

# The Most Important Lessons Learned Commercializing the First da Vinci Surgical Robot: Interview with Daniel Hawkins, CEO of Shockwave Medical

Daniel Hawkins is the President and CEO of Shockwave Medical. He began his career in marketing and business development roles for Advanced Cardiovascular Systems, otherwise known as ACS, which is now part of Abbott Vascular. Following ACS, he held senior roles in general management, marketing, and business development with a number of private and public companies.

Daniel started the marketing department at Intuitive Surgical where he guided product feature development for the da Vinci Surgical Robot and developed key foundational marketing strategies for the company. He has also held senior leadership and/or founder roles with Endologix and Calibra Medical, which is now part of J&J. Daniel has an MBA from Stanford, a BS in economics from Wharton, and is a named inventor on over 100 patents and applications.

Here are a few of the things we're going to learn in this interview with Daniel:

- How his early upbringing gave rise to his entrepreneurial spirit.
- Why focusing on pain killers is imperative for medtech startups.
- Daniel's early experiences at Intuitive Surgical and some of the most important lessons he learned commercializing the first surgical robot.
- A question every medtech entrepreneur should ask themselves, "Does your product have natural pull?"
- The importance of removing complexity and constraints when making key decisions.
- How Daniel and his team came up with a concept for applying Lithotripsy to arterial plaque.
- Daniel's approach to raising money for Shockwave and how he was able to convince early investors during a tumultuous economic time.
- Daniel's favorite business book, the CEO he most admires, and what he'd tell his 30-year-old self.

**Scott Nelson:** Hey Daniel, welcome to the Medsider program, I appreciate you coming on.

**Daniel Hawkins:** Certainly, very happy to.

**Scott Nelson:** Let's get started with Shockwave. You co-founded the company you're currently running with John Adams and Todd Brinton, back in the 2009 timeframe, to address an unmet need when it comes to peripheral vascular disease.

When you look at the peripheral landscape, it would seem from an outsider's perspective, that it would be flooded with a wide variety of different treatment options, from self-expanding stents, to plain balloon angioplasty, atherectomy, drug-coated balloons, and others.

I'm curious, if you want to take us back to that timeframe, what did you see in the peripheral space that led to this concept that you're developing at Shockwave now?

**Daniel Hawkins:** Sure, happy to. For perspective, in 2009, drug-coated balloons were emerging; they were not yet in the forefront as they are today. Back then, predominantly, there were varying versions of scoring balloons, like AngioScore balloons and other types of specialty balloons, high-pressure balloons, and atherectomy.

Then of course, there were stents, balloon expandable and self-expanding. The challenge with all of the non-stent technologies, which we identified in 2009, is that they are not addressing the fundamental issue of calcification embedded in the vessel wall. Balloons put pressure on the calcification, but really overstretch the soft tissue on the other side of the vessel, and then create vessel injury.

That ultimately leads to a healing response that everybody calls "restenosis", or if you injure it a lot acutely, then you end up having to put in the stent. The other reason to put in a stent is because those fundamental technologies can't take a blockage in the vessel that might be 70, 75, or 80% blockage and get it down to under 30%, a clinically meaningful endpoint.

If it is calcified, those technologies struggle mightily to be able to do that, and what happens is that physicians end up putting in stents. Atherectomy showed a capability of reducing the volume of plaque in the vessel, but there are a lot of risks associated with atherectomy, and quite plainly, its mechanism of action is to grind up the inside of a vessel and that causes a lot of injury, and can ultimately lead to restenosis.

What we realized with Shockwave is that the physics of high-speed pressure waves is completely different than constant high pressure that you get in regular balloons. High-speed pressure waves travel through the soft tissue and do not disrupt it, do not create the injury that is very common with scoring balloons or high-pressure balloons. Instead, it actually creates cracks in the calcification.

You can think of them as expansion joints, we create a crack at a very low constant pressure in the balloon, non-dilative pressure in the balloon, and then we inflate the balloon just a little bit. Frankly, very gently. What we're doing is expanding those cracks in the calcification and therefore the vessel without the injury that everybody else gets, and we're in fact, getting stent-like results without stents.

**Scott Nelson:** Let's set the stage for the audience, Daniel. You are the CEO of Shockwave, you raised a \$45 million dollar Series C this past November, and we're recording this in early 2017. Received FDA clearance last September, to be specific.

