that. There were a couple of faculty that hated medical students that had been hired into a PIMS line and had been teaching the PIMS students for many, many years, and actively talked about medical students as though they were a lower life form. They acted out in class. The students hated them in return. They taught a course that was not really at the level it should have been or content it should have been.

Thomas: Why did they hate medical students?

Hurt: Okay, I have a theory. Actually, I know that it's more than a theory. In the case of these individuals, I'm almost certain it's because they tried to go to medical school and didn't get in. I ran into a couple of those in my graduate education at Tennessee. A couple of professors in the department where I was hated medical students, talked about them like they were dogs, and I asked them and found out. Both of them had wanted to go to medical school and didn't have — it was a point of time where at the University of Tennessee, for example, they had 1,000 people apply for — 1,000 Tennessee residents applied for 100 slots and their class average was like 3.8 or 3.9 GPA, their MCAT was sky high. So if you didn't have sky high academics, you weren't going to medical school. So I don't know. Medical school students are, like professional students in general, are different from undergraduates. They know where they're going, they're goal oriented, they are very oriented towards grades, and that's because that's what the system is. I mean, we have students they're going to match tomorrow in the residency match, and in some of those specialities if you don't have a top Step 1 score and a top of the class average, you're not going to get a residency. You might as well not even apply. That's the system. So if you're going to deal with medical students, you have to deal with them knowing those things. All that said, I started teaching ninth graders and tenth graders, and the thing I know about medical students is they're not any different from any other student on the planet. If you're honest with them, if you're fair with them and they know that you're going to treat them with respect and you demand that they treat you with respect, you're going to get along fine. So I guess it's insecurity, I don't know. I don't know why.

But anyway, it was not a good situation. There was one class when I became instructor that the professor, who was a full professor – had been teaching for twenty-something years, and here I am and I'm an assistant professor and director of the program – he tells me I need to make those students stop talking in his class. I had to make sure my face didn't show what I was thinking, which was I can't believe you have so little control with your class that you have to say that to me. I mean, they were throwing paper airplanes and things. It was ridiculous, and it was because —. I'm telling you all this to show you that that was a problem that had to be resolved. Now part of the solution was eventually the next year we got an allocation from the legislature to hire some new faculty and staff. So we began to recruit faculty. But that said, in all academic departments you have a hierarchy of how decisions are made and who teaches what course and when and so forth. So without any real authority to change that, it was interesting. And it all ended up being relationships with — getting the dean to be interested in the success of the program and buying into what some of the changes needed to be and getting involved in meeting with the department chairmen to talk about situations and solutions and basically I guess just expectations and good will. Eventually demands that people not teach the students if they're not

appropriate.

Thomas: In the early years, accountability for the students to perform on boards and things, and then later accountability for faculty as well.

Hurt: Yeah. Well, the reason the students weren't performing on the boards were some of them were marginal students and they were in courses that weren't really parallel in objectives to those in the first year at Gainesville. And in some cases they were being taught — their time was not being used effectively, is the best way I can put that in terms of content of courses. So all of those things added up to poor performance. So you know, the first was easier to resolve – expanding half of the pool, make sure that you're accepting students that you know can handle medical school. And in truth, you know, it's not rocket science. Any average student with a good work ethic that's willing to work their rear off is going to be able to make it through medical school. So we wanted good students that had the warmth and compassion and the motivation for the profession, and expanding the applicant pool solved that.

Then making sure that the curriculum was correct was the second big challenge, and that involved getting our faculty into retreats with the guys in Gainesville, making sure that we didn't have to do the same things but that we were headed in the same direction. Then getting in some cases some new courses, new faculty involved in teaching those courses, and faculty that bought into what we were doing, that thought teaching in this program was important. We actually developed that. Because what I found in hiring faculty is if you talked to faculty at the front end, research faculty, about education and what your expectations are in terms of education, they will do it. Because they won't come here if they don't want to do it. And so that's how you get the atmosphere, the culture of commitment to excellence in teaching is you talk about it when you're hiring them. Yes, we want somebody that's going to be an academic scholar and succeed in your research and scholarship, but also we have a culture here that we're passing it on —

End side A

Thomas: I want to try to draw some thoughts together. I went back and read that article cited in — your academic medicine article on the ecology of medical care in the 1960s, and you've been talking about what was wrong with medical education, the inhumane nature of medical training, the emphasis on academics and little else that you think makes a good physician. Can you talk about some of the context of all those, what was going on in American medical education in general and why these — because this is coming up all over the country, it's part of a larger movement.

Hurt: Right, right. Well, you know, one of the first things — and I'm trying to remember how this surfaced — in my first year as director I was using some people from the family practice residency program at TMH to teach the clinical part of our curriculum. And the director of that program then was a guy named Mike McGill. I think he's a chairman of family medicine now at Utah. Anyway, we were talking a lot about problem-based learning and so forth and got — you know, what became obvious to me at that point through reading and so forth was that — and I hadn't seen that article that you're mentioning, the ecology of medical care, at that time. But

what became obvious to me was that it was a question of zebras and horses. In fact, that's the language that people use a lot, is that in the medical center like Shands, the students see the rarest, most exotic kinds of human conditions, the most extreme. And then they graduate. And if they leave the academic center and they come out to Tallahassee, the last thing they want to talk to you about is some chronic thing that you have that everybody in the world has, you know. Or colds. Physicians can give you a list of what the most common medical problems are. Well, what 80% of their practice is going to be. Well, they're not interested in that. That's boring. They want something exciting. And I don't know if you've ever seen any evidence of this yourself, but for example, my husband was on a fishing trip in Arkansas with the men in my family, and they rough camped up on the backside of a lake. He came back and two weeks later he had this thing on his back that I knew was not normal, and it turned out to be a bull's eye lesion that was Lyme's disease. And this was the first case that — this was like right when in the nation it was beginning to break as a story. When he went in to the doctor, showed it to them, I mean, they practically stood on their hands. They were taking pictures and calling people. So my point of telling that anecdote is they live for that. And the stuff that you and I live on every day and need a doctor for, they have no interest in. And that's because of this way they're trained. They're looking at that one case, not the 999 that they're really going to see. So there was that part of it.

The other thing I noticed going down to Gainesville to the executive meetings and so forth, I can remember going to a summer meeting in 1992 and they had invited in the head of AvMed, I believe, which is a big HMO from south Florida. And he was talking to them — I was in other meetings and I thought, "Oh, my god, this is a train that's going to hit them and they can't get off the track" because I could see that a place like UF's medical center that runs on patient referrals from out here, you know – it was going to ruin them, or at least carve them down, because with the managed care, those referrals are not automatic – they have to be approved. So it has cut them enormously in some areas. And so I could see that managed care was going to have this enormous impact on how the academic medical center functions. And in fact, over the last — you know, since that time many med schools have had huge problems with their — hospitals have had to change ownerships and close some down and so forth. So the financial implications of the change in the funding of the med centers has just been enormous in the last fifteen years, and I was kind of there at the beginning to see at the local level down there at UF how big that impact was going to be. And so obviously the way physicians are trained, the time was going to be right for that to change, pull it outside of this highly expensive setting in which so much of medical education occurs in the United States.

Thomas: I will stop there.

End

Interviewee:	**Hurt, Myra, Ph.D. (Associate Dean for Research and Graduate Programs, FSU College of Medicine**
Interviewer:	**Karen Thomas**
Date of interview:	**March 29, 2006**
Category:	**FSU**
Status;	**Open**
Tape location:	**Box #52 (3 tapes)**

[This is the second of three interviews with Dr. Hurt]

Thomas: So we had left off talking about the steps you took to get PIMS back on track in the early '90s.

Hurt: Right. So it was fall of '91, I believe, we put together the plan to upgrade the resources available to the PIMS program and what would be needed to enhance the applicant pool and so forth. The UF people approved of that. As I think I told you last, the Provost had put us on a list of endangered programs/species so to speak, because it was the year that the state budget was in a shortfall and red and they were taking money back from universities. So I didn't realize until a couple or three years later, actually, how narrow the escape was for the PIMS program. I mean, I knew that from the UF angle, they would have liked to have killed it if they could have.

