

## AMS - CM - Dr Andy Smith - Transcript

Helen 0:00

Well, welcome. I'm here with Dr Andy Smith, CEO of Sunnybrook Health Sciences Center. We're actually recording this on the day after Remembrance Day. So appropriate that we're here at Sunnybrook. And Neil Young's 80th birthday.

Andy 0:14

It is. It's a very important day for Canadians. And you know, Helen, it's great to be here, and it's great to be here chatting with you. We've known each other for a really long time, and I have to tell you how proud we all are here at Sunnybrook and as part of the community, having reached the culmination of Veterans Week and then Remembrance Day yesterday, just such a delight to honour the veterans that served and continue to serve our country. And of course, we work with the veterans. We also work with active Canadian Armed Forces right now, and it's something we're very proud of.

Helen 0:48

You have a bit of a history. When I was at St Clement's down the road over here, we used to come and sing on a regular basis at sort of Carol service in the veterans part of the hospital.

Andy 0:58

You know, we had that yesterday at the Cenotaph service, we had students from, I think it was John Wanless, and they grade four to six, I want to say, and they sang, What the world needs now, what the world needs now, just tears. Tears to just beautiful, to hear the choir so that that tradition continues.

Helen 1:17

Fantastic. I thought we might start with, kind of going back to our time together. We were obviously in different roles at Cancer Care Ontario. I've talked quite often about the CCO experience on these podcasts, you know, including with Anna Greenberg and others who were there. But really, you know, you were a really important part of the clinical leadership at CCO. And I thought this might be an occasion just to dig in a little deeper into what did you and we collectively learn from the CCO experience in trying to make improvements in the cancer system. Because we certainly were able to do that.

Andy 1:54

Yes, I have say, looking back, certainly on a personal level, the CCO experience was hugely formative. But in my current role and my role as a healthcare leader now, it continually serves as a template. So it's one template. It's one that I think is very effective. And I often ask, what are the elements of that, or what was the reason why that time at CCO was so very, very successful? I think the starting point is the ambition. I really think that there was a sense there that we had gaps in the cancer system that we were able to identify as we came toward the end of the 20th century. But there was

a really coming together of ambition on the part of government, the leadership of Cancer Care Ontario, and they did a lot of things right, but there was that North Star that, why can't we be second to none on planet Earth? And that's what was achieved. I think there was a step wise approach to that, but it starts with having that great clarity that we have the ambition to be the best or second to none on planet Earth.

Helen 2:58

Yeah, I usually start the story with the, you know, the quality gaps that were prevalent in the sort of early 2000 late 1990s where women were going to border communities to receive radiation therapy, and that there really wasn't a, you know, a functional cancer plan and capacity plan for cancer. And then I often, you know, we'll kind of take snippets and tell a bit of the story about how you and colleagues went around the province and sort of educated your other colleagues about the right number of lymph nodes to resect during colorectal cancer surgery. Do you have some stories that you like to tell that kind of bring this experience to life?

Andy 3:39

I do, and I must say, I always predicate things by saying stories have a way of becoming somewhat apocryphal as the years go by. And I've heard about either myself or many other people tell the stories of the time, but the kernel, the central element, is absolutely clear in my mind. For me, I like the fact that you talked about gaps. I think that for anything we're doing, we have to have a honest understanding and embrace of the fact that there are gaps or ways we can do better. For me, the singular point when I became aware that we could measure gaps and say we got to fix this actually was a newspaper headline, and it was something that Bernie Langer used to show on a slide, that was that the mortality rate in a particular Ontario city for pancreatic surgery was 10% so you had a one in 10 chance of dying just from the operation. And you can look at that and say, we've got to do things to fix that. So for the I call it the lymph node story. And I've heard people talk about it, this lymph node story. It really started off completely accidentally, as I think a lot of us, I'm an accidental leader. I think this was an accidental understanding of it. I was a new sort of Hot Shot young recruit back from Memorial Sloan Kettering Cancer Center in New York, and we had a young person come in, 40 something with colorectal cancer from Guelph, and he had had his surgery in. Wealth. Everything had gone really well. But he wanted to come to get an opinion from me about should he have chemotherapy. So he was a node negative, and the algorithm is no negative colorectal cancer there, you don't need chemotherapy. And so I came in and shook his hand and had a great chat with him, and said, You've got no negative cancer. You're great. Your operations gone really well. And then as I walked out of the room, the fellow at the time, who was Dr Calvin law. Now, he's a well known cancer surgeon, self now, but he was the fellow, he said, you know, Andy, how many lymph nodes do they have to look at to be confident that it really none of the nodes are involved with cancer. I sort of blushed a little bit. First answer in my head was, I don't know, but then, because if you look at this report, there's only two lymph nodes that they actually reported on. I don't know if more were resected, but there's only two. And can you be confident? Well, turns out you can't be you need to have a certain sample size. The number is 12. Just remember that 12 is the number. You can have arguments