Where are you at with respect to clinical data and commercialization?

**Daniel Hawkins:** We are CE marked in Europe, we're FDA cleared in the United States. Around the time period of the financing, we had six-month results in our second peripheral vascular study in 60 patients done in Europe and New Zealand with 17 or 18 different operators and at that point had achieved a 30-day outcome in our first coronary study using Lithoplasty for the treatment of coronary vascular disease prior to stent placement.

Lastly, we began our early commercial activities in Germany in the peripheral vascular space. From a standpoint of regulatory and commercialization, as well as data gathering, that's where we are currently .

**Scott Nelson:** That's great. Let's take a step back and rewind the clock, and focus a little bit more on your early career. What first brought you into the medtech space?

**Daniel Hawkins:** I actually grew up in a medical entrepreneurial household. My dad is a primary care physician, hung a shingle immediately after medical school and started his own practice that frankly was on the first floor of the house we lived in West Philadelphia. I grew up in the Philadelphia, Pennsylvania, and his practice was on the first floor, and ours was a house that was exposed to healthcare very early. He treated a lot of Department of Public Assistance patients.

One of the jobs that me and my brother and my sisters had was to make sure the coding on the DPA forms was correct. We were in and around that regularly. It was a small business house, if you will. I went on to personally doing some small business related things, everything from door-to-door sales of clippings that came from a Holly tree in our backyard around Christmastime to operating soda machines to put myself through Wharton undergrad. Along the way I became a bit fascinated with the combination of science and medicine, didn't really know what to do with any of it, but I had always been scientifically minded, attracted to chemistry and biology in high school and the like.

I was really driven to go into business because I was fascinated with how businesses get created and was fortunate enough to be accepted at Wharton undergrad. I was intending on pursuing a premed and Wharton undergrad simultaneously until the Dean of both schools suggested I might want to reconsider that thought. Quite a bit of work.

I ultimately opted not to do that, but I held on to the goal of somehow combining business and medicine, and then ultimately discovered what venture capital was. I didn't know it existed at the time. Out of Wharton, I ended up joining a leveraged buyout house that had about 50 or 60% of their business in venture capital and was attracted to the deals that were involving medtech. The prospect of being able to move the clinical needle on millions of patients versus one at a time, like my father, was compelling for me, very compelling.

What was not compelling was staying in a financial engineering kind of an environment, if you will. I ultimately elected to go back to business school and was fortunate enough to get into Stanford. Following Stanford, I looked immediately at medical technologies, medtech, medical devices as an area of interest.

At that time period, angioplasty balloons were \$600 a piece, stents hadn't been invented yet, and the hottest areas back in 1993 were orthopedics and interventional vascular. I was fortunate enough to get a position in marketing at ACS, Advanced Cardiovascular Systems, a division of Eli Lilly at the time. I joined there pre Palmaz-Schatz Stent, so that was a long time ago.

The first indication of that stent was abrupt closure, or threatened abrupt closure, that comes from high-pressure dilation of the vessel due to calcium. The IVUS studies, intravascular ultrasound studies, in the mid-90's confirmed all of that and really, that laid the groundwork for what I later traded on when I came up with the notion for what is now Lithoplasty, to avoid those dissections and see if we can get better results long term. But I became fascinated with the space back in 1993, I've stayed in it and have been fortunate enough to be involved in a number of significant startups along the way.

**Scott Nelson:** Such a great story. Looking back and connecting those dots even to your early days growing up watching your dad who is a physician run his own business right at home. Very cool to hear that story.

Looking at your extensive career arc, I'm sure you've learned a ton across those experiences with these early stage medtech companies. Are there a few things that really stand out, or perhaps examples or situations you recall that really had a profound impact on your career?

**Daniel Hawkins:** Yeah, there absolutely are. You don't realize when you're in the midst of career shifts, or shifts in your experience, the meaning of those. I think it's very appropriate to look back at some of those. Fundamentally, what I discovered more than anything else is to focus on the true needs, not the wants, not the desires, not the vitamin pills. You need to focus on the painkillers. The ones that are so fundamentally needed and are solved by technologies that are fundamentally effective while avoiding a bunch of the issues you might otherwise want to avoid. In our case, avoidance of vascular injury, by way of example.

