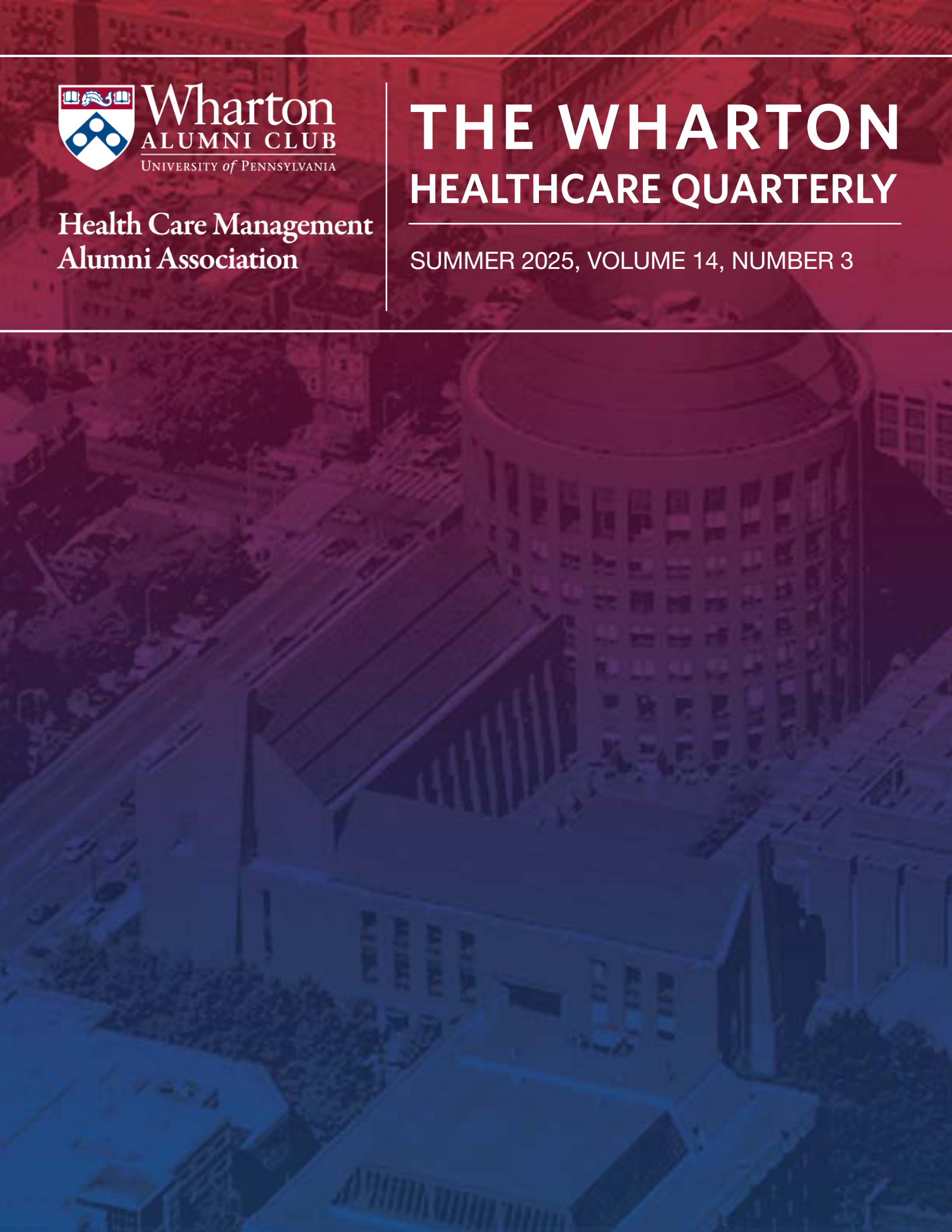

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UNIVERSITY of PENNSYLVANIA

Health Care Management Alumni Association

THE WHARTON HEALTHCARE QUARTERLY

SUMMER 2025, VOLUME 14, NUMBER 3

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EDITOR'S LETTER

Z. Colette Edwards, WG'84, MD'85
Managing Editor

To learn more about Colette, click here.

"In a time of drastic change, it is the learners who inherit the future. The learned usually find themselves equipped to live in a world that no longer exists."
~ Eric Hoffer

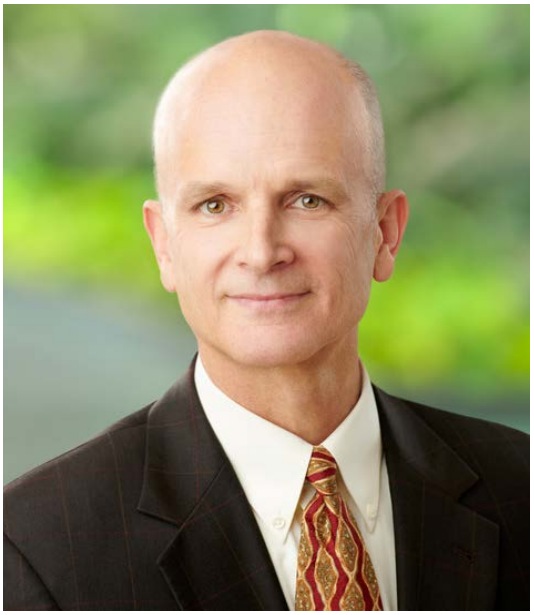
The second quarter of 2025 has ushered in even more widespread and extensive changes in most areas of healthcare. To name just a few, they include major cuts to Medicaid and the ACA which will leave millions uninsured, a new ACIP committee with revised vaccine guidance found alarming by many medical societies, FDA staffing cuts which may impact medical device reviews and approvals, exemptions from Medicare drug price negotiations for medications that treat multiple rare diseases, and cuts to SNAP.

The stakes are higher than ever before. The need for active engagement by all healthcare stakeholders and courageous leadership is clear. How are you going to use your talents and expertise to make a positive difference amidst the many challenges we all face?

Z. Colette Edwards, WG'84, MD'85
Managing Editor

Contact Colette at: info@pausitivehealth.com

THE PRESIDENT'S DESK



Bryan Bushick, MD'88, WG'89
To learn more about Bryan,
click here.

Greetings!

I'm delighted and honored to serve as the WHCMAA's President after completing my duty as Vice President. I'm also very grateful to have partnered with Katherine Clark '15, who just concluded her two-year term leading the Association's Board. Under Katherine's thoughtful, steady, and effective stewardship, the WHCMAA passed the pandemic's 5th anniversary on an upward trajectory.

The Alumni Association has been revitalized, now having more dues-paying members than ever and a growing array of sponsors after losing all such support at the height of COVID's impact. In-person and online programming is flourishing, and the Kinney and Kissick scholarship fund balances have continued to grow.

Thank you, Katherine, for your service as President and your many meaningful contributions!

Thanks also to John Winkelman '80 and Marisa Bass '14, both of whom devoted their time and talents over the last six years. Having reached their term limits, we'll miss them on the Board. Fortunately, John and Marisa will surely find ways to continue contributing.

As part of the largest Board turnover in the WHCMAA's history, we'll also miss contributions from Carrie Hiebeler '05, who served as Secretary, and Hannah Plon '22, a two-time Alumni Conference co-chair, as well as Vivien Ho '21, Bhuvan Srinivasan '11, and Charlie Robinson '15.

Another noteworthy transition involves the arrival of the eight new Board members, all Health Care Management program alumni, who were elected last month. I hope that you'll have many opportunities to congratulate those listed below as they commence their first two-year term (effective July 1st).