The following summer, in '92, the legislature gave us (I'm trying to remember the exact amount) — it was like basically a half million dollars non-recurring and a number of faculty lines and staff to enhance the program. Out of that money, we renovated — we had been in the basement of Montgomery Gym, as I told you, in very poor facilities. We moved into new administrative space in what had been the amphitheater of the School of Nursing building, which we, for a little over $300,00, built a new administrative suite and a learning community space, learning center space for the students, which had been a PIMS thing from the beginning. It was a space they had 24-7 access to, to study in, group study and so forth. That summer, in '92, I was acting basically as the external director of PIMS; Bob Reeves was still nominally the director of the program until August. But I went to Gainesville that summer and met with the executive committee of the College of Medicine at UF. Our Provost (no, he was not Provost yet, he was still Dean), Larry Abele, went with me, and I made a presentation to the executive committee. It was a big room full of them, all the department chairs and the deans and the associate deans. I suppose it was a fairly intimidating crowd, if I remember right. I did a video presentation, slide presentation, to them about the plans to overhaul PIMS, basically, refocus on our historic mission, return the students to doing primary care preceptorships, enhancing the academic program by adding new faculty, by having yearly retreats with the UF faculty so that we could make sure that we had a comparable curriculum. It didn't have to be identical, but it certainly had to have the same objectives. And the fact that we were going to establish a novel outreach program to under-represented minority, particularly African American students, that we were going to create beginning in grade seven in Leon County schools; that we were going to — the key piece from their angle would be allowing us to participate in the national application service as a separate program. Prior to this time, we had had access only to applicants from Florida State, FAMU, and

UWF, I believe I told you before. And it was clear from my study of things that we needed to open our applicant — or we didn't have enough applicants, and that if we could be a separate AMCAS (that's the American Medical College Applications Service) – if we could be a separate AMCAS program and have any legal resident of the state of Florida have the ability to apply directly to us for one of our thirty slots, then we would benefit enormously. As I told you, we had sixty applicants for our class in, I believe, that cycle beginning in '92. There was quite a spirited discussion. I remember that Jerry Modell (Chair of Anaesthiology), who's still at UF (I'm trying to remember his name – Jerome —), he was the only one that really questioned letting us do that. He said, "Won't we be competing for the same students?" And I said, "You get over 2,500 applicants a year; we know that at least 1,800 are from the state, and you are only admitting eighty or ninety. I think there are enough for both of us." And so they approved letting us become a separate AMCAS program. This was critical to our success.

So in the following year when we became an AMCAS school, we went from sixty applications not being AMCAS to 900 in the first year that we were an AMCAS program, and ultimately stabilized over the period of the program that I was director at around 1,100 applications a year. So that was a critical part of turning our program around and becoming a program that was successful in the eyes of UF.

Thomas: I have a couple of questions at this point. At that point in the early '90s, you already said that state revenues were kind of in crisis and my understanding is that nationally medical school applications were in the decline?

Hurt: They were in the mid-'80s. They had already begun to increase. So it's interesting, in the US — books have been written about this — but when the economy's great, medical applications go down. And when the economy's bad, medical applications go up. In the trench in the '80s, that was in the junk bond - MBA period. So when we went into a recession in the early '90s, that was when the applications began to come up again, and they peaked late '90s (I can't remember which exact year it was). So it was an excellent time for us to do what we were doing. In retrospect, it was perfect, because lots of applicants applying and so forth. And that actually helped us in the establishment of the medical school as well, because we had some rough years we were out of AMCAS when we weren't an accredited program yet.

But you know, historically, looking back at it, it was interesting that this time period coincided with the time when again medical applications were on the upswing. So it was nice.

Thomas: So that seems like a really critical point, where you separated your applicant pool from UF when you had historically been —

Hurt: Well, we had the limited application pool here in the Panhandle, and it wasn't big enough; it wasn't nearly big enough to support picking thirty students. And so as I had told you last time, I believe, UF was supplementing our applicant pool with the applicants that they felt weren't quite good enough for prime time in Gainesville, but that were good enough for Florida State. Now, I said this to you before, and I'll say it again: all of those people that were admitted during the bad time and when people were failing and so forth, this doesn't mean they are bad doctors; they're good doctors. We are, you know, hog tied to this standardized test mentality for MCATs,

for national boards, et cetera. And people that come from rural areas, people that come from disadvantaged populations that aren't reading by the time they're, you know, five years old, are at a great disadvantage in this system. So I'm not saying that they're bad doctors. In fact, I know who some of them are and they're great doctors. But I'm just saying that from UF's mentality, and from the national accrediting bodies mentality, when you have half of your students fail in Step 1, you're not doing a good job and they're not going to accredit you.

Thomas: Well, that also speaks to another question that I had. You said that you were encouraging primary care preceptorships and also upgrading academics, and my understanding is that medical education was moving more and more toward a larger academic classroom component and away from the old style preceptorship.

Hurt: Well, so one of the founding principles of PIMS was that we wanted to — it's the principle on which we based the College of Medicine, which was we want to pick kids from — we want to recruit as many as we can from rural and urban under-served areas; we want to give them primary care experiences so that some of them will return to those communities and practice primary care medicine. That was a very '70s - '60s kind of deal at the time. Of course, all American medical schools went very far from that in the following twenty years. And so when I was looking at the original documents, the original grant proposal on which UF got money from NIH to create PIMS at FSU, here was all this language. And we had the remnants, because nobody had really overhauled the curriculum of PIMS in twenty-something years because of benign neglect, because of lack of visionary leadership, because of money, however you want to put it. So the remnants were there. And so I began to talk to people, read, and so forth, and what we did was we introduced some small group experiences for our students, which put us ahead of the curve, okay? Not of all schools; University of New Mexico was already doing some case-based instruction and so forth. So anyway, we were basically going back to our roots while incorporating some of the novel stuff that was happening in more innovative medical schools. Already it was becoming trendy to do some preceptorships out in the community. We actually had the time in our schedule because PIMS historically was a three-semester first year. The students started in the summer and then they had three semesters. So that decompressed the first year medical curriculum which everywhere is just a nightmare of cramming too much information into too short a period of time. Because we had three semesters, then we could require two semester-long preceptorships. And so our students all did that. We required that those were primary care preceptorships unless we had extenuating circumstances to the contrary. So our students had gross anatomy and began their physical diagnostic doctoring skill training in the summer, and then did their first preceptorship in the fall. And in fact, that's the way the curriculum is in the College of Medicine today.

Thomas: I think there's a very interesting theme running through here of there was this period of idealism in the '60s and also concern about the health manpower crisis, and a lot of work with like the Josiah Macy (Robert Wood Johnson?) Foundation, trying to increase recruiting under-served minorities and into health professions. And you say that medical education in general kind of got away from that as the '70s went on and into the '80s.

Hurt: Well, it was a big money period for NIH. So NIH, the growth of the research machine in medical centers in the United States reached a peak, really, in the '90s, where now, you know, in this very dark time where there's zero budget enhancements because of a lot of things including the war in Iraq. But anyway, so the growth of the research engine which was driving a lot of the medical centers in terms of money really made medical education, from my perspective, be the last priority in many big schools. Because the residency training programs were raising big money from the feds and the research was drawing down big money from the feds. And medical education, on the contrary, in a state-funded medical school, a big academic medical center was say, let's use the example of our colleague in Gainesville – only about 10% of the money that was funding the medical school, not Shands but the medical school, was coming from the state. So it's really a very small piece of the pie. And as you know, money drives most things. So medical education had gotten very far away from the patient, if you will, and the training of the medical student in terms of the patient. They were being trained in terms of disease.

Thomas: So part of your reform in PIMS, then, was to balance the preceptorships and patient-centered activities with upgrading the academic —

Hurt: Yes. We wanted both; we wanted both.

Thomas: And what did you do with the academic?

Hurt: Well, this has been my experience in dealing with faculty in terms of teaching. We recruited some new faculty. We used some faculty that had been here for a long time and had been involved in teaching of PIMS. And what I did was I organized these retreats where we got — we met with the year one faculty from Gainesville's College of Medicine. We went down there the first year — no, we had them come up here the first year. And then we went down there the following year. We did that for about five years. And it developed a sense of pride, which they hadn't had a source for before in terms of what they were doing, an identity with their colleagues at UF, a healthy sense of competition. We weren't doing things exactly the way they were, but when — we had this outcomes measure. Every year, our students would take the board at the end of year two, and they would split the scores out according to the content. So you could look at how well do our students do in comparison, because that's what UF had been pounding us with for ten years. And so it was a source of great pride to the faculty involved that here these scores are going up, you know, that you can see that what you're doing is making a difference. And also, we were able to do things for these faculty. In other words, cultivate their interest in the program. We did a lot of socializing, we did several major social activities a year with the students, with the faculty. So you know, it's building an identity, building a culture, if you will, in which teaching matters and is a source of pride and is rewarded. And this works, actually.

Thomas: My observation would be that that's a more feminine approach in some ways, but that it's also been recognized in, I guess, business circles as very effective. You may have mentioned that last time. I mean, it strikes me that what you're saying is you're building community.

Hurt: Yeah, it is a more feminine approach. As you just said, business models have recognized how important this is, major companies and so forth. But I read a book several years ago, I can't remember who wrote it, somebody — I'm not big into non-fiction and so forth, but somebody — it was feminine styles of leadership, and they had interviewed in the book several people, like the head of Girl Scouts of America and a woman that ran a big construction company and blah, blah, blah. And the big difference in female management versus male, at that time, anyway, when they wrote this book, was that women tend to have a wheel kind of concept where you have someone in the middle, the hub, and then you've got these spokes going out in all directions. And so you have more of a horizontal management style. On the other hand, men tend to be much more pyramid and top down oriented. The guy at the top talks to the guy next in line and the leadership filters down, where with this feminine model it's more that the hub is interacting with all of the component parts that are important. And it always works, in my opinion, if everybody is buying into this kind of community concept.

