Interviewee:	**Mahoney, John, MD** **Chief of Medical Staff, Tallahassee Memorial Hospital**
Interviewer:	**Karen Thomas**
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Thomas: Dr. Mahoney, could you tell me about your medical background, your education and training as a physician.

Mahoney: I received my MD degree at the University of Florida. I received my internship and residency in anatomic and clinical pathology at the University of Florida. I subsequently went and worked approximately two years at University Hospital in Jacksonville as an assistant professor of pathology at the University of Florida. Left there in approximately 1979 and joined the faculty at the University of Missouri medical center in Columbia, Missouri, and came to Tallahassee in 1981 in private practice.

Thomas: And why did you choose Tallahassee?

Mahoney: Our family enjoys being in a college town. We prefer having four seasons, and this is the only place in Florida that has truly four seasons, so that's why we came.

Thomas: Tell me about your career as a pathologist and some of the most interesting aspects of that career.

Mahoney: I joined a group in 1981, Ketchum Wood and Burgert Pathology Associates. It was a very interesting group to me in that it practiced all facets of pathology – anatomic, clinical, and forensic pathology. They also had an active out-patient anatomical laboratory at that time, and that was interesting to me because you could practice both community pathology and also hospital pathology.

Thomas: Tell me about how you became involved with the PIMS program.

Mahoney: Our group for a very long time – I've heard as early as its inception in the early '70s – has participated with the faculty of the PIMS program in teaching the first year medical students some basic principles of pathology. In most medical schools, the pathology rotation begins in your second year, but in the first year there are a number of courses that we participated in a specialized lecture series.

Thomas: Tell me about the clinical rotations. What was the experience like for students on a pathology rotation?

Mahoney: Well, in the early PIMS, there were no rotations; it was pure lecture series. Since the medical school has been formed, the rotations in pathology is really for an upper level medical student in their third or fourth year. It's usually a four-week rotation in which the student will see all facets of pathology. They'll start out usually in an anatomic area with both anatomic surgical pathology and autopsy pathology. The autopsy pathology will include both hospital autopsies and forensic medical examiner cases. The student will then rotate through the clinical laboratory, will be exposed to serology, hematology, chemistry, special laboratory work, and microbiology. The third area that they will begin to rotate through will be the correlations that occur between cytology in surgical pathology, particularly in the arena of Pap smears and OB-GYN biopsies.

Thomas: Can you tell me about some of your own teaching experiences when you started teaching and what that was like for you?

Mahoney: At the University of Florida, you usually began teaching medical students in your third and fourth year of your residency at the University of Florida, and in Jacksonville, I was participating in the lecture series involving gastrointestinal pathology and OB-GYN pathology. At the University of Missouri, that was expanded not only in those two areas but also included electron microscopy.

Thomas: Let me ask a follow-up question for the PIMS program. My understanding was that PIMS tried to emphasize early clinical experiences for students, but you say that PIMS students did not have a pathology rotation.

Mahoney: No, not in those years. There were the occasional students that would request, for example, some exposure to autopsy pathology while they were on their rotation through gross anatomy. But it was not a formalized course. It was more the initiative of the medical student calling and arranging for that, and at those times we did that, but it was not a formalized course.

Thomas: Okay. That was just too advanced in the curriculum.

Mahoney: They were pretty busy, and so I think they tried to make sure that they did not get overstretched. I'm not aware in the early PIMS of a lot of rotations, clinical rotations going on as far as the hospital. There are the occasional primary care physicians that allowed students to come and work in their offices, for example. But I'm not aware of the formal training program at this hospital.

Thomas: So your involvement with PIMS students is primarily lecturing.

Mahoney: That's correct, yes.

Thomas: Did you interact much with students on an individual level in those lectures, or was primarily a large lecture hall?

Mahoney: It could be both. If there was a laboratory component, we would sometimes have

selective laboratory components on a lecture series such as in Pap smears analysis. What we were trying to do is have a much smaller group interaction. But for the most part, it tended to be a lecture series delivered to the entire class. It was a small class – it was only 30 kids, so it worked out pretty nicely.

Thomas: Sure. What did you enjoy most about teaching PIMS students and what did you find most challenging?

Mahoney: I liked the small class. I think there's a better interaction with 30 people rather than talking to 120 to 150 people. It's much more difficult and impersonal. And in that sense, it was very enjoyable. I'm not aware of any impediments other than parking [chuckles].

