**David Pencheon Interview**

**Forbes: Great to have you all here and I’m just going to ask a few questions of David because I think it’s important to know just a bit more about what’s been happening with the last decade in the UK National (Health) Service of Sustainable Development Unit.**

**David, what do you think was probably the most important thing that you’ve achieved as part of the SDU?**

That’s ... I don’t know ... that’s a good question. What have we achieved? I think what we have achieved - just by existing - not by doing anything, just by existing - is normalising the conversation, made it normal. Ok, so I think you heard some of the eminent leaders at the front this morning. I think one of them said low carbon patient pathways or something or low carbon procurement. If you said that ten years ago, you would have been laughed out of court. So, just making it a normal part of the conversation, a normal part of quality, a normal part of duty, I think that’s the most strategic thing or the most cultural thing we have achieved.

In terms of practical things we have achieved, there are lots of things and, funnily enough, I think some of them are regulatory. So, for instance, I’ll give you one example, is that all hospitals and commissioning boards are obliged to report on what Dan was talking about - about financial sustainability, which is a law, but also around social and environmental sustainability. They have to report on it. If they don’t, I will publish no data from this hospital and the CEO’s are going to look red faced and the interesting thing about that is that, although regulation looks like a big stick, we did it very gradually. So, we spoke with CEO’s and, of course, some hospitals were doing it already. They were doing it already, because as a duty of care. They were well led, and they had good staff engagement and they wanted to do this and if you start the journey, if you try and start the journey, you’re going to get less - you’re going to get more room for making mistakes because you’re experimenting, you’re piloting it. If you wait until everything is set and the regulator is breathing down your neck, then you’ve got to do it and you’ve got to do it in the way in which the regulator says. It’s much more fun - it’s much more exciting, it’s much more interesting and engaging for staff - to say, “Hey, can we be one of the pilot hospitals or boards that do this?” Then you’re allowed to make all sorts of ghastly errors when you do it and you won’t have egg on your face. So, it’s much more fun being on the front of those that you serve, it’s much more fun to be at the front than the back. To be on the front of the wave, it’s much more fun.

**Forbes: In terms of the ... if we start, I suppose, at the level I’m at - a senior doctor, middle aged - if you reflect on some of the doctors you’ve interacted with in the UK, what do you think they’ve most gained from having someone like you and having something like the Sustainable Development?**

I don’t know if they’ve gained much from having someone like me, but I think they’ve gained from being allowed and being encouraged to speak about this as a normal part of their job. So, if you’re an anaesthetist and you spend a lot of your time staring at a huge amount of waste and a huge amount of single used instruments, instead of sitting there thinking, “This is terrible, we shouldn’t be doing this.” You say, “Uh, I don’t think we should be doing this and I think we could probably and we could be doing something about it and we can report at board level about the progress we’re making.” I’m sure the Chief Executive would be very interested to see the progress we could make and, after all, it is written into the NHS constitution. It is written into the NHS mission about steward-wise stewardship of resources and, I think, the most important - the most moving time I’ve seen in the Sealey [sic] conditions to talk about it in an audience like this is when they were challenged in a

similar way to you. This is just a duty of care. It is a responsibility to our patients. So, not talking about climate change or just talking about we have a duty of care. All this waste costs a lot of money and its money we could be spending on other patients, so it just doesn’t make sense to waste in the high watering levels we’re wasting and people like, you who not only did it on the ward level or the operating theatre level, but also publish about it in peer review press. That’s particularly impressive.

**Forbes: You mentioned having pilot hospitals, perhaps leaders and others not so much. Was there much interaction between the leading hospitals and giving the, you know, collaborating with other hospitals as they went along on the journey over the last ten years?**

No, hospitals are competitive, you know. I suppose there are places, actually. Collaborative procurement - if you ever get into the procurement business, you’ll know that you can do much more innovative and ambitious deals by collaborating. So, if you, for instance, if you’re buying something which is very expensive and a lot of it - food, energy, pharmaceuticals - if we use the muscle of the health system collaboratively to purchase, that’s a good example where it does work well because markets respond. You’ve got experts in the room on procurement, but markets tend to respond. If you say, “We’ve got a 21-billion-pound budget for this and we’re going to be around in ten or fifteen years”, markets respond. In fact, I would go even further forwards and say that there’s much more innovation in the market than there is in the health system - much more innovation. I think our challenge is we probably over-specify what we require from the market, rather than say, “This is the challenge we’ve got. How can you help us respond to that? Impress us”. Impress us, rather than say, “No, we want it packaged like this because of this standard.” You micro-manage it and it drives innovation out of the supply chain but that’s a rare example of collaboration. Most hospitals - and I’ll tell you a story about this hospital in a minute - most hospitals are quite competitive, actually, but they’re competitive not always in a bad way. They’re competitive for their communities. They’re saying, “We aim to provide the best health at the least possible cost and the least possible damage.” Not to our community, not for our community but with our community. It’s ‘with’. Get used to the ‘with’ word.