- Megan Ax, '06
- Sigal Ben-Ari, '11
- Edward Chan, '11
- Cristina Gutierrez, '05
- Christina Liu, '13
- Ashish Parikh, '10
- Scott Shandler, '06
- Yves Zinggeler, '03

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PRESIDENT'S DESK

Fortunately, we'll all benefit from the return of Katie Ellias '06 (who'll now serve as Vice President), Ron Kero '86, Leticia Lazaridis '10, Michael Rovinsky '86, and Kathryn Tong '07. Each was re-elected in June. Amid his two-year term, Ryan Berger '06 will serve as Secretary, and Vikas Goyal '10 will continue as Treasurer.

I'll close with a brief announcement and then a reminder. I'm extremely excited to share that a Strategic Plan for the next four years is being created. Based upon input from both current and prospective members as well as the previous and recently elected Directors, the Board will soon finalize the priorities and tactics that will govern how the Association's time and other resources are devoted. I'll provide an update in next quarter's "*The President's Desk*" column.

Finally, given the large number of alumni who expressed in their Membership Survey responses their willingness to assist, I wanted to remind you that serving on the Board is but one of many ways to contribute. Wharton alumni (and graduates of other Penn schools and programs) are welcome to:

1. Be a "Class Ambassador" and engage fellow alumni from your graduating class.
2. Recommend prospective Association sponsors to the Sponsorship Committee.
3. Help organize a regional event, ideally in conjunction with one or more Board members.
4. Co-host a reception in conjunction with an industry conference that you'll attend.
5. Identify prospective speakers for webinars, the annual alumni conference, or other events.
6. Regularly contribute to or facilitate a WhatsApp interest group.
7. Recommend and help organize new WHCMAA programming.
8. Serve on a Board Committee.

To learn more, please contact Ryan Berger (wryanberger@gmail.com).

Best wishes to all throughout the summer!

Bryan Bushick, MD, MBA (WG'89)
President, Wharton Health Care Management Alumni Association

Contact Bryan at: jbbushick@gmail.com.

ALUMNI NEWS

Jill Gardenswartz Ebstein, WG'83
In March, I published my third book, *Coming of Age at Forty*, which is part of a fictional series. Book One in the series, *Alfred's Journey to Be Liked*, is about a neurodivergent teen, his coach and his friends in the making. Book Two, *Hannah's Journal to Be Happy*, features Alfred's best friend, who is an angry teen who doesn't understand why.

Now comes Book Three, whose protagonist is Alfred's mother. Per its back cover:

Meet Ellie. She is a 40-year-old single mom to Alfred, and she is struggling. In the blink of an eye, her son will be off to college. Her dear mother is getting up in years and seems fragile. Her boss's boss is indecipherable and impossible to please.

With the sensitivity she bestowed on Alfred two years before when she found him a coach to help him build a circle of friends — helpful because he is neurodivergent — Alfred asks his mom to find someone to help her.

Through Alfred's coach and Tovah, her newly found coach, Ellie's world opens up.

Readers get a front-row view of Ellie's transformation as we root her on and become inspired by a roller coaster ride of discovery.

All is available on Amazon. Here is my author page: Jill Ebstein Author Page

Contact Jill at her website.

Jody Schuhart, FAS'80, WG'84
Last July Scott (MacDougal) and I sold the SaaS business we've been building for 25+ years, and RETIRED January 1st (woo hoo!). We've been living in/on Fox Lake, IL for 10 years, and enjoy boating with our dog Odin. Our 2 daughters live in Skokie IL and LA...no grandkids yet though. Retirement is good so far--more reading, golf, learning pickleball, 3+ daily walks with Odin. On the docket: more boating, visiting friends & family we haven't seen enough, starting a new hobby or two, and LOTS of travel--Scotland and Portugal this year, Greece, Croatia, and Africa next year. Would love to see any Wharton classmates in/visiting Chicagoland and perhaps connect for a drink or two...we finally have some time!

Contact Jody at: jodyschuhart@gmail.com or her cell – (847) 404-4001.

Z. Colette Edwards, WG'84, MD'85
I was pleasantly surprised and thrilled to be named one of WOW's 2025 Trailblazing Leaders in Menopause:

"These individuals are founders, researchers, healthcare providers, advocates, and innovators who are challenging outdated norms, creating groundbreaking products and services, and empowering women to take control of their health and wellbeing during midlife and beyond."

It was great encouragement to continue my work as Founder and Chief Medical Officer of pausitive health, a holistic, one-stop digital health destination for women+ in all stages of the menopause journey. We offer empowering, omnichannel education, access to menopause-trained clinicians, physician-vetted services and resources, and community.

Contact Colette at: colette@pausitivehealth.com.

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ALUMNI NEWS

Jeff Voigt, WG'85
Recently published: Gillian D. Sanders Schmidler, M. Sasha John, Jeffrey D. Voigt & Mitchell W. Krucoff (31 Jan 2025): Cost-effectiveness of continuous real-time intracardiac recurrent event detection and alerting in high-risk acute coronary syndrome patients, Future Cardiology, DOI: 10.1080/14796678.2025.2457831

Contact Jeff at his LinkedIn profile.

Kristen Nwanyanwu, M'09, WG'09
Dr. Kristen Nwanyanwu is the inaugural Associate Director of Community Engaged Research and Participant Recruitment Science at the Yale School of Medicine. She manages a team to optimize community partnerships and support community-engaged research from design to dissemination.

Contact Kristen at:
k.nwanyanwu@yale.edu or her LinkedIn profile.

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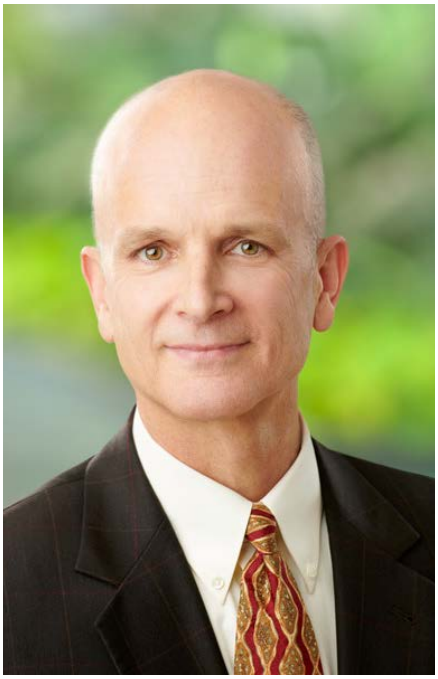
THIS MONTH'S PHILOSOPHER:
Bryan Bushick, MD'88, WG'89

To learn more about Bryan, click here.

THE PHILOSOPHER'S CORNER



Bryan Bushick, MD'88, WG'89

LIFE LESSONS

If I knew then what I know now, I would have...

…maintained my license to practice medicine.

That said, I don't regret the path I chose – often blazing a trail with early-stage ventures or accepting the challenge of a newly created position in larger companies – and am grateful for the diverse experiences as well as the relationships that have developed. Yet, with 40 years dedicated to healthcare (starting with a summer job as an orderly in a community hospital), I also have a heightened and refined regard for the special place of individual caregivers in serving patients and their families.

The intimacy, sanctity, and consequences of some patient interactions provide a unique opportunity as well as a responsibility. Many of my early career patient encounters created lasting memories. They also shaped my views and subsequent decisions.

I've greatly appreciated the chance to impact millions of people through various IT-enabled solutions with which I've been associated, and in other roles that improved population health. Even so, it would have been ideal to have somehow continued caring directly for patients or to be able to do so now.