Thomas: There was a change in leadership at PIMS when Dr. Hurt, Myra Hurt, came in in the late '80s and then became director in 1991. When did you meet Myra Hurt and were you aware of that change in leadership at the time?

Mahoney: I met Dr. Hurt, really, through her husband. He is a cardiovascular surgeon that had been recruited as part of a transplantation cardiovascular surgery team. So I met her as part of the family of a staff member. I probably did not really see much of her as the director of the PIMS until the very early '90s. But that's when I first met her.

Thomas: Do you remember any early conversations with her about PIMS or —?

Mahoney: I do remember early conversations as far as the early development of the PIMS program, where they were in the 1980s and where she wanted to hopefully take the class in the 1990s. There were tough times in the 1980s, and she felt that she wanted to bring up the academic standards dramatically in the 1990s. And also, she wanted to insure that the very best candidates for medical school would look at the PIMS program as a exciting adventure for them. She was looking for top quality candidates. I think that meant also she had to change somewhat perhaps what the future vision of the PIMS program would be, and when they would perhaps expand from just being a one year program into a two year or even possibly a medical school.

Thomas: Were you at all involved, either formally or informally, with admissions for PIMS?

Mahoney: I can't tell you the year I started; I think it was in the mid to late '90s when I was asked to participate on the credentials committee. It was a committee composed both of FSU and University of Florida faculty members. I believe I participated on that committee for three to four years.

Thomas: What did the credentials committee do?

Mahoney: Well, I call it "credentials." It was mainly a committee that would select medical students. And we would receive applications after they had been evaluated by the FSU faculty as

final candidates. We probably would interview somewhere around 120 students, and we would then meet one night a week. It was a large group of faculty members and physician members in the community who had very distinctive criteria for making recommendations on the final selection of pre-med students. There were interview processes I found fascinating and very helpful. The criteria were a little different then the processes that were developed at the University of Florida, but I think both faculties were comfortable with what had been developed at FSU PIMS program.

Thomas: How were they different and can you tell me as much as you can remember about some of the individual candidates that might stand out in your mind?

Mahoney: Well, it was always an interesting discussion about what was the ideal PIMS candidate. It really did vary tremendously among the various members who were interviewing candidates. I felt like many of the committees that I served on were looking for an unusual, outstanding candidate who had demonstrated a commitment in their pre-medical education to the health of the community. These candidates often were older than the more traditional pre-med candidates. They may have gone to the military, they may have had jobs for five years before completing their medical education. They could have been in a completely different health care arena such as in nursing or a medical technologist in a laboratory. But there was really a lot of emphasis placed on the maturity of the candidate. I think that over a three year period, I became convinced that there were differences in some of the candidates we were selecting compared to the traditional medical schools. The traditional medical schools tended to place a very large emphasis on the MCAT scores as a culling mechanism. There were many candidates who were not granted interviews solely on the basis of their MCAT scores. FSU, I felt, looked very hard a the MCAT scores, but also balanced that with a perspective of what the candidate had been doing for the last four to five years prior to being a formal applicant to medical school. And I thought that brought some different types of candidates to the table that helped fulfill, perhaps, the mission of what the FSU school was about, and that was trying to find the person that had a high probability of becoming a primary care physician serving the rural communities.

Thomas: What were some of the experiences or qualifications that you felt were good indicators that they might go into rural health or go into a rural community?

Mahoney: Well, one is when you read their applications. I always looked out for people that tended to come from small to middle-sized communities in the state of Florida, had demonstrated a commitment already to their community – and it didn't have to be necessarily in health-related areas, but they had a proven track record of commitment. It could have been in sports, teaching children in high schools and grade schools, the Boy Scouts, the Girl Scouts. I was also interested less in how many different activities they were in, but that they showed at least a major commitment to one activity and showed definite follow-up in it. For me, that was a very important aspect of it. There were a number of candidates that we accepted on the basis of that type of experience, with average MCAT scores. At the time, I served on the medical alumni board at the University of Florida, so I was aware of how the PIMS students were performing at the University of Florida when they finally transferred down there at that time in their second,

third, and fourth years. If you looked at MCAT scores, it was clear that the first year class at the University of Florida had higher MCAT scores than the PIMS students. It was also clear that by the second, third, and fourth year, you could not tell a difference as far as the performance. They were essentially identical. The one thing that Hugh Hill (who was at the University of Florida and also on our selection committee at FSU), had noted is that many of the PIMS students that we had selected had demonstrated maturity and leadership in medical staff issues. Many of the PIMS students had been selected as class leaders. I think that was an important reality that FSU was using a track of selection that was working, and it was respected. They can be criticized for perhaps not going after the student who has the highest MCAT score, but the criticism I don't believe is justified unless it fulfills what your mission is. And I think selecting people on the basis of what they do in the community and what their dreams and aspirations are is as important as an MCAT score.