Thomas: If like the standard analogy for medical education is to say that it's like a three-legged stool, that there's teaching, patient care, and research. How did you — you said one of the things that you did was to emphasis teaching, because that often was the least emphasized thing of those three.

Hurt: And there are no rewards for it. So the way PIMS was structured, as I told you in our last chat, the problem was that the faculty were hired into academic departments in Arts and Sciences, specifically psychology, biology, and chemistry. And the director of the Program in Medical Sciences really had no input on their annual review. Now, they were hired into lines that were given to Florida State for the program, but those faculty lines were placed in these departments. So basically it was up to the kindness of the biology chair or the chemistry chair or whoever to make sure that faculty were assigned to these courses. And what had happened over the years of the Program's existence was that it came to be something people really didn't want to do, they didn't care about, they weren't rewarded for it, medical students are high maintenance, you hear all these things. And of course they're high maintenance – they care about their grades; they have to care about their grades or they're not going to go anywhere. And so, people were being assigned to these courses that weren't the best possible people to assign. And so what happened, when we got these new lines and I became director of the program, and the Dean became committed to making the program succeed, then we got some — I began to have input into the faculty evaluation of these faculty in their home department and who's going to be assigned to the course and so forth and so on.

Thomas: So there's more oversight —

Hurt: Yeah. Well, I call it the accountability thing. Before there had been no accountability, really, at Florida State in terms of the PIMS program. All of the accountability things happened in Gainesville. In other words, they took the exam at the end of year two, and this was the outcomes measure. There wasn't really an outcomes measure at Florida State that would have prevented the thing that happened in '91. And so with these yearly retreats where we were taking the faculty, we're looking at how the students are doing on the exams, et cetera, we got that

moved back to where it belonged. How are we doing here, at least by the objective measure that we have, which is the Step 1 on the United States medical license exam.

Thomas: Were there other types of accountability that you _____[??].

Hurt: Well, yeah. To give you one example – I did an exit interview every year that I was director of the program with a third of the class, one that we "selected at random." They were one-hour interviews. Actually what we tried to do was get a general distribution of the class in terms of performance academically, in terms of gender and ethnic diversity, and they thought it was random but it was not quite random. And I did this hour-long interview about the year. And I got a whole lot of feedback about courses, about the professors, about all kinds of things, about the learning community concept, about the whole — their preceptorships, how they felt about going to Gainesville, et cetera. Because we had built this sense of community, they felt — I assured them that nobody was going to see these except me, they could be honest. And so I kept these private. I would distill points which I would feed back to the faculty that were not linked to people or particular incidents. But I knew a lot about what was going on, and it was very helpful. And the faculty developed pride in the fact that we're trying every — we're not going to ever be content; it's always going to be an evolutionary process where we're trying to be better and trying to do a better job and so forth. And in return for that — I didn't have much financial resources available to me, but if somebody, one of the faculty, needed a computer and they couldn't get it otherwise, I could help them. And so again it was kind of a communal effort to make sure everybody had investment and was happy and so forth.

Thomas: Did you try to make teaching more important, for instance, in being evaluated for tenure or —?

Hurt: Well, I was fortunate this happened in a time where, for the first time at Florida State, people were recognizing that the teaching portfolio was an important part of the tenure binder. I actually had a faculty member tell me, "Well, you know, you don't really need to put anything in there except your evaluation forms." And I said, "Well, I've been going to some leadership meetings, and I believe that this is an important part of your binder." So he went in to meet with the chairman of biology and he came back and he said, "You know, you're right. Maybe we do need to work on this." So that was something that was also good, that the university had moved to the point, and actually I think nationwide, where it was recognized by university faculty that teaching was an important part of their getting tenure.

Thomas: Do you think PIMS was somewhat ahead on that or did that just evolve alongside what was already happening?

Hurt: I think we were different from the mainstream, yeah. Like I said, I think when you recruit faculty, if you tell them (and so we've done this in recruiting the basic science faculty in the College of Medicine, the young junior faculty) — if you tell them, "We have a culture in which teaching is valued, and so we're going to give you the time to develop your scholarship but we expect that you will become an expert teacher, and that's as important to us," they'll do it. I

mean, if they know up front that this is a valuable thing — I mean, when you recruit bright people that are goal-oriented, ambitious people, they want to be excellent at everything they do. And so if you encourage that, then they're going to work at being an excellent teacher as well. I mean, I think it's that simple.

Now, if they're not interested in it, if that doesn't appeal to them, if you talk to them enough about this during interviews, then they won't come here. And that's just fine.

Thomas: I think one thing that we had started to talk about but hadn't really gotten into much detail about is the program to recruit under-served minorities. And you said that from its inception, PIMS had wanted to bring people from rural areas in the Panhandle. Now, was ethnicity originally part of that or —?

Hurt: Yes, yes. So this was why FAMU was involved in PIMS' origin. And if you go back in history, there was at least one or two faculty members located at FAMU in the program. And that fell apart over the years. I actually tried very hard in my early years in the program's history to rebuild the relationship with FAMU, but it just didn't seem to be possible. And so, yes, recruiting African Americans in particular was always an important founding principle of PIMS.

Thomas: You can get into this or not, but why do you think it was difficult to retain those relationships with FAM?

Hurt: Ownership. I think that — I actually know that Frederick Humphries, who became president of FAMU about the time I became director of PIMS, had established as one of his goals getting a medical school for FAMU. And so he was openly hostile towards us. There were people at FAMU that claimed that PIMS had been stolen from FAMU. That was twenty-five years in the past at this point and I can't — all the documentation I found, the program was founded at Florida State. Because it was a research university, UF felt that we had the infrastructure, et cetera; because it was the '60s and the '70s, this relationship was built with FAMU to recruit students, and there was a pharmacology professor over there. At that time, pharmacology was in year one; later it was moved to year two. There was actually a staff person over there that — FSU had to send money over to FAMU every year to pay for this staff person in – it was an advising office, I think. Eventually we just transferred the line over there so that we'd have — you know, so that it would be cleaner, so to speak. Yeah, I actually brought the minority dean up from Gainesville to kind of mediate a couple of meetings. There was a woman in their (what was that office called? – it was the office that was involved in pre-med development), and she got a number of minority grants over the years to develop minority pre-med applicants. She, for whatever reasons, did not wish to work with us. I think I'll leave it at that. I was legitimately interested, motivated, and from my own point of view, wanted that relationship to work, because it is such a horrible societal need to have more non-middle class white males in the medical profession. I was absolutely dedicated to that even at that stage. We got very few FAMU applicants during the years that I was director of PIMS. We never got the best applicants from the elite program that was being run over there. Those people, those students generally went out of state to medical school. I knew because we had the data books come every year, so I could tell you everything about the applicant pool from FAMU or from any school in

the state, because I made it a point to know how many black applicants there were in the state, where did they go to school, what were their academic credentials, did they get into medical school, et cetera, because we studied this in great detail.

Thomas: Where did they tend to go to school?

Hurt: Out of state. The excellent applicants —

Thomas: _____[??]

Hurt: The top tier that are looking for — you know, they — this is such a problem in the country, recruiting black applicants, that the top students have their choice. And then there are a number of historically black medical schools. And for whatever reason, students from FAMU, not surprisingly, tend to go to some of those schools. So the students that were not in those elite programs didn't get the same advantages in advising and so forth. I know this because a number of them ended up coming over here for advising and mentoring. So we did recruit FAMU students, but it was difficult and there weren't many. So it became clear to me that — and also, I looked at a number of these what I call one-shot outreach programs. So you got these — NSF pouring money into these minority outreach programs where a student goes to — has a summer research experience or a student goes someplace and they have a six-week kind of mini medical school experience that's going to help them study for the MCAT or whatever. Those are kind of one-shot deals. And from — what was already clear to me was this is a holistic problem, okay? The problem is deficiencies in educational background, standardized test taking skills, vocabulary, knowledge of the system, knowledge of what the process is in terms of what's important to get into professional school. Because of disparities. And so that's how we began; kind of a farm team mentality, we thought. We will grow our own, so to speak.

Thomas: This is kind of a side question going back a little bit. When you were having discussions with the University of Florida about their applicant pool, aren't a much larger proportion of their applicants from out of state already, and then your applicant pool is limited to Florida?

Hurt: They actually were only taking about 5% from out of state, because — and actually, I think it's lower than that now. We have enormous pressure on us from the legislature. They're underwriting medical education, which is much more expensive than undergraduate education, for example.

Thomas: _____[??]

Hurt: Yeah. So if you — every meeting I ever had with — during PIMS' history and during the development of the medical school, any kind of staff member of the legislature, that would be their number one question: "How many out of state students do you take?" And I knew what the right answer to that question was.

