# The Overnight Success Story of NeoTract that is 12 Years in the Making

Biz Stone, the cofounder of Twitter, has famously stated, “Timing, perseverance, and 10 years of trying will eventually make you look like an overnight success.”

In the world of medtech startups, this is almost always the case. And it’s certainly true with UroLift, a device that came to life in the fall of 2004.

In this interview with Ted Lamson, cofounder of NeoTract and primary inventor of UroLift, we learn how they achieved U.S. and European approvals, obtained a category 1 CPT code in near-record time, and their approach to convincing CMS and commercial payers to cover their device. Here are some of the topics we cover:

- Ted’s experience at ExploraMed and how the idea for UroLift came to fruition.
- The process Ted follows when pursuing ideas for disruptive medical devices.
- Why Ted and his team at NeoTract decided to pursue a CE Mark and what they learned through that process.
- Lessons learned after raising 4 different rounds of financing for NeoTract.
- Against the advice of consultants, why Ted and his team decided to pursue positive guidance from NICE.
- How NeoTract was able to obtain a category 1 CPT code for UroLift less than 6 months after receiving FDA clearance.
- The approach Ted and his team are taking to convince CMS and commercial payers to cover UroLift.

SCOTT: You founded NeoTract back in 2004. We’re recording this in the fall of 2016, so that’s over 12 years ago - a long time in the medtech space. You’ve been on quite a wild ride and have experienced quite a few challenges over the past decade. Before we go back in time, can you provide us with an overview of your product, UroLift, as well as the disease state that it treats?

TED: We’ll start with the disease state. Our product is used to treat an enlarged prostate - also called BPH for benign prostatic hyperplasia. It essentially affects half of the population – that being you and me (men). By the time men reach the age of 50, about 50% have BPH symptoms. By the time you’re 80, it’s over 80%. So it’s a really large problem and significant quality of life issue. In essence, if you have BPH, you have to go to the restroom all the time, getting up

several times at night, etc.  So a lot of men end up feeling tired and weak because of it. It's been proven to lead to depression as well. So it can really be pretty life-debilitating.

The options prior to UroLift involved surgery – there's actually a pretty good procedure that was developed in the 1930s called TURP. It's where physicians go in through the urethra and carve out the inside of the prostate. It definitely removes the obstruction, which is the issue, but it's fraught with side effects. You're almost guaranteed to have sexual dysfunction one way or another, and then there are low chances of other things like incontinence, strictures, transfusion - that sort of thing.

Because of these side effects, it turns out that only about 3% of men that qualify for BPH surgery actually elect it, and that's a tiny minority. So really, the majority of patients are treated with medical therapy. There's a few different medicines. But the issue with the medicines is that they're palliative, so they make you feel a bit better.  But there are some side effects such as dizziness and weakness and also sexual dysfunction. Many men with BPH are very well-served through medical therapy, but there's a pretty large population of them that are not being very well-served.  And they really don't want the surgery either. If you were to ask them, they'd give up taking a pill a day for the rest of their lives and get rid of the side effects if they had some way to "get fixed" without the risks or the extended recovery associated with surgery.

That's where UroLift fits in. This is the exact question we tried to solve - how can we create a procedure for BPH that a man will actually elect? And men don't elect things very well. Something that's actually attractive enough and safe enough that a man will elect it earlier in the disease process versus managing the problem with drugs that aren't serving him well.

With UroLift, it's inserted into the urethra with the little scope physicians use to diagnose the problem, and then with the system on the scope, it deploys these little implants into the prostate.  They're about the size and shape of the little things that hold price tags on clothes, but they're made with a lot of technology. It's basically sized into the prostate at exactly where the device is put. Essentially, it holds open the lobes of the prostate without removing the tissue or hurting it, cutting it, or anything like that. So these tiny little implants just hold the obstruction open.

With UroLift, you're not changing the prostate tissue or architecture, so it doesn't affect sexual function.  And because it's just a quick little implant, the recovery is a lot more rapid. It's a matter of a few days being back to normal, and a few weeks for significant improvement in symptoms versus weeks of recovery from surgery and months for symptom relief. So it really

has shifted the paradigm, and that's what we're seeing. The men that are electing this are indeed those that are unhappy with their options and looking for something different.

SCOTT: Did I hear you right with respect to the incidence? You said 50% of men deal with this by the age of 50, and it goes up to 80% by around age 80?