Do you want me to tell me about this hospital? Okay, so this is a hospital. Some of you may know where it is. Someone tell me where it is. Where is it? Yes, this is a classic big hospital.

**Audience: Liverpool!**

Yes, so this is a classic big, it’s a children’s hospital, actually. I don’t know if Robert’s still here. This is especially for him to show you that ... because he was asked about infrastructure. An infrastructure is almost diversionary in the sense that in with hospitals - after all, it’s where we spend all the money and there’s probably the least health gain made - so, one of the things about a future proof health system is we need to de-hospitalise care. Only do in hospitals what only hospitals can do, ok. Repeat after me. Only do in hospitals what only hospitals can do. Then you’ll reshape your health care system, probably for the better. Definitely for the better.

Anyway, this is a children’s hospital and it needed to be refurbished. It wasn’t fit for purpose. So, they built a new hospital. So, this is the new hospital here. Can you see it? You can’t actually see it very well because it’s got green rooves but it’s much, much smaller. It’s much smaller. It is a care coordination centre for the whole area, ok. So, this is where chemotherapy for children at home is coordinated - not delivered, coordinated. Ok? But that’s not the impressive thing. There are two things that are really impressive about this. One is what happened to the old hospital, which is that. So, that’s what happened to the old hospital and part of the reason for doing it like that is because these two parts of the community were severed. This is now a part where people can get access to other people in the community but the other impressive thing is that - do you know who designed

it? It was designed by children. Isn’t that great? And one of those children actually went onto become an architect, which is even better. They were patients. Reading through responses from children, it was very interesting because one of the children said, “I’m seven years old and I don’t want to share a ward with any eight-year old’s now”.

[Laughter]

If you think planning is problematic, try planning with that in mind. Anyway, let’s move on.

**Forbes: What do you think the role of the Sustainable Development Unit has been and how important has it been to have and I say it particularly because Victoria has a Climate Change Act and, me, as a doctor, I see wonderful things happening at the level of the Capital Management Branch here in 50 Lonsdale Street, but I see a profound disconnect with clinicians on the topic of sustainability.**

Not all clinicians. I mean, you don’t need to get everybody on board to create a movement, but you do need to get critical mass on board and I think everybody who is trying to engage in such a big issue as this - this is where collaboration is important. It needs help from each other in how you frame it. How you frame it and, actually, you saw one of the interesting things about what you saw, as these five leaders say, if you took any one of those leaders there that did everything that they were advocating and are really doing it, it wouldn’t be enough. It wouldn’t work. Sorry, it wouldn’t be enough. If you took everything they did together and integrated it, that would probably be enough. We’d stand a chance.

So, there is a big issue here about how different people from procurement, from management, from leadership, from patient representation matters, but clinicians are really, really important. Clinicians are dangerously trusting so we should use that trust massively and, in every public opinion poll, nurses and doctors and other face-to-face carers are the most trusted people in society. So, you need to get them on board and how many people in here are clinicians, incidentally? How many people have touched a patient three times in the last week? Ok. Ohhh...

**[Laughter]**

What are you doing? Ok, so, it’s really important and I think it’s important to acknowledge, with any large system change, fiefdoms get upset. People don’t normally - if you say, “This is a great opportunity for the health service”, people don’t normally think, “Ooh, how are my patients or public going to be benefited?” They’ll think, “How’s it going to affect me? How’s it going to affect my car parking space?” You know, so, we are fairly gritty about what our lives are like. So, if you for instance employ a diabetes consultant in a hospital like this and you say, “You’re going to spend 95% of your time working in primary care”, that’s a bit spooky. That’s a bit spooky because we’re trained in one way and then we’re being asked to operate in another way. So, part of it goes back to training. How we train our workforce? So, we have a workforce of 1.3 million people. That’s a big workforce. That’s 8% of the working adult population. So, that’s huge.