Thomas: None.

Hurt: Exactly. So we had it all over our website then and we do now. Legal residents in the state of Florida only.

Thomas: I guess I'm a little surprised by that. I thought in Florida we'd have more out of state students.

Hurt: No. Miami is the school in Florida —. It's a private school, although it's heavily subsidized by the state. People don't know that. They get probably in the neighborhood of $15 to $20 million state money a year, which is approaching what UF gets — for example, we got $30 million this year, and we'll probably never get more than $35 or $40 [million]. Our applicant pool is big; it (the pool) is a little bit stretched by the idea that we're going to add two new medical schools, and some people see this as a problem more than others. But yeah, so legal residents of the state are the ones that the legislature in the state of Florida is interested in educating.

Thomas: So going back to the programs to recruit under-served minorities, you spoke about some of the tensions with FAMU and some of the difficulties, and just the fact that it was a holistic problem going all the way to _____[??] grade school. Just tell me more about the development of the recruiting program and of your leadership.

Hurt: Okay. So when we got the new staff positions — a part of the plan that I had proposed for enhancement of PIMS was the development of this outreach program, so we got a staff position for an outreach coordinator. But that wasn't one of the first positions we filled. I believe that the first position we looked for – we were looking for someone to do pre-med advising here, because that's what the PIMS office had always done, a heavy amount of pre-med advising. Which is money well spent, in my opinion, because our number one applicant pool should be Florida State University, the students at this school, because those are the ones we know the most about. And so when I was interviewing people for the first position that we had open after we got this enhancement money, one of the applicants was a middle school teacher at Havana Middle School. Her name was Thesla Berne-Anderson. And she applied for this position, this other position, and I told her at the end of the interview, I said, "This is not the position for you, but we're going to have an outreach position in six months or so, and you'll be ideal for that." And so I can't remember how many months later it was we got the position established and so forth, and I believe she began in like January of '94, and we started the program later that year, the program we know as SSTRIDE. So she's still with us; she is the executive director of outreach for the College of Medicine. She was a person with a bachelor's degree, just enormous energy and commitment and ideas and so forth, so it was just a marriage made in heaven, so to speak. Since then, she got her master's in higher ed – I can't remember what aspect – educational leadership or something, I forget, here at Florida State. Since then we've developed a complete pipeline program which — we were together in our vision that this is something that these kids, we need to start with them in middle school, we need to — and my whole thing was basic skills – reading, writing, arithmetic. Build their basic skills, build their standardized test taking skills, give them

motivational opportunities, and prepare them for science careers. And obviously we wanted to develop kids that would go medical school. And so first we built SSTRIDE in Leon County schools, in middle and high schools. At various points we were affiliated with various schools, but usually we were in about four school, two middle and two high schools. Then we eventually added an in college component which was basically support for any pre-med at FSU. Our target audience is obviously minority students, under-served minority students. They have a number of activities that you can read about on the web or you can talk to Thesla. But the whole goal's the same, to help them get through the pre-med curriculum, to give them support, tutoring, standardized testing taking, prep, et cetera, so that when they get to the point for professional school that they'll make it.

A really important piece of this whole program were the mentors. So we used college students that we recruited from FAMU and FSU to be mentors for the in-school SSTRIDE. This took place in school or after school, depending on what year they're in. Our SSTRIDE center here on campus or in their classrooms in their schools. And the mentors are our biggest success story. These kids that served as mentors in our programs, over 90% of them are in — went to medical school and are either practicing physicians, in residency, or in medical school. So it's been an enormous part of our story.

In the College of Medicine classes, the first five classes — so we have 200 — I forget what our total number is, but basically about a quarter of the students of the College of Medicine have come through one of our outreach programs. And the other piece of our program that I didn't describe yet is the Bridge Program. The Bridge students are students we choose from the applicant pool who are from under-represented populations, primarily rural and African American, that we take into a bridge year and they take some courses with the medical students and other science courses, and if they successfully complete the bridge year, they're automatically in the next class. And we've had enormous success with our Bridge students.

Thomas: Could you clarify something? You said that 90% of the —

Hurt: Mentors.

Thomas: — the mentors – that is the college students serving as mentors?

Hurt: Right.

Thomas: Okay. But then there's another group of people who are benefitting from the mentors.

Hurt: Yes. So we have a student in the first year class, Uchenna Ikediobi (Med Class of 2009), that started in the seventh grade in SSTRIDE. So we're just now beginning to see the first kids that came through the pipeline. The thing is — and we started rural SSTRIDE with the College of Medicine, so now we have SSTRIDE activities in — what's the county Crestview's in?

Thomas: Okaloosa.

Hurt: Thank you. Okaloosa County. We have a SSTRIDE program there. And I view the junior colleges in these counties very important, because that's where the mentors come from. And it's been very hard to convince some of the AHEC people we're working with that the mentors — I view the mentors now as the target, because the mentors are the ones we can succeed with. I mean, I think we'll succeed with all the kids coming through, but the mentors get the most intense experience and the teaching experience and so forth, and they're a real success story.

Thomas: Connecting back to what you said before, it's interesting that you're already training college students as teachers to prepare them to go to medical school, where you're emphasizing a culture of teaching. So there's all these reinforcing things going on. That's very interesting.

Hurt: To finish the rural SSTRIDE story, we have a program in Gadsden County this year for the first time, and then we have a Madison County program that's in its third year, I believe.

Thomas: When was rural SSTRIDE —

Hurt: The year after the founding of the College of Medicine, or maybe it was two years. But anyway, it was '01 or '02. And it's early yet. But the objectives are the same, to develop an applicant pool that —

Thomas: If I can just ask — if the original goal of PIMS was to recruit students from under-served areas, I guess, what were they doing before?

Hurt: The way that all medical schools do it, by picking kids from the applicant pool, looking at applicants from these rural counties – and there aren't many of them. Okay, that's the problem. You know, I have heard faculty in this college, "We're not picking enough rural students." Well, there aren't any rural students that end up going to medical school. The obstacles for a kid from an under-served population, where, let's say that the educational opportunities are less robust – they tend to not do well on standardized tests, they tend to not end up at a university like Florida State or UF, and they don't apply to professional schools. That's our problem as a society.

Thomas: So in order to bring more students from under-served backgrounds into the program, if you'd just look at the existing applicant pool _____[??] having to lower your admission standards. Is that correct?

Hurt: Well, yes, that's one way of looking at it. Kids from what I call an underprivileged background — let's just say the politically correct way to put that is from an educationally deprived background — they tend to not do as well in science, they tend not to do well on standardized test —. And I am absolutely convinced it's English language and reading, and if we taught English as a foreign language in our schools, I believe — you know, like you teach Japanese or whatever — I believe we'd do much better with all of our kids —. Anyway, those kids tend to not do well on the MCAT or the LSAT or any of those kinds of – the SAT, et cetera.

And so if you prepare them for the SAT — I could show you data where just a few little lessons on approach to taking standardized tests — we can show you — will make at least 100 points on the SAT difference. So yes, I could tell you that the average score on the MCAT, that predicts that you're going to pass Step 1 of the national boards, is 24. The average score for kids going to medical school in the US is 30 – six points above that. We have accepted people while I was director of PIMS that had scores as low as 15 – 15, okay? But because I knew what I was looking for, which was a combination of work ethic, the MCAT scores were lowest on verbal, not on science, they did well in school in terms of their science GPA, and they were deeply motivated – work ethic. They make it. Now, they have to work hard because they're starting out behind. But this is not rocket science. The problem with the medical curriculum is that it is enormous; it's big. It takes a lot of work. You have to really want to do it, and you have to be willing to put in the time. And that means you don't have much time for anything else. So if you pick out the right people and you know what you're looking for, you can go beyond the numbers that people tell you that you have to have to succeed in medical school. But people aren't willing to do that.

I could show you that with individuals that we've worked with, that, you know, this is simply an educational problem and you can remove those obstacles if you know what you're doing. And our society doesn't — and it comes from all directions. What has made our students succeed in our outreach programs, the in-school, seven through twelve – require that the parents be partners in that process. If the parents aren't interested, then it's not going to work. Now, you know, people will say, "Well, that's not fair." Well, that's a fact. If the parents don't value and promote the opportunity to their kids, it's probably not going to work. So the parents are an important part of the in-school SSTRIDE.

End side A

Thomas: We were talking about educational reform in the big picture and how you had gone back and looked at kind of the founding documents of PIMS and there were all these very visionary and ahead of their time ideas that seemed to have kind of faded out over time, over the past two decades, and then you came in and wanted to revise them, and by that time they were kind of cutting edge again. Can you speak more about the origins of PIMS and the ideas that influenced the founding of the program and then they way you said you picked those ideas up again.