They become, if you will, intuitive. No pun intended to the name of that company, but that is the place where I in fact learned that. The intersection of focusing on true needs and keeping the usability, the function of whatever technology it is, very, very simple. Those two together will drive adoptions. At Intuitive Surgical, the robot was incredibly complicated. It started off, I'm sure it's many more parts now, but it started off with 2,700 parts on the BOM, on the bill of materials. It had 1.1 million lines of software code.

Now mind you, this is back in 1999. So that was a watershed of activity. That's a lot of complexity. But in the end, what it was is something the surgeon looked into, saw the operative

field, put their fingertips into the tip of a controller, and moved their hands like they're operating with their fingers. What we really did is use complexity to make the experience simple. Now, what problem did we actually solve? The problem we solved in that particular example is we allowed the physician to operate in an open surgical environment, but do it through a hole the size of a trocar.

Trocar-based surgery, or minimally invasive surgery, is fascinating stuff - truly enabling. However, there were lots of compromises and what the physician needed to do was advance their capabilities in spite of the restriction of that tiny hole. Intuitive removed the restriction. That was a pain killer and they made it incredibly easy to use, and that's the reason why it ultimately took off

I've got a fundamental belief that great products are purchased and not sold. If you create a fantastic product, users will come to you and of course, it is your job to sell properly and you've got to do all the marketing and everything else. But the great products have a pull to them. If you know you're working with a technology in a company when there is that pull, when the activity is more than you can handle. That is exactly what we had at Intuitive Surgical and frankly, it's exactly what I'm seeing here at Shockwave.

One of the other things that I've learned more than really anything else, mistakes made early or changes in judgment made at point A, by the time you get to point D, you learn what mistakes you made back at point A but you're a mile away from where you should be. You've got to start early when you're making a decision and to go down an essential path, you've got to check your core assumptions. Make sure they're the correct ones, and they're the relevant ones before you proceed.

One of the things I find more often than anything else is when there's disagreement among very bright, experienced people about a direction or a pathway to go down, very often they're operating under different core assumptions. One of the things I will often do is get back to, "What are your assumptions?" They'll list them, and I'll say, "Take away that constraint. Take away that other constraint. Now, what would you do?"

Meanwhile, I will know in the back of my mind how to get rid of those two constraints, and now we're in a very different solution set. That's exactly how we ended up with the device that we did at Shockwave because my engineers were saying there was a constraint; we couldn't get more than one emitter in a balloon. I asked them to remove a couple of constraints; now it's limitless. I didn't know how to solve it, they did. All I really did was remove that constraint.

So those are some of the more significant elements that have popped up now and again throughout my career, and there are certainly more examples of those.

**Scott Nelson:** Really good points and really good anecdotes, especially regarding the concept of a pain killer versus something that just fits a superficial need. I think that's great and it seems like you've got a knack for stripping away the complexity. Not only in product or even

messaging per se, but even the way you explained that latter part of the answer with respect to removing constraints. It's simplifying the challenge or problem ahead and removing those constraints. I'm not sure if that's something that just comes natural to you or something you've learned over time, but certainly seems to be an important lesson for sure.

**Daniel Hawkins:** It's something I actually learned watching Fred Moll through a decision process. If I can, I'll share a little bit of an anecdote from one of the earlier company moments at Intuitive Surgical. There's a small group of us — seven or eight, I think it grew at one point to 12 — that would meet every Tuesday morning, and we would run through critical elements in the way towards our milestones.

The meeting was called the *Critical Path Meeting*. There were representatives from each of the subsets of the technical areas. Mind you, we had large-order mechanical, small-order mechanical, software vision, we had electrical, all of those subsystem groups would have a representative, and sometimes one would represent two or three of those functional areas. There was always marketing, that was me.

The CEO, was always there at the time, at the time it was Lonnie Smith. The current CEO, Gary Guthart, was always there, he was a senior member of the engineering team, and of course Fred Moll was there. There were a number of times that we would have things pop up, and we solve them through, and you'd leave a meeting a little uncomfortable or maybe a lot uncomfortable and two meetings later, we'd have a solution for it.

We thought we were pretty far along, frankly, quite far along, centering down to our final design, and Fred came into the meeting — I'll never forget this day — and said, "I think we have a problem. I think our vision system is inadequate." That was a very material statement to make at that point, because we were marching along with a set of presumptions. A discussion ensued for 45 minutes to an hour, the meeting ran long that day, we ended up ordering in food.