TED: Yeah, isn't that amazing? In 2015, there were 12 million men under care for BPH, whether that's a drug or a procedure or something like that. So it's a really big target population. Not just the guys that are suffering, but the ones that are actually getting some form of treatment.

SCOTT: That's an even higher incidence than I suspected. Prior to UroLift, the procedure that was most common was this TURP procedure, a pretty invasive procedure that was done, I would imagine, in the OR setting?

TED: Yeah, that's right. It requires full anesthesia. There are some other ways of doing TURP – laser, bipolar, etc. There are a tremendous variety of ways to remove tissue, and each has different advantages - less bleeding and quicker recovery. But they all require pretty invasive surgery – and they still have a very similar adverse event profile because they're based on removing tissue.

SCOTT: One more follow-up question in regards to the market and the number of patients that deal with this type of issue. Because the TURP procedure is so invasive, you said most men opt for pharmaceuticals as a way to deal with the symptoms of this disease. Do the symptoms get worse over time - or do the drugs get less efficacious if someone has been on the drug for 10 or 15 years versus when they first start to take it?

TED: Yeah, that's a great point. In fact, what we're seeing is the men that are electing UroLift are actually stopping medical therapy at two points. One is very early on, and those are usually the guys that are just really upset with the side effects. The others are quite a bit later in the disease process, where it's really been wearing off over time. You can add on another hormonal agent called 5-ARI that shrinks the prostate, but it also does away with the testosterone production process, and that's an important element for a lot of guys. So there are side effects to consider with medical therapy for BPH.

SCOTT: I definitely want to address the level of clinical evidence that you have for this product, because it's pretty robust considering it's a relatively new and it's pretty disruptive in nature. But before we go there, I'd like to rewind the clock and go back to the early 2000s, when this idea came to light. You were at the incubator ExploraMed, correct? For those that aren't

familiar with ExploraMed, can you provide an overview of the incubator as well as your experiences there and how UroLift came to fruition.

TED: I've been very fortunate to be a part of ExploraMed and its activities over the years. I was lucky enough to work with my friend, Josh Makower, when we were both back at Pfizer in the very early '90s. There, he was initiating this think-tank for how to innovate and how to address clinical needs, and I was fascinated with that and running R&D for one of the divisions. This was back when Pfizer had medical devices with divisions such as AMS, Schneider, etc.

Josh and I hit it off with a mutual respect on what we brought to the table from an innovation perspective, and we also had complementary skill sets too. When he left Pfizer to start ExploraMed, I ended up leaving Pfizer about 6-7 months later and joined him in the first venture coming out of that, which was called Transvascular.

ExploraMed has a single mission, and that's to create important, positive shifts in healthcare. A lot of medical device innovation is focused on iterative improvement to devices – the "me too" concept. At ExploraMed, we really have no interest in that. That's important work, but it's not ours. Instead, we like to approach innovation with this question: is there a way we can absolutely improve healthcare in a dramatic way through a medical device?

The special part of the process is what Josh started in Pfizer and further refined in ExploraMed, and now it's part of the Stanford Biodesign program where it's taught as a process now. The key aspect that made it unique from a lot of others was the absolute belief – and I share this to this day – that the most important thing you can do regarding innovation in medicine is to spend the money and time upfront to develop exactly what the need is and address all the stakeholders involved. So that once you're done with that process, you can essentially create a report card. With that report card, you can then gauge how your efforts are going and not deviate from it.

As engineers, we learn that engineering is done through compromise. But this process is not compromising. You have to address the identified needs in order to create the paradigm shift. That's the great strength – through this process – you end up with a very solid, validated need specification that you can take forward. Developing devices and bringing them forward is hard, but doable. But unfortunately, there are some processes that bring devices forward that, when they get there, it turns out they aren't solving the right problem. So this process I mentioned is a way to avoid that mistake by making sure you spend the necessary time defining the problem and solving for the right thing once you bring the device to life.

SCOTT: It really comes down to finding that core need and being able to address it - checking all of those boxes on that report card. Is that a process that's taught as part of the Stanford Biodesign program now?

TED: Yeah, it absolutely is. It's really a fundamental process that I think we've been able to improve through our successes.

SCOTT: Before we hit the record button for this interview – you mentioned that being able to identify a true need and addressing it in a way that's achievable – having that as your beachhead as you encounter various challenges – was extremely important to your success with NeoTract and UroLift. Have I described this correctly?