Hurt: Well, so PIMS was one of a number of programs that were born in the late '60s and in the early '70s in the United States. And as I said before, NIH had capitation (head count) money because of a physician workforce study showing that there were deficiencies. So they put out money to increase the class sizes in the United States. And the way several schools did it was like PIMS did it, and the most notable example of that, the WAMI program in Washington (University of Washington), WAMI, which is an acronym for the states involved. And the idea was you had an off site first year experience. The recruiting of the students was from that area; that area was rural or otherwise medically under-served, and you did this off site first year and then you brought them to the main campus to finish their education. In the WAMI program, they actually sent the students back to their home states for part of their clerkship training in year three. Wyoming, Montana, Idaho, and Alaska participated in the WAMI program. And that's a

still viable program; it's very successful. Anyway, PIMS was born at UF. Manny Suter was the dean at UF then and he's a very visionary guy; I met him later. And he had this same idea, that the Panhandle was a good spot for them to expand to because we have all these under-served communities, I mean counties. We have like, I think, twelve counties in the north part of the state that are federally mandated medically under-served counties. I think we have one county that has one physician – I forget which county that is. Anyway, that's true now and that was true then. So Florida State had the research infrastructure to — one of the founding precepts for a medical school, according to the accrediting body, is that the teachers of medical students are supposed to be engaged in the generating of new knowledge. So that mean research faculty, right? And so this was an up and coming school. The science part of the university was born in the late '40s, so by the '70s we had a big physics and chemistry and so forth. And so the idea was that they would start a program at Florida State. They sent someone that was on the faculty at UF, Paul Elliott, up here and he was the first director of the PIMS program.

Thomas: And then — obviously the predictions in the '60s, with all the talk of the health manpower crisis and the enormous expansions of class sizes and new medical schools left and right, that kind of played after a while. How does that affect PIMS? Because there wasn't necessarily a health manpower crisis —

Hurt: There actually was. See, I would argue with you on that. What we had — the AMA, basically, the professional group in the United States that is the American Medical Association, took the stance in the '80s that there were enough doctors in the United States, and they never varied from that. There were a number of studies, and the AMA and the AAMC, the American Association of Medical Colleges, jointly accredit medical schools. So you've got an enormous conflict of interest. You have the AMA, which is the professional group of physicians, very involved in the size of the physician workforce, so that the position became, "We don't need any more physicians in this country." At the same time, the population was growing enormously. So what happened was residencies began to grow. And because the residencies were growing but the medical student numbers weren't, foreign physicians began to fill those residency programs. So we got the international medical graduate becoming very important in the physician workforce. It was an implicit policy, not explicit, but implicit, that we would not grow American physicians; we would use internationally trained physicians to meet the workforce needs. And so this began to be something I began to read about in the '90s. It was obviously not correct, what the American Medical Association was saying, in a state like Florida, where we had at the time I became involved something like 400 seats in medical schools and a population of 16 million people. This is ridiculous, okay? And that's why 95% of the doctors in some years that are licensed in this state are educated out of state, and 40% of them come from other nations. So many of the physicians in this state are international medical graduates because of this implicit policy of the AMA, that we don't need more medical graduates in this country, while at the same time bringing in foreign medical graduates to populate residencies which were growing like crazy because the federal money was there. So the workforce was growing, it just wasn't growing by educating our own physicians. So there were no new medical schools — no new medical schools came into being in this country — Mercer Medical College was established in the '70s, late '70s. University of South Florida was established in that time period, but Mercer was the last one to get

full accreditation, I believe, in the early ‘80s.

Thomas: There was one established at Morehouse, I think.

Hurt: It was before then. I can’t remember when, but I remember the list. So when we began to talk about having a medical school in the late ‘90s, this is the flak we were getting. “We don’t need more physicians, different studies have shown that we’ve got too many doctors, blah, blah, blah.” And it was all based on what I call misguided ideas about physicians and competition and so forth.

You know, there have been enormous stresses on physicians in this country in terms of the health care system, reimbursement, malpractice, et cetera. And the simplistic people who don’t look beyond the surface thing, supply and demand is the problem. And it is not supply and demand. It’s not from competition that those stresses exist; it’s from the inadequacies of our health care system. And all of those studies have turned around now and the AAMC — I sat and watched the president of the AAMC in November tell the whole body in November that every medical school in this country, “We need to increase the number of MD graduates of our medical students in this country by 30%. Timing is everything.

Thomas: And I wasn’t claiming that the manpower crisis <u>didn’t exist</u> [??], I’m just saying that politically it goes up and down and people disagree.

Hurt: Well, I mean, in the early years of this country, until there were medical schools really like we have today, you know, anybody could become a physician if you just went and paid your tuition. So it really was after World War II that that all changed.

Thomas: I think this is probably a good stopping point.

End interview

Interviewee:	**Hurt, Myra, Ph.D. (Associate Dean for Research and Graduate Programs, FSU College of Medicine**
Interviewer:	**Karen Thomas**
Date of interview:	**May 23, 2006**
Category:	**FSU**
Status:	**Open**
Tape location:	**Box #52 (3 tapes)**

[This is the third of three interviews]

Hurt: The question that people commonly ask is, "Why do we train our students this way? Why would we want to train our students this way?" I can't remember — somebody was asking me this in the last two weeks. And I said, you know, "The number one reason is that this is the way the health care system is structured today. The hospital is the last resort. Most care happens outside of the hospital." And this has been going on for ten-fifteen years, you know, the conditions that you went to the hospital for, now you're treated outside the hospital. So we're training our students for real life. And the other reason is the economics of building a hospital is such a tremendous investment and it's an investment in a system that is not working. Most hospitals or not-for-profits are losing money. Hospitals in the last twenty years have gone bankrupt and everybody knows that small towns are having horrible problems with hospitals. So the hospital, per se, is a different thing than it was ten years ago. So basically, why would we build a hospital is my question. We don't want a big hole in the ground to pour money in, because that's basically what they are.

Thomas: Going back to our first two interviews, is there anything that you want to pick up on? I know one thing was _____[??].

Hurt: Well, what I was going to say is that the idea — FSU had wanted a medical school for thirty-four years. But when I became director of PIMS in 1992 and really got to know all the aspects, had dug through all of our historical documents and kind of refocused us on our mission and so forth and learned the people at Gainesville and how this program worked and so forth, it became clear to me that because of the emerging sources, I could already see the forces, and so could a lot of people, that were going to drive health care out of the medical center. I actually put together a proposal that I gave to my bosses here at Florida State and eventually presented to the dean at Gainesville in 1993 to have a community-based track in the University of Florida College of Medicine where students would do their first two years at Florida State and then there would be three clinical training sites. There would be Tallahassee, Gainesville, and Jacksonville. Jacksonville is already the "urban" training center for the University of Florida. And that students from UF could train and actually do electives at Tallahassee. That wasn't going to be an unusual thing. But anyway, that we would put together these three training sites, and we would have a community-based track in the UF College of Medicine for students that wanted to do more training outside the med center. And I went to Gainesville with the provost at Florida State at that time, Bob Glidden, and presented this to the dean and a couple of the associate deans. Allen Neims was the dean of UF CoM then. And they listened politely to me, and I never got a real

response. I learned later that they actually talked about it. But every medical school in this country that has existed for longer than twenty-five or thirty years, all of their resources are invested based on history and tradition. And they don't have any loose change anywhere. In fact, doing anything new or innovative means that something historical has to be given up. So the pressure to maintain is way more than the pressure to change or innovate. So obviously that went nowhere.

That idea, I talked about it with the dean and the provost here. Larry Abele was the dean at that time; he's our provost now. And so we always knew the time was coming. We were talking about it. I was busy doing a lot of other things, cleaning up PIMS and so forth and so on. But when things really got rolling (and I can't remember if I told you this or not), but I got a phone call at my desk the Friday before Thanksgiving of 1997 from the president of Florida State, Sandy D'Alemberte. And he said he was going to US for a ball game. I'm certain I've never verified this with anybody, FSU, UF. And he's on his cell phone. And he said I had to meet a person in the House of Representatives named Durell Peaden, who was a physician from Crestview and wanted to come visit PIMS because he had — he was talking about the same kind of model for a medical school that we had been talking about. And so in early January of '98, Durell Peaden came to visit PIMS. The people meeting — Larry Abele was there and D'Alemberte and Don Foss, the dean of Arts and Sciences until 2005, and I think Jim King might have come from Jacksonville, and perhaps Senator Childers from the Pensacola district. But anyway, it was primarily a dialog between Durell Peaden and I. Durell had practiced in Crestview for twenty-something years and had seen for himself the inadequacies in the health care system for rural and elderly. And he asked me if there was a medical school at Florida State, what would it be like? What would the mission be like, what would the clinical training be like, et cetera? And so I told him about this model, and I told him I'd read about it and I knew about some of the pieces that had been tested in other places, in Minnesota and Michigan and so forth, and that this wasn't rocket science but it would work and so forth. And he was grinning like a cat down there at the other end of the conference table because he had been, you know, had some of the same ideas. And so we really hit it off. Politically we're as far apart as the moon is from the sun, but on this particular project he and I were of one mind.