Thomas: In the early years of PIMS, part of its mission – it was based at both Florida A & M and FSU, and part of its mission was to encourage minority students to enter medicine. Were you aware of minority physicians here in Tallahassee being involved in the admissions or teaching process, and do you remember anything while you were on the committee about bringing minority students into medicine?

Mahoney: It was one of our primary focuses. We had representation from FAMU. I don't personally know about the faculty teaching aspects as far as FAMU representation – I cannot tell you, although I met some members from FAMU on the selection committees. But as far as the selection, there was great emphasis in diversity of selection. When you get a highly qualified minority student, it's very hard to get them into this program because they're such in high demand at every medical school in America. There are amazing opportunities for minority students in getting into medical schools if they have excellent scores and are academically in the higher levels of their class. They can about name the medical school they want to go to. The bigger challenge is, what do you do with a minority student who wants to go to medical school, who has low MCAT scores and also academic grades that are below the level of the rest of the candidates that you're looking at. That's a real challenge. Sometimes it's cultural as far as their primary language that they speak. I remember we had a number of Cuban candidates where English was not their first language, so when they went to some of the universities, it was felt that some of the grades they received in courses was a problem of English not being their primary language. So we did place a lot of emphasis on looking at the science courses versus non-science. If we saw somebody that did great in sciences but in English perhaps the scores were not as high as we would have liked and they were a minority student where English was not their primary language, we understood that and that was not considered a reason to rank them lower.

Thomas: You had said that there were a lot of physicians in the community involved in PIMS and in the admissions process – were any of those physicians minorities when you were on the committee?

Mahoney: When I was on the committee, I don't believe I personally remember, for example, an African American physician on the committee when I was serving. But you know, it wasn't a

static committee; it was a very fluid committee. It is very possible that MD physicians that were on the committee were African American. I just don't remember.

Thomas: If we could get into your involvement with helping to establish the College of Medicine. When do you remember first hearing about the possibility of a College of Medicine being established at FSU?

Mahoney: I think it was in a bar [laughs]. It was really — Dr. Hurt had been ruminating on this for some time, and was discussing the possibilities. At the time – I can't give you the exact time – it was in the mid-90s – she had been doing a lot of background work as to what type of medical school could be perhaps formed at Florida State University. She was particularly interested in looking at every possible model, again with the goal being concentrating on getting primary care physicians as the primary product of the medical school and with the opportunity to serve many of the smaller cities and rural districts of Florida. She began to look at many models throughout the United States. I believe at that time she had the support of the president of FSU, Dr. D'Alemberte, as far as the concept of looking at possibilities. I did not enter into that equation other than in some informal talks with her until later.

Thomas: So tell me about your role and your relationship with establishing the College of Medicine.

Mahoney: She called me one day and said she wanted to meet, that there was a small committee at FSU with an important member being Sandy D'Alemberte, the president, that was interested in pursuing further some opportunities, and that there was also some legislative support for looking at the possibility of FSU having their own medical school. Told her I'd be happy to meet with her. We discussed many of the concepts. They certainly were innovative. There were some models that she had looked at both, I believe, in the north central United States and also in Europe. They still were unique models as far as I was concerned. But she really was asking me for help in that she felt the next member of the team needed to be a strong leader in medical education, recognized throughout the United States, to assist them in looking at the structure and also looking at the politics of trying to start a medical school in the state of Florida. We discussed a number of descriptions of who that would be, and I felt at the time that it would be very difficult, but if you're going to select a physician with academic credentials, it would probably have to be the stature of a dean of a medical school elsewhere, a dean that has a proven track record working with the politics of running a medical school and the politics of having to interact with the state legislature, which is going to be critical. It would be best to go outside of the normal FSU boundaries of who you would select; go out of state, and hopefully, I felt, he'd have very little connection with FSU. You get that independent feedback that you so desperately need. It could be positive feedback, it could be negative feedback, but at least you're hearing from somebody else who's been in that track before. At that time, I was serving or I had served on a board of directors of a public company, and I had interacted with a dean of a medical school who I felt really was a possible candidate, and his name was Dr. Richard Janeway. He was interesting and at first he was — he had been dean at Wake Forest University Bowman Gray School of Medicine for an incredible number of years. I believe he was dean for 23 years, which is a very