High praise and gratitude to all caregivers: physicians, nurses, therapists, technicians, nursing assistants, and first responders.

If I knew then what I know now, I would NOT have...

…taken as many things so seriously.

Goal-oriented and naturally driven, I worked (and played) hard from a young age. I took to heart my commitments and any that were made to me, maintaining high standards for myself and those with whom I engaged. My diligence was accompanied by an intensity, and I did not often enough appreciate the context, the longer view, or the relative importance associated with many circumstances.

No question, the attributes noted above served me and others well. Yet, I now better appreciate the incredible benefits of reframing one's views. I recognize that there are many fewer truly significant matters and that I'm much better off preserving my intensity and sense of gravity for those instances. Easing my way forward across many of life's dimensions – no longer taking myself, my aims, my decisions, or my losses as seriously – is more sustainable, effective, and pleasant for me and, without a doubt, those with whom I interact.

I'm serious about that…;)

THIS MONTH'S PHILOSPHER:
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THE PHILOSOPHER'S CORNER

FAVORITE QUOTES

1. "Fall down seven times, stand up eight." ~ Japanese proverb
2. "Don't cry because it's over. Smile because it happened." ~ Ludwig Jacobowski, it seems, rather than Dr. Seuss, who often gets credit
3. "It's not having what you want. It's wanting what you've got." ~ Sheryl Crow
4. "Life, if well lived, is long enough." ~ Seneca

RECOMMENDED READING

1. *The One Life We're Given* by Mark Nepo
2. *The Spectator Bird* by Wallace Stegner
3. *The Book of Two Ways* by Jodi Picoult
4. *When Breath Becomes Air* by Paul Kalanithi

Contact Bryan at jbbushick@gmail.com.

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AFFIDAVIT: HEALTHCARE AND THE LAW - NEW DOJ BULK DATA TRANSFER RULE: A COMPLIANCE MINEFIELD FOR THE HEALTH CARE INDUSTRY — WITH COSTLY CONSEQUENCES

In an effort to address national security concerns associated with foreign entities accessing the sensitive data of U.S. persons, the U.S. Department of Justice ("DOJ") has recently issued a rule entitled "Preventing Access to U.S. Sensitive Personal Data and Government-Related Data by Countries of Concern or Covered Persons." The rule prohibits U.S. entities from knowingly sending bulk U.S. sensitive personal data or government-related data to what the rule designates as "countries of concern" or "covered persons."[1]

Affected data includes data frequently transmitted in the healthcare industry, such as human 'omics data, personal identifiers, biometric identifiers, precise geolocation data, personal financial information, and personal health data. The rule took effect in April 2025 and contains both civil and criminal penalties for violations (up to $1M per violation and up to 20 years in prison). DOJ had indicated that it would initially focus only on willful, egregious violations of the rule until July 7, 2025, to provide affected companies time to get into compliance. Full enforcement, including civil enforcement, began on July 8, 2025.[2] Thus, it is essential for U.S. businesses to not only understand how this rule may apply to company practices, but work with counsel to engage in risk assessment and comprehensive data flow auditing to support robust and timely compliance efforts.

Broadly, the rule makes it illegal to knowingly provide access to bulk U.S. sensitive personal data to covered persons or countries of concern. Countries of concern are currently designated as China (including Hong Kong and Macau), Russia, Iran, North Korea, Cuba, and Venezuela.[3] Covered persons can be individuals or entities with certain ties to countries of concern, or that are designated as covered persons by the Attorney General. Outside of Attorney General designation, entities may be covered persons as a result of their ownership, location, or formation status, while individuals may be covered persons through their employment or residency.[4] This means that companies must take steps to determine whether an individual or entity is a covered person before entering into data transactions that implicate the rule.[5] This may require new institutional policies that dictate how frequently a company checks against the covered persons list, methods for assessing residency and employment, and ultimately renegotiating vendor and employment contracts.

The rule primarily prohibits or restricts the following "covered data transactions":

1. **Data brokerage:** U.S. persons knowingly entering into a data transaction involving data brokerage (commercializing the exchange through data licensing or sale) that will allow a covered person or country of concern to access bulk

government-related or U.S. sensitive personal data. Of note, the rule is broad, and traditionally "non-commercial" transactions may still be considered data brokerage under the regulation.

2. **Data transfer to foreign persons without required contract provisions:** U.S. persons knowingly entering into a data transaction that will allow access to a foreign person, who is not a covered person, to bulk government-related or U.S. sensitive personal data, and involves data brokerage, an employment agreement, vendor agreement, or investment agreement, without entering into a contract with particular provisions against certain onward data transfer.[6]
3. **'Omic* and biospecimen transfer:** U.S. persons knowingly entering into a data transaction that will allow access by a covered person or country of concern to bulk human 'omic data or human biospecimens, and involves data brokerage, an employment agreement, vendor agreement, or investment agreement.[7]
4. **Data transfer to evade the rule or directing prohibited transfers:** both transfers that are aimed at evading the rule and knowingly directing a non-compliant transfer are violations of the rule.[8]

The rule provides a pathway to engage in certain covered data transactions that would otherwise be forbidden. However, this "restricted transaction" pathway requires significant recordkeeping, a data compliance program, and auditing.[9] There are also particular exempt transactions, such as for a covered data transaction that is pursuant to a federal grant, contract, or other agreement.[10] Companies will need to determine the applicability of exemptions and availability of the restricted transaction pathway based on a comprehensive overview of the proposed transaction, including the nature of the data to be transacted.

It is also important to note that, starting in October of 2025, U.S. entities that reject an offer to engage in a prohibited transaction are required to file a report describing the offer and rejection within 14 days of occurrence.[11]

DOJ released supplemental guidance on April 11, 2025 to address certain ambiguities. For example, in determining the "knowing" standard, DOJ will consider an entity's sophistication.[12] DOJ is also clear that U.S. entities have not knowingly directed a prohibited transaction in the case that a foreign person, an individual who is not a covered person, who has access to bulk sensitive personal data decides to then employ a covered person and gives them access to that data without the knowledge or direction of the U.S. person.[13] However, once the list of covered persons is published in the Federal Register, it will serve as constructive knowledge of a person's covered status.[14] Companies thus may not rely on a single check of the covered person list's contents, but rather must be checking at a frequency determined through risk assessment.

Additional compliance takeaways include sample contract language DOJ provided for U.S. persons to integrate into contracts with foreign persons. The suggested language requires foreign persons to periodically certify that they are not engaging in prohibited onward data transfers, and DOJ is clear that U.S. persons should be taking "reasonable steps" to ensure that foreign persons are complying with these contractual provisions.[15] Of some comfort, DOJ noted in its guidance that an entity's failure to detect non-compliance does not usually create a prohibited transaction if that entity was conducting "adequate due diligence" as a part of its risk-based compliance program.[16]

In summary, this rule is complicated and provides DOJ with broad enforcement authority. Companies might consider applying to DOJ for a license to engage in a covered transaction or requesting an advisory opinion from DOJ on a proposed data transaction. Each of these approaches carries a certain amount of legal risk and that should be evaluated carefully. It is essential to engage with trusted counsel on this topic and to ensure the development of a robust compliance program.

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To learn more about Ryan and Victoria, click here.

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AFFIDAVIT: HEALTHCARE AND THE LAW - NEW DOJ BULK DATA TRANSFER RULE: A COMPLIANCE MINEFIELD FOR THE HEALTH CARE INDUSTRY — WITH COSTLY CONSEQUENCES

Contact Ryan at: RWBrown@duanemorris.com
Contact Victoria at: VHawekotte@duanemorris.com

* 'Omic = the comprehensive study of a collection of biological molecules within a living system, often employing high-throughput technologies to analyze large datasets.