The issue was very fundamental, and this gets back to what I had described about keeping it incredibly simple, make the user experience simple. For a physician to be able to trust a robot, they need to be able to see perfectly. Be able to discern tissue edges in the different tissue planes, the resolution needed to be there. The problem is that there was no existing camera system at the time that could solve the problem. We literally had purchased one of every camera system available worldwide and none of them was good enough.

Fred put out there that we should create our own, as if we didn't have enough to do, right? And then a discussion ensued along the lines of, "What makes us think we can do that?" It was a hand-ringing time period. Then one of the folks in the room said something that triggered something in Fred's mind. Fred said, "Wait a minute, isn't the real reason why none of these cameras work is because they need to make them lightweight because the procedures are an hour or two hours long and a human has to hold it? We don't have that constraint; we can make this thing 30 pounds because we have a robot holding it." The second that statement was made, everything changed.

100% of the goal was to get optics, and we removed weight as a constraint, and when that happened, we were able to fast forward to the best laparoscopic vision system available on the market that you'd never use in any other system other than Intuitive, because it weighed way too much, but we didn't care. The second we were able to make that and put it in the system, it became crystal clear what you were looking at and the physician community raved about the vision system and their sense of control and accuracy. Fred was 100% right that was a need, and he was a 100% right to test the assumption.

**Scott Nelson:** That's such a great story. I sincerely hope that it gives people a really good idea of great decision making in process through that concept of stripping away all of the assumptions and trying to really understand the core problem.

Let's shift now; can you take us back to the pre-Shockwave times? You were an entrepreneur in residence at Three Arch when you came up with the concept for applying Lithotripsy to arterial plaque. Daniel, can you give us an idea of what you were doing at the time leading up to the light bulb moment?

**Daniel Hawkins:** Sure, so the light bulb moment was after a series of different events. John Adams and I were busy in Bellevue, Washington, trying to come up with the next great thing. John has fantastic experience. In fact, he ran the engineering departments at Medtronic back in the early pacemaker days. Great understanding of electrical engineering.

He happened to be working on identifying the root cause for a product failure, and part of that investigation had him put the two leads for a pacemaker in a beaker full of water to test what happened between those two leads. As it turns out, he created Lithotripsy, but he didn't know what it was at the time. He ended up researching and discovering it, but what he definitely discovered is when he did that, he shattered the beaker and there was 30 or 40 ounces of water all over a high voltage table.

So he realized he had a problem, and he figured out ultimately that it was Lithotripsy. He shared that anecdote with me and while I found it interesting, because I am interested in learning different technical things, there was no particular utility at that time. Fast forward about six months and I happened to be looking at the angioplasty market. My job as an entrepreneur in residence was to look at unmet clinical needs and with John, either invent or license a technology to solve those needs.

And then Three Arch and Prospect Ventures would fund a company around that if everybody agreed. I happened to be looking at angioplasty and came across some specialty balloons that claimed that they were able to, with differential pressure, crack calcium. I am not a physicist, nor am I a scientist but again, being scientifically-minded and frankly taking a page out of some of the learning I got from John, that didn't make good sense, to me.



I started wondering what would actually crack the calcium, and then I remembered John broke the beaker with electricity. So I looked at Lithotripsy a bit more, and I frankly just dropped some bread crumbs between the two, suggested it to John and I asked him if he thought it would work and he said, “Not only will it work, it will work great and the pressure waves will be so fast, they won’t pop the balloon.” They’re faster than the speed of sound.

So we built a very crude prototype. John spent three-quarters of a day putting wires down the length of the standard angioplasty balloon into the fluid in the base of the balloon and then we drilled a hole in a piece of chalk and tried it out. It worked great! Along the way, Todd Briton joined us to help guide us clinically. We identified the opportunities in the peripheral vascular space as an area of interest initially.

And then we created a prototype that leveraged a lot of existing technologies. We were able to do it quickly and cheaply because we leveraged those technologies, which was no small effort. So I managed all of that process from a position of CEO of the company back in the early days, but I really was program managing it all. We did not have a VP of Engineering at the time. We had two engineers and a technician, and John Adams in Seattle.

At that point, I was down in the Bay Area. We had done some work up in Seattle, but it became clear that we were not going to be able to attract the catheter engineers we needed so we moved down to the Bay Area. Our initial catheter work was really borrowing off of existing Lithotripsy technology and building a balloon around it, which is exactly what we did. Todd’s role in all of that was to help us with the clinical view of the performance requirements, with designing the protocol for first in-human, and developing the relationships with clinicians along the way.