TED: Absolutely. Once you've done this process, and you believe in what you've come up, and you've validated it with everyone involved in the process – the patients, the doctors, the administrators, the payers, everyone – then it gives you the confidence and momentum that when you hit the hurdles – and we all know there are hurdles at every step – when you hit them, you approach them with a level of confidence. As we faced challenges along the way, there were several times along the way I remember thinking, "I'm going in the right direction here, and I'm going to figure this out because I need to get past this."

I think that fosters enthusiasm, and it also leads to confidence and just sheer, "irrational optimism." But it's what gets you there a lot of times, knowing that this should be done, so it's going to be done!

SCOTT: Specific to UroLift, do you recall how this device came to fruition? Were you looking at other disease states or other needs to potentially solve? Or were you really eyeing BPH alone?

TED: This actually started just as ExploraMed was launching another company, Acclarent. I took the task of coming up with what was next. Our technique at ExploraMed is usually not to have a single idea or a single disease state, but to pick two or three and develop them in parallel. As you develop them, they naturally shake out. Some don't address a big enough need while others have more straightforward paths to a solution. These are some of the various things you look for to differentiate them.

I founded what was called ExploraMed NC2 in an orthopedic area, and next to it was another specialty. During that time, I had a personal incident where my father and uncle each had prostate issues, and it really started piquing my interest. Then it came up that maybe we should

look at that. Talk about compelling yourself to get into a project and get it going. There's nothing like a personal interaction with it to say, "Wow, things could be better here."

SCOTT: That's interesting. You were actually pursuing a couple other ideas at the same time when you had this personal experience. On that note, how far down the path do you typically get as you move these different ideas forward? Do you get fairly far along before you say, "We're not going to pursue these other ideas; we're going to double down on this particular one"?

TED: It seems like we go very far, because it's a lot of work. But it's still well under a year. If I were to use NeoTract as an example, I started the NC2 effort 12 years ago almost to the day. I started with at least two areas, ran that for a couple months, and then it was really around the beginning of '05 that I started getting very interested in BPH. Probably in Q1 of '05 we threw everything else away and said, "This is what we're doing." It took 3 to 6 months to get to that point where we narrowed it down.

SCOTT: Before we fast forward to your experiences getting a CE Mark for UroLift, I have just a few quick questions in regards to raising money, which is oftentimes pretty difficult in the medtech space. You raised what I think is four different rounds in 2006, 2009, 2011, and then again in 2014. When you think about your experiences raising money throughout the course of 10 to 12 years, are there certain best practices that come to mind, or certain things that you remember really stand out?

TED: The most important thing is the fact that raising money is like entering into a partnership. It still and always is about people. If you have the ability – and hopefully you do – to choose between venture capital firms, choose the one that you have the most confidence is going to be there with you through thick and thin. Over the years, ExploraMed has partnered with NEA, and I've done a lot of work with them. They have been tremendous partners. I've been up against the wall, and they've been right there too. None of these things are ever easy; there's always a snag, and your investors have to have the same long view that you do. NEA has been great.

I would say my biggest challenge was in 2009, because it was the perfect storm. We had the banking crisis where the economy was shot. Quite frankly, the VC firms were taking advantage of that because they could. I mean, GE's stock looked like a startup at that time. Essentially, it was a really difficult time to raise money and not lose all ownership in the company and wipe out your current investors. We sort of pulled a rabbit out of the hat with the help of Johnson & Johnson Development Corp. They are another great partner. They are very mature, and because they're in the medtech business, they understand these things take time.

We have, obviously, other investors at this point, but those two have been the real backers during the early formative times.

SCOTT: That's good advice. I've always heard that Johnson & Johnson Development Corp is a very good early stage medtech partner. Certainly it sounds like that was your experience as well.

Going back to that 2009 timeframe that you referenced, were you pretty far down the regulatory path with the FDA before you made the decision to pursue CE Mark? What were your thoughts at that point in time with respect to NeoTract and UroLift?

TED: There are a lot of things in a startup, in a new venture, that are all about your company – how it's doing, how it's progressing, etc. And then there's the great big world and how that affects you. In this case, it was the great big world. In addition to the perfect storm regarding financing, at that time, quite frankly, there were some very serious issues at the FDA. They had a whistleblower issue, internal management issues, and they were really trying to figure out how to work with industry.

But the net effect, intended or unintended, was that you simply couldn't open up a U.S. IDE clinical study at that period. They were asking infinite questions and not allowing something to go forward. I will say my observation at this point is that that these issues have been largely resolved, and we've been really happy with our relationship with the FDA. But there was this period from 2009 through 2010 where it was really difficult to start clinical studies. And it wasn't just me – I had friends that experienced the same things.

