

Oral History of ECT with Dr. Mark Messer of Terrell State Hospital

Interviewee: Dr. Mark Messer

Interviewer: Zachary Doleshal

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Hospital

List of Acronyms:

ECT = Electroconvulsive Therapy

CRNA = Certified Registered Nurse Anesthetist

EEG = Electroencephalogram

RN = Registered Nurse

MOCA = Montreal Cognitive Assessment

RUL = Right Unilateral

UT = University of Texas

TMS = Transcranial Magnetic Stimulation

DBS = Deep Brain Stimulation

FDA = U.S. Food and Drug Administration.

Doleshal: Okay, so this is Zachary Doleshal with Sam Houston State University. It is April 3rd, 2023. I am in Huntsville, Tx, in my office at SHSU, and I am with Dr. Mark Messer, a psychiatrist, superintendent, and medical director of the Terrell State Hospital. And Dr. Messer, where are you?

Messer: Terrell is a town approximately 30 miles east of Dallas.

Doleshal: Okay. And you're- are you in your office right now, or?

Messer: I am.

Doleshal: Okay. Alright, so he is here with me today to discuss the history of electric convulsive therapy, or ECT. So, Dr. Messer, thank you for being with me here today. I want to first, you know, we're going to discuss the history of ECT within the state hospital system and your significant role therein. But I want to begin with a little bit about you to, you know, learn a little bit about your journey to where you are now. So, first, where are you from?

Messer: I'm originally from the Houston/Galveston area.

Doleshal: And what, was there anything in your childhood that suggested your future career?

Messer: Yes. When I was born in Galveston, my father was in medical school there-

Doleshal: Okay-

Messer: -so I grew up in a medical family.

Doleshal: Okay. And what was his specialty?

Messer: He was in a family practice.

Doleshal: Okay, and so, where did you go to school?

Messer: Well, I did my undergraduate at the University of Houston, and then medical school at North Texas, University of North Texas Health Science Center, and my residency at the University of Tennessee.

Doleshal: Hmm. And so, when you were in- when you were in med school, what- what was it about the psychiatric rotation that pulled you in?

Messer: Well, there's an irony there, my- my psychiatric rotations in medical school weren't optimal, or really played a big role. I just always had an interest in that, and I had started medical school with the belief I would be doing family practice, [cause] that's what I knew the best. But approximately 60-70% of family practice is psychiatry.

Doleshal: Hmm. Hmm. Can you elaborate on that a little bit? Family- 60-70% of family practice is psychiatry, that's really an interesting statement.

Messer: Well, in this country, no one is going to go straight to a psychiatrist. That would be very rare and it's really incumbent upon our primary care physicians to screen for the common disorders like anxiety disorder, insomnia, and the milder forms of depression. And when you put all three of those together, you've got a pretty large percentage of your total practice population. And fortunately, those three conditions aren't terribly hard to treat, although the patients typically come in with a different complaint, but yet it's still up to primary care docs to find these

things and screen for them. 70% of all the antidepressants written in this country are written by primary care physicians.

Doleshal: Hmm. Hmm. So, what- how- how did you end up at Terrell? You specialize in psychiatry, and then what?

Messer: Well, I worked at the state hospital in Memphis, which is quite a unique place, it's actually right near the downtown, [laughs] downtown Memphis, and I really enjoyed it. I love inpatient work and I love teaching medical students and residents. I was wanting to come back to Texas and the medical director at the time- at Terrell was on a visit doing a drug sponsored lecture, and I asked him if he had any open spots, and the rest is history.

Doleshal: [laughs] Yeah, which is why we're here, right? So, see, you go over to the state hospital and start there. Can you tell me a little bit about Terrell, when you first got there, and around what year that was?

Messer: Well, I came to Terrell in 2009, so I've been here 14 years, and my first 6 or 7 years I was on a ward treating acutely ill males, and I loved it. I mean it was, I love inpatient work. It's at a state hospital. You have to realize you're treating a more severe population versus like, as I mentioned earlier, a primary care would from people in the community. The people here, it's the end of the road for them, a state hospital, and so, these cases are more challenging, which then makes them more fun. And they're just fantastic teaching cases for medical students and residents.

Doleshal: Hmm. Well, I- you know, not using names or anything, but maybe a few case study examples here in a minute would be really interesting for this-

Messer: Sure.