around the nuance and that. But the bottom line is, if you don't assess something, whether it's molecular assessment or lymph node assessment or margins, how can you make intelligent decisions around what additional treatment or prognosis, etc. So Calvin led a study here locally as the fellow to look at 399 consecutive cases of colorectal cancer, and found out that only in 24% of them was 12 lymph nodes looked at, so one in four had 12, three out of four had less, and a lot of them had 0, 1, 2, or 3. So we then did a study across the province, 8848 the kind of thing that the number never goes away from your head, 8848 cases with cancer. Ontario cancer registry, which was a blessing to have that not everything has that. And we found the number was exactly the same. 24% of people had the proper assessment, and 76% did not. So that was a gap. You know, I could go on without taking a breath and tell the rest of the story, but the key part, the key part was then saying, how would you bridge that gap? And we wrote a few grants, Dr Francis Wright, critical in that to look at what would a multi pronged change initiative or knowledge translation initiative, looked like, and we looked at various things, including opinion leadership, audit feedback, so looking at the numbers, showing people their data, things like that. Anyway, there's lots more details to the story, but basically, that's what God certainly Me, personally and a group of people focused on, wow, this is exciting. You can find gaps in cancer care, identify them quantitatively, show the data to the people, and then say, what's it going to take to fix that?

Helen 7:51

Yeah, I remember my retelling of the story again, sort of, it's this about 20 years ago...

Andy 7:57

Closer to the 25 almost, Helen!

Helen 8:00

Thanks for the reminder. But was that we could almost see, you know, people, we put out the data, but we could almost see the numbers change as you went out there with your colleagues to have the conversation with individual surgeons. You almost say, Oh, you must have been in Waterloo last month or something like it was a bit like that. The clinical leadership, in some ways, was the secret sauce, I think, to the model of cancer care, all the other stuff hugely important. But then what sealed the deal, I think, was the leadership that you and others provided to their colleagues to help change practice. Is that a fair retelling?

Andy 8:38

I will say it's always important to note that stories told in retrospect sound clear and straightforward, as if everything was planned. That was not the case. Some key parts of what you just described happened a bit by accident. So the way the trial, it was a cluster randomized trial, nicely funded by a couple of the grants for which we're very grateful. It was a cluster of randomized trial, and it intended to have surgeons be in the audience, but also pathologists. That was important. Now, in point of fact, when we started going around the province, and we went from the small, we were in Sioux Lookout, we were also at the Toronto General Hospital, and from east to west, north to

south, covered the entire province. In my retelling of it, I remember it I remember is when it was in Niagara. I was at the their meeting was at a winery, which was in the evening. Was this nice meal, and sort of I was giving my talk. But in the sort of schmoozing part of the proceedings, it started dawning on me that, first of all, there was some medical oncologists came to the meeting too, so pathologists and the surgeons. But I remember seeing people shaking hands and saying, Well, Dr Jones, I've seen your name on reports for the last 10 years. You know, I've never met you. It's so great to be here and to actually meet you. I thought, my goodness, this is there's something more here, the human element of bringing folks together, showing them their data together. They're smart people, they're energetic, and then they could sort of own the gap that we showed them their own data, of course, and then say we're going to get this fixed. So that got me inspired in many ways, including especially when it came around time for CCO to say we're going to make tumour boards mandated and put structure around that, put remuneration in there for Docs. It really in my mind, that's where I said to myself things like tumour boards are going to give cause better care and better outcomes for patients, which is ultimately our goal.

Helen 10:31

Yeah, I think also about, you know, some of the people that I had the privilege of working with, including you, but also Alan Hudson and Bernie Langer and Hartley Stern on the surgical side, they were all so brave, right? And I really appreciated that in the sort of watching clinicians, kind of at the top of their game, really doing the best for patients, really seeking the truth.