Eventually it came down to a decision, as it did with a number of startups at that point, where either we're going to duck and cover – meaning we have to downsize to just enough to keep this thing going and wait it out – or we're going to Europe to learn how to commercialize this. It won't be profitable, and it won't be where we make it or break it, but we'll take advantage of this time to learn how to introduce our product into "the real world." That's sort of how we were thinking at that point in time.

We ended up making the decision to go to Europe. And it was a good one at the time because it really did give us a leg up on a number of things. Maybe some people thought we went there to make money, and maybe I sold it as that too. But our decision was really not about making money – our real hope was that maybe we would break even, which is even a struggle sometimes.

But in the end, what it did bring was maturity. By the time we did go into a U.S. study, we had a mature commercial product. We also learned how to train physicians, we learned what the marketplace did and did not tolerate. There were a lot of good learnings from that experience. It was expensive and lengthy, but in the end, we saved a lot of money through that experience.

SCOTT: Those are good anecdotes regarding the maturation process. Pursuing the CE Mark and then commercializing in Europe probably taught you a lot about entering the U.S. market. Maybe that's underappreciated sometimes when folks are considering pursuing a CE Mark versus FDA clearance.

On that note, I remember having a conversation with Duke Rohlen about this same topic – I believe with CV Ingenuity – where they made a very definitive decision not to pursue CE Mark and instead go after the U.S. market alone. That decision laddered up to their overarching strategy. But what are your thoughts on whether a medtech startup should initially pursue a European approval versus a U.S. regulatory approval?

TED: Personally, I think it's really specific to the disease, the device, the reimbursement landscape, etc. Ironically, when I started NeoTract, I didn't want to go to Europe first. I wanted it to be a U.S.-first thing. That was primarily because of the cultural connection - the U.S. healthcare system rewards efficiency and lower complication rates better than other markets. To this day, for instance, in Germany, there are hundreds of men that get UroLift, but everyone that does spends two nights in a hospital, because that's how the system works. Here, it's done in the office and you go home. So it's really interesting how systems can dictate how care is given and valued.

The other thing to consider is reimbursement.  On that note, I would never say Europe is Europe. Europe is comprised of many different countries, and you have to consider all of them. But if you have a code that's been validated, and the country will pay for it, then you may actually have a good early commercial opportunity. I know Kevin Sidow experienced this with St. Francis Technologies, and that really worked out well in his venture.

SCOTT: With UroLift, you ended up getting some pretty favorable guidelines from NICE in 2014. Are there any tips and tricks that you can share in regards to your relationship with NICE and how that came about?

TED: Absolutely. It's a long story, but I'll try and make it quick. The UK was actually just shifting the national healthcare service when we were heading into Europe. They were very publicly

trying to become more efficient, more patient-centric, and they were overtly saying they would value more efficient and less invasive approaches. So, against the recommendation of every consultant that I tapped into, we actually decided to embrace that and try to become a flagship story for this initiative in the UK.

Also, one reason that gave us the boldness to do that was because we'd invested at that point probably about $25 million in clinical studies. We had the data, and it was very high quality. So we were able to go to NICE with the idea that, "We're doing it the right way. Do you want to work together on this?" I think that really carried the day.

Good clinical data is essential. It's worth investing in, and unfortunately, it's just table stakes. The good data just gets you to the table; it doesn't win the hand. My advice would be to never go to the table unless you've done all the other work – working with the medical societies, making sure you have active clinical experience going on in the market, and really building advocacy from within. Getting that "pull effect" versus the "push effect" is imperative.

SCOTT: I think it's interesting that virtually all of the consultants you had conversations with as you approached this decision with NICE recommended not going down that path. But you did anyway. What led you to make that call? It seems somewhat risky. I'm curious to get your thoughts regarding that.

TED: It was risky, and I will say that part of it was serendipitous as well. We were running an international clinical study that involved some of the key opinion leaders in the UK. And one of the things I'm really proud about is that we were always aboveboard at NeoTract. We received positive feedback from many stakeholders – they trusted us.

I always feel like trust, in the end, is what wins the day. No payer or healthcare system ever decides to adopt something if they either don't trust the data or don't trust who is giving them the data. So it really did come down to who we are, how we approach things, but also who we team up with and their relationships with us. We were all locked in together and that allowed us to approach the decision with confidence.