Doleshal: -but I want to talk now a little but about ECT and where that procedure was when you started out, and kind of when you first learned about it, your first experience with the procedure.

Messer: Well, as a psychiatry resident, you would hope that every residency in the country exposes the psychiatry residents to ECT whether they end up doing it or not. I saw it one time in my residency. It was very brief, so I didn't really know a lot about it. Here at Terrell, I wanted to become a part of the ECT program here with 2 other physicians, and ECT had been going on for many, many years here at Terrell. In fact, speaking to some of the history, they had- ECT was performed on each ward instead of one centralized location-

Doleshal: Hmm

Messer: -like we have now here at the hospital.

Doleshal: Hmm. And do you know, kind of when that changed over to a more centralized process?

Messer: From what I can tell, time wise it would have been probably in the late '80s or early '90s.

Doleshal: Hmm, okay. So, what- you said that you kind of sought out being part of the team, why was that?

Messer: Well, it's just, to me, it's an honor to get to do it, and it just- it's so effective. So, if you want to see somebody go from a severe condition, perhaps depression with psychosis, to blossoming and reaching prior baseline or their best level of functioning, it's just dramatic, the changes and the affect it has. And that's very rewarding.

Doleshal: Hmm. So, for someone who, you know, has not read anything, let's say, listening to this in the future perhaps, how does ECT work? What is it that makes it that effective.

Messer: Well, first of all, it's a very simple procedure. It involves having an IV started, this is after the patient's undergone a complete physical exam, chest x-ray, blood work, and they're laying down on a gurney in the treatment room and an anesthesiologist or a CRNA [Certified Registered Nurse Anesthetist] first gives them an induction agent, which is something that makes them fall asleep. It's very short acting, like a short acting barbiturate, and then they give them a paralytic agent, also again, very short acting, and once the patient has had both medicines administered, we deliver a small electrical stimulus to the nondominant hemisphere, which is the right hemisphere on their head, and that creates a short, controlled seizure lasting approximately 20 to 25 seconds. So, we're measuring the motor seizure in their foot because there is a blood pressure cuff occluding their [laughs] leg, so you can actually see the tonic-clonic movements of their foot, and we're also measuring it with an EEG [Electroencephalogram] machine on a paper strip, and approximately 20, 25 seconds, the anesthesia wears off very quickly, it only lasts approximately 4 to 5 minutes. They're wheeled into a

recovery room similar to what you'd find in a medical hospital, and they wake up easily, and once they're fully awake, we feed them breakfast and they walk back to the ward like nothing happened.

Doleshal: Wow. So, the kind of stigma, the popular idea of this procedure as if, like, you're awakening Frankenstein's monster or something, right, is- it couldn't be further from the truth-

Messer: Yeah! Yeah! It's seen as torture-

Doleshal: You have to look at the foot to see if it's even working, huh?

Messer: Correct.

Doleshal: Wow! So, so the total, the total time then, from patient in to eating breakfast, what would you say that is?

Messer: Probably, I don't know, 45 minutes maybe. We let them recover and wake up, they're being monitored with a blood pressure cuff, and there's a nurse, an RN [Registered Nurse] in the room with them, and a pulse oximeter, and they might wake up a little drowsy, and then that wears off quickly, so by the time they're sitting fully awake, alert, sharp, eating breakfast, yeah, probably 45 minutes.

Doleshal: Wow. Though-

Messer: The procedure itself is very quick. I mean, it's very short, and there's no pain involved other than having an I.V. started, guess that would be probably the worst part about it. They're full, they're completely asleep, they feel nothing, and the

amount of electricity introduced is about the amount that it would take to light a household light bulb.

Doleshal: Hmm. And I imagine that has been really looked at, studied overtime. What is the most effective- I mean, its voltage, right? I mean, you're talking about what, you know, how much electricity to use-

Messer: Correct

Doleshal: -and does it, does that vary based on who the patient is? You know, if you're a heavier person-

Messer: It does-

Doleshal: -you know?

Messer: It's very interesting, young people, particularly young women, seize very, very easily, and the procedure, for example, is so safe we can do it on pregnant women. What's interesting is that a person ages and they reach their elderly years, you know 60, 70, 80, there's cortical atrophy of the brain, and that makes it separate from the skull, which of course, it's bathed in spinal fluid, so the electricity has to travel farther, like a moat around the castle. The electricity has to travel through the spinal fluid to reach the cortex, but it takes a lot more electrical energy to do that and get them to seize. So, young people, the machine is set very low, and in older people, it's set somewhat higher.