Andy 10:55

So you know, you've mentioned three giants of the Department of Surgery here at the University of Toronto, but three, frankly, giants of Canadian surgery. And I do have a very soft spot in my heart for all of them who were mentors and teachers, but here's what I think that they did have. First of all, they are strong leaders. There are no shrinking violets amongst the three of Alan

Helen 11:18

Nope!

Andy 11:20

Alan and Hartley and Bernie, and that's important now, but importantly at the time, and certainly in retrospect, had the sense that they had the strong backing of government at the high at the higher level. I believe that was a key ingredient. So they were allowed to deliver on their firm and most of the time empathetic hand but there's certainly always firm, great clarity as to what needed to be done. So I think that kind of strong leadership if we're hoping to change any element of the health care system, whether it's cancer care, cardiac care, mental health, whatever it is, I do believe it's an essential ingredient. It's not the only thing, but it is an essential ingredient. And they were able to galvanize, pulling people together, including, ultimately, lots of clinician horsepower to make things happen. So I think that they were a necessary element. If they didn't have

clarity and that sense of ambition that we were going to get this done, I think it would have been certainly slower and perhaps not as successful as it ultimately was.

Helen 12:23

Yeah, it was earlier in my career, and I must say, it was exciting, and to be part of that, yes, right, and to be making a contribution, and to have that leadership made the work, frankly, worthwhile and a whole lot easier. Absolutely, any other leadership lessons from that time?

Andy 12:39

So I would think, I mean leadership lessons. Of course, we can talk about the general and then the specific. Let me dive into some of the specific elements, because these are certainly things that when I mentioned the that I think it's like a template for work in other areas. I think it was critically important to galvanize clinicians from around the province and to be able to pull them into the enterprise. I think that clinicians, and often case in this instance, it was physicians that are highly motivated, focused, folks who are really smart and want to do the right thing. So when there was clarity of leadership ambition, they were able to sort of be pulled in and put to work. Quite frankly, it was done for remuneration was not high. It was recognition was high, respect was high, sense of personal reward and purpose driven activity was off the charts, great. And there was stipends here and there. I would not say that that they threw a lot of money at it. Rather, they threw a lot of clarity and firm, excellent leadership at it. So engaging clinicians, super, super important. The second thing was right off the bat was this idea, show people their data, yeah, show them their data, and that alone. And it's not as simple as, oh, there'll be peer pressure. That's part of it. Of it. Of course, it is. Humans have do respond to that, but it's a sense of professionalism. And if you see your data and you're at the bottom quartile or the bottom decile, there's a sense to say, folks, come on, we can do better. That's not us. Let's get better. So I think that that was important. I also think when you hear that CCO story told government did inject very strategically and in retrospect, very successfully, financial incentives. They were not massive Helen, they were not, they were not, but they were very thoughtfully, very, very thoughtfully deployed incentives. And it shows that incentives need to be aligned, but not necessarily massive alignment might actually even be more important than the size of the quantum of the...

Helen 14:46

Yeah, I was, I was struck from that experience and later on, how responsive the healthcare system is actually to small amounts of incremental funding. That may be like, you know, how tight things are. But I think it sends a signal. And I think that was something that CCO deployed to great advantage, was it didn't have to have all the money for all the surgeries, but for the additional ones.

Andy 15:09

That's right,

Helen 15:09

it actually gave the organization leverage over everything.

Andy 15:14

I could not agree more. I mean, I was an active, very busy colorectal cancer surgeon at the time, and I remember our monthly staff meetings where they would say, Well, you know, we might fall a few cases short, and we won't get our CCO money. I had no idea but the overall budget and how a hospital runs at that time. But I did know that, by golly, we're going to get that done here at Sunnybrook. And so we did chase that. That's what incentives are supposed to do. That's a that's a good thing. And it was fun when you reached your target, and people said, well, done. It worked out.

Helen 15:46

Yeah, they need to be intelligible, right? We need to understand what they're actually designed to achieve.

Andy 15:51

I could not agree more. I mean, there's a whole bunch to talk about there, around how funding models do and don't work, and where they fall short and where they excel. And yes, they need to be intelligible.

Helen 16:01

Absolutely, they need to send a signal. If it's murky, it doesn't work.

Andy 16:04

That's right.

Helen 16:05

So let's pivot a bit to sort of now, you're, we're on the campus of Sunnybrook Health Sciences. It's, you know, a \$4 billion enterprise, and there's 12,000 employees. So that's a pretty big career progression from being a colorectal cancer surgeon to really running a very successful hospital. And congratulations on the Hurvitz Center, and...