SCOTT: Piggybacking off the favorable NICE guidelines and shifting our conversation to the U.S., the UroLift device got FDA clearance in the fall of 2013 – that's almost 3 years ago now – but it wasn't awarded reimbursement codes from CMS until the following spring, March of 2014. Most people would argue that reimbursement sometimes can be the most challenging aspect of going to market, even more so than regulatory approval.

You've had a lot of big wins from a reimbursement perspective, so can you describe your approach here in the U.S.? You previously mentioned that your level of clinical evidence was really, really good, and I'm anxious to hear your thoughts on how that played into the reimbursement for UroLift.

TED: I don't know if I was precocious or lucky. But I remember back in 2006, raising our Series A after doing the first patients, and standing in front of investors, I remember my pitch was that our tallest hurdle was going to be reimbursement. I remember saying, "We're raising $10 million, but if you're not prepared to put in $30 million, then we shouldn't be talking." It was about the fact that this was going to take time and money. We needed to develop the evidence for our customers, and we needed to develop it early. We had to make sure it was broad so that we would have a quick and more thorough pathway to reimbursement. I was just a young CEO at the time, but looking back, that was probably one of my better intuitions.

SCOTT: No doubt. You called it 10 years ago.

TED: We actually raised money and planned the company on the idea that we are going to develop an expensive, big, deep clinical package, and that was going to be our strength. We structured our clinical studies to deliver on the right publication set that qualified us to rapidly go forward. In September 2013, we got FDA clearance to market, and almost exactly 5 months later, the AMA approved a Category I CPT code – other than J&J's drug eluting stent, I'm not sure if anyone's done it that fast.

SCOTT: Wow, that does seem extremely fast at 5-6 months.

TED: It does unless you're in a startup, and then it seems like plate tectonics! The problem is they awarded the CPT code that February, and then the RUC analysis followed, and then nothing went into effect until the following January. So that was an entire year. It all seems good, but seemed really far away at the same time. With most medtech startups, that's a 2 to 3 year process, so our strategy paid off very well. But it wasn't just the data; it was the fact that we made sure throughout our clinical studies, we were very close to the specialty society – in this case, the AUA – where key members were involved in our trials. Also, in regards to the society itself, we were informing them of the progress too. Because they bring the codes forward, they were comfortable early on and ready to do it before they might otherwise normally would've been.

SCOTT: Clearly the clinical data was really, really good, and you'd done your due diligence there, but also getting involved with the key clinical societies well in advance of the CPT code cycles

and making sure that when the timing was right, the societies could bring your device to the table. Sounds like that was really important in regards to your reimbursement success.

TED: Yeah, it's a tricky balance with startups because the general conventional wisdom is to be as secretive as possible because of competition. You obviously have to be when you're really vulnerable on a patent basis. But beyond that, you have to give that up a little bit, and I believe you need to share the news with your ultimate customers. Because it takes a while for people to get comfortable with change. I think that's something we've probably done right – we've been able to cultivate that pretty well.

SCOTT: Most people would think, with a Level 1 CPT code in hand, the RUC has valued your code - you're off to the races. But there's this whole other phase of convincing the private payers to not only cover your therapy, but to pay for it as well. How did you convince the private payers that UroLift should be covered and that they should pay for it?

TED: That's really easy, because they all wanted to pay for it. [laughs] Joking aside, we're still doing this. I'll tell you, that is a job secure environment - the reimbursement world. I think it all comes down to value and pulling. My experience is that very few insurers will ever adopt and cover something if they don't perceive a need, and that need means their beneficiaries and their providers are asking for it. They never just want to hear the noise in the network, but they need to hear the noise in the network asking for it.

While that's going on, presenting your data and having a very steady cadence of clinical publications is really important. Every quarter, there should be another report coming out, because that report creates the ability to have another discussion with the payer. Sometimes you just want to get everything published, but lining it up like an annuity of clinical evidence really helps the process along. That's been our strategy. We're by no means done, but the progress we have made is another good example of some really nice work. As of Halloween, we will have all of Medicare in the U.S. – which for our BPH men, that's 65% of them, so that's great.

And then a lot of commercial insurers that do their own analyses have come onboard as well. Some of the third party payers don't do their own analysis; they just sort of look to the side and wait for someone to step forward. So that, to some extent, is something we're doing now - working with someone to take the first step forward where all the competitors then jump in as well.

