

Oral History with Pam Cumming, July 15, 2020
Interview by Benjamin Spohn for Hagley Museum and Library
Hologic oral histories project

Q: Okay, we're recording. Today is July 15th, 2020 and I'm interviewing Pam Cumming for our oral history project on medical imaging and Hologic. Hi, how are you today?

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A: I'm doing great, Ben. How are you?

Q: Doing all right. So to get started, can you tell us a little bit about your early life and educational background?

A: So, early life meaning – how early? Because I've been around a few years.

Q: Let's say college onward. Just a quick overview.

A: Yeah. So, I grew up in Colorado and went to the University of Colorado where I was one of those kids that go to school not sure what you want to be or where you want to be it. So I majored in business and in Spanish. Business because it was practical and Spanish because it was something that would open my eyes to the world in a different way when you have a second language. So I graduated with an undergraduate degree, and then I went straight into the workforce.

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And actually, getting into the questions that you were asking me – how did I land here. I landed in medical devices sort of by accident. And that is the University of Colorado is located in Boulder, and Boulder was a pretty fertile area for startups, at that time particularly in medical devices. So there were quite a few young companies that were located there. And a friend of mine turned me onto a company called Life Imaging, which was really pioneering a new technology in breast imaging using ultrasound, which at the time was akin to heresy. And I got a job there in marketing working in the two person marketing department of a startup in Boulder.

So that's kind of by luck, I ended up in this field. Although I think back, and I remember very clearly a memory of one of my very good friends in high school.

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And her mother passed away from breast cancer. And at the time, it was sort of a hush-hush thing. You didn't talk about it. It was very invasive, the treatment. And survival rates were not very good. And I think about that and I think about her, and at the time being so young and to lose her mother to that. And I don't think that ever really left me. So, getting involved in technology and feeling like you were doing something that mattered for people and the people around them really kept me loving what I did.

Q: So you got there by luck and that's kind of what kept you there.

A: Yeah, luck and then feeling like yeah, there's something here. And I do something every day that I love. I love the marketing. I love the communication side of the business more so probably than the product inbound side of it. But that's a very critical part of how people respond to your company and what you're doing and how you're trying to impact what they do and help them. So that was my introduction to medical device, and really to marketing and growing a business. And I think that experience as a startup company and how you act as a startup company really carried the skills and that sort of independence, I guess.

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Or understanding that every decision that you make has a huge impact, because you're financially usually operating on a shoestring. It's carried me through, and that was very helpful in the days – of the early days of Hologic. Because it was a startup in those days really compared to what it is today.

Q: Yeah, what was that like, working in a department of two?

A: So, it was pretty close. My boss is awesome. The CEO was a little bit of a crazy person, but he was really creative, and had a good vision. He was a good marketer in the sense of

communications and reaching out to customers and not being afraid to take some chances. So this goes way back into, let's say, the early '80's. And everything in medical device was pretty buttoned up, pretty clinical.

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And he sort of showed me the way of no, it's really about the patient and the impact on the patient. We can't forget that. So from that standpoint, wasn't the easiest company to work for at the time. But I did learn a ton. And then sadly, about two years into that stint, they went out of business. So the technology sort of disappeared for a while. But it has come back, like the phoenix rising from the ashes. And there are a few companies that have resurrected – now that we know a lot more about ultrasound and ultrasound in breast imaging in particular, its limitations and where it has strengths, you've started to see that technology come back. Whether it takes hold or not is really more of a financial decision because the technology can be really helpful now.

Q: So what happened after that initial company went out of business?

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A: So then, I moved to Chicago to another medical imaging company. It was Full Line, and had all kinds of different products, much akin to what you might see at a GE or a Phillips or a Siemens right now. They also had a mammography product that was struggling. Beautiful images, but I think my takeaway from that experience was obviously just the Full Line and understanding more about how department decisions get made in radiology, and understanding more about how the nuances of the breast imaging world and how fickle it was because at the time – I would just say was and is, but at the time, it was pretty much its own – how do I say?

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Its on enclave I guess, compared to radiology. It was cut off. Different decision making processes. It was treating just women for the most part. And so, it didn't move with the same cadence or rhythms as other x-ray products might have. And it's all about image quality because x-ray is not really ideal for screening soft tissue. But at the time, had started to gain traction as

being reliable, reproducible, and affordable. So seeing that product fail – live and learn. You learn more from your failures than success. I believe that to be very true. And then from there, I actually got out of the medical device field. Did some training for Xerox in the sales field. So I learned a lot about that.

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And then spent quite a bit of time – I did some consulting at the same time when I started having my kids. So I never really moved too far out of the radiology realm. I started doing marketing and marketing, communications, consulting for startups, which was fun. Quite a bit of time completely in an unrelated field, exporting building supplies to Spanish speaking central and Caribbean, which sounds not very exciting maybe in many ways, but it's interesting what you see from people who are seeing water run in their house for the first time. So it was, for me, just the idea of – it was just a really rich cultural experience. Spent most of the days speaking Spanish and I loved that. And I think back to a high school teacher I said who really inspired me to keep at it, to get past that point where you can order a beer and your lunch pretty well.

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Because she said, “You'll experience things you just can't even imagine when you can understand not just the words, but the culture and what's built around it.” So that was awesome. And then that went on for probably about ten years. And then I got involved at Hologic right after they both Low Rad [00:08:58], which kind of takes you to where you are in the story.

Q: All right. So you said that you were with Xerox for a time. Did you ever – were you ever involved in any of their medical imaging devices that they had, or was it --?

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A: No, they had a product called Xerox Learning Systems, and it was training basically. Sales training, customer service, management skills. And not any other products.

Q: Okay. And then you said that the world of sort of mammography operates on its own cadence and has its own rhythm. Does it tend to be slower than the rest of the radiography world, faster, or just totally different?

A: I would say slower, particularly because it's the one area in medical imaging really that you're using x-ray as a screening – x-rays to screen patients. So there were a lot of factors that went into making it really – optimizing that technology for breast screening. So when you think about dose, you think about annual dose built up over time, and how easy it is – it was and still is today to miss a really subtle cancer. It became, I think, a little bit slower out of caution and risk. And as this country became more litigious, it became even more difficult. So people were slow to move.