And so the process began really — he introduced a bill that spring and withdrew it because there wasn't the support there. We immediately — I mean, when the talk got serious, the state medical schools circled their wagons and there wasn't a need for a medical school because they always have this idea that there's one size pie. They're still using this argument against the other proposed medical schools, that the state pot of money is the same size, so if they get — if somebody else gets a slice, I get less. And the stupidity of that argument is, "Of course the pie's not the same size. This state is growing by leaps and bounds and our revenue is going and who knew that hurricanes would be good business." But they're still using that argument.

Anyway, so basically the bill that created the medical school at Florida State was introduced three times, in spring of '98, in spring of '99, and in spring of 2000. In the spring of '98, the compromise was that FSU would hire some consultants and we would do some studies on the model and so forth, and that the university got some resources to begin to create the infrastructure for the medical school. In '98 — (I'm trying to remember what the activities were that happened. I have this all in my journals). But anyway, over the next two years, a group of us visited North Dakota, which has a rural mission and rural training sites. We visited Michigan

State, we visited several of the campuses of Michigan State, Kalamazoo —. East Lansing is where the home campus is. We visited Kalamazoo, we visited Grand Rapids, and a group of us went to the northern peninsula of Michigan where they have a small rural campus. We began to look at and talk to the people that are involved in similar kinds of models of medical education. We hired a consulting company called MGT of America, and they did a number of studies for us. But the most interesting was the one on need. Because at the time, the conventional wisdom of the AAMC, American Association of Medical Colleges, and the AMA, the American Medical Association, based on studies from the Pugh Trust and Carnegie and I don't know, said there was a surplus, there was going to be this huge surplus of physicians in the United States. And this defied logic, because there hadn't been a new medical school created nor a seat added to an existing medical school since 1981. What was happening to the population of the United States? I mean, come on! Plus, the physicians were getting older. I found a paper published in, I believe, JAMA, by a group of New York physicians in like '96 that began to talk about international medical graduates, that the AMA was allowing international medical graduates to fill the gap in the need for physicians. Now there's nothing wrong with that per se, but what that means is that students in this country didn't have the opportunity to become a physician if they wanted to be one or were talented enough or otherwise called to be one. And also, a huge number of our physicians were not trained in settings where the culture and the ethnic, you know, the various cultural competencies that you need to really serve the patients that you treat.

So all of this came out in the study that MGT did for us. It's not rocket science. I mean, if you looked at the licensure rate in Florida, over 90% in any given year from outside the state, 40% of those people were international medical graduates. And if you looked at the big states and how many medical schools they had, if you looked at small states – look at North Carolina. North Carolina's got 7 or 8 million population and seven medical schools. And here in Florida with this — you know, at that point when we were studying this, it was like 16 million population; now it's 18 million — we had three allopathic medical schools. The numbers didn't work.

But we had a huge uphill battle. It was very contentious, and the local physicians were very threatened. Because when you said to them, "medical school," what did they see in their mind? They saw Shands. They saw the teaching hospitals where they were trained. And so they actually said to me, you know, things like — because my husband's a physician and I socialize with some of these people — you know, "You're going to hire x-number of surgeons and we'll be out of business." And my argument was, "No, we're not going to do that. But moreover, you can't see the patients that you have. You have so many patients, you can't see people for months in advance. What does that mean? When was the last time any of us called the doctor's office and said, "Sure, come tomorrow." So you know, the whole inadequacies of the system were abundant and still are, but yet people aren't — actually, all the studies on physician workforce now have turned completely in the other direction, and the leadership of the American Association of Medical Colleges wants the number of medical students in this country to increase by 30% in the next five to ten years.

Thomas: The AAMC does?

Hurt: Yeah. So we turned that around for people. You know, our arguments, our studies, et

cetera, are responsible for the fact that now there are — I've been offered two consultant jobs in the last six weeks from people who want to create medical schools in other states. And almost every medical school in this country is planning to expand. So you know, we were the first and we paid the price for it in terms of accreditation. We had big opposition at the national level, at the state level, and at the local level.

Thomas: When you say at the national level, you're talking about AMA and AAMC?

Hurt: Yeah, yeah.

Thomas: Was there ever any discussion of like federal funding or federal programs that benefit medical education and how they might help or not help FSU?

Hurt: Well, sure. I mean, our students — many of our students, in the PIMS program and currently, are kids from rural areas who are the first in their families to go to college, much less medical school. You talk about returning to their community and there are national funds that students could get to support them in medical school. Our students couldn't qualify for that until we were fully accredited. We sent people to talk to, you know — absolutely we could not qualify for that. There are lots of foundations. There's been federal money available for the very populations that we want to serve. We were not able to apply for any of that money until we were fully accredited, but we always knew it was there. Our geriatric department has been applying for both federal and foundation money. They got federal money this past year which unfortunately the Republican Congress is getting ready to zero-line all of the aid to the elderly and the under-served; all of those programs are — well, it's a $2 billion bill. I forget what it's called, but it's about $300 million in programs towards the very population we want to treat are being zero-lined. But that won't always be true. So yes, that's always been part of our picture. And building our research and so forth in the areas of our faculty is part of our big picture.

But we always planned to run our educational program on the money that the legislature allocated. By comparison, a state school in our state (which will remain nameless), you know, allocates resources based on history and tradition. And in an academic health center, you have a hierarchy. You have the clinical practice fund which is creating the dollars on which things run, and you have the research mission which is also bringing down federal money and creating dollar flow. Then the training of residents in residency programs also bringing federal dollars. And at the bottom of all that you have the students. And the students really are the last priority, because they're not generating any cash. I mean, that' s a cynical way of explaining it, but — well, if you look at the percent of the dollars of a several hundred million dollar budget of a typical academic health center (and I'm not talking about the hospital budget, I'm talking about the medical school's budget), if you look at the percent that goes to purely education, you'd be shocked because it's all tied up in the practice of the faculty, the research of the faculty and the training of the residents and at the bottom of that is the medical education.

Thomas: This traditional model of medical education being this three-legged stool of research, clinical, and education is inaccurate.

Hurt: I didn't say it's inaccurate. I'm saying that in the early twenty-first century, all of the schools that are older than fifty years old have become addicted to the cash from those two sources and grown their faculties enormously based on those two sources. And so they are invested in maintaining those cash flows. There are very dedicated people invested in the medical education in these schools, and they're doing a great job. But what I'm trying to say is that that's not the place where the money's coming from. So you have to pay attention to that, because you've got this enormous infrastructure, thousands of faculty, you know, a huge facility, and to keep it going requires huge sums of cash.

Thomas: I think that in comparing some of the other states that have founded medical schools, especially in the South, there was a desire on some legislators and other people that medical schools would be a way to channel federal funding and other types of funding and basically that medical schools would somehow be an economic engine.

Hurt: Oh, they are an economic engine, locally.

Thomas: Right. So they're very expensive on one hand, but they also generate —

Hurt: Well, it's one of those deals where the spinoff is — well, look at our medical school. We've hired over 100 full time faculty in the last four years. All of those people came to FSU, a huge number moved here from elsewhere. They bought a house, they live here and they're being paid salaries that they're spending in our community and so forth. And then the research labs are growing and they're bringing people here from other states and nations and all of those people live here and so forth and so on. So yes, it is a big economic engine. But the structure itself, the beast itself, has to be fed to run. So yeah, it is a successful enterprise.

Thomas: It's almost like football.

Hurt: What do you mean?

Thomas: The beast having to be fed. That's it's a very expensive enterprise and yet it also —

Hurt: It spins off — oh, yeah, there is no doubt about it. And now when you look at — you know, the governor of Florida wants our state to expand in the biotech arena because, you know, the days of hard industry are past. And so if you want to grow economy, a good area of investment is biotech. If you look at North Carolina, if you look at, you know, California, et cetera. So yes, biotech growth comes out of the medical schools. And so this is an area that our governor is throwing money at now. And it's long overdue, in my opinion.

But when you get back to focus on education, see, what I would argue is that you can have it all. You can have the money, you can have the growth, but you have to have the commitment to the educational program as well. And that's, I hope, the way we're structured with these community-based clinical training sites. We don't get the clinical revenue. Our faculty are part time faculty that are affiliated with hospitals in their cities, that are in private practice, et cetera.

And so the money that they make on their clinical practice belongs to them or whoever they're working with. We pay them to teach our students. So our students, it's clear to them the value of our students. We're not asking them to volunteer, we're asking them to, you know, invest in learning to become a teacher, learning to, you know, be a clinical faculty member, et cetera. But we're actually paying them. So it's kind of the reverse of the relationship in an academic health center.

Thomas: And my understanding — I've done interviews at University of Minnesota where they told me, "We became more and more dependant on the research dollars because the state funding just wasn't enough."