long time to survive in that milieu. When I served on this board, he had a great public stature. He spoke well, he handled the politics of a board of a publicly held company in a superb fashion. He was also a senior vice president of health affairs for Wake Forest for seven years. And he was recognized, really, as the longest surviving dean of an academic community, and had actually retired as senior vice president. So he had survived everything; he had lived the life, he was very well respected, he was a member of an ACC school, he was not connected with FSU, and I felt like he was an ideal candidate to at least approach. She asked if I would do that and I said I'd be happy to. I gave him a call. As I said, he was retiring or just had retired, and I remember him saying, "You realize that there hasn't been a new medical school in the last —" I believe it was in the last fifteen or twenty years, and he was a dean of a traditional medical school. He said, "I'd like to understand the concepts, and I'll try to keep an open mind." I said, "Well, all they want is an open mind and all they want is for you to look at the model. You may disagree with the model, but they want to proceed forward with it. They want you to give advice on how to build it and how to interact with the legislature." And he was interviewed.

Thomas: And since the school was established, I assume that advice, you know —

Mahoney: I assume that — I was on some of the very early meetings, and these meetings had to deal with a meeting with the FSU administration, Dr. D'Alemberte. I believe it was also a dean of the Biology Department and Larry Abele at FSU. I think it was sort of — each of the members of the early committees were trying to feel each other out about how they were going to interact together and what their respective jobs would be. About that time, I had other hospital issues I had to go and solve, and I could see there could be conflicts if I was going to be involved any further in the discussions with Dr. Janeway and FSU. So I told Myra a that time, "I need to bow out, because if I don't bow out as far as the hospital and medical staff, it will cause a conflict of interests." So I bowed out and Myra took the various combatants that had been selected and ran with it.

Thomas: One of the very unusual parts of the FSU model for a medical school is that it has no teaching hospital. As chief medical officer here at Tallahassee Memorial, how do you think or how was that model thought out and how has Tallahassee Memorial intended to participate within medical education at FSU?

Mahoney: Well, it was a difficult time because FSU was doing everything possible to interact with all the components that had to come together to make this possible. But there was a lot of various dangerous traps for all people in this. You had to appease an awful lot of people out there. People had doubts, people had excitement about it, people that wanted something out of it. I think the hardest thing for them to understand was you were introducing a model of medical education that was really dramatically different from what most people felt would work. So early on, I think the medical community was dubious that FSU would be able to get a medical school of this description, and was dubious that it would work. And you have to understand their point of view. I mean, they had been trained in the traditional model, and this was a model that they felt although anecdotally there were certain small members of medical schools that had used it, they didn't think it would work.

Thomas: When you say the "medical community," are you talking about like members of the Florida Medical Association or just mainly here in Tallahassee or —?

Mahoney: Yes. Both. I think many people were dubious that it could work. It was both here and in organized medicine. Although there was still an undercurrent of people that wanted to be supportive. They wanted to see where it was going to go before they committed. I think for the hospital, that was probably the most fascinating dynamic I've ever seen. I was not part of the administration of the hospital at that time; I was on the organized medical staff. It was quite clear that the board of directors and the hospital administration at that time were very concerned about the number of responsibilities that would be placed upon it for facilities, personnel, teaching, and what you're really getting down to is money. That's what it was really coming down to. "You want to go from 30 students to 120-150 students, and you're not going to have the facilities, no teaching classrooms – who's going to pay for this? Who's going to give you the classrooms? Who's going to be the teachers? Who's going to be the support personnel?" So it was frightening, quite frankly, and rightly so. Early on, FSU was concentrating on getting the program approved by the legislature, so its real focus could not be allaying the fears of organized medicine and the organized hospital. Well, I think that, unfortunately, people going off in different directions, trying to influence what was going to come about. I think that was probably, unfortunately, a time in which the hospital and FSU kind of parted ways. It was an interesting time because on the board of directors were some of the strongest supporters of FSU. So obviously, even though the FSU people had concerns about the hospital – and they were responsible for the direction and financial responsibilities of the hospital —. So they were protecting the hospital and FSU was protecting, if you will, its turf, and trying to get a medical school up. So it did not work well. And essentially they parted ways and FSU decided to prove the model could work. I give an awful lot of credit to FSU that once they got the funding for the model, once it was going to become a four-year school, they went out and established these various pods of education in different cities which were closely affiliated with hospitals, which were closely affiliated with the hospital medical staffs, and showed it could work. It was less threatening to those hospitals in those communities because FSU wasn't there.