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In fact, the breast imaging suite was the last part of the hospital probably to go digital besides recordkeeping in terms of imaging. So when GE introduced digital, it was pretty revolutionary for [00:10:55]. And everybody at that point was beginning to understand that digital technology brought something to detection that you couldn't do with film. You had more tools in your toolkit to do that. So it was pretty amazing the year that GE came into play. And they were the first. Does that answer your question? Sorry, I'm opening up some water.

Q: Oh yeah, go for it.

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A: Yeah. And then since then, I would say today – and through my experience with Hologic – and then I went on to work at Siemens for a while – it's the same thing. People are very conscious. And every single breast that a radiologist looks at is different. Dense breast legislation came into being because cancers were being missed in a certain demographic of women, young women in particular who tend to have denser breast tissue, and that can change as you age. So the risk of missing a breast cancer – one radiologist said she learned in medical school, it's not if you get sued, it's when. So they're very, very cautious. Again, as I said, it's a screening environment so they read many, many mammograms and they do it very, very quickly.

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So, any tools that we can give them to make that easier and give them more confidence in their diagnostic accuracy is really the game of mammography these days. And then other technologies like MR and ultrasound are used to supplement that. But because of the reproducibility of a mammogram, the cost – and it has proven to reduce mortality over time – it is really considered the standard of care for breast cancer detection.

Q: So you mentioned changing legislation. Is that something like the Mammography Equality Standards Act?

A: Yeah. So, the neat thing about the Mammography Equality Standards Act is that for a very long time, in the early screening days, the surgeons ruled the roost. And it was thought that if you couldn't feel it, there wasn't a cancer there. So as breast imaging started to evolve, and you think back to the Xerox days – Xerox produced some really wonderful looking images. But the dose was a concern. And again, thinking about dose building up over time and what that might do to a woman – she's been having a mammogram starting at 40 annually to – some women – 70's, 80's – it could have an impact.

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So when that was introduced, it was really to start to standardize what the dose was going to be, what a diagnostic mammogram was so there would be some consistency throughout the United States. And it was really landmark in my mind in the sense of making sure that women were getting the best care but not detrimental to their long term health. And then it really became about, okay, how do we improve these images? How do we keep the dose as low as possible and still provide diagnostic accuracy?

Q: Cool. So, you started at Hologic right after the purchase of Low Rad. Had you been with Low Rad at the time?

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A: No, I wasn't at Low Rad. I was asked to come in because during that transition – when Hologic first bought Low Rad, they were known as a bone density company. And so there was a pretty big – as you hear with many corporate buyouts, it's not easy. And absorbing cultures and integrating cultures is probably the biggest detriment to success. So when that happened, I was asked to come in and help with the breast imaging side because I understood the mar-comm side of it. I understood the RSNA. RSNA is really the beacon of meetings for this group of people because there's so much clinical evidence, clinical research that is introduced at the RSNA. So, I came in there thinking, okay, I can help you through this time, but ended up staying for about 15 years, I guess. So that's how I got there. Again, very much by happenstance. But in the sense that I just happened to have that breast imaging background and RSNA background familiarity with the cogs that turned on the marketing side. Outbound marketing side. And they needed to get somebody in there quickly and hit the ground running.

Q: Yeah. And it certainly seems like you did a lot of running for how rapidly the company grew.

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A: Yeah, we did. It was fun though. Not always fun, but it was – it's one of those experiences that you probably wouldn't ever get to duplicate again. You'd only hope. So one of the things that I can remember telling my team was that there were times when we were doing things on a shoestring, but I think that breeds creativity. We couldn't always hire people, so we kind of pull from different places and create an [00:16:48]. But when it started to really gain some traction, we started to see sales happening on a pretty consistent basis and systems moving out – it's one of those experiences that A) makes you even more motivated because obviously, you're doing the right things. And also a time to be reflective and appreciative of the fact that you get to be a part of something like that. So, there were a lot of ups and downs, sure, and a lot of quick growth in acquisitions in particular.

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I think in 2006, there were probably four or five. And integrating those and creating some cohesiveness internally and externally was my goal. So, from the communication side of the business.

Q: How do you manage that? The sort of, I don't know, growing pains, and keep that cohesion?

A: I'm trying to – that's an interesting question, and it's a difficult one. I don't know that there's a magic recipe. I think there's a couple of things that were very motivating about being at Hologic in the early days, and one of them was leadership. The focus was not on – yeah, it's always on the bottom line, but it didn't feel that way. It felt like a company that, if you do the right thing, you can build a successful company.

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And there was management that was accessible to everybody, knew everybody's name. If you needed to see the CEO, you could see him. And I think that kind of an environment of that management by walking around, and not so much emphasis on hierarchy and you make decisions this way creates a breeding ground for creativity and also for taking some risks. So I think little by little, you get the resources. And there's always periods of expansion and contraction and you lose some resources, or you end up absorbing teams of people that you may not know and you've got to work on that. So I guess I would say you have to focus on the people. And my management philosophy was always, raise your hand if you want to be involved in this, and let me know. And we'll see what we can get going. Because you can't do it all yourself. You sort of have to let go and trust. And that was very successful for me.

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So I felt like as we grew, yeah, I had some attrition. But it was always usually like, that's okay. It wasn't working anyway. And then somehow or other, you just kind of get it done. It's like, how do you raise a family of more than one child? You just do what you need to do. But I would say really specifically, it was about -- the messaging that we started to build was not just about what we did, but why we did it. And our impact was on finding cancer earlier, changing lives, saving lives. And that mantra really was reflected in all of management from the very top down. So we were all kind of on the same ship paddling to the same goal. And it became a very successful, cohesive group of people in those early days.

Q: This is kind of a follow-up and I guess something semi-philosophical. How did you – sorry, I'm tripping over my words here. Sorry about that. How did you suss out what was an acceptable risk to take and what was an untenable risk? Because I'd imagine where there were some cases where that would be really, really obvious. Like, what to try or not to try. But what did you do when it was less obvious?

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A: So from the product development and product enhancement parts, I wasn't as involved in that other than in some industrial design of the product line. More from that point of view than actual functionality. But because I would say from – my perspective maybe on the outer ring of that group of people that were the scientists and the people who had been in breast imaging for a long time, like let's say – I think you talked to Kathleen Picket and to Georgia, who were more of – knew all the nuances of the patient journey of getting a mammogram. So they were the ones that really influenced that. But I think being a smaller company that didn't seem bogged down too much in formality made it possible through the leadership ultimately – it was their name that signs the bottom line. But they listened, and they listened to people that were more expert than they were, in my opinion.