Doleshal: Hmm. That is interesting. Huh. So, let's see. Let's talk a little bit about the stigma of ECT. Before thinking, I'd like to hear more about your, you know, your work

with patients and outcomes and all that. But do patients come in when you tell them, you know, that they're a good candidate for this, with a certain stigma, a fear of it, based on-

Messer: Sure.

Doleshal: -popular culture and how do you deal with that? I mean, and why do you think that is so, you know, persistent?

Messer: Well, the media, the movies, portray is as either a torture or a punishment, and just the word "shock therapy" sounds horrific. But one movie, one singular movie made in 1977, set back modern psychiatry dozens of years, and that was *One Flew Over the Cuckoo's Nest* with Jack Nicholson, because in that movie, which was a very popular movie, they used it as like a punishment. And after that session, he received, he's seen in the movie as a cognitively dulled and impaired, and that type of thing I guess, just carries on. And then any movie since then, they portray it as a, something horrible. You know, the patient is in pain or- and then there's been various groups, quote "patient rights groups" that have vilified it. So yes, even today ECT has a- carries a heavy stigma, but yet, what I tell people is because there's so much information at our fingertips, just look up the response rate, it's tremendous. It has, depending on which article you read, range from 80 to 90% effectiveness, and there are few medical treatments anywhere that have that level of success.

Doleshal: Wow. So, who are the- what is the kind of diagnosis that is ideal, if you will, for that procedure, what, you know, who are the patients that are ideal candidates for ECT?

Messer: The perfect patient, I mean the perfect patient would be someone who's depressed, psychotic, and has catatonia. Those 3 conditions, you're just- you're just watering at the mouth because you know these people are going to get better. Its effect on Catatonia is just tremendous. But a psychotic depression, be it bipolar depression or major depressive disorder, either one, it's just tremendous. And the books, any book or literature read speaks of memory loss, even though in the smaller print it'll say it's temporary. But here at the State Hospital, we give them an assessment called the- we call it the MOCA, M-O-C-A, it's the Montreal Cognitive Assessment. It's a very well-known 12, 13 question instrument, and what we see is that their scores improve, they have an upward trajectory, as the treatment goes on. So, we're not seeing the memory loss, and I think the memory loss was more associated when they would stimulate both hemispheres. They would put the leads on each temple, the left and the right temple. Now you're stimulating both hemispheres, and that might be- that's a little more aggressive of a treatment. We are stimulating the non-dominant hemisphere, the right. So, one is on the right temple and the other one is on the right side of their head, at the crown of their head. Takes a little longer, so instead of 6, 7 treatments, it's more like 12 or 13 treatments, but we don't see the memory loss that it seems like every article or book mentioned.

Doleshal: Hmm. That sounds like an article in and of itself right there.

Messer: Oh, there's many of them. Trust me-

Doleshal: Yeah-

Messer: -trust me. They call it right unilateral, R-U-L, and the amount of [laughs] studies on it would fill a football stadium.

Doleshal: [Laughs] I see. So, it- How- how does it work? I mean, how-how would someone with the catatonia, or you know, manic bipolar, you know, and really severe depression, how does it make them better? Do we know? Is it-

Messer: This is the problem. This is what causes ECT to not have as much acceptance in the scientific community, is because it's not known exactly how it works. The best current theory is that it resets your neurotransmitters, and there's something about the mechanism your brain possesses where it can stop a seizure. It's kind of like in a building with the fire sprinkler system puts out a fire. It's called suppression. So, what we watch, not just their right foot, but we're watching the EEG strip reading out. We can see when the seizure stops because you're seeing these big high wavelength waves and then all of a sudden, you're seeing a very fine saw tooth pattern wave. And there's something about the-the amazing ability of the brain to just stop the seizure and go back into a normal wave or rhythm, and that's [laughs] that's very scientific. There was also for years a thought that it was harmful to the brain, but it-years later, through much research, they found the very opposite, that it's a -regenerates. For example, on the neurons, they have these little branches or arms called dendrites, so it actually promotes dendritic growth in the brain-

Doleshal: Wow.

Messer: -so the-the notion that it damages the brain has been completely (dis)proven [?].