John kept us pointed straight from a technical perspective and I served, if you will, as program manager and head of marketing and CEO and all of that together to drive the creation of the first prototype, the builds, the testing, the verification, the animal testing the like, etc. Once we finished all of that, we went into the clinic and headed a very successful first in-human experience.

**Scott Nelson:** Then if we fast forward to the lifecycle of Shockwave, you made a decision to move into the peripheral space against the advice of your investors.

Sometimes those types of decisions are somewhat easy to gloss over, but if you can take us back to that decision-making process when you’ve got your investors saying one thing, but your core team believes in a different approach. How did you deal with that and where did you end up landing?

**Daniel Hawkins:** Sure, so for clarity, let’s start with the statements around, “Gee, you shouldn’t start with the periphery. It’s a graveyard of dead technologies.” Those actually were from a number of investors that passed on the idea in 2008. Between 2008 and 2009, we actually acquired the intellectual property out of the incubator because Three Arch and Prospect did



not move forward with the idea. That was a very difficult time for startups and nothing really was getting funded.

So we acquired the intellectual property and then moved forward from there. So the thought to not go into peripheral really came from a number of folks in '08. Having said that, it was definitely a departure. It was a departure from the conventional wisdom. As an entrepreneur, you've got to listen to advice that other people have, and you've got to gather all the data you possibly can, and then very often, you need to deliberately not follow it.

This is exactly one of those circumstances. Why did we do that? Well, fundamentally, it was going to be difficult to create a device that had Lithotripsy in it, make it deliverable, make it small enough to get through the vasculature, through a blockage, and be able to deliver the therapy. Peripheral vessels are bigger. Because of the risk profile, peripheral vasculature had a greater chance of a 510(k) pathway versus a PMA pathway.

Chances are, because there is such an enormous need in the periphery, we had a very wide margin of potential benefit. So if we were able to go halfway to optimal, given how wide that margin was, we would be incredibly successful. In the coronaries, the margin is a lot tighter because devices have gotten better.

Not that they can necessarily deal with calcium particularly well, but the burden of proof is immediately higher in the coronaries because of how good all those devices are and how large the studies have been. In the periphery, we had greater opportunity to be able to create a solution that, with a relatively lower bar, could show a benefit. That's the reason why we chose that and you're right, it was against the advice of many, many very smart people. But we trusted our gut and foraged down the path that we felt was right.

**Scott Nelson:** I love the fact that the founding team believe so much in what they developed and it's ability to address a need in the market that you ran against the advice of other folks. Very cool to hear that story.

Let's fast forward and spend a few minutes talking about the financing for Shockwave. I know there was a lot of interest in your most recent rounds of financing, which was a pretty stark difference from your early days of Shockwave back in that 2008-2009 time frame. I'd like to ask you a couple of questions.

First, I know in your most recent rounds, you raised money from several different types of investors, from traditional VC's, to large strategics, to crossover investors. I'd like to get your take on that and the thought process around getting that variety of investors involved. Then really, anything that you can add that really helped you solidify that investor interest, that would be great.

**Daniel Hawkins:** Sure. I guess we should rewind to the Series B round. The first institutional investor was Sofinnova out of Paris. They were the first money in Core Valve and a great

visionary group. They were our first institutional investor. When we broadened our footprint in the Series B in 2015, that's when we first brought in strategics, and we brought in crossovers and the like. We had in fact, strategic offers for the entire round in a non-diluted fashion.

We were in a business that is very, very strategically significant. So we had an offer on the table for that. At the 11<sup>th</sup> hour, terms got inserted into that deal which were not attractive, so we walked away from it. What we tried to do from the very beginning was lay the groundwork for a long-term play in the company. We believe we've got a company that has staying power. We believe we have an opportunity to be a very successful standalone organization.

Along with that, of course, not only do you need financing, but you need strategic advice, if you will. We'd love to learn from strategic relationships and if those lead to something, that's great, but that wasn't the primary goal. While we did want to have a strategic involved, what we did not want to do is have just one. That's really the reason why we ultimately ended up with two different strategics.

You also asked about crossover investors.

The reason why you bring in crossovers, if you have opportunity to, is to set up for future rounds of financing, not the least of which is a public offering. In our Series B, we brought in quite a number of crossover funds. As it turns out, in our series C, there was a great interest to complete the round from inside investors and the only new investor that we brought in was T. Rowe Price, again for the exact same reason of setting ourselves up for a future public offering.