So, yeah, you have got to get clinicians on board, but you often have to get them on board in ways like you’ve done which is very practical and tactical while not losing sight of the big strategic issues. Because everyone feels helpless when you talk about climate change and that’s possibly not the best entry point but if you talk about waste and food and energy and procurement - ethical procurement - you allow people to do something, which health services don’t really do well, which is allow people to live their values at work. So, if you are one of those people who are responsible for, you know, quite a lot of people in the organigram of your institution, one of the challenges I would set yourself

is to ask how do we let people live their values at work? Because most people who work in the health system have got relatively good values, but we are very good at beating it out of them before they come in through the hospital door or the health centre door.

So, when you liberate people’s values at work and say, “I’m really interested in what your ideas about addressing waste or compassion or food or energy”, not only have they got great ideas, but they say, “Well, we try to do that anyway despite the system, not because of the system” and that’s why that question someone asked about barriers is crucially important. Innovation is about removing barriers, not shiny toys.

**Forbes: The Sustainable Development Unit is half a dozen people set in Cambridge. You, as the doctor, I think, are the only real clinician, most of other people are data ...**

Well, we all started off as clinicians, actually. That was quite interesting and we soon realised that actually clinicians do not have the monopoly of skills. Funny that, isn’t it? So, actually, the people we’ve really learnt a lot from - and we haven’t learnt from them by dragging them into the SDU, we’ve kept the SDU very small and nimble and cheap and agile, I think, is the word used in Australia. So, we’ve done that, but we’ve largely used the - and this is where the partnership issue comes into it - we’ve largely learnt from people who are good communicators, fantastic communicators, community activists who, in our community, is the staff, government specialists, finance directors. Finance directors have been wonderful. Hey, who is a finance director here? There you go. Come up to the front.

So, finance directors have been really good because the big mistake we made with finance directors is they’d only be interested in finance and you know what? They’re human beings. They’re human beings with families and values and futures and my fear is once you’ve got a finance director on board, the world is your oyster. Is that true?

**[Laughter]**

Fantastic, good. So, they’ve been really useful because you’ve got to be ... sometimes you’ve got to be ruthlessly rational about this and one of the things we did - just following about your earlier question - is we’ve always been quite specific about how much - because when we started, we divided up Chief Executives into two groups. This is interesting. Those Chief Executives who said, “We can’t afford to do this” and the other group who said “We can’t afford not to do this”. So, choose which group you would be in because it’s much more interesting to be in the group that says, “We can’t afford not to do this” because it sends out a very important message, even if you don’t know what to do actually. It sends out a very important message to your staff. It legitimises them and allows them to do these things, not under the radar, but above the radar and finance directors are all fantastic at that. So, we’ve loved how much money we’ve saved for the health system. So, the first year we saved 13 million pounds which is not very much actually but by the end of the year nine, we’d saved 1.85 billion pounds and that’s an incredibly conservative estimate. So, you know, we probably saved a lot more than that. We didn’t do it directly but we put in regulations or normalised issues. We took best practice and made it normal or helped other people make it normal. We did very little actually except capitalise and accelerate what was normally happening. You know, basic change in most health services is blatantly slow so you do need to go scale and pace. We don’t have much time. The clocks is ticking, ok. So, finance directors have been great. Some conditions have been really good but a lot of conditions have been talked too much about climate change and not about health, ok. I mean, obviously, they are connected, but it’s better to talk about air pollution and food and safe streets and biodiversity and green spaces and high-quality education - and one thing which we should have stumbled on earlier, I think now you say it, was the role of prevention. Prevention is absolutely extraordinary. We’ve got 60% of our beds in hospitals

full of people with largely preventable disease. If you were in the business sector and you came and looked at us externally, you’d think, “What a terrible business model you’ve got. You’re monetising illness, you’re not monetising health” and it’s terrible but we’re so immersed in it, we’re so busy doing it. We all think we’re doing great jobs, which we are at a micro-level, but we’re doing it ... it’s a pretty sub-optimal business model at the macro-level.

**Just briefly, the role of nurses?**

Oh, nurses are great. I mean, if you actually look at the polls in detail, nurses are trusted more than doctors. Sorry about that.