Doleshal: Hmm. Well, let's talk about some of the patients that you've seen and-and outcomes. Do you have any case studies that you would like to share?

Messer: Sure. One that really sticks out in my mind, because I think it's unfortunately common phenomenon, was when a family brought in their loved one. He was an older gentleman, approximately in his mid to late '70s, and his wife and his daughter brought him to the hospital because they felt he was suffering from dementia, and they were beginning their search for a nursing home to place him in. And when- upon evaluation, you would see this gentleman who didn't talk much, he didn't appear alert, he had no facial expression, all of his physical movements were just blunted, and his ability to answer questions or open-ended questions was poor. And so, I said to the family, "Just please give us a chance to try and help your husband before you put him in a nursing home." So, we took him, and we put him on a very aggressive medication regimen designed to treat his depression, and there was little effect, so obviously ECT works very well on elderly people, the geriatric population. So, we did ECT, and this guy just came alive and by- at the conclusion of the therapy, he-he- they had their husband and father back. He was bright, sharp, articulate, and what it was was he had depression, and depression effects memory, it effects cognition, particularly in elderly, in the elderly population, and so this poor guy was fixing to be thrown into a nursing home, which is where people go to die. And all it was- was just a treatment resistant depression that medications were going to struggle to improve.

Doleshal: Wow.

Messer: That's my favorite one.

Doleshal: So, he went back home to his family.

Messer: That's right.

Doleshal: Wow.

Messer: Just a dramatically different outcome.

Doleshal: And so how often is this procedure given at Terrell?

Messer: We do it the way pretty much everyone in the ECT community does it. It's a Monday, Wednesday, Friday schedule. Here, we do it early in the morning and I want to say that one of the biggest, I don't know if it would be a breakthrough or change or revelation, was the fact that once you get them better, which is usually 12 to 15 treatments, and they're-they're well enough to where they're ready to be discharged and go back home. What is new, and I say new within the past 10, 15 years, is you want to prevent them from relapsing by having them come back as an outpatient to your hospital for at least one treatment a month, more if necessary if they're starting to sink. But by the- if you start a stopwatch, let's say at the time they get better, if you can keep them better for 6 months through monthly, let's say maintenance ECT, it has a tremendous effect on their prognosis and disease course. And I don't think they knew that back, you know, in the- prior to the '70s or '80s, and maybe even the '90s. I don't think they knew that because there was a relapse rate with ECT.

Doleshal: So, it kind of maintaining periodic treatments for 6 months, you found that that has a tremendous result that- that they're not going to relapse, the chances of relapse go way down. Is that right?

Messer: Exactly. Exactly.

Doleshal: Wow. So, how, out of curiosity here, how did-how did that- how did we find that out? Just trial and error?

Messer: I don't know-

Doleshal: Yeah-

Messer: I don't know the answer, but I can say that we're very fortunate to be next door to UT [University of Texas] Southwestern, which is a big research based medical school, very well-funded, and their leading ECT professor um well known in the community, he's-he's retired, he did retire several years ago. He would come- we would have grand rounds presentations by their faculty here at the hospital and for our doctors to get BME [?] credits and learn, and he told us that, I don't know if he found it or if the ECT community founded- found it, I don't know.

Doleshal: So, among the community of ECT practitioners, I imagine you have national conferences, is that right? Is that-

Messer: Yes, absolutely.

Doleshal: -kind of where you, yeah, and where a lot of this information is exchanged and cutting-edge research. Where do you see the field going? What-what's kind of the future for this?

Messer: Well, the biggest areas of-of, they use the term neuromodulation therapy.

[Laughs] That's an umbrella term for ECT and TMS, transcranial magnetic stimulation. Under that umbrella, there's also deep brain stimulation where they implant an electrode in the brain, very, very tiny, tiny electrode and it's operated by a battery, a small battery that's implanted in their upper torso. And its effect on depression, and I mean, this is treatment resistant, this is for a population that not only doesn't respond to meds, they don't respond to ECT. So, deep – DBS, deep brain stimulation, and TMS, transcranial magnetic stimulation, is really where the hot research is going on. In ECT itself, UT Southwestern is actually trying to develop a magnet, an ultra-strong magnet, that will induce a seizure instead of using electricity, and it's still in the early stages. If it's ever passed by the FDA, it would probably be I don't know, 3, 4, 5 years from now. And it seems that the only advantage it offers, if any, would be- said to be less memory loss, which I've broached. Apparently, they're still seeing memory loss with bitemporal lead placement. But that's I guess the newest under neuromodulation therapy.