Andy 16:27

thank you.

Helen 16:27

Just talk a little bit about what you did to prepare. How did you go from that experience and your early part of your career into where you are today?

Andy 16:36

Perfect. So first of all, it's 1.7 billion. I don't want, I don't want, I don't want people to think we're being overfunded. It's 1.7 but yes, 1.4 million patient visits over 11 sites in the year. And very, very proud of our people and teams, the 12,000 doctors, nurses, other professionals, other staff and volunteers that make things happen. So I will start by saying I'm a complete accidental leader, absolutely accidental leader. I did not

ever aspire to this job as I was coming up, I had a really phenomenal training here at the University of Toronto. And as I look back, I feel grateful for a lot of things, but top of the list is the people that I intersected with as it went along the way. You mentioned certainly Bernie, Allen and Hartley. There three amongst many. So of course, you do sort of absorb that. And of course, to some degree, some people have more of a natural inclination to take leadership roles on. For my journey, pivotal piece. So I did have an inclination toward that. I was the chief resident. I was the valedictorian of the surgery class, but, but so there's a natural inclination, I'm not saying, but it but, but the ability to encounter great mentors. But for me, the top of the pantheon of people who influenced me was Dr Sherif Hanna, yeah, and I got a little emotional thinking about him and his impact on me, but he was the man who recruited me to come back from New York and to come here. He stepped aside as chief after about two years of me being back, and said, you know, you're going to have to apply. There will be other people applying, but so I get, I got to start early as a divisional chief. So I do think practical things like getting your feet wet and frankly, learning about leading are really, really important. But the pivot to come out of the operating room was not only accidental, I would say, it was a bit forced, and I've been out of the operating room for 13 years now. And that I give all credit to Dr Barry Mclellan. He was the chief executive who preceded me, a spectacular chief executive himself, a physician CEO. And I remember Barry...

Helen 18:55

Former coroner of Ontario...

Andy 18:57

He was, Yes, fantastic doc. I think he still does a bit of corner work and very, very smart doctor. But Barry said, you know, Andy, I'm actually not asking you. I'm sort of very strongly suggesting that you look at leaving you've done these leadership roles as a division chief, as a head of a cancer program. I was chair at the university. I was the Langer Chair at U of T he said, You'll work harder than ever. It's at the time. He said you'll take a pay cut, and by the way, you're going to thank me forever. You're going to really think it's going to be the best thing. And so I said, Well, that sounds like an offer. I can't refuse Barry. So I did apply for the job and became EVP, and then ultimately, Chief Executive, after Barry passed the baton. But I look back on that journey, the number one thing, and it's such I think gratitude grows, at least. I'm just about finished my 50s, the looking back in the sense of gratitude people who, either in short bursts or longitudinal mentorship, had a profound impact on you. So it's something I carry with me. And. Try to be very intentional about feeding into those who are earlier in their careers.

Helen 20:07

Yeah, I have similar experience right, having worked in the ministry and government Cancer Care Ontario, and then sort of late mid career, all of a sudden I found myself, you know, the deputy of citizenship or international trade or Treasury Board. And people just think, if I think back on it now, I think that actually it was the secretary of the cabinet creating opportunities for me to lead in a different way and see whether I could

actually step up. It was quite intentional. Now that I think about it, maybe not for me, like accidental, like you, but people around me create opportunities. And I guess, like you, I had this sort of temerity to kind of walk through those doors, right.

Andy 20:46

Exactly, well, you've mentioned a couple of things that I think are separate and distinct and critically important. The first is that there are lots of great people out there trying to mentor, coach, sponsor, people to come forward at the time when you're living it, I do have clarity that there's a lot of unawareness of it happening. I remember the Physician in Chief at the time when I was busy as can be, operating, running a research program, doing the chair work, saying, you know, Andy, I think that the boss might want you to sponsor, you to go to a course at Rotman, the advanced healthcare leadership.