Thomas: And those communities were —

Mahoney: Pensacola, and then Sarasota, Orlando, and subsequently the other areas have expanded. To show that it could work, to show that you didn't have to be a pure traditional academic research medical center with a model that could work and bring forth the production of a high probability of having many primary care physicians trained.

There was then subsequently a change in administration of this hospital. That was an important turning point, I believe, for the Tallahassee community. You had a change in leadership at FSU administration and in the hospital. You had people that came into both institutions who were willing to rethink a relationship. You had FSU demonstrating a model that would work in communities. And so they concentrated on the Tallahassee community and getting that model to work. It became obvious that there were very – there was good interest by physicians in teaching medical students. And FSU and working with Molly Hill from that department were able to go out and select the high quality physicians to train medical students.

And they had their own building developed where they could be trained in a building with faculty members from FSU and local physicians could come in and teach in that building. The hospital now had an interest in building a relationship with them – for a variety of reasons. One, you have a school producing medical students who are going to become doctors. A hospital always has an interest in having more and more doctors, particularly in the areas of primary care. We have a demonstrated shortage in that arena still in this community, and that's particularly in internal medicine. So if you have somebody who has – if you have a need for primary care and students coming out who are interested in primary care – for example, they want to go into internal medicine – we could easily hire 10 to 15 internal medicine physicians immediately in this community, and their offices would be full. So this was important to the hospital.

Two is, there is that natural constant need of hospitals for healthcare professionals – nurses, laboratory technicians, radiology technicians. So the hospital began to develop relationships not only with FSU – with FAMU and with Tallahassee Community College to help develop those relationships. And for the first time has actually donated a large tract of land to Tallahassee Community College so that they could build an allied health facility there to train them. And it hopes, believe me, that many of those people who get trained at that facility will come and work in our community and that Tallahassee Memorial Hospital will have a shot at hiring them. It's very important. So developing a relationship with FSU is a natural.

The third reason is Tallahassee Memorial Hospital is on a different track than it was in the 1990s. It has certain centers that it is trying to develop to become a world class community hospital. I'll just go over one of them – one is the new cancer is getting ready to build. There are specific tracks of cancer therapy. It wants to be the model for gastrointestinal cancers, breast cancers, lung cancers, and prostate cancers. So it wants to develop research protocols and have an active interaction with medical centers. One medical center it is aligning with as far as their cancer model is Moffett Cancer Center in Tampa. It's very interested, though, in interacting with FSU in the basic sciences. And FSU wants to expand basic sciences in cancer therapy, like they have done in breast and maybe are trying to do in some basic sciences of prostate cancer. It would like to have that type of affiliation with the basic science professors in its program. It is a plus; it is a natural between the two institutions.

Thomas: So you said earlier that there was a parting of ways in the '90s – early on —

Mahoney: Late 90s.

Thomas: — late '90s – that even though this would be the geographically obvious place for FSU to establish a teaching relationship with Tallahassee Memorial Hospital, that they didn't happen initially and that FSU actually went to other cities first. Is that correct?

Mahoney: Yes.

Thomas: Okay.

Mahoney: It developed one here locally but it was very limited compared, in my opinion, to what the scope would be in other communities.

Thomas: Okay. And these are all clinical rotations for undergraduate medical students that we're talking about?

Mahoney: Initially it was really — yes, when the third and fourth years actually started, that's when it was going to be. But first on it was just an expansion to the second year. It was going to be clinical rotations going through both hospitals in this community.

Thomas: Is there talk now of trying to do more with graduate residency training?

Mahoney: The hospital has identified areas of interest that relates to the real needs of this community and the real needs of this hospital. The areas they're looking at are internal medicine, general surgery, and emergency medicine. We have shortages in all three areas; we have a current independent program of family practice training at TMH which is not directly affiliated with FSU. But in these three additional areas, we'll be working with FSU to develop these training programs. The most important one right now is going to be internal medicine. The second one will be general surgery, and the third one will probably be emergency medicine. The timetables are fluid because there's got to be a lot of work that has to go on in the US Congress concerning getting increased funding for residency program slots. They've been frozen for a number of years now, and we're trying to get that to change. I think as far as residency slots needs in the state of Florida, we're ranked 49th. I mean, we have huge needs. Our state is growing leaps and bounds compared to other states, and yet the number of residency slots has been frozen, and this is most unfortunate. And it's really related to money. But that's where all the emphasis is right now.