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And I think that in the end, it started to then translate into success in the field. So, I don't know a lot about some of those agonizing decisions. I know there were many when – in the early days when every dollar counts and you've got problems with service and certain parts that aren't working and things like that. But I think that management always tried to do the right thing. And the people that were working believed in doing the right thing very unselfishly to get that product off the line, you know, off the ground. So that's a very general answer to your question. But I think in a small environment, that's a lot easier to do because you don't feel – again, from my experience in a larger environment in a bigger company like a Siemens, it's just not the same. It could take years to convince somebody of something.

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And a young company and a startup company – I just think part of the culture has to be a tolerance for risk that you might not find in a more established, structured decision-making environment.

Q: So when you were answering that question, you used the phrase “industrial design,” which is sort of a magic word at Hagley. We’re very into that. We have the papers for several industrial designers. So can you tell me about your involvement with anything related to that?

A: Yeah. So, in the early days at Low Rad Hologic, if you will, they had an established product. And we were starting to move into the world of digital and we had screen film and digital and we had a very in-cohesive look and feel to the product. It was very industrial in my mind. Sort of like manila folder medical. And when you think about screening and you think about women going to get a mammogram, in those days, it was a lot about the spa environment. It was a business trying to get women here to come here for a mammogram, the latest technology, the nice environment, all of that. So it was important that we create something that spoke to that as well.

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So when you walk in to get a mammogram, you're walking into a room. It's very small. There's a lot in there. You're a little intimidated. You're going to be naked. And so, having something that is appealing from a design perspective just visually, and then also having everything that you can do to make a comfortable, ergonomically friendly for the technologists, aesthetically pleasing to a woman who's having her mammogram is really important. And so, one of my fondest memories was the early Low Rad product, which was very well-loved by technologists. Had these two big circles on the side of the tube head that looked like slices of bologna. And they actually called them the bologna slices. And so, we were trying to convince people of not the importance, but maybe looking at some different external skins, and could we reskin everything?

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And then as we went into the new product design, could we incorporate this thinking of the experience less than some of the early engineering where things get designed by engineers and

then it kind of misses the mark a little bit. So we did. We went through that. It was pretty cursory because the early digital systems were pretty much just reskinning the early screen film systems. But at the RSNA when everything was laid out and it looked like a family of products that were there for a purpose and were designed for a purpose, I can remember a couple of the real diehard engineers saying, "Oh, I guess you were right." So I don't know. I believe a lot in obviously, why is Apple so successful? There's just some subtle things that you don't realize are playing on you that play into how you feel about something. And ultimately, that's how we make decisions, right?

Q: So over the course of your time at Hologic, how much did your department change? Because I know I've talked to some of your colleagues that – their title by the time they left Hologic was smaller in scope than the one they started off with, but they were managing dozens and dozens of people, whereas before when they started it was only ten or 12.

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A: Yeah. I'm trying – we went through all these acquisitions. I can't even remember. I know that – let's say you bought a company in San Jose and there was an internal department there that was doing more of the outbound marketing side. Eventually, it seemed like that got absorbed into my team and that allowed me to hire people. If people didn't move or people – just through natural attrition, I was able to grow that team internally in Boston. But [00:27:54] also. As we grew internationally, we had remote teams. And when I left, things had started to break up a little bit. New management had come in. I think the company had kind of peaked in that moving into more of a stable management style from the early – as one person described it, Wild West days. So I did have less responsibility.

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I don't know. I just felt like things winding down and things were changing when I left. And I didn't stay as long as some other people at the time when the new CEO came in – I think it was 2014 – I was pretty early in their exit strategy with most of the senior management team that was with the CEO at that time. So I think you just have to kind of hold on during those times and go with the flow. So I knew at the point where the new CEO came in who is the current CEO now –

the landscape had changed, the goals were different. We'd had this great experience with the stock and growth and excitement was kind of – the feeling of being one of the darlings of Wall Street. And then things had started to slow down.

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And I think the reason they started to slow down from that perspective was just the bigger the company gets, the harder it is to grow. So you start looking at acquisitions and some pay out quickly, others don't. And at that time, a different philosophy came in, a new leadership team. And it was just time to go. Does that make sense?

Q: Yeah, I think so. So, what did a typical day look like, a typical work day?

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A: So really, my days at Hologic were pre-Zoom and pre all these internet meetings. So, most of the team was based in Bedford. So, there was a pretty consistent rhythm of things that happened throughout the year in terms of marketing, meetings, advertising. It got to a point where that for me was pretty routine, and I had a great team with people who were executing on it. So in that sense, I felt like we had a good bond. We had a lot of trust with each other. My friend Jim, who I think you know – when I met him, he had had all kinds of interesting experiences. Obviously a really brilliant person. A lot of energy bottled up into one. And I think about him in particular as you see that there's just all these great ideas. And my feeling was, I've got good people, they've got great ideas. I want to let them run with things. And I think we just started creating some great external messaging that was moving away from – here's what we do, here's our buttons and whistles, and much more into a – the power of technology and changing women's lives.

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So we had this really nice mix of product story and also – oh, a story about women. And I don't know if Jim sent you any of those movies that we made, but at the time, that kind of messaging really didn't exist. So it was us internally and externally, I think, trying to step outside of what was the status quo in medical device imaging. Like I mentioned before, very clinical and so on. And into something that was more about the patient. So the communications part was a big part

of it. And the rest of it – because it wasn't a very – I guess at the time, it was a very fluid structure. There were leadership meetings on a monthly basis. But also, it was just the ability to interact with people if you needed to and stop by the office and have those conversations. So it's a little bit harder. I wasn't in a meeting culture at that time. That was really nice.

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But it was more about managing the team and managing just the different objectives that we had in front of us. And then my job grew from just not – outside of just the breast imaging product and breast tomosynthesis into the corporate message. And I think one of your questions was, were you always a women's health company? And the answer was no. I think as Hologic grew from the bone density company, the story – and we started to do acquisitions and we started to become successful in breast imaging, really what we were trying to do, as I said, was impact the lives of women. So we bought [00:33:03], which was taking care of sort of the OBGYN side of women's health. And when you think about it, an OBGYN to a woman is really the gatekeeper of her health through a big chunk of her life, not just childbearing ages.