Helen 21:24

I bumped into you there, actually,

Andy 21:26

Yeah! And I thought, Wow, that's nice, isn't that there just sort of, isn't that nice that they might think of me, not another thought beyond that, I, you know, but I went, and it became a very, very useful and important thing. So people are doing that all the time, and you do it, I do it, and I think it's, it's an important piece, perhaps not even necessary, that the people who are being coached or sponsored like that fully appreciate the depth of possibility that it does bring. But the second point you mentioned, I think, is equally critical, and I don't know if it's something we should try to influence, to expand or not, and that is that I believe it's a minority of people that you use the word temerity, that sort of have the boldness or the acceptance of uncertainty to go through the doors it would have been easy, or the easy, maybe the smart answer. And many people told me I made the wrong decision when Barry said, Listen, this, this and this. Andy, you love surgery. You got this huge practice. You love the residents, you love the patients. You love in clinic. You're in your element. I just couldn't believe you would walk away from that and do so abruptly. It is kind of quite frankly crazy when you think of it that way, but it is the I like your word temerity, there to do it and realize that the universe unfolds in different ways. And I mean, it worked out. It's been incredibly rewarding on a personal level, and I'm proud of the team that it gets to serve. But it does require a certain boldness to take chance or be comfortable with the uncertainty, to hop from something to something quite different.

Helen 23:04

Yeah and I think its neighbour is resiliency, right?

Andy 23:07

Interesting...

Helen 23:08

I think that, you know, I think about my experience during covid, and I parked outside the hospital, which is where your field hospital was, think about, you know, the cycles

and time and everything else. You know there's, there's, you have to have an ability to dust yourself off and get back in the game pretty quickly in a crisis, right? And I would think that that's kind of, to me, that's a neighbour of being, kind of having that confidence or boldness to try something new,

Andy 23:37

Yeah, confidence, boldness, maybe Blythe, ignorance. It's possible, but dust yourself out. You won't succeed all the time, especially as you move up into these really important roles that a lot of people are depending on you to do well. And you know, I really adhere a lot to the sort of construct of servant leadership. Obviously, none of us is perfect, but everyone needs to have a construct of what drives their leadership. And you know that in these roles, people need and want you to succeed and you to do their best to elevate them to be the best versions of themselves.

Helen 24:14

So you're known for your walking meetings. In fact, when I came in, you were just coming back from one. What's that all about? I think it's fantastic, but what's the thinking behind it?

Andy 24:24

So again, I would frame this as this is a shtick that I have that is way easier to explain in retrospect. It was not something thought up a priori, or was it ever thought of in a structured way, but the short story of that is that I used to be quite an enthusiastic runner. I was about 15 pounds lighter than I am now, and used to love running 10k and but in 2012 I had to have major surgery on my right leg. Was something that I'm forever grateful to Dr Tim Daniels, who did the surgery at St Michael's Hospital. And I remember when I was coming out of that, Tim said the surgery went really well. You can go back to running, so I'm never running again. And I sort of became like Forrest Gump at that point walking. And then over the intervening time, but especially as the pandemic started, I sort of went into this, I guess it's borderline obsessive notion of walking 365, days a year, rain or shine, doesn't matter what the weather is. And it started then to evolve that people always ask, Well, do you have a dog? Actually, I don't have a dog. My wife doesn't like dogs. I don't miss not having a dog, but I love walking with humans. And it turns out, there's a lot of humans who will walk with you, and I'm endlessly fascinated with people's stories, so it becomes a vehicle. Sometimes it's friends and family, many times it's a student who just has had the boldness out of nowhere to send a note on LinkedIn or contact my assistant, and never met them. But I've never, ever had a person who hasn't been a blast and been fun. Sometimes it's mentoring. Sometimes it's a repeated meeting with somebody who reports to me. I use it a lot as a recruitment tool. I will tell you, I It's, we've got this gorgeous ravine behind when we're getting down to finalists for key roles, I say, Well, how about we go for a walk? And whether they know it or not. It's, it does suffuse people with a sense of wonderfulness. So I use it as that sense. But also, for me, it it's just been such a blessing. So there's a book that I reference a lot called the extended mind by Anne rose Paul. It's, she's a scientist, but it's written in lay language, and it shows the changes in our brain physiology, brain function, and all kinds of empirical data as to

how our mind works differently and how we interact differently on a walk, as opposed to have said, well, let's go for a cup of coffee. That's great to go for a cup of coffee. It's different if we go for a five or 10 kilometre walk in the ravine, in many instances, depending on what we're talking about, or brainstorming, but it's better, like the creativity. I won't go on at length about the lessons in that book, it's jam packed with them, but it's influenced my you can call it an obsession with with the walks and the ravines of Toronto.