Doleshal: Oh, thank you for that. That was- that was an excellent survey of-of the field right now, and-and very concise as well. Uh, so, the field moves forward and-and as, you know, an academic historian, I see this quite a bit in a very different kind of way. But the field moves forward, there's, you know, new ideas, new concepts being applied, and but-but then the-the general public/general population and politics in general, you know, it can really be an obstacle to some of this-

Messer: Absolutely.

Doleshal: -and I really wonder if-if that, if that remains, in the ECT community, a threat, and-and I understand that ECT on the, when was that, early '90s, late '80s, or something like this? If there was a bill actually put forward to ban it outright in the state of Texas. And-and I wonder if-

Messer: That's a great question!

Doleshal: -that still-

Messer: I'm sorry, I didn't mean to cut you off-

Doleshal: No, no, [laughs] I-I was basically just wrapping that up into a question, but yes. How would you respond to that, what is- what is- yeah?

Messer: Well, there's two parts, that's a two part answer. Number 1, to me it is a complete embarrassment that the United States, with all the medical technology, where all the books are being written, we rank 14th in the world in the use of ECT. 14th. So, the, for example, China. They do tremendous amounts of ECT. They just line them up down the hallway, and-and it's grossly underutilized. So, when that very same professor came back for another grand round, I-I asked him "Why is ECT, so what's the reason we don't use it more often?" and even more important, "what's the reason we don't use it for schizophrenia? Why are we only using it or mood disorders?" And his answer was money and politics, and I didn't get a chance to have him elaborate. But that- that just- that was upsetting almost, to me, to hear that answer. Money and politics shouldn't have any place in the medical field, but it does. And then the second part [laughs] of the answer is very simple. The-the-the Church of Scientology, their- I guess their biggest motivation is their

resentment and dislike of psychiatry, so you can imagine how they feel about ECT. And in Austin, the scientology community is very powerful because they have so much money. It's money-based power. So yes, in the '90s and the mid '90s, and they changed their name. They don't go in as scientology, they change it to other titles like Human Rights of Texas or something. They camouflage it with some other name, but usually the words human rights are involved, and they petitioned or, I- I don't know if they petitioned. They had such a strong movement that they almost got ECT banned in the state of Texas in 1997. But as a result, Texas and Colorado are the only 2 states in the country where ECT on patients under the age of 16 is not allowed. Texas is easily one of the most regulated states in the country for ECT. Every single machine has to be registered. It's-it's-it's just amazing, the regulations-

Doleshal: Are those regulations, I mean for a state hospital, obviously you know, you-you can do it, you-you can kind of go through those hoops. But for more of a smaller clinic, would-would those be prohibited?

Messer: No, a smaller clinic could do it-

Doleshal: Okay.

Messer: -they have to register the machine and they have to do a lot of paperwork. There's a lot of paperwork we have to do that's sent in to the State and in to Austin that other states done have to do. I mean, it's all we've ever known, so [laughs] we don't know any different-

Doleshal: Yeah.

Messer: -so when you hear that other states don't have all of that, you know [both speaking unclear], [it's kind of disappointing].

Doleshal: Yeah. Yeah, I'm sure. Well, okay, I-I have kind of one more ending question for you, and that's on-

Messer: Sure.

Doleshal: -what lessons you have gained and that you think the, you know, general public can gain from the history of ECT and your-your role in it.

Messer: Oh, that's a great question. It- this is- I- I'm going to try and make this succinct. I think in-in- in the public right now, there are a lot of people who are depressed and don't know it. These are people that are raising families, going to school, grinding their way through life, but they're not enjoying their life. And-and-and again, these are mild cases, alright. Your garden variety, mild to moderate cases, where perhaps-perhaps it isn't even their mood. And when I say mood, I describe it as happy or sad. Maybe they have symptoms where they have lack of energy, lack of motivation, they can't sleep, maybe they lose their interest in food, or they have too much interest in food; those are all classic symptoms of depression. And yet, those are the very people that respond so well to the basic first line agents that we've all heard of like Prozac, Zoloft, Paxel Lexapro, Celexa. Those are all very easy, very well tolerated medications. They're safe, they have minimal drug-drug interactions, they're not expensive. And so for the primary care docs that do look for it and just write them a simple prescription for whatever antidepressant, you're changing these people's lives. I mean, they come back to you and they're hugging