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So that's when we started thinking, you know, we are the women's health company. And because it was very easy at Hologic to socialize ideas, we started to throw that out there because it made a very compelling story about who we are and why we do what we do. And I think that it resonated, I think, in breast imaging. As I mentioned, they were slow to change. Also, maybe not the heroes in radiology like some of the other devices would be. But there are people who are passionate about their jobs as well. And I think – not to say that other physicians aren't. It's one of the few areas in radiology also that you're touching the patient, that you're telling a patient that she has cancer. And you're with her when she comes back into the screening environment.

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So I think that that environment and the people in the company and the accessibility to management – it was a natural story, and it felt good for us internally and externally as well. And ultimately – I don't know. I think for me, that's what it's all about, is that people want to know why you do what you do. And when they make that decision, a lot of decision making gets made

on a gut feeling in your heart. And I think it made it easy for people to get onboard and stay onboard. And after I left Hologic and I went to another manufacturer, I realized wow, this is almost like a cult we had created. And that was basically through nurturing relationships and really listening to – I mentioned how we have a company was set up internally, but also advisory boards and things where people had a chance to share their experiences and share their ideas and then seeing results come out of that in a timely manner.

Q: So I'm pretty naïve to the world of marketing. Can you walk me through how you would develop a marketing campaign for a project, sort of like product sort of from start to finish?

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A: Yeah. So, in an early phase of a product introduction like breast tomosynthesis, for example, you spend a lot of time on technical education. So when you look at the product, there's a lot of different touch points, right? You've got not just a radiologist, but you've got technologists, you've got radiology department managers. You've got the C-suite, especially today. It's become very complex. And even today, you might be talking to buy-in groups, hospital systems. It gets super, super complicated. So what we would do – we had an internal team of designers, and sometimes I tried to do as much in-house as we could because it was a lot less expensive. And I ended up finding some small boutique kinds of agencies that we could work with, mostly on developing the messaging and writing because they didn't have those resources internally.

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So thinking about where we were in the stage of adoption was a big part of it. But then we had the messaging around the impact on women's lives and we also had messaging and we always talked about the mission of the company and what we were doing and why we were doing it. So there were different tiers of things that we needed to just put out there in terms of the basics. I think for us, that was a process of identifying what our messages need to be. Then the creative team goes back and comes up with some concepts. And that was probably the most fun. Everybody wants to see the concepts. And because it was internal and because I had different designers, very different thinking, some were more visual on the paper side, and some were more visual on the digital side. Everybody was a part of that.

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And then they would come back and pitch their ideas. And we would usually – you have to have a safe idea and you have to have an in between idea, and then just take it wherever you want to see what we can come up with. And mostly – so, those things just became a process. This is the way it works, this is the deadlines, this is how much time we have. I think the most successful thing we did at Hologic outside of just sort of marketing collateral 101 and trade shows and things like that were two things. Clinical research that supported the growth of the product and the growth of the product impact in the marketplace. That was a pretty continuous thing at Hologic. So there was always thought leaders presenting and things like that. And then the second part of it was the voice of the customer.

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So you explain your technology and you create that foundation of understanding through lunch-and-learns and through – yeah, lunch-and-learns. You go to trade shows. You present and those kind of things. But really, what we tried to do was take a very immature market and look for people who wanted to tell their story and why they were integrating breast tomosynthesis into their practice. And in the early days, you can imagine that one maybe wasn't that easy because there weren't people that were either ready or had ever done that before. The market was pretty much dominated by GE at the time, and GE had done a super good job with some of the more well-established breast imagers [00:39:28]. So we started really from scratch. But we found committed, passionate people – radiologists that were very interested in the technology and continuing to do research. And we had them tell their stories. And we did it mostly digitally and through a little publication that we did called Images for Life.

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And it was just a compilation of stories from different types of – it could be a university environment. It could be a freestanding clinic. It could be a hospital chain. And we just told their stories and we put them on stage when we could. And it really built good rapport. So to me, marketing in this field is about clinical evidence and KOLs and stories that they tell because really, what they say to their peers when you're not there can make or break a product. So I don't

know how many of those that we put together, the images for life publications. But it got to the point where we had not only a paper copy, but we had electronic copies. And we tried to keep everything relevant and scientific and still sensitive and personal to women. And I think – so that's not really the ABC's of marketing. But for us, that's what made us successful.

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And the other thing I would tell you is when you look at any product, you look at what's your market? And in mammography, I think it's easy in some sense. Because of the NQSA Act, everybody that is doing a mammogram has to be certified. So you have a very well-defined body of potential sites and customers to talk to and to target as far as introducing your product. And so, it's a little bit smaller world than general x-ray for example. So that was something that made it easy to kind of define. And then where they are in their buying cycles. And at the time, it took a very long time to go from screen film to digital mammography. That was a very labor intensive education process. And then the same thing from digital mammography to tomosynthesis. So when you looked at who are your early adopters and who were the ones who were a little bit lagging, you start going back to the early adopters of digital to say okay, you want to take it to the next step, and little by little, staying close to them, and making sure you're listening and responding, I think, builds success.

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Maybe it was a little unconventional. And I'm happy that I didn't have to try to build one percent market share on a shelf at a grocery store, if you know what I mean, for my diet soda or whatever.

Q: Right. So, you talked about the voice of the customer and keeping things centered on patients. Are those one and the same?

A: So, the voice of the customer is more from the, I would say, the peer to peer. So you get to a point in any technology where you can say whatever you want, and it's like, yeah, I know, I know. I got it. But it's when your radiologists start talking to other radiologists and start recommending. So the experience that they're having with you as an organization have really

deep – it can have a very big impact on others making a decision to adopt your technology or not. So, think about a small company like Hologic, not well known. Everybody knew [00:43:28], but we were late to market compared to GE on the digital side for specific reasons which were based on science.

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But you still miss that early adopter move. And so, I think you've got – the focus at Hologic was always very strong on keeping the early adopters, building the relationships with them, building roots with them, and making sure that they were speaking in a positive light about us. So in some of the early days, some of the key components of the detector, for example – it was very fickle. Some detectors would fail. It took some time to get them to a point of reliability. So that becomes a big sticking point because you can't do anything if your detector's gone. So here we are, investing in a service engineer, sitting on a plane with the detector so that he can be at a site next morning first thing to replace a detector so that they're not losing patients. When you lose patients that you can't screen that day, you're losing a lot of revenue.