REFERENCES

1. *See* Preventing Access to U.S. Sensitive Personal Data and Government-Related Data by Countries of Concern or Covered Persons, 90 Fed. Reg. 1636 (Jan. 8, 2025).
2. *Data Security Program: Implementation and Enforcement Policy Through July 8, 2025*, Department of Justice National Security Division, 1-3, 2 (April 11, 2025), https://www.justice.gov/opa/media/1396346/dl?inline.
3. § 202.601.
4. § 202.211.
5. *Data Security Program: Implementation and Enforcement Policy Through July 8, 2025*, at 19-20.
6. § 202.302.
7. § 202.304
8. §§ 202.304; 202.305
9. *Data Security Program: Frequently Asked Questions, Department of Justice National Security Division*, 1-45, 37 (April 11, 2025), https://www.justice.gov/opa/media/1396351/dl; § 202.1101.
10. *See, e.g.*, § 202.510.
11. *Data Security Program: Compliance Guide, Department of Justice National Security Division*, 1-21, 10 (April 11, 2025), https://www.justice.gov/opa/media/1396356/dl; § 202.1104.
12. *Data Security Program: Compliance Guide*, at 5.
13. *Id*. at 9.
14. *Data Security Program: Frequently Asked Questions, Department of Justice National Security Division*, 1-45, 19-20 (April 11, 2025), https://www.justice.gov/opa/media/1396351/dl.
15. *Data Security Program: Compliance Guide*, at 6-7.
16. *Data Security Program: Compliance Guide*, at 7.

Source: Bigstock

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TO YOUR HEALTH: BURNOUT IN THE DIGITAL AGE - UNDERSTANDING, MITIGATING, AND OVERCOMING THE STRAIN

In today's fast-paced, hyper-connected world, burnout has evolved beyond a buzzword — it's a pressing and pervasive issue affecting individuals across industries, especially in healthcare. The constant demands of work, digital communication, caregiving responsibilities, and societal expectations have created the perfect storm for emotional exhaustion, chronic stress, and professional detachment. Yet despite its prevalence, burnout remains cloaked in shame. Many who experience it feel as though they're failing, which only compounds their sense of isolation and depletion.

Source: Bigstock

I've experienced this firsthand. As the founder of a digital mental health startup and the mother of a neurodivergent child, I found myself overwhelmed by competing priorities. While I was committed to supporting others' mental well-being, I was silently neglecting my own. I wasn't sleeping well, felt emotionally depleted, and struggled to be present — in my work, at home, and with myself.

At the time, I didn't label it as burnout. I just felt that I wasn't "doing enough" anywhere. I was passionate about my work but had no energy left to give. Over time, my physical and emotional health began to deteriorate, and I realized I was no longer embodying the very mission I had set out to champion.

THE HIDDEN STRAIN OF BURNOUT

Burnout can be difficult to detect — especially in high-achieving professionals — because it doesn't always present as overt stress or fatigue. Instead, it often creeps in gradually, manifesting as chronic emotional exhaustion, reduced motivation, cynicism, or a diminished sense of personal efficacy.

A landmark study by Shanafelt et. al. (2017) in The Lancet emphasized how burnout, particularly in healthcare, correlates with higher levels of emotional exhaustion and depersonalization. This affects not just the provider, but also patient outcomes and overall team performance. I saw echoes of this in my own startup. Even though I cared deeply about the mission, my depleted state made it nearly impossible to lead effectively or connect meaningfully.

THE GENDERED EXPERIENCE OF BURNOUT

Burnout doesn't affect everyone the same way. Research by Maslach et. al. (2018) highlights gender differences in how burnout is experienced and expressed. Women — especially those in caregiving or dual-role positions — are more likely

to experience emotional exhaustion. Men, by contrast, tend to exhibit burnout through depersonalization or emotional detachment.

As a mother, entrepreneur, and partner, I felt a constant tug-of-war between responsibilities. I internalized the belief that I *should* be able to do it all. When I couldn't, I felt ashamed. That shame — common among women balancing work and caregiving — often keeps us from seeking help or setting boundaries.

Maslach's work also underscores how societal expectations around nurturing, achievement, and selflessness contribute to higher burnout rates among women. The pressure to meet unrealistic standards without adequate support or rest creates a dangerous, often invisible cycle.

BURNOUT VS. NORMAL STRESS

To help clarify what burnout looks like in contrast to everyday stress, here's a simple visual comparison:

Normal Stress	Burnout
Temporary and situational	Chronic and persistent
Motivation returns after rest	Motivation remains low even after time off
Feels manageable	Feels overwhelming and inescapable
Physical fatigue but emotional resilience	Emotional exhaustion and detachment
Maintains sense of efficacy	Diminished sense of accomplishment
Occasional irritation	Frequent irritability, cynicism, or hopelessness
Rest and breaks help	Rest feels insufficient or unproductive

RECOGNIZING THE SIGNS OF BURNOUT

Symptoms of burnout can be mistaken for "just a bad week" or "being tired," but they often go deeper:

- **Emotional exhaustion** – Feeling constantly drained or overwhelmed
- **Cynicism or detachment** – Becoming numb or indifferent toward work, relationships, or responsibilities
- **Irritability and mood swings** – Reacting strongly to minor issues
- **Decreased performance and productivity** – Working harder but accomplishing less
- **Physical symptoms** – Headaches, sleep disturbances, digestive issues, and frequent illness

Left unchecked, burnout can lead to long-term consequences like anxiety, depression, and cardiovascular disease.

BREAKING THE SHAME CYCLE

One of the most profound barriers to addressing burnout is shame. Too often, we view burnout as a personal failure rather than a natural response to unsustainable pressure. The truth is, burnout doesn't mean you're weak — it means your system is trying to protect you.

By naming burnout, we create space for self-compassion and change. Whether that means reducing workload, drawing clearer boundaries, seeking support, or simply giving ourselves permission to rest, healing begins with recognition and honesty.

Burnout is not a flaw. It's a signal that something is misaligned — and an invitation to realign.

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TO YOUR HEALTH: BURNOUT IN THE DIGITAL AGE - UNDERSTANDING, MITIGATING, AND OVERCOMING THE STRAIN

ALLEVIATING BURNOUT: WHAT HELPS

Healing from burnout isn't about grand overhauls. It's about intentional steps, taken consistently. Here are five approaches that made a significant difference in my own journey:

1. **Prioritize rest and self-care.**
   True rest goes beyond sleep. Build recovery into your day with breaks, movement, stillness, and activities that bring joy. Establish clear boundaries between work and personal time.
2. **Seek social support.**
   Sharing your struggles can be healing. Whether with trusted loved ones, coworkers, or a therapist, support creates connection and helps dissolve the isolation that burnout feeds on.
3. **Reevaluate expectations.**
   High achievers often set unsustainable standards. Reassess what truly matters. Learn to say "no" and delegate when possible. Give yourself permission to not be everything to everyone.
4. **Disconnect from technology.**
   Constant digital engagement creates a sense of urgency that can be mentally draining. Designate "no screen" times — especially in the morning and evening — to help your nervous system reset.
5. **Focus on meaningful activities.**
   Reconnecting with purpose — through creative projects, volunteer work, or simple joys — can restore a sense of meaning. Sometimes burnout stems from misalignment with what gives you energy and fulfillment.