Hurt: Well, see, that's true and it's not true. The example I know best is the one I studied at close range, and I was down there (UF) every other week for about four years. So what happens is — how it happens is that the research enterprise is growing and you get this indirect cost money coming back from NIH, which is very lucrative. And you want more research faculty to create more dollars. And so you hire people into soft money positions or you do what a lot of state-funded medical schools did, they took their state-funded positions and began to split them so that maybe if you're a faculty member at XYZ medical school, you only get half of your salary from the medical school and you must bring in half of your salary from NIH grants. In some private institutions, that's 100%. You get a lab and the right to do research and you have to pay your own salary, right? And you bring in the indirect cost money and the school hires more people, right? So at some point you have 500 basic scientists and you're counting on those research dollars to pay their salaries. That's when it becomes — to maintain where you are or to grow, you have to have it. And the percentage of the state money is shrinking in comparison because it stayed the same. It's not that it's less, it's the same. And the clinical money's growing and the research money's growing and so, you know, we're getting less state money. Well, no, you're not getting less, it's less of the percent, you know, of the whole. Where at one point maybe it was 50%, after fifty years maybe it's 10%.

You know, when we started in year one, basically state money was 100%. And we're down to about 70% now or something like that. And what will it be in five more years? Of the total budget is what I'm talking about. But what you have to do is you have to have a mission-based way of budgeting that state money, and actually Bob Watson at UF wrote a very nice paper on that several years ago, that you use that state money for what it was supposed to be used for. Novel idea, huh? But for us it's easier. We're new and we know this money comes from the state and this is the way we're allocating it and the primary mission is to, you know, educate medical students in this new way.

Thomas: That's really interesting. So you had gotten into how the College of Medicine was founded. You had started talking about that. And Durell Peaden. And you have talked some about the opposition from the AMA and AAMC and they way they did the applicant pools and things like that. Politically within the state and within the university, tell me what kind of obstacles you faced in founding the medical school and how you overcame them and what that process looked like since '98.

Hurt: Well, you know, our opposition in the state – the Board of Regents — the medical school energized the Board of Regents and they took a negative stance. We couldn't afford another medical school; the was no need for a medical school. So we're getting hammered from the oversight body for the universities who are supposed to recommend new programs to the legislature. They actually took a negative vote on it in '99, I believe. In the year that we came into being, we had a new chancellor; I forget his name. Anyway, they refused to take it up as an issue. But they had hearings on it in '99 and we called in witnesses and so forth, and they refused to take it up as an issue. The university — inside the university there were people that were quite excited about the idea, but my boss was the dean of Arts and Sciences (as PIMS director), and he wanted to own it. He wanted all of the resources that were coming, because —

Thomas: Was this Larry Abele?

Hurt: No, this was Don Foss. By this time Larry Abele was provost and Don Foss was dean of Arts and Sciences. He eventually wrote a document describing how this would be in the College of Arts and Sciences, and he was my boss. So on one hand I'm trotting around the state trying to sell this idea, going to rural communities with our consultants trying to develop some momentum, visiting the AARP and testifying in the legislature, writing the program, and the dean is postulating this model that I know, and anybody that knows about medical education knows, we would never become accredited because the person — to be an accredited medical school, the number one thing they have is that there must be central management of the medical curriculum and that person must have complete authority over resources. Well, the dean of the College of Arts and Sciences is not going to be that — you know, you're not going to be able to sell the LCME (Liaison Committee on Medical Education), the accrediting body, on a model like that. And moreover, you know, my doing my job as director of PIMS showed me the folly of such an idea because I was in biology as a faculty member and I had basically no authority to appoint faculty for PIMS. They could take the faculty lines that I got for PIMS and we would do a departmental search, and I was the witch because I demanded that these people actually be able to teach the courses we were hiring them for and actually be — that I have some input on their annual evaluation as to whether they were doing that job or not, teaching medical students. Because when I came in as director of PIMS, the professors that were teaching were teaching a graduate course or whatever course they wanted to. And the fact that these students couldn't pass the national boards was no problem on this campus. It was a problem down there at UF. So you know, the first thing I saw was the disconnect between the quality control of our product and the control of the resources that led to the students being able to pass the boards. So I knew that that wasn't going to work, because that's just the nature of the beast. The biology department, the faculty of the biology department, you know, their investment in the PIMS program was their commitment to teaching or more pragmatically, most of the department saw it as a source of faculty positions. So it had worked well and not so well over the thirty years of the program depending on leadership. It was clear to me that it wasn't going to work; we wouldn't be able to do it otherwise, and everyone involved knew that.

The dean decided to fight. He tried to get control of the design of this building (College of Medicine) in the early stage, and in fact did spend some money on design of the building. And basically it was a research facility for the biology faculty with a little bit of space committed to

teaching of medical students. He created a committee to work on creation of the medical school, and he put — the people on it had absolutely no background in medical education, knew absolutely nothing about accreditation. And I'm not going to name any names, okay? But I could.

In August of '98 was when I knew it was going to be war. We had gotten some positions from the legislature to hire people to replace some people for the PIMS program, and the dean gave those lines to biology and basically tried to cut me out of the loop. It was at that point that they all realized that I was committed to this vision we had for creating this new kind of medical school. You know, the reason that President Sandy D'Alemberte wanted a medical school was that any top-notch research university in this country has one, right? So that was why he wanted a medical school at Florida State when it started. He'll tell you that. He came around, but that was how it — where it began. But for myself, I saw that we could do something that needed to be done and we had the perfect environment in which to do it. We had the knowledge and experience of, you know, several generations of medical educators that we could build on without all the baggage. And so at that point I became kind of an outcast in my department where I had become tenured. I was the first woman in biology to become tenured with an unanimous positive vote, ever, since FSU became coed. All right? And because of my commitment to this project, there are still a couple of people in leadership over there that absolutely hate my guts because I'm "no good" because I went off in this direction, whatever. Anyway, I guess my point of all this is there was a high personal price to be paid, because these were my colleagues; these were people I've worked with for years and they'll tell you right now, some of them that don't know me, five years later, you know, that I'm no good, my science is no good, you know, blah, blah, blah, all this stuff that pushy women get called. Anyway, if they want to blame me with the medical school, then I say, "Thank you."

So it was a tough battle, and there's still baggage there in biology. We still are working to build relationships, because they didn't want the medical school. Because of Don Foss's "it's my way or the highway" kind of commitment, and he's left that behind him. I understand that when big resources are at stake, these things are going to happen. But he left that kind of legacy behind in biology that —

Thomas: When did he leave?

Hurt: He got a job last year and went to the University of Houston. Up until the time he left, everything we did that involved anybody on campus or anybody in Arts and Sciences or you know, he was tattling to the provost, "Oh, the medical school did so and so," you know. So a lot of antagonism which hopefully will be completely gone when all of us are gone. But anyway, everybody else on campus, I think was very excited about the idea of getting a medical school because it brought so many new opportunities for collaboration and growth and so forth.

Thomas: I'm sorry, I'm still not clear on why Foss was so hostile and why he didn't see it as a mutually beneficial thing.

Hurt: Because he and some of his colleagues decided that it would be a drain on resources. That even though there was money coming to create the medical school, ultimately the university

would have to somehow make up the difference, that it would cost all of them. That it would change the culture. That we would have all these high paid faculty over here and it would create morale problems, because the other people in life sciences wouldn't be making as much money. All this is complete junk, okay? But nevertheless, that's what it was about. So you know, the thing for me that has been instructive is that you think that academics would be people that are the most open to change, because in general academicians are liberal in their politics and supposedly open to new ideas, et cetera. But in fact, it's just the opposite. They're just like everyone else – change is the most scary thing there is. And so I think for the rank and file in biology that got sucked into this (and it was primarily biology and chemistry departments that were energized by their leadership to be the most terrified of this idea – and psychology), it was "how is this going to affect me? I've got it pretty good, and how's this going to affect me?" That's how people always are, regardless. You know, "I'm in my comfort zone; there's something new happening. How's this going to affect me?" Don Foss is a nice man. I could sit down with him today and have a nice conversation. But visionary leadership is rare, I have learned. This (the Med School) happened because the leadership in the House of Representatives, John Thrasher, wanted to leave a mark. And one of his colleagues, Durell Peaden, came to him with this idea. You know, John Thrasher was an alum of Florida State, he'd worked for the Florida Medical Association, he was their executive director or something in the past. I don't know how it really evolved, but I know that some combination of Durell, but certainly John Thrasher was why. He had the political clout and he became committed to making this his legacy, okay? Sandy D'Alemberte, as president of Florida State, was transforming our campus in terms of how it appeared and new buildings and so forth. But he viewed getting a medical school for Florida State as his legacy. And that was the sum total at the beginning of his expectations – and John Thrasher's – a medical school at Florida State. Larry Abele was provost, and so it would become his legacy, right? Now that was the total of their ideas. They had no knowledge of medical education. And to be honest with you, John Thrasher is a politician. He could have cared less.