[00:44:40]

So imagine in a mammography suite some of the room times were getting down to ten minutes. So over the course of the day, one technologist would do a patient, ten minutes. She'd leave the room, take the patient out. A different technology would come in the room. So it's really a continuous activity. It doesn't slow down. So when your detector doesn't work or you're down for a day and you're not getting response from the company, it creates a lot of bad blood. And that was something I think that Hologic excelled at managing. Yeah, it's not perfect, but we're with you and we're listening. And the CEO would hand out his cards. He also traveled a lot, spent time with customers, and they could call him. You know, when you give somebody your phone number, they don't always want to call you. But they have it, right?

Q: So that level of service – would you say that's something you did deliberately to try to set yourselves apart from your competition?

[00:45:46]

A: I think there's an old adage that they buy from you the first time and from the service guy the second time. So in this business, especially mammography – well, any imaging device – if it's not working, you're not making money. And reimbursement isn't that great for screening. So it is a synergy, symbiotic relationship I suppose, that you can't minimize. And again, I've been on the other side where you don't have good service, and those wounds are – those bad experiences are – especially with new technology are very hard to heal. Whoever it was that drove that vision from a service side – I have the utmost respect for. It's like anything. We don't have any patients for things that don't do what they're supposed to do.

Q: Right. So, did you do – would you call on individual doctors, health networks, hospitals? All of the above?

[00:46:49]

A: All of the above. So especially in today's day, the radiologists – the leading radiologists are critical because they're looking at your images and they have to find cancers. The technologist is the one that interacts with the patient. So she wants her patient to have a good experience with ergonomics and things like that. But she also wants her job in terms of software interface and flexibility if she needs to change something up as she's doing a mammogram to be there for her. And then thirdly, you've got radiology departments, managers, and then it just kind of goes up depending on – if you're rural, it's a little less complex. One of the big things that started to change was there is a decline in the number of radiologists that want to specialize in breast imaging. So you're seeing more general radiologists coming into the picture.

[00:47:48]

So now you've got reading groups of radiologists that are certified that are reading for other hospitals. So you've got this more complex group of people that you need to connect with and make sure that they're comfortable with service, with your technology. You can't leave anything, any stone unturned and expect to be successful. So every different site – a university site is going to be different than, let's say, a tenant site, or Providence up in the northwest. You get into these things where you've got maybe 35 people on a call, and presenting your technology, and then you've got to touch those people individually and make sure that they're comfortable. But it's as

much pre-sale as it is post-sale. So I think again too with Hologic, there was very good applications training. There have been follow-up programs that were available to customers if they were struggling.

[00:48:52]

Some technologists are better than others. They also have to abide by the NQSA and the ACR Accreditation. So they have to submit images. And if they're not doing a good job, they get dinged for it. So there's a lot of – it's not just, here's your mammo system. We changed you on it and now we can move on. It's a lifetime commitment of that piece of equipment. And as a manufacturer, you to your customer during its lifetime, which obviously gets easier as it goes on. But there's a lot of movement and transition in the world today. So I think when you start to forget that and stop to have flexibility – we're always saying, "No, I can't do that. I have to charge you." You have to really think about that customer management, customer care over the life of a system, which could be seven to ten years now. So, that's a long time.

Q: And that's just the lifetime of an individual system, not the span of time between major advancements like the switch from a digital to a tomo.

[00:50:04]

A: Yeah. Digital to tomo is like – I think Hologic introduced digital in about 2004. And then it was 2009 when the first systems were put into clinical use in Europe. And 2011 was when it was FDA approved here. You know, there was something else you had asked about too that really – the NQSA was one of the things that you felt – that somebody mentioned as being pivotal. Also, I think that the Sunshine Act, when that was put into place also became very pivotal because you couldn't give anything away anymore. You had to – the days of all those [00:50:49] or whatever to close business work on, and also even things down like to education – you had to have value. You just couldn't say, "Oh, I'll send somebody out there," anymore.

[00:51:02]

Everything became much more structured in that standpoint. And I think it was a good thing that that changed, although it was sort of a paperwork nightmare. But it did create guardrails and

make it maybe a little bit more of a fair playing field if you were a smaller business compared to some of the bigger companies that have assets or funds to do things like they used to be in the old days. So for me, that really made things easier if – you had to stay within a certain limit. In some states, you couldn't even buy a sandwich for a radiologist. So it changed – it really became focused on the business aspect of it and maybe not on some of the other stuff.

Q: It certainly sounds like – what, you couldn't even do something like that period? Or you had to have remittances and a lot of paperwork if you wanted to do something like that?

[00:52:01]

A: Yeah, there was a period of time where the government gave you a grace period, and then they'd have to report in. So everything that you do on your expenses ends up being documented. And some radiologists would say no, it's just not worth it. I don't want to show up on your Sunshine Act reporting. So in that sense, it just became a little bit easier than the early, early days back when I started life imaging when people were [00:52:35].

Q: Were there any other major legislative challenges within the business?

A: Reimbursement is always an issue, right? So with digital, the reimbursement – I wasn't so much a part of that. There was a group at Hologic that focused on working at Capitol Hill and lobbyists and whatever you have to do to make that happen. But it's always been scrutinized, mammography has. I think maybe a little unfairly so compared to other things.

[00:53:14]

But it seems like every year, it got cut a little bit, cut a little bit. And that always hurts. Especially when you're trying to introduce new technology. But it took – I don't know – a few years for tomo to get reimbursement. And it's still lagging in the way it's described and the way it's coded and things like that. But the early adopters at Hologic were really buying a product that didn't have reimbursement. So part of our commitment to them had to be, yeah, we're working to make this happen. It will happen. So that was amazingly – it's a challenging process sometimes. I

don't know how it all works or what are the drivers and why there seems to be heightened sensitivity around breast imaging, but there is.

Q: Is it just more contentious since it's a diagnostic thing that might not pick up anything?

[00:54:20]

A: Gosh, you know, it took a long time – mammography, like I said earlier, is now proven. There've been studies that show it reduces mortality. It's reproducible. All those things. So I think that gives you a base. But then people are saying it seems like as time goes by, well, you're spending – with tomo for example, you're spending more time looking at images, but your accuracy is probably going up. So why would you not get more reimbursement for that? And the downstream costs are reduced if you find a cancer early versus late. You know, survival rate changes' impact on treatment pathways is significant. So you tell me why it's so different for breasts. Think about, like I said, the legislation for dense breasts, to be able to go and get an ultrasound and have it paid for.