A meta-analysis by Dewa et. al. (2021) supports this approach, finding that mindfulness-based practices such as meditation, breathwork, and present-moment awareness significantly reduce burnout symptoms, particularly among healthcare professionals.

A PATH FORWARD

Burnout doesn't have to define your story. With the right tools, mindset, and support, it's possible to recover and build a more sustainable, fulfilling life. If you're experiencing signs of burnout, know that you're not alone — and that recovery doesn't require a massive overhaul. It starts with small, conscious shifts: naming the experience, allowing support, setting boundaries, and realigning with what matters.

Above all, remember: self-care isn't selfish. It's essential. In honoring your own needs, you reclaim the energy and presence needed to show up — for yourself, for others, and for the life you want to build.

Burnout is not the end. It's a turning point — and an invitation to return to yourself.

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DOWNLOADING SUCCESS: EMPATHY IN PHYSICIAN LEADERSHIP - CURRENT INSIGHTS AND STRATEGIES

In our work with physician leaders through WittKieffer's Physician Leadership Institute, we meet experienced professionals in role transitions. After establishing themselves as dedicated colleagues, capable clinicians, and committed patient advocates, these leaders attract the attention of senior administrators and hiring managers and are often tapped for leadership roles, including department chair, chief medical officer, and chief physician officer.

These opportunities, which present a chance to build one's leadership capacity and have greater impact on a hospital or system, also pose a bit of a Faustian bargain – or an invitation to the "dark side" of administration. As leadership advisors, we've found our most critical task is to help these leaders explore their motivations and preferences to shape a leadership role that they embrace on their own terms.

Empathy has emerged as a critical trait for physician leaders, influencing everything from patient satisfaction to team morale. In an era of high burnout and evolving patient expectations, healthcare organizations increasingly recognize that emotional intelligence and empathetic leadership are not “soft” skills but essential competencies.

THE VALUE OF EMPATHY EMERGES THROUGH GREATER SELF-AWARENESS

Numerous studies confirm that when physicians and leaders practice empathy, patient care markedly benefits. Empathy is often described as the “emotional bridge” between provider and patient, fostering trust and open communication. Outcomes data bear this out: patients under the care of high-empathy physicians have better clinical results across a range of conditions. For example, higher empathy scores have been linked to improved control of chronic illnesses like diabetes and asthma, faster recovery from the common cold, and reduced patient anxiety before procedures. Empathetic medical care also correlates with greater adherence to treatment – patients are more likely to follow doctors’ advice when they feel understood and cared for.

Empathy's positive impact requires truly knowing – and then managing – oneself. Scientist and journalist Daniel Goleman defines self-awareness as the capacity to recognize our emotions and their effect on others. It is foundational to Goleman's conception of emotional intelligence, the necessary-but-not-sufficient set of skills that allows us to manage interpersonal relationships intentionally and productively. (For our part, we have yet to meet a leader who has realized their potential without a commitment to taming these tendencies through self-management.)

Sigmund Freud famously opined that "the self you know is hardly worth knowing," highlighting the difficulty in uncovering our motivations, desires, and essential natures. While we are sympathetic to the idea that this work is never truly done, we believe there can be great value in a disciplined approach to understanding what makes us tick, and how we harness that knowledge in working with and through others.

We are fond of research psychologist Tasha Eurich's approach to the topic. Eurich's research has determined that, while 95% of the population believes itself to be self-aware, only 10-15% actually meet the criteria of being able to accurately see themselves as others see them and understand their own values, goals, strengths, and weaknesses. Curiously, Eurich and colleagues find a negative correlation between self-awareness, experience, and power – attributes we might otherwise associate with knowledge or wisdom. But it makes sense when you consider the insulating effects of things like a private corner office, or a legion of subordinates more eager to flatter than to speak candidly.

THE VALUE TO PHYSICIAN LEADERS

As professionals who have embraced the ambiguity of dual roles and, at times, conflicting loyalties, physician leaders can particularly benefit from enhanced self-awareness – even in the context of a profession traditionally skeptical of navel-gazing.

"As a surgeon and as a leader, I understand deeply how important being self-aware is. My ability to operate and my ability to lead is rooted in first understanding how I show up and how present I am," says Trey Eubanks, MD, CEO of Le Bonheur Children's Hospital in Memphis.

Physician leaders today face intense pressures – heavy workloads, administrative burdens, and life-or-death decisions – that can tax their empathy. Research shows that without intervention, physician empathy tends to decline over the course of medical training. By the end of residency, many physicians experience "empathy erosion," which, if unaddressed, can carry into their leadership roles. This decline is not without consequence: lower empathy leads to more uncompassionate care, dissatisfied patients, and damaged trust in the physician-patient relationship. Recognizing this problem, experts now emphasize that practicing empathy through greater self-awareness is a skill that can be taught and cultivated rather than a fixed trait.

IMPACT ON TEAM DYNAMICS AND ORGANIZATIONAL OUTCOMES

Self-aware leaders profoundly affect healthcare teams and organizations. Physician leaders set the cultural tone for how staff interact and cope with stress. Leaders who listen and understand their team members' perspectives build psychological safety and trust within teams. Research in physician leadership has shown that bi-directional empathy between leaders and clinicians helps address burnout, creating a sense of connection and mutual support.

In contrast, when leaders lack empathy, team members may feel isolated or undervalued, fueling disengagement and turnover. Interviews with clinician-administrators reveal that a lack of trust and personal connection in leadership leads to frustration, defensiveness, and even dehumanization of colleagues. These dynamics can hurt organizational performance and contribute to staff burnout, higher turnover, and poorer quality care.

DEVELOPING EMPATHY THROUGH GREATER SELF-AWARENESS

We believe that cultivating self-awareness is an essential responsibility of physician leaders. (The American Medical Association agrees, codifying "continuous self-awareness and self-observation" as part of the ethical obligation of competence.) In fact, physicians' perceptions of their work environment and values alignment are strongly tied to their leaders' behaviors, underscoring how a leader's empathy (or lack thereof) sets the tone for team culture. Surveys outside healthcare echo this need: in one study, 61% of employees and 76% of CEOs agreed that empathy is key to organizational success. Taken together, these insights paint a picture of both a challenge and an opportunity — while empathy may be under strain in today's healthcare climate, physician leaders who prioritize it can significantly improve their teams' well-being and performance.

Here, we share a few recommendations for developing self-awareness.

Get some perspective. In our engagements with physician leaders, we usually start with an assessment. The WittKieffer Leadership LIFT assessments, which leverage the Hogan

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Assessment Suite, provide a robust, validated look at personality and motivation. Combined with interpretation by a certified coach and developmental feedback customized to the participant's context, assessment provides (in our opinion) an excellent return on investment to the participant by increasing self-awareness.

Formal assessment isn't the only way to get perspective, however. Remember New York mayor Ed Koch's famous inquiry, "How'm I doing?" Getting the perspective of others can often be as simple as asking that question – but you must be willing to hear the answer. Leadership coach Kristi Hedges proposes an elegantly simple approach: find five people you work with and ask them two questions: "What's the general perception of me?" and "What could I do differently that would have the greatest impact on my success?" When we've recommended this simple experiment to physician leaders, they've told us it has reliably produced both anticipated and unexpected feedback and strengthened relationships as a result.

Ask yourself *what*, not *why*. Eurich and her colleagues have found reflection and introspection can be valuable to developing self-awareness, but many people go about it the wrong way. The natural tendency is to ask yourself "why" you feel a certain way, which can lead to unproductive overthinking, rumination, and assigning blame. A more productive approach can be asking "*What* situations or triggers bother me, and what do they have in common?" This line of questioning lends itself to identifying patterns, which in turn present the opportunity to design interventions and, ultimately, solutions.