So I was sitting in a leadership workshop at Harvard in June of 1999, and we had this business professor talking about how change happens in established corporate cultures. Basically it doesn't happen because the commitment to maintaining the culture and how the decisions are made is a product of the culture. You just don't find transforming change. I mean, he used the computer industry as an example for us. The people who made the mainframes back in the early years, the only company that survived the change to the chip was IBM. And the reason was, they put out this pod in Boca Raton that was self-governing, completely separate from the rest of the company. There was no influencing of decisions from the parent. It was a completely independent pod, as it were. And that's how IBM survived a dramatic change.

So I'm sitting in this classroom and I was listening to this and I thought, "My god, we can do this!" Everybody in medical education in the US knew what the new medical school should be like, what the new medical curriculum should be like and how clinical training should happen in ambulatory sites and how medical students should be trained in small groups and to restore the art side of medicine, blah, blah, blah. I mean, reams had been written on this, you know. This wasn't new. But the existing medical schools couldn't do it, and it's because they were so invested in maintaining the culture. And I thought, "My god, we can actually do this, because all John Thrasher wants is a medical school at Florida State. Now yes, he wants something that's going to serve the state, but you know, he's not a medical educator. And Durell Peaden knows

what his people need in west Florida, but he's not a medical educator, right? And our president and our provost, you know, down the line — so we can actually do this." And from that day on, I thought, "My god, whatever I have to compromise professionally in terms of my time for science, in terms of the teaching that I love, who gets this kind of chance in a lifetime?" And then I remember the moment in the spring when I knew it was going to happen (it will make me cry). It was amazing – it just all lined up.

Thomas: Spring of 2000?

Hurt: Yeah. So it's something that — it was an honor, but it was hard work. And I don't know where we go from here, but it's certainly worth the cost because where I felt — I believe in God, and I'm not saying I was chosen. I'm just saying it happened because of amazing things.

Thomas: You were in the right place at the right time.

Hurt: It just was amazing to watch it all line up. It's like that — what is it called when the planets all align? There's a word for it.

Thomas: Convergence? Harmonic convergence.

Hurt: To be involved in something this grand and watch it all fall into place. And it was hard. I'm not saying it was easy after that. My god, that was just the beginning of the hard work. But it was truly amazing.

Thomas: So the political forces that had been so against this medical school — what changed their minds? What overcame especially the opposition for the Board of Regents? You said there were hearings and people testified —?

Hurt: People blamed John Thrasher for the death of the Board of Regents, and there's probably truth to it. And we're in this transitional state now with the Board of Governors, right? But the Board of Regents, the legislature did away with them that year or the next year, I forget which year it was. And I would say they deserved it! Because I had been studying them at close range for several years, and it was a reactive body; it wasn't a proactive body. It was this gigantic monster that sucked $20 million worth of revenue to run and it was invested in maintaining. And so it was never out there on the margin doing the "what does our state need? Do we need physicians' assistants? Do we need lawyers? Do we need scientists?" It didn't do that stuff. It was all invested in oversight and maintaining. That's my point of view. I didn't vote for the governor, but he was right, and John Thrasher was right in my opinion, because all I saw was this gigantic bureaucracy that wasn't really driving higher education in the state, it was just dragging, holding us back. So yes, it went away.

That didn't mean that we didn't have to jump through all the hoops, but our primary obstacle became time. We had medical students, we had to create it, we had to make it happen, and we had to get accredited. And we didn't have much time. We admitted our first students in '01, directed by the legislature. We wanted them to graduate from an accredited medical school.

People were saying, "Will the national board of medical examiners allow them to sit for Step 1 of the boards at the end of their second year if you're not accredited?" And I went so far as to investigate. The secretary of the Department of Health for the state of Florida could have demanded that they allow them to sit, had we needed to go that far, to meet the needs of the state. So it's all in the details. But time and accreditation became our biggest obstacles.

End side A

Hurt: It's all in the details, but time and accreditation became our biggest obstacles. Yes, campus politics remains a problem. The legislation that created the medical school, the money for this school was put in a separate line from the rest of the university, like all the other medical schools in the state. And this has not been a popular thing with our leadership in the university. But it was absolutely essential.

Thomas: Separate from the rest of FSU?

Hurt: Yeah. So that means that it's out there for anybody that wants to see that it's actually being used for the medical school, right? That makes it easier for us to maintain our own resources and what we do with them, in terms of maintaining a commitment to this mission-based study, budgeting and so forth. It's the biggest pot of new money on campus; all kinds of people complaining about it, the medical school's got all that money. Well, look what we had to do in the short period of time. But they weren't seeing that; they were hearing, "they got this many million dollars," et cetera, et cetera. So it's been an interesting journey.

Thomas: You've already stated in your article in *Academic Medicine* what many of the obstacles with accreditation were and so I won't really go into that much here. I guess one question I would ask is are you surprised or do you think it's unusual that the first new medical school in the country in over twenty years was in Florida and was in north Florida, not south Florida? Because in some ways it seems like a somewhat unlikely place to put the first new medical school. You might think it would end up in New England or something.

Hurt: No, I don't think it's unusual that it's in Florida, simply because, you know, I wrote in that *Academic Medicine* article what the population of Florida was in 1950, and it was like two million people or something like that. And this is one of the most rapidly growing places in the United States, and it is certainly the lowest number of physician output. I mean, we have one of the lowest ratios of medical students to population in the United States. So that made us a place that it should happen. That doesn't mean it would, but it should. And north Florida, sure. You know, Larry Abele always says that for a student to come to Florida State, they have to drive by ten other universities. You know, here we are up here in the place where there's the least higher ed in the state. We have a population — it is not where the big cities are, but eleven of the twelve federally defined as under-served counties, medically under-served counties in the state, are here in north Florida. So it is clearly a pocket of the biggest need in that regard.

Thomas: What do you think are the challenges of actually fulfilling the legislative mandate

to serve those under-served counties and why do you think so many other medical schools with the same mandate have failed to do that?

Hurt: It's pretty easy. Universities are just like medical schools. They become faculty-centered. And I've already seen it happening in our school. We're becoming faculty-centered, and once you become faculty-centered, then you're going to be following a different Pied Piper. I think if you're student-centered and you're focused on recruiting the students that will meet the needs of the state, that means you've got to get outside the box and look for non-traditional students and minority students that may need some help in — because they come from perhaps disadvantaged schools and disadvantaged homes and they don't have the role models and they're not read to when they're infants or they don't come from professional parents, et cetera. They don't have the overall advantages that my kids have. That's how you meet a mission.

Now, our students are training in community settings, and that gives us an advantage. But recruiting students that the faculty want versus students that represent the need is a critical problem.

Thomas: Those two groups are sometimes diametrically opposite

Hurt: Right. So if you talk to some of our faculty here, they would want students like the students at Harvard that have a 34 MCAT and they're approaching the 98th percentile and that have been to the best undergraduate schools in this country and are commonly twenty-one years old and have two professional parents and they've had just enough experience in the medical profession to interview well and they want to practice some speciality in some large city and have a nice lifestyle. And those are model students; they're easy. They know how to take tests, they know how to tell you exactly what you want to hear. It's harder when you're taking a disparate group of students who come from different backgrounds and who aren't all at the exact same level of polish. They can all do the work, they all have the smarts. There aren't that many dumb people, okay? I'm a professional educator, and the number of people that I have taught in my lifetime that couldn't learn if they want to is a handful. Now, there are huge levels of speed of learning and facility in terms of seeing connections; these are where all the differences are. But in terms of being able to learn, being teachable, most of us are. That's why the faculty is faculty-centered. Most university professors on this campus and any campus you go to, they spend all their time thinking about *their* scholarship and *their* teaching load. I'm not saying that they're not dedicated to educating students, but the education mission of the university gets lost in all the other things that happen there.

Thomas: So what it sounds like is that you need to instill basically a service ethic in your faculty in a way that's not done —

Hurt: Yeah. And our faculty would argue with you that they do have a service ethic and they do go and they instruct students at this or that place.

Thomas: But it's peripheral and not central.

Hurt: I'm trying to explain what I'm thinking. I hear people talk about the curriculum and not the students. I hear people talk about the scholarship and not the students. I hear people talk about processes and not the students. I mean, I went through the strategic plan of UF the year before we went out separate ways as medical schools. I didn't see the word "student" in it once. Not once. And that's where we're headed. It's the nature of the beast. And the reason I'm different is I came from a different background than these people. I was the first person in my family to go to college; I was the first person in my family to get an advanced degree. I know where these people came from. I didn't have anybody helping me, let me tell you. I taught high school students; I've taught at every level now, and I know what education's about. So if you want your students to be service-oriented, if you want your students to treat each other with dignity and respect and you as a faculty member and so forth, you have to treat them with dignity and respect. If you want the students to trust the faculty, well, you have to earn their trust. You can't just expect it as your due. So all of those are things that don't come naturally to faculty. I learned in my life you can mentor young faculty and you can actually teach this, but unfortunately, it doesn't always happen.

[recording ends]