Thomas: I think I have covered most of my questions, and we're right at an hour, which is what you said you had. Do you have anything you wanted to add?

Mahoney: I'm amazed where we are at. The model continues to grow and expand. And I don't know what the future holds [chuckles], but it looks good. I really am pleased that FSU and TMH are working hand in hand now. It took a long time, but I think they're working hand in hand to get financing to do what they both need, and the different constituencies they both serve. That was missing before, and that was sad, because I think we lost three to four years. But when you work hand in hand, I think both institutions which serve this community and this Big Bend area are now able to make some real positive progress, and that's exciting.

Thomas: Can you speak briefly about Tallahassee Memorial is a — I would imagine was in the major tertiary care center —

Mahoney: Community care – tertiary care, right.

Thomas: — and you get patients from across north Florida here.

Mahoney: South Georgia and some in Alabama.

Thomas: So there are a lot of patients that you see here who are in these very medically underserved communities. Could you speak about TMH's role in trying to improve or increase care for those patients in those communities?

Mahoney: Well, what it's done – I think it's been a very positive aspect – is it goes beyond just, say, "Send us your patients; we'll take care of them." It has placed family practice pods out into those communities such as Monticello, Blountstown. It right now is building a facility down in Crawfordville to service the Crawfordville area. It's not easy to do. There's a lot of expense involved.

Thomas: Financing is very difficult.

Mahoney: Yes, the financing is difficult. But, I mean, that's why we're here – we're a not for profit institution. We're not here to make gobs of money; we're here to service the community. We have to turn a profit or you don't exist. If you don't have cash, you don't have a mission. So we're very cognizant of that, and I think we've made a major impact in these small communities. For example, we have a pod that's out in Havana and the Quincy area, and that has served Gadsden County very well. You know, they've had closure of their hospital, and it has impacted Quincy. So we're working with Quincy and got at least like an urgent care center up and going again for them in the old hospital setting. We still have our family practice office over there servicing patients. And that's what we feel our mission is. So we will continue that. Having FSU interact with that in the future will be very important. If we can turn out, you know, five to ten internal medicine people a year and have two or three actually settle in our communities, boy, that's going to be critical. And it's extremely difficult to get internal medicine candidates to come into this community. Most of the candidates we get are trained outside the state of Florida and often outside the United States to come and practice here.

Thomas: And it is so difficult to attract them because —?

Mahoney: There's such low numbers of them coming out of training programs. Low numbers.

Thomas: You said before that the —

Mahoney: Could I expand on that?

Thomas: Please.

Mahoney: The key is, when you come out of a training program, the odds are the first place you look to practice is what you're familiar with. So if you're trained by the University of North Carolina, there's a high probability you'll probably settle down somewhere in North Carolina. The second high probability is you might want to go back and live where your family came from. Now, trying to get somebody whose family is not in Florida and you have not trained in Florida to come back and practice to come to Florida, it's tough. So if you're not turning out many

candidates, our odds of getting somebody to come here are very low. And that's why we feel having a local training program here will give us increased odds. Do we have proof of that? Absolutely! Our family practice residency program. I mean, we have the highest population of family practice physicians for a county in the state of Florida. So it works. They stay.

Thomas: The question I was going to ask you was when the administrations at both FSU and Tallahassee Memorial changed and that created an atmosphere where there could be more cooperation, was that when you became chief medical officer or —?

Mahoney: No.

Thomas: When did you —?

Mahoney: When it changed, I was on the medical executive committee. It was a palpable change. I mean, you could feel that suddenly there was an opportunity to re-enter the picture and start discussions. So I gave a call to Dr. Hurt, and I said, "This is the best time you're going to have to change the atmosphere." There's no better time than right now. You have a brand new administrator who comes with no baggage, no previous biases, has an open mind, is looking around the community, has a vision that I knew, having talked with him, was very close to the vision of FSU. If we could just get past some of this baggage and the politics of money and the politics of control, then there was real opportunity. So I arranged for our CEO, Mark O'Bryant, to go to lunch with Dr. Hurt, and I think that was the first time for a number of years that there was some open interchange and subsequently, I think it's moved forward rapidly.

Thomas: And what year was that?

Mahoney: I want to say 2003-2004, and I'm sorry I can't remember. It was when Mark O'Bryant was here, and that's be easy to check the date if you needed it.

Thomas: That is all my questions. Do you have anything else?

Mahoney: That's it.

Thomas: Thank you very much.

End