CONCLUSION

Cultivating empathy through greater self-awareness is more than a moral nicety in healthcare leadership. It is a practical driver of better outcomes for patients, stronger teams, and healthier organizations. The current landscape shows both concerning trends (empathy under duress amid burnout and training gaps) and hopeful momentum as many physician leaders and institutions work to rebuild this crucial capacity.

Physician leaders can enhance their empathetic leadership by committing to emotional intelligence development, engaging in leadership development and coaching, and adopting daily practices that prioritize understanding others. In doing so, they not only improve the human experience of care for patients and practitioners but also drive their teams and organizations toward greater success in our patient-centered, compassion-demanding era.

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CYBERVITALS: THE SILENT THREAT WITHIN - NAVIGATING SOFTWARE VULNERABILITIES OF MEDICAL IMAGING DEVICES

THE CONVERGENCE OF TECHNOLOGY AND PATIENT CARE

Imagine a bustling hospital, the heart of modern healthcare. Sophisticated medical imaging devices — MRI machines, CT scanners, X-ray machines, and ultrasound systems — are the workhorses of care delivery, providing critical insights for diagnosis and treatment. In 2024, Forescout Technologies highlighted the most vulnerable connected medical devices, with DICOM (Digital Imaging and Communications in Medicine) workstations and PACS (Picture Archiving and Communication System) at the top of the list. For healthcare leaders operating not just in the US but also within the European Union, understanding and mitigating the software vulnerabilities in medical imaging devices isn't just an IT issue; it's a crucial business and patient safety imperative - no matter whether you manage a hospital or are a manufacturer of imaging devices.

THE INTRICATE SOFTWARE ECOSYSTEM OF MEDICAL IMAGING

These imaging devices aren't just hardware; they're complex systems dependent on a web of software components. Think of it as a software stack:

- Operating systems (often older, embedded versions)
- Image acquisition and processing software
- Network communication protocols (DICOM for images, HL7 for orders, patient data, reports, and billing)
- Integration with hospital information systems (HIS) and picture archiving and communication systems (PACS).

This complexity creates challenges. Interoperability issues can lead to security gaps. Maintaining devices' security posture requires reliable patching cadence, but many devices are considered 'legacy' and patches are no longer available. Proprietary software makes independent security audits challenging. For example, a vulnerability in the DICOM communication protocol, as highlighted by researchers from Aplite, could potentially allow unauthorized access to millions of patient images.

WHY IMAGING DEVICES ARE PRIME TARGETS FOR CYBERATTACKS

Why are these devices so vulnerable? Several factors make them prime targets:

- **High-Value Data:** Medical images contain sensitive protected health information (PHI), making them attractive targets for data breaches and ransomware attacks.

- **Critical Infrastructure:** These devices are essential for diagnosis and treatment. Disruptions can have severe consequences for patient care and hospital operations.
- **Interconnectedness:** Integration with hospital networks but also to external referring physicians and specialists expands the attack surface, providing pathways for lateral movement within the system.
- **Lifespan Discrepancy:** Medical devices have long lifespans, while software and cybersecurity threats evolve rapidly, leading to broad and prolonged exposure to vulnerabilities.
- **Computer Likeness:** More so than other medical devices, imaging systems are architecturally closer to regular computers and therefore are exposed to a multitude of viruses and attacks written against standard computer environments but may inadvertently compromise imaging - whether the attack was targeted or not.

THE BUSINESS IMPLICATIONS OF UNSECURED IMAGING DEVICES

To contextualize what this means, the WannaCry ransomware attack on the UK NHS compromised computer systems but also medical devices, such as MRI machines and infusion pumps. There is no evidence that the attack was a targeted event, yet, it resulted in appointment cancellations, delayed diagnoses, and significant financial losses estimated at £92 million in disruption to services and IT upgrades. The identified impact of an insecure device being exploited are:

- **Financial Losses:** Ransomware payments, legal fees, regulatory fines (HIPAA violations in the US, GDPR fines in the EU).
- **Reputational Damage:** Loss of patient trust and negative media coverage, impacting market share and patient acquisition.
- **Operational Disruptions:** Downtime of critical equipment, impacting patient flow and revenue.
- **Patient Safety Risks:** Delayed or incorrect diagnoses due to compromised systems, leading to potential liability and regulatory sanctions.
- **Increased Insurance Premiums:** Higher costs associated with cyber insurance in recognition of elevated risks.

THE REGULATORS STANCE ON CYBERSECURITY: PRIORITIZATION AMIDST RESOURCE CONSTRAINTS

While discussions about resource allocation for regulatory bodies exist, cybersecurity of medical devices remains a high priority for both the FDA and EU lawmakers.

- **FDA:** The FDA has numerous guidance documents emphasizing premarket submissions requiring cybersecurity considerations and postmarket management of vulnerabilities.
- **EU MDR:** The EU MDR (Regulation (EU) 2017/745) explicitly addresses cybersecurity in **Annex I, Chapter III** concerning the information supplied with the device and general safety and performance requirements. It mandates that devices are developed and manufactured according to the state of the art, considering risk management, including information security and protection against unauthorized access. Guidance documents like MDCG 2019-16 provide further detail on fulfilling these requirements. You can find more information on the EU MDR requirements here and here. Both regulatory frameworks emphasize a "security by design" approach and require manufacturers to conduct risk assessments and implement robust security measures throughout the device lifecycle.

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CYBERVITALS: THE SILENT THREAT WITHIN - NAVIGATING SOFTWARE VULNERABILITIES OF MEDICAL IMAGING DEVICES

MITIGATING THE RISKS

As you head into the second half of the year, the following strategies (if executed in 2025) can inform priorities in 2026:

- **Comprehensive Risk Assessments:** Regularly identify and evaluate software vulnerabilities in imaging devices, aligning with both FDA and EU MDR risk management expectations.
- **Robust Patch Management Programs:** Establish processes for timely updates and patching of software, adhering to post-market surveillance requirements in both regions.
- **Network Segmentation:** Isolate medical device networks to limit the impact of breaches, a recommended security practice globally.
- **Strong Access Controls:** Implement multi-factor authentication and role-based access, crucial for compliance with both HIPAA and GDPR.
- **Security Awareness Training:** Educate clinical and IT staff on cybersecurity best practices relevant to both US and EU regulations.
- **Collaboration with Manufacturers:** Engage with vendors to understand their security measures and update schedules, ensuring compliance with both pre-market and post-market requirements.
- **Incident Response Planning:** Develop and test plans to address potential cyberattacks, a critical element for mitigating the impact of breaches under both US and EU frameworks.

Addressing software vulnerabilities in medical imaging devices is critical. Proactive cybersecurity measures are not just an IT concern but a fundamental aspect of quality patient care and sound business management. Healthcare leaders must prioritize cybersecurity investments and foster a culture of security within their organizations.