SCOTT: Specific to convincing those payers, what does that look like from a pragmatic standpoint? Is that almost like a roadshow, where you're making your rounds into the various payer offices throughout the country? Or is that a matter of employing other field-based people, almost like payer sales reps that do a lot of that legwork for you?

TED: I feel like it comes down to finding inroads, finding people that are in your specialty that have some sort of connection – and by that I don't mean a financial connection. It's someone that has a relationship with the medical director of a payer so that when they actually say something, they're somewhat believed. That usually can get your foot in the door.

A lot of people think these payer-related conversations are all about the cost of the therapy. Instead, it's almost always focused on clinical data and clinical value proposition. That's why I love being in those conversations, because I know that very well and I feel like I can tell that story because that's what we've always been about. That's actually been my role as of late. I have a lot of these conversations.

SCOTT: Looking back, would you do anything differently if you had to do it all over again?

TED: On the reimbursement side, I think we've done a nice job. Regarding the overall venture, that's an interesting question. This may be more of a word to those founding CEOs out there. I've come to liken a founding CEO to a starting pitcher. Typically, it's one person who can really take almost nothing and turn it into something and build a team around it. And a lot of times, it's a different person who then can take that into a real successful, commercial venture. That happened in my case, too. I was the starting pitcher on the mound at the 6$^{th}$ inning, handing the ball over to the coach. [laughs] But it's a really important thing to do, and it's important to do it at the right time.

If I were to do it over, honestly, looking back, I feel like I gave up the ball in the 5$^{th}$ inning, and I probably could have pitched to the 7$^{th}$ inning. But we're in the 9$^{th}$ inning now, and we have the right guy pitching, and that's Dave Amerson, our CEO. It was great to hire him to really build out this stellar commercial organization. I stepped aside and now I run all of clinical, medical, reimbursement, and I do some R&D – a lot of stuff. But it's the non-commercial stuff, if you will.

SCOTT: So you wish you would've gone a couple more innings? Still had a little bit of juice left in that arm before you handed it over?

TED: Yeah, I think that transition to Europe was one that I could've managed. I think I called it a commercial organization before it was. I think I probably should've run that period and then brought Dave in when we were keyed up for the U.S.

SCOTT: It's great to hear more about the story of NeoTract – a company you've been working on for 12 years. Certainly not an overnight success by any means. It's very cool to see what you and the rest of your team have built.

With that said, let's get into the last three rapid fire questions. They don't necessarily have to be rapid fire answers per se, so feel free to expound if you want.

First, what is your favorite nonfiction business book?

TED: The one I go back to a lot is a pretty old, but very good - *Crossing the Chasm*. The distribution of customers, the early adopters, the chasm that you have to get across – I've seen it play out every time I've done this. I also feel like it gives me a barometer, not only with the market, but with the company and as well. Because as a startup, if you reach a million dollars in sales, it feels like you are an overnight success, but that's not your goal. Your goal is hundreds of millions of dollars, and there is a huge chasm between those two. I think that's been a really good book to help plan and keep us honest with where we are in our process.

SCOTT: Is there a business leader that you're following right now, or one that has inspired you over the years?

TED: There's several. I'm fascinated by Elon Musk and the stuff he's doing. I feel like he embodies "thinking big" and in the team he has developed. But it's never the one person, but as a leader, it's what you set up and what you cultivate. When you cultivate an environment, it's amazing what can happen. I just see this guy out there with crazy big ideas, but because he's delivered and because he's built this environment around him, the ideas just keep getting bigger.

SCOTT: Last question - thinking back over the course of your medtech career, is there one piece of advice that you'd tell your 30-year-old self?

TED: Stay in shape, man. [laughs] I've always been an innovator, and I've always been really turned on by changing things. I think to my 30-year-old self I would say, "Hold on just a second." There's a lot to learn from the people around you and the people above you. Even if you're at a big company, you may not feel like the system is as productive as it should be. But

even if someone doesn't think, act, or lead entirely like you do, there's always something really interesting to learn from them.

So probably for me, it would've been to have a more open mind to those seasoned veterans that had a lot to offer, but weren't necessarily very innovative.

SCOTT: "Always be learning" is the phrase that comes to mind as I listen to that advice. Really good stuf, Ted.

Like I said before, the NeoTract story is very cool. A long one in the making, and I don't put this lightly when I say it's really nice to see what you and the rest of the team have built. Again, thanks so much for your willingness to have this conversation, Ted.