Helen 27:24

Fantastic. I'm going to ask a bit about where we are in the health care system. Clearly, there's some challenging times. You and I attended a conference. I think one of the stats I came away with was we're sort of at the natural ceiling right of health care spending from a provincial government perspective, right? We're about 40% and, you know, there's a sense of going above 40 is going to be pretty hard to achieve, maybe not even desirable. And some depends on where you sit. At the same time, we have, you know, an increasing number of reports that talk about the numbers of people living with chronic diseases. And not only that, is the complexity of the patients, because the numbers of chronic diseases that they're living with is growing. So that seems to be almost a mismatch. At AMS, we are kind of hoping that technology will actually play a role in helping us get out of this jam, AI specifically, but obviously other digital tools. When we first started talking about doing this podcast. You just come from the can health conference,

Andy 28:27

Great group.

Helen 28:28

Just wondering what observations that you might have to, you know, the challenging times that we find ourselves in and where we might want to double down on in terms of effort.

Andy 28:39

Well, with that framing, I think, and I want to repeat a couple of the anchors. I think it's critical that we embrace these anchors. So first of all, I'll start in an unusual place for a hospital CEO, I think we need to be empathetic and understanding of government's challenge that 40% that there's not an infinite amount of the tax base that can go to hell. You have to say, I get that. I empathize with that, and it's important to accept that that's a common challenge. That's number one across the country, across the across the western world, yeah, so that is a that is something that we it's a challenge, but let's park that. The second is that we have the challenge of dealing with a growing population, an aging population and a population that has higher expectations than ever. So I want to just talk a little bit about those two. So the aging and so forth, all the data shows that. I mean, when I was an intern, you did not have 90 year old patients. Now they're everywhere, and we all hope to be one. And Steven Pinker, I guess, has done all the books that show all the data that we are living better than ever and at any time in human history, that despite all the tumult and the challenges in the world and

concerning narratives, the fact is, we're living longer. And we want to be just said, you and I want to be that person who's swimming at the YMCA at age 92.

Helen 29:58  
Absolutely.

Andy 30:00

The third of three pillars needs to be emphasized to the growing expectations. Now, I find that sort of finds its expression a lot of times in works like Peter Attia's *Outlive* but the expectations are high. The 90 year old patients that I did see with aortic stenosis in the 80s at the general he'd be holding their hand. It'd be palliative care, and it would be the end. Now we do a replacement of the aortic valve through a percutaneous approach to put in a Tavi valve, and they're going home on the same day. So that used to be, you just wouldn't do that surgery in a 90 year old. If you did do it in an 78 year old, it was a four week stay in hospital, and now they're going home in a day with they can breathe again. They go swim at the YMCA again. That's an actual patient. So I think about that as the it really is a big challenge, growing population, aging population, with higher expectations. So how are we going to deal with that? First of all, I do believe, you know, at the beginning of our chat here today, talked about the fact that ambition is important an attitude. I will say that I think that sometimes, sometimes as Canadians, we have a little bit of a tendency to be a bit too embracing of deficit or negative narratives. I think someone might say, Andy, I'm just being realistic. Yes, I get that. But what if we think, can it be done? I think it can be and a lot of that to do that will require a different thinking, and it's going to require courage, which you mentioned earlier, and alignment from the top, highest level of government right on through to the front line. My belief, my observation is we have the ability as Canadians to get this done. So we have to say this is a winnable or a solvable puzzle, and we can solve it here in Canada and Ontario, as well as anywhere. And I could talk about numerous areas where see it already happening. I mentioned the heart valves, but think about it, me and Helen. Can remember, even when you were deputy, I think that people were still having inpatient stays for hips and knees. Now, across the province, it's the same day or one sleepover and hip and knee. So with lots of advances already to move to get more efficient, or more productive, if we can use that word, but with technology and, for example, more care at home, or moving people to home more quickly, close alignment between, for example, health care elements like hospital and home care, strong, courageous push and support from government. I think we can do that within that 40% and provide care that is both high quality, compassionate and more efficient. So you know, value equals quality over cost. We can improve all parts of that equation.

Helen 32:45

Fantastic. That was fantastic. It was wonderful to spend time with you. I don't think it's accidental at all when I hear you talk you, this is innate to who you are as a leader and I, I share your optimism. I hope that from both our purchase, we can play a role in making it happen.

Andy 33:04

Well, Helen, it's been a delight to to spend time with you today and talk about this, and it is incredibly exciting to be involved in healthcare, and it's a challenging time, but my goodness, is it ever exciting.