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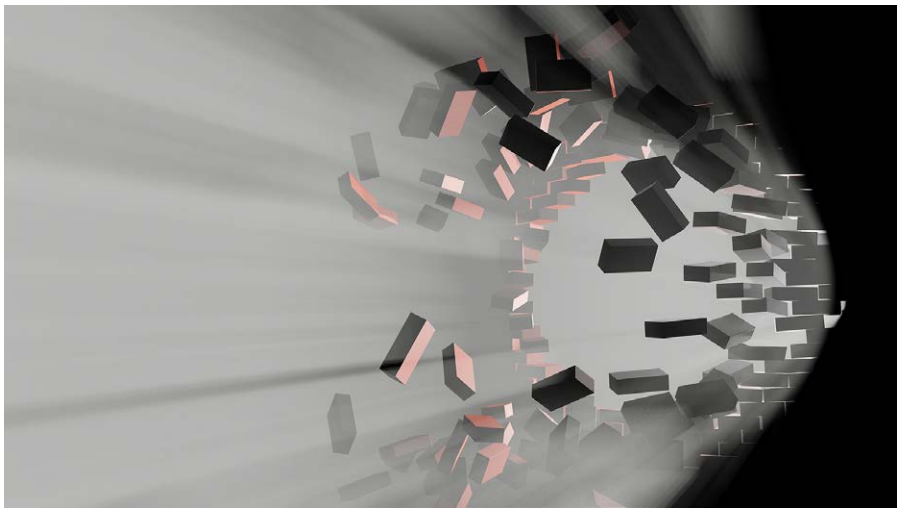
DISRUPTORS – PART 4: MEDICAL DEVICES, PHARMACEUTICALS, AND LIFE SCIENCES

INTRODUCTION



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In this fourth installment of our series on healthcare disruptors, we focus on the intersection of research, science, and clinical practice. We discuss medical devices, pharmaceuticals, and other life sciences because of the impactful positions in the healthcare ecosystem and exponential growth in all these sectors. Disruptors specific to these sectors rely on a diverse network of pathways that allow innovations to first be born from research and then invested in for commercialization. Throughout this article, we contrast and compare startup disruptors with large established life sciences firms (e.g., biopharma, biotech, biomedical, etc.) as they share some of the same facets of their business models; therefore, facing some of the same opportunities and threats. We start with external factors and conclude with some keys to success to consider.

EXTERNAL FACTORS

In the current environment, a wide range of investments being made in startups (often disruptors) are now facing many evolving external factors. These include changing priorities within Health and Human Services Administration (HHS) and Centers for Medicare and Medicaid Services (CMS) that could impact funding for development activities on a moment's notice, as well as ensuring sufficient reimbursement levels critical for long-term sustainability in the market. These unpredictable factors influence the reliability of future-focused business plans. Disruptors may face increasing pressure from stakeholders (such as investors and potential customers) during and after both funding and development phases. We look at each of these here:

GENERAL THREATS TO RESEARCH AND INNOVATION DUE TO FUNDING CUTS

The historical course of development often included external funding from third parties; a mix of government-funded (the predominant source) and/or sponsored research, coupled with private investment, to reach commercialization. Large companies would (and still do) invest in their own research and development activities, whereas disruptors braid together various funding sources to be able to bring a disruptive innovation to market. In recent times, anticipated or actual reductions in government funding for research pose a great risk to initial stages of a disruptor's path to connecting innovation with commercially viable offerings because of the dependence upon the success of early-stage research (i.e., bench research). Promising results in early development may not be realized (and therefore may not attract investors if grants are cancelled or not awarded at that stage), potentially resulting in disrupting the progress and forcing the research to end altogether. Large and/or more established private firms may be able to react to this impact and cost-shift across a diverse range of offerings/products, whereas a disruptor often brings a single or limited number of offerings forward and therefore may be more vulnerable to upheaval pre-commercialization.

HEALTHCARE REIMBURSEMENT

Once commercialized and sold into the healthcare delivery market, disruptors rely on reimbursement for medical services to pay for and sustain the product. Reimbursement in the U.S. continues to face downward pressure from all parties on the payor side. For those products that are separately reimbursable (e.g., pharmaceuticals), any threat to coverage or reimbursement levels can destroy demand. As an example, GLP-1 class drugs have been prescribed and dispensed with favorable reimbursement by many payors (including Medicare) – generally for all indications, including other than weight loss. Recently, CMS has disallowed coverage for off-label indications for GLP-1s for Medicare recipients. Therefore, patients who were being treated medically for an obesity diagnosis now need to cover their own drug costs, which we believe will lead to significant decreased demand. In some cases, it has also led to a utilization drop off after a few months of treatment. Commercial payors are following this lead by using primary diagnoses to deny coverage. Other classes of drugs face similar pressures. For others, such as wearables or tools used in procedures (e.g., robotics and remote glucose monitoring) the same issue will apply.

PRESSURES FROM INVESTORS AND THIRD PARTIES

Investors and other financial third parties play a crucial role in the lifecycle of healthcare disruptors, because they can often provide the necessary capital to bring innovative solutions to market. However, their expectations and demands can exert significant pressure on these companies even during normal times – not to mention in times of uncertainty like today. Some key factors investors typically consider can include:

- **Return on Investment (ROI):** Investors are primarily focused on potential financial returns. They look for disruptors with scalable business models and ability to generate sustained margin over time. This often means that startups must demonstrate a clear path to commercialization and profitability.
- **Market Potential:** The size and growth potential of the target market are critical success factors. Investors favor disruptors who address large, unmet needs in the healthcare sector. However, the current environment may unpredictably and negatively change demand for innovations in traditional growth areas such as chronic disease management, telehealth, and personalized medicine, due to the external factors already described above.
- **Regulatory Pathway:** Navigating the regulatory landscape is a significant concern. Investors typically prefer companies with a well-defined strategy for obtaining necessary approvals from bodies like the FDA. A clear regulatory pathway reduces uncertainty and accelerates time-to-market. Given the external factors we discussed earlier, investors in certain segments of life sciences may not feel confident that approvals can be attained timely, or even at all.
- **Management Team:** The experience and expertise of the disruptor's management team are crucial for success. Investors look for leadership and management teams with a proven track record in the healthcare industry capable of executing the business plan and adapting to challenges. If the work of the original/founding team is interrupted due to external factors, this reduces the attractiveness of the disruptor overall (e.g., if a founder leaves due to an external factor.)
- **Risk Mitigation:** Investors are wary of risks associated with healthcare innovations, including regulatory hurdles, market adoption, and technological feasibility. Disruptors seeking external partners must present a comprehensive risk management plan to anticipate and address these concerns. In fact, they may need to get through this period of uncertainty before a reasonable risk mitigation plan can be adopted.

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DISRUPTORS – PART 4: MEDICAL DEVICES, PHARMACEUTICALS, AND LIFE SCIENCES

KEYS FOR SUCCESS

There are a few ways to still navigate toward success as a life sciences disruptor in uncertain times. A few potential keys for success could include:

- For organizations currently aligned with funders, partnering more closely to increase any investment and/or involvement that offsets the drop in funding that may have been cut or reduced from the public sector. These kinds of tactics are often coupled with a stronger business case, except with philanthropic funding sources. Consider some ways to mitigate the uncertainty we have outlined in this article as part of a recast business case.
- External pressure on reimbursement from payors such as Medicare can be offset in the market by buyers realizing efficiencies or transformations in other parts of the delivery system. For example, as reimbursement drops for office-based procedures as contemplated by the current Medicare Provider Fee Schedule (MPFS), a disruptor selling to office-based providers must highlight any cost savings and/or efficiencies their product offers.
- Pressures from investors and third parties may be addressed in a few ways. First, pushing for alignment across investor portfolios may result in economies of scale to address external threats. Consider agreeing to consolidate administrative services (e.g., Human Resources, Information Technology, etc.). Consolidating services may produce savings without negatively impacting the costs associated with commercialization of the innovation itself, as those savings accrue to the investor and allow continued focus on getting products to market.