**[Laughter]**

But more importantly than that, there are more nurses and nurses tend to be slightly more compassionate and they spend much more time with people, with patients. Unfortunately, the system never allows nurses to show the sort of leadership that they can deliver which is unfortunate. That was brought home to me by a clinician actually who said to me “Why is it that nurses love guidelines and doctors hate them?”, which is a really interesting analysis of how some people are what I call ‘over obedient’. Ok, they don’t challenge the system enough and I don’t mean challenging it in a destructive way; I mean in an inquisitive, academic open minded ‘we can do better’ sort of way. But nurses are great. There’s a huge social movement of nurses right across Europe, right across Europe, on sustainability and they are way ahead of any other professional group, in terms of their ability to move systems but they do find themselves working in systems which are very tightly prescribed, in terms of the actual face time they get with their patients. They do great.

**Forbes: On a sort of ... I mean, there are an enormous amount of frustrations in this area and people talk about barriers, but they are real barriers, although you can be innovative about them. As an example, at Western Health - and we could see it coming – so, gas prices have gone through the roof, electricity has gone through the roof, our budget went from $4.5 to $7.5 million in the year. So, a $3 million influx, we saw this coming.**

**And it was interesting. A group of us we went to the board and we discussed all these issues and they knew it was coming but you just had to wear it and, as the CEO was saying to me just a few days ago, there is once again a disconnect between what we’re able to do as a healthcare and, you know, the wonderful overarching carbon neutral by 2050 and there’s day-to-day, you know, driving difficulties of trying to bring down energy, the amount you spend on energy, for example. I mean, on the other hand, hearing exciting things coming from Health Purchasing Victoria to have wind power as part of the health purchasing. I don’t know what advice you might have on approaching that.**

Yeah, but it sort of goes - breaking up a journey into manageable chunks that individuals or departments can do can be tricky but there are some things that are certain about the future. Very few but some things are very set. Well, one is - we need not only a zero-carbon energy system soon, but we probably want a negative carbon energy system soon. So, one of the things - this is where collaborative procurement is important. Now, many of you will know that a lot of the energy within hospitals is actually generated within hospitals, in tri-gen or co-gen or in little power stations in the basement of hospitals. So, you’d have to look at how much energy we actually buy from the grid, but this is where, if your hospital or your network of hospitals - and this is where networks and hospitals do matter - commit to buying renewable energy, you can buck the market. You can buck the market

and the market will gain confidence because it’s got guaranteed purchaser of a lot of stuff. That always bucks markets.

So, I would ... I would, first of all, I would challenge hospitals to report on how much renewable energy as a proportion of their total energy they buy off the grid comes from renewable energy. That’s a fairly simple thing to do and you just need to be ahead of the curb. We need to be a leading sector in this for health reasons - for health reasons, that’s very important and, I mean, clearly, we should divest from coal. I mean, that’s madness. And thirdly, any roof space in any hospital that’s not covered in the most modern panels, you might as well tear up money and put it down the drain. I mean, people do this in British hospitals. You know how sunny it is in Britain and even when we can’t afford to do it, there are hospitals that can’t afford - because of the money flows, they can’t afford the capital. They’ve done community share offers. So, to their staff and patients and public, they’ve said, “We’ve got this big hospital roof. Would you like to invest in...?” People say, “Yeah, I will buy shares as a member of the public” and they get a profit and some of that profit goes into fuel poverty charities. Now, that’s because of great partnerships because of hospitals, energy companies and charities and that should be routine. We shouldn’t be giving awards to the people for that, great though it is. We should be routine and a country with so much sun and so much space, it’s an economic no-brainer. So, yeah, what was the question?

**[Laughter]**

**Forbes: You’ve answered the question. We could ask many more questions, but would the audience like to ask any question?**

**Male Speaker: I’m just interested in your reference to the workforce. I’m involved in teaching first year medical students for the University of Melbourne. So, I’m interested in how we could change the culture of the next generation so that it’s normalising this kind of thinking, as opposed to previous generations.**