you because it's- they're-they're just, they're enjoying life again and they've got energy in-in their interests. Things they were interested in come back. Where I- I'm at, I see- I don't get to see that type patient, but I know they're out there. I see the more moderate to severe depressions, where I don't think the docs in general, this is a global statement, they're not aggressive enough in treating depression. And-and it may take several antidepressants in combination to treat their depression. I think, if the psychiatrist ever could spend one day with severe depression, it would change their whole outlook and approach to treating bad depression, because these are people that- that are not enjoying life, and they're just not performing well. Their relationships, their occupation, they suffer. And-and I haven't even touched on suicidality, people that-that don't really want to end their life, they just want the pain to stop.

Doleshal: Hmm.

Messer: You know, they're-they're people that aren't going to end their life, but they're "I wish- it'd be fine with me if I just didn't wake up tomorrow morning," that type depression, and it's treatable. ECT though is held as a last resort. It's end of the line, we've tried everything, nothing works, and it shouldn't be such a last- last line agent, you know, when everything else has failed. It's- it's very safe. I would have it done. I would have any of my family members- and, by the way, when you look up literature, look at the percentage of people that would do it again, they actually rate that, a percentage of people would refer a loved one to have it done. It's very high.

Doleshal: Hmm.

Messer: It's up over 80% for both of them. So, it's-it's- it's- ECT, it's a-a positive that has very little negative, except I guess the stigma, and you'd have to be admitted to a hospital in most cases now. And that's- I think there's too much depression and it's not being treated. That's my summation.

Doleshal: Yeah. Yeah, and- and here, you have a really effective tool and it's kind of-

Messer: Very, underutilized.

Doleshal: -on the shelf in a lot of ways, a lot of cases.

Messer: Yeah, it's a crime. It-it works so well. There's very little downside. And yet, I'm embarrassed, I'm embarrassed how few patients we have here that we use it on. I should be- I should be able to spend my entire morning hours doing one patient after another, but that's just- like they do in other countries, but that's not the case.

Doleshal: Hmm. Well, this has been very enlightening, and I- I really thank you a lot for your time and your- your-your- your answers-

Messer: Sure!

Doleshal: Before we end, are- are there any questions you would like to answer that I did not ask? Is there- is there anything you'd like to add?

Messer: I'd like to add that back- this all started in 1938, and so this has been around [laughs] a tremendous amount of time. Been around, what? 34, 35, I'm sorry, 85 years. [Laughs] 85 years. And in the beginning, they didn't use electricity. They used things like oil of camphor, you know, to get the person to seize. And if you

look at the movie *A Beautiful Mind*, in that movie, they were using insulin shock therapy, where they would inject the patient with a pretty fair amount of insulin, and that was used for severe depression. Although, I always thought they were doing that to induce a seizure. It turns out that's because the patient would convulse-

Doleshal: Huh.

Messer: -turns out that's not the case. So, the electricity portion didn't come about until, I want to say the '50s. It was 2 Italian men, gosh it, right- I had their name and now I'm going to block on it, of course. Benetti and- no, it was Cerletti, C-E-R-L-E-T-T-I, and the other one started with a B. Anyway, it's gone through a lot of changes, and now that we use anesthesia, it's very safe and effective. And that's just a little brief history.

Doleshal: Yeah. Yeah, it- it's quite, it is quite the story arc here, and there's a longer story too, right? You can- you can go back to kind of the history of the use of electricity on humans in general, and the different pathways that has gone. And this- this particular procedure, the- the changes in it, I don't know, I'm no expert I'm- I'm not a historian of psychiatry, and obviously not a psychiatrist, but I- I really think you'd be hard-pressed to find a more dramatic change over time in any single procedure in the 20th century, then you would with ECT. And-

Messer: I totally agree.

Doleshal: Yeah [speaking unclear]-

Messer: It's amazing.

Doleshal: Yeah, it's really amazing. So, well thank you. Thank you again-

Messer: Oh, I enjoyed it! I could talk on this all day!

Doleshal: [Laughs].

Messer: [Laughs] I- I was trying to be brief.

Doleshal: It was fantastic, and-and- and like I said, I'll- I'll send you the- the forms and everything, and you can- you'll have a copy of this for- for whatever, however you want to use it.