[00:55:24]

They always categorize density, what they call bi-rads. So now the legislation says, if you are a woman with dense breasts, then you have to be told that, which is awesome. But then what? So the recommendation would be either supplemental screenings such as ultrasound or MR depending on family history and genetics and all those kinds of things. But a lot of times, that supplemental screening isn't paid for. It depends on the payer. So again, the woman that started the dense breasts, Nancy – I'm drawing a blank on her last name. I'll remember it. But she lost her life because they missed cancer on her mammogram. So that was her life's work, was to get that turnaround. And so, we've gotten to a point where there will be federal legislation on what you say and what you have to communicate to the patient. But that, to me, seems pretty straightforward.

[00:56:22]

And now and then from there, it'll go to – you have to go to all these different payers and convince them that the downstream costs are reduced. So there's a disconnect, I think, in our

healthcare system between – sometimes between actual benefits of a technology and just – I don't even know what. But I'd love to figure out why it seems like it is so hard for breast imaging and why it's always under scrutiny. Because a woman who's diagnosed early – her survival rate over five years is like 99%. But then once it gets into the metastasis phase, it's an ongoing lifetime of treatment and fight for her. So it would seem to me that if there were any question – and I know radiologists find ways to work around things and things like that. But it shouldn't be that way.

Q: And when you talk about having to navigate things with payers, are you talking insurance, Medicare, Medicaid?

[00:57:30]

A: Yup, all of the above. So, Medicare usually sets sort of the standard. If you're reimbursed by Medicare, then that's a nice stake in the ground. But then you can have different – like ETNA or Blue Cross Blue Shield, state by state. Hologic did a great job and put a lot of money to educate and to put these payers I guess on notice. So at one point, little by little, payer by payer, you start to find that tomosynthesis was reimbursed. And the early adopters would say, you know, if it's not covered, I'm going to do it anyway because I feel like I'm seeing so much more than I was before. So it was something that they had to really absorb. [00:58:23] reimbursement the initial fee investment that they were making. So I think that speaks a lot about the technology and the commitment of the radiologists that are dedicated to breast imaging.

Q: But there's less and less that are specializing in breast imaging.

[00:58:41]

A: Yeah. So you're finding general – in different demographics, too. If you think about rural situations, you might have one radiologist that covers a certain area and reads in different hospitals at different times, or is a general radiologist that reads breasts. So that's why the technology is so important. And I think why tomosynthesis has really helped women in those – radiologists interpret very difficult kinds of cases. I don't know if you've ever seen a mammogram, but it looks like a snowstorm on a lot of women. And if you go back in time even

ten years or 20 years, you would just look at these examples of mammograms and think, how did they find anything?

[00:59:31]

But they did. And now they're looking at very, very subtle changes in tissue, which is why women are screened every year. Because it's not always, oh, I see a cancer, that I see some changes here that might be indications of early cancer. So the whole mind instead of – used to be a cancer, you'd see it. It would have circulations. And by then, it would probably metastasize, or definitely not in those early stages. And now they're looking at simple – I shouldn't say simple, but subtle changes in tissue that could indicate cancer. And that's why tomo has been so helpful – because you're actually slicing through the breast and looking at a millimeter at a time. And it makes it – instead of looking at a book an x-raying top down, seeing if there's anything through that book, you're actually flipping through the pages. And that makes a huge difference in what you're able to see. I would think reimbursement should be very, very strong for that.

Q: So can you say anything about what the work of convincing, making the argument for reimbursement is like?

[01:00:48]

A: You know, not from a personal standpoint. I was on some calls and we were working with some government policy people. But there was a very specific group of people that do that at Hologic. So that was a little bit outside of it. But I know that some of the outreach that we did at Hologic which was outreach to patients from a grassroots perspective to try to drive some of that, to say I want tomosynthesis. And that would then push the providers, the hospitals and whatnot to push their payers as well. So it became kind of a team effort of women, manufacturers and hospitals to push the payers because as I said, they change state to state. So it's not like we've got a nice national healthcare policy necessarily. Although in Obamacare and the Affordable Act, it was – your screening mammogram was covered at no cost. So that was a good step forward.

Q: Actually, I wanted to ask you about that. I wasn't sure if it might've been a little bit too recent for when you left Hologic. But how did the ACA change things?

[01:02:07]

A: Yeah, I don't know if I can really give you anything specific on that other than just personal things. For any woman, it's hard enough for women to find time often, to take time off of work for childcare, whatever. So if they can schedule a day and they know that it's paid for, it's an incentive to go. And like I mentioned earlier, it's about annual screening and looking for changes over time. So if you skip a year, interval cancers happen. And interval cancers seem to grow faster than other cancers. So it's one of those things that if you know it's provided, it's no hassle. You just have to make an appointment. That's enough. Women find excuses not to get a mammogram. So not having to pay for it is a big deal.

Q: Sounds like a huge deal to me.

[01:03:23]

A: Hang on one second. [side remarks]

Q: Okay, we're back recording here. So we were talking about the Affordable Care Act essentially making it easier for women to get mammograms because they are covered.

[01:04:25]

A: Yup. Emotionally speaking, like you said, it's a big deal. Think about a woman trying to take time off, a woman who's diagnosed, a single mother, something like that and the impact of that on her life. And yeah, it's absolutely huge. So it makes perfect sense to me that it should be covered 100% no questions asked, just like an annual physical. Because that, in the end, benefits everybody. Healthcare, downstream, and families.

Q: Yeah, absolutely. So did you encounter much resistance to tomosynthesis within the medical field about, oh, it's another thing to learn and another set of storage challenges since you're collecting so many more images than if it's a bunch of one millimeter slices?

[01:05:37]

A: Yeah. So, both. The file size and infrastructure, the networking and getting images from here to there – and you’ve got these big data sets – was a huge challenge. And a lot of hospitals didn’t have the infrastructure to handle – it was sort of like, oh, do I have to do this? So yeah, it was essential that that be handled. Because obviously, you can hang a whole system. I’ve heard of whole pack systems going down because of not having enough bandwidth to handle the volume. Or getting the images from the technologist to the radiologist. And especially when you’re doing a diagnostic mammogram, usually those are read live. So obviously, there could be some exchanges going back and forth.