Well, one of the things that really surprised me for the good was that, in the UK, we have a national union of students and they have a very big sustainability department, far bigger than ours and they have done some very interesting behavioural studies that when young students come to university, you know, aged seventeen or eighteen - they think they’re the bee’s knees, they think, “Hey, I’m cool, I’ve gotten into University” but, actually, they’re at some of the most vulnerable times of their lives because they want to fit in. They want to norm with a new peer group. They don’t want to look stupid and there’s a fascinating behavioural - this is for all students, not just for med students - whereby the NUS does a blitz on the first two weeks of all students in British universities and all sorts of things about environmental sustainability, waste recycling, climate change and it’s changed the whole culture of some universities. It’s been going for three years now, you see. So, you’ve got this whole group of people emerging from universities, where recycling and looking at the environmental consequences of everything we do as individuals or institutions is absolutely routine and, for medical students, as you will well know, medical students, like many other students, come to medical school bright-eyed, bushy tailed, you know, creative, questioning, critical, outward-looking and we just beat it out of them. We beat it out of them bar hardly none, but we beat it out of them. So, you know very well if you ask medical students on their first day what is it ... what are the big issues of our time that you think affect health, you have to wait about three minutes before one of them says the sorts of issues we’re talking about today. Ok, and one of the really important lectures I never went to at medical school was what causes health? Ok, I went to plenty of lectures on what causes multi-facular melena ciliopathy but very few on what causes health? So, having what they call a salutogenic element to your, you know - looking at what causes prevention, looking at what causes health. I once said to our Dean “Why don’t we change the name of our hospital from a teaching

hospital to a learning hospital?” and he said “I don’t understand” I said “My point exactly!”. You know, it’s extraordinary, isn’t it? Isn’t it extraordinary? But, we really need to step back. What used to be done at McMaster and Newcastle, we need to do again and again and again. Completely revisit how we’re probably badly socialising the next generation of leaders. Yeah, there is lot of work done with the General Medical Council in the UK about how we introduce this issue in medical schools that don’t say” Let’s put it between ENT and cardiology”. That won’t work because it’s a completely different approach.

**Forbes: She’s saying...**

One minute?

**Forbes: One minute, oh ok.**

**Female speaker: We have one more question.**

**Forbes:** There’s a ... maybe two ...

**[Laughter]**

**Forbes: Ok, go on.**

**Female speaker: David, have you got your slide with you about showing the proportional contributions of the carbon footprint in terms of pharmaceutics and transport and - and the reason I’m just asking is a question about Australians have a love affair with two things. One is the car and the other are pharmaceuticals. Our health system is very much driven to pharmaceuticals and I just think that slide shows the carbon footprint of these two things. Any comments you’ve got about aiding us to address that?**

Ok, so, shall I have a go at the other question while I’m sorting this out?

**Male speaker: Oh, well, I’m interested in your comments on what I perceive to be a tension between infection control and waste sustainability ...**

... single use items ...

**Male speaker: yeah and the shift to shift single stuff, which seems to be a big opportunity.**

Sure, sure and these are really important concerns. Infection control is very important. You only need one avoidable infection or one death from sepsis, which is avoidable and it’s all over the newspapers. So, these are very real concerns. My only advice is to get someone who’s a really good infection control professional on your side, to learn from them. Don’t make it a battle between is sustainability more important than infection control. I mean, that’s the road to ruin, actually. You need someone who is broadminded on both sides. You being broad minded about infection control, that maybe an infection control nurse or doctor or professional - you just need to jaw-jaw not war-war. Talk about it. That’s really important because there are ways through these things. There are things called balance risks and risk registers and, yeah, you’ve got to do it proportionately. You can’t say, you know, “My business of infection control is more important than your business of whatever it is - climate change”, you know, because infection control will win hands down every time.

So, that’s for obvious reasons. So, you need a more balanced approached. You’ve just got to get people - you’ve got to talk to unusual partners. That’s what partnership is all about. Talk to unusual partners, they’ll tell you the answer. You had a quick question?

**Female speaker: I just had a question about consumer implications, you know, and you talked about nurses being very sort of more focused in [sic] direction. I mean, there are worse things to [sic] in terms of setting these expectations. Have you done anything about any patients voice about what their expectations are as a health service and how that can be leveraged to drive change?**

Yeah, I’ve always followed the mantra of ‘trust me, I’m your patient’ in the sense that that is where most of you are. As a clinician, that’s where most of your answers will come from

Yes, so the question here is to what extent are we really listening to, if you like, the consumers about service?