I'm a believer that the round you're raising is actually setting you up for the next round you're going to raise. So in some respects, you are raising two rounds every time you are raising one. So we try to keep that in mind going forward.

**Scott Nelson:** That's great insight, especially for a lot of the medtech entrepreneurs that are looking to raise their next round. I love the strategy for your two most recent rounds. It gives you plenty of options moving forward, so it's a very good lesson to learn.

I want to ask you one more question with respect to Shockwave. A lot of your investors have also been publicly quoted as saying they believe Shockwave can become a company that is able to sustain itself versus traditional medtech startups that are gobbled up early in their life cycle. So with that said, give us a brief answer in regards to what's next for Shockwave.

**Daniel Hawkins:** Our future is going to be defined by how we perform clinically, and of course, how we perform commercially. In the very near term, we're going to start what turns out to be history's first randomized-controlled study in peripheral vascular calcified lesions. So really, our specialty is calcium. In the legs, there's lots of it. Half of the patients have it. Surprisingly, there's never been a randomized-controlled trial of one technology against another one to treat those patients.

I didn't realize that we were going to be the first one until some reporter told us that, frankly. We think it's the right thing to do. We're doing the right clinical work going forward, with at least 330 patients kicking off very shortly. With that, we intend to demonstrate the capabilities and usability of the Lithoplasty system versus angioplasty and recognize those differences across a very broad patient set.

We're also looking at commercialization in Europe and in the United States for our peripheral vascular system. In the second half of 2017, we would anticipate entering the coronary vascular system, as well, for commercialization in Europe. In more of the medium and longer term, a logical next step for us would be an initial public offering.

The markets will determine the timing of that and whether or not we do that in the near term. Or if the market cycles aren't there, then we'll raise additional funds privately. But really, our goal here is to play for the end game, and to build this into a standard of care level of technology through a long-term sustainable franchise around Lithoplasty technology.

**Scott Nelson:** It will be exciting to watch what you do with Shockwave, not only in the near future, but also along that medium to long term timeframe as well. We'll conclude here with the last three rapid-fire questions, Daniel. We'll start with number one: what is your favorite business book?

**Daniel Hawkins:** *The 22 Immutable Laws of Marketing*. There's great clarity in there; it's really outstanding. One of my favorite parts of that book is if you're not number one in a category, create a category in which you can be number one in. That allows you to shift markets and change the dialogue. At Intuitive, we combined that into one of the other laws, that says no two companies can own the same word in the minds of customers.

If you combine the two of those and look back into the history of Intuitive, we created the EndoWrist. That became coined directly along with robotic surgery, and therefore we were able to create the beginnings of a departure from existing technologies, and ultimately ended up winning over that entire industry from the capability as well as the positioning. That would certainly be the number one.

**Scott Nelson:** Yeah, such a great book. Number two, is there a CEO that you're following or one that you really admire?

**Daniel Hawkins:** There's a couple of different ones. I'd say Fred Moll. Terrific visionary, he's the inventor of the safety trocar, continues to identify the pain-killers and remove barriers, as I had mentioned a little bit earlier. You know, I'd have to say, Omar Ishrak from Medtronic. I've been extremely impressed with the culture that he's been able to create, the quality of people in that organization, and the consistency of the messaging, and the capabilities within the organization. I think he's got an incredible vision for the value-oriented future of healthcare.

I'd say Mike Mahoney over at Boston Scientific for what he's been able to do in terms of the turnaround of Boston Scientific. He launched them into the number one position in stents and pushed the entire franchise, the entire business forward.

I'd be remiss if I did not mention Mike Musallam. I've had some exposure to Mike and I'd have to say that his vision for what became TAVR and acquiring Sapient early, and then the management of that has been nothing short of spectacular. He's created an incredible amount of value for shareholders and incredible therapy categories for patients.

**Scott Nelson:** Four CEO's that are definitely worth their salt. Last question before we end the conversation. If you had the chance to rewind the clock Daniel, is there any advice that you'd give to your 30-year-old-self?

**Daniel Hawkins:** Number one, two, three, four and five is trust your gut. Your gut is never truly wrong. When you trust your gut properly at those high-intensity moments, it won't fail you.

**Scott Nelson:** Great piece of advice to end the discussion.