[01:06:34]

A radiologist might say, “Can you do another view of this? I just want to make sure,” and those kinds of things. So having that was huge. And also, as we were getting more satellite kinds of operations going, most of those images might’ve been read at a central place. So now you’re moving them not just within a building, but onto a wide area network. So those kinds of things were huge, and still for some hospitals create challenges. They don’t have the money. The investment is in the technology. And then it’s like, oh, by the way, you also need to upgrade your network. So that was one. And then the other one was yeah, the technology. And this happened actually in the world of digital mammograms as well because they looked different than film screen and people were very comfortable with that. But with tomosynthesis, it added another layer.

[01:07:35]

And it took more time because you were looking at a lot more data. So I think that again, that goes back to – they’ve got to be convinced, and then you’ve got to be there and you’ve got to provide the learning that they need so that they feel comfortable signing their name to that report. And that takes time. Different radiologists have different learning curves. So having a clinical education team and a clinical library, I suppose, is a good way to put it to work through and look at cases and practice before it’s actually going live was a really important aspect of adoption. So we would do radiologist workshops that were just building case libraries. And they were all documented, proving cancers with a backup. Here’s an ultrasound or MR, whatever, and here’s the outcome of that so that it was actually a complete study.

[01:08:40]

And then the radiologists would work through those on their own. And that's still happening today. There are a couple ACR, American College of Radiology does boot camps. And then at RSNA, most of the vendors have different reading workshops as well because different vendors have different looks to their images and different technologies. So if you were trained on one and you have to switch to another, it's almost like going back and starting the process all over again.

Q: How do you convince someone that it's worth doing that to make the switch?

[01:09:21]

A: I think the investment up front. Obviously of – you introduce a technology, you show a radiologist, they'll tell you, oh, these are all of your beautiful cases. Of course because you choose curated cases because you have a limited amount of time. So typically, there's an introduction to it. And then the second phase of it would be more of an in-depth imagery view where you walk through a series, again, of curated cases. But they have different teaching purposes. So here's dense breasts, here's an asymmetry, here's a multi-focal cancer that shows up in one view but doesn't show up in another and that kind of thing. And then that's like a one-on-one kind of thing. And then having these different workshops available at different times – it used to be that each vendor had to provide eight hours of training, vendor-specific training to get the radiologist comfortable.

[01:10:21]

But that's changed. You have to have eight hours of training, but it can be on any vendor. So once you've made the commitment, before the system goes in, then it's important that there be another learning opportunity of proving cases so that – and normal, by the way. We learned the hard way is that you can't just show cancers. Because most of what a radiologist is looking at are normal. So there might be – in every thousand cases – five that are cancer. So you're reading cases in batch, moving through them very, very quickly. So it's important that they have that exposure. And then system goes live. Support afterwards. Sometimes you have to have a peer work with them, somebody that's gone through it. Different people have different learning styles

and different comfort levels. So I think taking a personalized approach and making sure that you've got the right support people available to talk to them, be it a peer or clinical specialists, is really critical.

[01:11:34]

And then eventually they have an a-ha moment and they see something that they would've missed and tell you that. Say like, "Oh my gosh, I would've missed that." It's kind of at that point just the independence and the momentum moves on from there.

Q: And what was your most important way for disseminating information? Was it always RSNA?

A: Yeah, RSNA – it's really been changing over time. It used to be a can't-miss kind of thing, but it's harder and harder for people to go. But the important thing – yes, RSNA is where you want to have new clinical evidence. You want your customers submitting papers and presenting because of that peer to peer level of communication is critical in convincing somebody to adopt a new technology. So those, and then really the workshops. There's a series of smaller shows that happen through the year. And it became more about not just having an exhibit and a product and all of that, but rather having speakers. I guess I can't emphasize enough the importance of having peers talk not just about their adoption experiences – especially when you're moving from a different vendor, one vendor to another. Because there will be different nuances in different things that you have to be aware of.

[01:13:17]

So those shows were critical. The dedicated – let's see. There was SBI, the Society of Breast Imaging, and NCBC which was the National Consortium of Breast Centers. And were two of the, I will say, smaller meetings that happened in the springtime after RSNA. So those were critical. And then there's Santa Fe in the mountains or Music and Mammography in the Mountains or something, which was a big, very important meeting for – especially for radiologists who were interested in getting into mammography or ones that were general radiologists. It was a very rich teaching environment with a pretty prestigious faculty. So those

things happening through the year were great opportunities to step outside of just like, here's my little exhibit, into here's some meaningful clinical information for you to work through and to talk about. Now it's all virtual, so we'll see how that goes. ECR which is European Congress of Radiology, RSNA, they're all doing virtual meetings this year.

Q: It's that sudden switchover. It's gotten everybody.

[01:14:48]

A: Yeah, exactly.

Q: Have you ever been involved in any philanthropic organizations related to imaging?

A: So, personally on the breast imaging side, no. On women's health, yes. Mostly also what I guess I feel big advocacy for the support that we did at Hologic for Susan G. Coleman and some of the smaller health fairs that happened. I would tell you I was more involved on that level than I was specifically – let's say Susan G. Coleman because that's a name everybody knows. No, I feel like we had a nice balance of activities at Hologic. So we supported many, many regional kinds of activities and as part of marketing, that was my job. So we participated at that level too with health fairs and whatnot. [01:15:56] I don't know if I'm drawing a blank. It seems like I am. If something pops in my mind, I'll let you know.

Q: Sure. So, what were some of the toughest calls you had to make at Hologic?

[01:16:17]

A: Oh gosh. I'm trying to think. For me, the things that were the hardest were during some of the contractions of the companies or when we were growing. And like I said, the cycle of hiring, absorbing new companies, and also there's ebb and flow. So there's always people that just aren't working or don't fit in or whatever the reason may have been have outgrown. And I think that was, for me, the hardest part. I'm a very people-oriented person. So delivering that kind of news, for me, was always the most challenging. And then I think also whenever there's new leadership that comes in, it's hard to weather the storm sometimes. And as the company got bigger and you

were such a part of the pulse and the heartbeat of what was happening and you kind of knew everything and everybody, I think watching that change and becoming a more mature company, for me, was hard.

[01:17:35]

Because you're isolated a little bit. But I would say for me, it was the people. It was always hard trying to integrate companies and keep people focused, and also growing so that you don't lose your talent.

Q: So do you prefer the feel of a smaller or a larger company?

A: For me, unequivocally a smaller company.