And what have we done about facilitating? Well, not enough. Not enough. That’s absolutely ... and it’s easier, it’s easier in the retail sector because they’ll determine your share value, whereas largely, patients are not a powerful part of the machinery and the health service and greatly... and that’s the most important source we’ve got. So, the only glimmer of hope I can give you really - and it’s not my specialist area – but, when we were talking earlier about barriers and innovation, one of the - I’ll tell you a story which is just typical of this journey. When we said we’re going to ... in fact, I could tell you one about the retail and food sector for you actually, which you would understand well, which is ‘patients won’t like this’.

When you said, “Well, we’re going to change all the food in the hospital, ok. We’re going to change all the food and we’re going to make it local and organic and seasonal” and someone said “Patients won’t like it”. How arrogant. How on earth do you know? Ask them and, of course, patients loved it. Yeah, so, it’s ridiculous. So, that’s an example of people saying “I don’t want this to change. How can we stop it changing? Oh, I know. Patients won’t like it”. No evidence at all.

So, when we said - when we started our journey and we said “We should be doing this with prevention” for instance, people said “Oh, patients won’t like it. Patients will want to go to the big shiny hospital for their minor surgery”. Do they? Do we know that? Is that true? Have we asked them?

So, did ... we commissioned big public surveys about how they would feel their health tax being spent on making the health service more environmentally sustainable and the first one was 92%, the second one was 94% and it just kept on going up, ok, and if we’d had more money, we’d have said “What specifically or why?” but it actually was mainly because we don’t want to go to the hospital and get MRSA actually or we can ... our relatives can park more easily at the local hospital and do it and actually, the clinical outcomes are no better in the big hospital than in the small local hospital, actually. So, that gave us a mandate. So, I wasn’t ... if I’d had more money, I’d have got specific ideas. I was looking for political mandate or just to address people who said “Patients won’t like it” but, actually, I should have gone much further than that and said “Exactly why and what would you like to have in your local hospital? Or, how would you feel about having your melanoma diagnosed locally, in your own home actually with your own phone maybe?”. So, that’s an example that speaks to people. It doesn’t speak to the public, it speaks to professionals.

Yeah, so, just before we wind up because I know we are short of time, this is the - where we measured footprints in the UK. In England, actually, not the UK and that’s where it needs to be, down there. Why does it need to be right down there? It needs to be down there because of the

science and because of the law and getting from there to there - we’ve got some of the way there - is important. We’ve got, we just got over the first ten-year trajectory point. We’ve reduced it by 11% and we needed to reduce it by 10%.

But your question - who asked the question? Lisa asked the question about where does it all come from? And, it comes from travel. It largely comes from procurement, actually. It’s the stuff you buy, massively the stuff you buy. It’s the same in your home and mine. It’s what we buy - stuff. And, if you break that down, the largest component in pharmaceuticals. Ok. Why is it pharmaceuticals? Because we waste them in an extraordinarily large amount. Half of all money spent on primary care in the western health system is spent on one thing: pharmaceuticals. And we waste it in such industrial quantities. Not only do we waste it, but the waste is toxic. Not only do we waste it and the waste is toxic, but the supply chain in many parts of the world - especially if you include medical devices - is unethical. It’s completely unethical. Half the medical instruments of the world start their life in northern Pakistan. So, this is a really interesting challenge for you. It might give more weight to your job is that, if you start - and this is very difficult, I’m not saying it’s easy. If you put wording in contracts that we wish to see the ethical providence of the people that supply you and the people who supply your suppliers and the people that supply your suppliers and the people that supply your suppliers, this is a nightmare of procurement. Then, you’ll get back to some deeply unethical - with little children making surgical instruments where they won’t reach adolescence without an iron filing in their eye and you throw it away after one use. That’s completely unethical. It is cost ineffective too. There are much better ways of doing it. So, a brilliant important question about coming down on where it comes from. And, actually, to be fair, the pharmaceutical industry are good at thinking “We need to address this collaboratively”. So, don’t look for false enemies. They are as interested in innovation as we are.

**Female speaker: ... [sic] about the human slavery act, I just thought maybe that’s a potential opportunity too, but you’ve got it already.**

Yeah, we have. We have got a non-slavery act. There are more slaves in the world now than there have ever been in human history. Don’t think these things which we thought we abolished in 1803 are gone. There’s more smoking in the world now then there ever has been. So, we’re not immune. We’re not isolated to the issues going on in the globe. And most importantly, we can do something about this and it makes our professional lives more fulfilling, more meaningful, more effective and helps us leave a legacy we can be proud of.

Thank you.

**[Applause]**