Q: And I guess we pretty well outlined the reasons why, but is there anything else, any other advantages to a smaller company that you haven't touched on yet?

A: No, I don't think so. I think there's some risk in that. But you can thrive on it too. And I think you learn quickly and you learn rapidly. And like I said, the idea that every decision matters is pressure, but also rewarding.

Q: So throughout your time at Hologic, was there any one thing that was most likely to keep you up at night, or was it those tough calls?

[01:18:50]

A: I think the early days of – when there was no market presence and nobody knew our name, and how do we go to market? How do we – just trying to figure those things out. How do we fight the big GE's and Phillips of the world? So those were the kinds of things. I can't tell you – there was one event. I think it's just an ongoing thing of being better and standing – creating that confidence in what you're doing and what you're saying. So it takes time. And you know, what I would probably lose sleep on was getting that done or finding that person to tell that story or the

fundamental mechanics of what's needed to get out in the field and to be responsive to what sales needed were things that sometimes took time that we didn't have.

[01:19:53]

For example, thinking about how important these case libraries were. It seems like it would be easy, but it's not easy to get them. It's not easy. There's legalities. There's all kinds of things. But you need it now. And you need clinical evidence. That takes time. A research takes time. So I wasn't involved and responsible for all of those, but it all comes down to at the end getting that information out and present and on a constant enough basis where people don't forget you. So it's like drips, you know? Not one big splash, not one big event, but over time consistently high quality information was what kept me up.

Q: So, what were the first and last Hologic products that you were involved in?

[01:20:50]

A: So the first one was – we called it Selenia Dimensions. That was a digital product. And then the – wait, no. Selenia was the digital product, and then Selenia Dimensions was the tomosynthesis product. So those were in the breast imaging world. And then the final acquisition that we did that I was a part of when we were starting to try to integrate – complete our story of women's health was when we bought Gen Probe. And Gen Probe had product for HPV testing, molecular testing. Actually, you probably maybe have seen some of the Hologic news around COVID testing. It's laboratory science, and it was very, very different than anything – than what do I say? Medical device. So that was the last one that I was involved in.

[01:21:49]

It's turned out to be a good investment. It was a very quick one, quick decision to do that. And it was driven on the need for growth and that the jump rope had been tremendously successful. But very much like Hologic when they bought Low Rad, they were kind of focused in the blood business and they needed to grow. So there were a lot of really smart, creative people there. And with the leadership, it's really grown into a really nice business.

Q: So can you say a little bit about what it has felt like to have been a part of something so important? We talked about your early career a-ha moment. But as you were part of this company that was putting out all of this wonderful new technology, did you ever have any other a-ha moments where you and your colleagues realized the gravity of what you were working on?

[01:22:55]

A: Yeah, I guess when you meet somebody who has been diagnosed with cancer and it was on your system that you were a part of bringing that to – of changing that person’s life, impacting that person’s life and hopefully in a really positive way – I think the other thing has just been some of the relationships that I’ve had with different radiologists and what it’s meant to them and how it’s changing their patient care. One radiologist told me that – she said, “I just keep seeing more, and things that I didn’t realize.” She said, “I have to tell people they have cancer every day.” And she said, “But what I feel so good about is the technology that I’m using is helping me make their lives better as well. So I can’t change the news, but I can change the timing they get the news.” So when you hear that impact that you’re making on a radiologist as well – but I guess for me too, going back to the – so many women are diagnosed. A very common cancer for women.

[01:24:12]

And so much can be done to improve their outcomes. So to be a part of that, we always felt like it was our mission at Hologic is to make women aware about what mammography can do for them, but also providing these technologies is a great reason to get up and go to work every day. And then when we bought [01:24:39] and we had the OBGYN portion of it, it came about – you know, women’s health, reproductive health. And I don’t know. It’s just an easy thing to feel passionate about because I’m a woman, right? And also, I have friends who have been diagnosed with cancer and breast cancer in particular. I know I’ve lost somebody to ovarian cancer. I lost a sister to ovarian cancer. And there’s so much that we still don’t know about the connection and the genetic influences on cancer.

[01:25:12]

So to be a part of that in a small way, I think, is really satisfying. Sometimes, you don't stop to even think about it from that perspective. But sitting here and talking to you, it really makes me think like, yeah, wow. Everything that we said and we talked about and who we were as a company, I felt that way. I guess I was drinking the Kool Aid, but it was really good Kool Aid. And the best of it is that I've been gone from Hologic for, I don't know, how many years? Five years or so? And I still can see the residual effect and the passion around the company. And I know that that isn't just a product. It's about the mission that we were on and the people that were there that created that foundation. So to be a part of that is, I think, a once in a lifetime opportunity.

Q: So is there any one particular part of your career that you're most proud of?

[01:26:30]

A: Yeah, I guess I would say for me, when we really got to a point in Hologic where we were just producing a lot of really great stuff and in messaging, we were building such good relationships. And I think it was when we really got our number and somebody said to me, "Oh gosh, Pam. When you used to put that stuff out at GE, we would just tremble." It was such a good feeling because you realize yeah, we're on the right track. Little Hologic is on the right track. And it was a good feeling. It was a really good feeling and I'm really proud of that and the work and the people I had doing that work. Because I guess that was something I really loved was when you watched that creative process turn into something that actually touches somebody else – externally touches somebody else, I suppose is what I'm trying to say. And people relate to it and want to spend time with you or want to come to your exhibits because [01:27:35]. So anyway, I think that's it for me.

Q: Okay. So, yeah. We're about at the end of my list of questions.

[01:27:52]

A: Okay. Well, I hope this was helpful.

Q: Yes it was. Thank you for taking time. If I could ask one concluding question, is there anything that you would do differently?

A: You're catching me. That's a hard question because enough time has gone by, it's hard to think of one thing like that. Sorry. I'm coming up with – I'm drawing a blank, I suppose.

Q: That means it was good.

A: Yeah, I think back on an overall – time always smooths out the rough edges on everything. But certainly we had our days and our moments. And it wasn't easy, but it was satisfying and it was meaningful. And I think the financial success that comes out of it is a reward. But that really wasn't the driver. The driver was being a part of something and a part of a team of people that just were amazing.

Q: All right. Do you have anything else you'd like to say before I stop recording?

[01:29:29]

A: Yeah, no, I don't think so.

Q: All right. Okay. So I'll stop on Zoom.

END OF INTERVIEW