CONCLUSION

In conclusion, we have covered how disruptors are individuals and/or organizations aiming to transform parts of the healthcare ecosystem through some transformation and/or innovation.

In our next article, we will focus on healthcare payment systems and how disruptors in that space are focused on changing the status quo of medical/healthcare economics in general and reimbursement.

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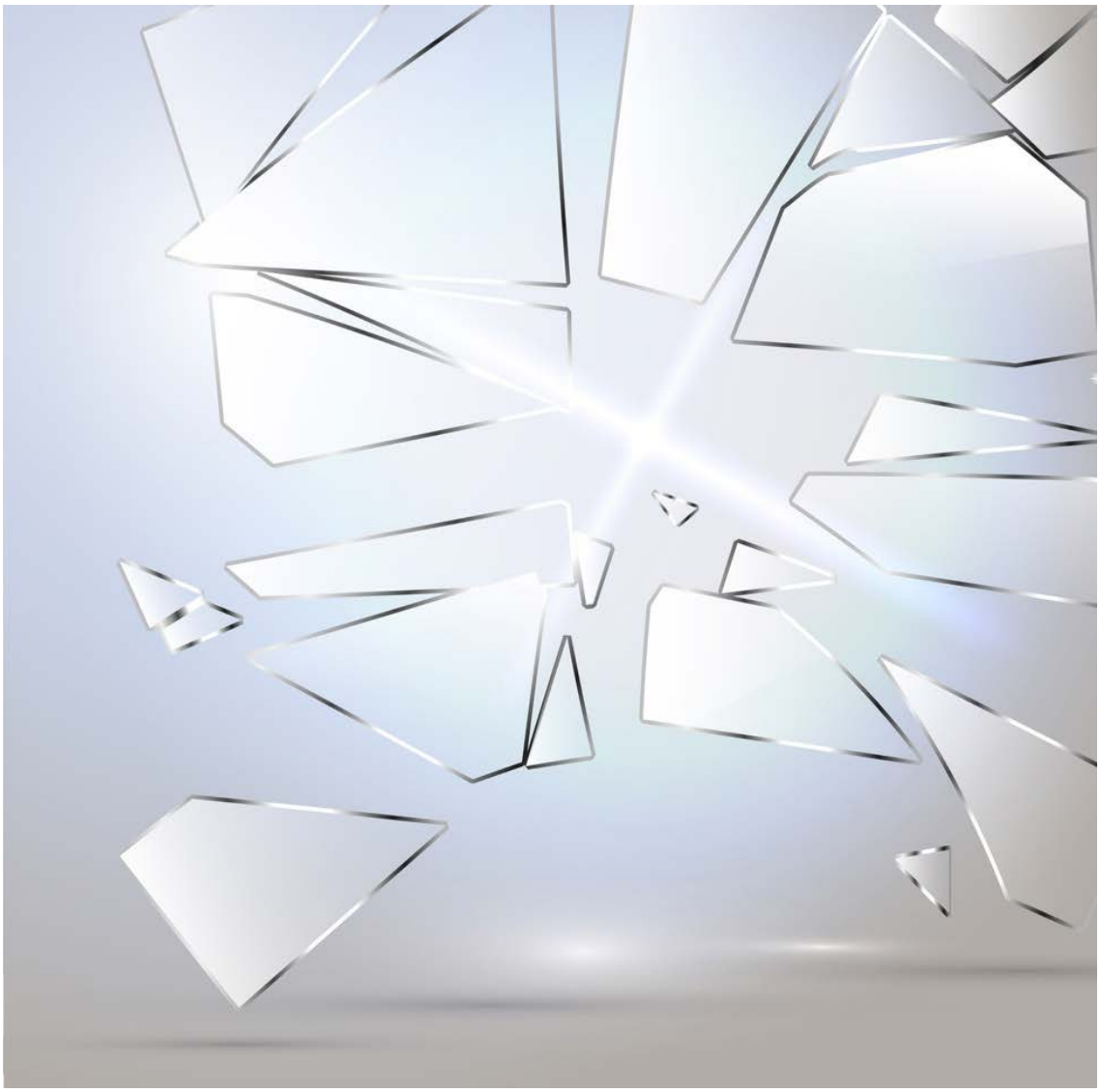

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BIOTECH AND BIOMEDICAL FAILURE: IT'S NOT THE SCIENCE – PART 3

WHAT WILL IT TAKE TO TACKLE THE 90%?

We began Part 1 of this article with our fundamental premise: that

- The biotech and biopharmaceutical (biomedical) industries are failing us, medically and economically, addressing barely 10% of the solutions and preventatives for known diseases,
- We have the science to serve us better, and
- We only need the right market participants in order to deliver greater coverage, access, and outcomes to begin to tackle the 90% of known diseases causing human suffering across the globe.

The Ninety-Ten Institute

In Part 2, we laid out our Theory of Change for this dire picture: if we build a new biomedical industry, focused first and foremost on health and funded by mission-aligned impact investors, we will sustainably produce affordable medicines to serve the people affected by that 90% gap.

Here we offer a blueprint for putting this theory into practice, as well as a nod to a likely category of stewards who may carry it forward along with us.

MISSION-ALIGNED CAPITAL IN AN EXAMPLE MEDICAL IMPACT FUND

To make the picture of Biotech Financing V2.0 visible, we offer one example of how impact-oriented funding sources can participate in this next generation of biotech investing. In this example, wealthy individuals, donor-advised funds (DAFs), private foundations, government treasuries, and impact investors can impactfully use their 'benevolent assets', ***collectively and at-scale, as mission capital*** for fueling the Biotech v2.0 industry. Such aggregation and professionally managed funding can deliver appropriate risk/return generated from affordable and equitably accessible medicines.

Medical Impact Funds are designed to reduce the cost of capital for biotech/pharma companies across their business life cycles. The key element for this new generation of biotech funds is a governance structure that is aligned to appropriate financial incentives for the limited partners (LPs) and Managing Partners in order to deliver the highest possible medical impact.

Figure 2 below shows a simplified structure chart for a "stacked deck" fund. The key aspect of a stacked deck fund is that certain investors serve as first-loss capital or provide concessionary capital through another mechanism. The added security can de-risk the investment for other investors, unlocking capital for riskier investments or investments where a lower return is expected.

This general fund structure is intended to bring investment capital into alignment with the capital requirements of companies in Biotech v2.0:

- Scale of capital suitable for biomedical products
- Reduced risk/reward balance
- Duration of investment
- Flexibility re debt vs equity

- Mission 'lock' to align investor interests to company interests = health outcomes
- Alignment of financial rewards for LPs, Fund managers and investee companies

Sponsor: Governance is modeled here to be organized by a Fund Sponsor, which could be an existing management firm, a nonprofit 501(c)(3) entity, or a Public Benefit Corporation (PBC). The Sponsor would provide 'mission lock' by having a 'golden share'[1] position in the Manager or appropriate governance mechanics could lock in guideposts for how investments and returns are managed by the Manager.

Management Company and General Partners: A Management Company provides the investment management services to the Fund. The Fund, through General Partners, will make investments into portfolio companies. While limited partnerships are the most common vehicle for organizing US funds, it can also be organized an LLC or a Public Benefit LLC ("PBLLC"). If organized as a PBLLC or LLC, there is less of a need for separate GP and Management Company entities. The Management Company will manage the fund's investments pursuant to an investment management agreement, and the fund may be charged a fee for such services. The Fund can be limited in duration or evergreen/permanent.[2]

GPs are otherwise compensated and incentivized by earning 'carry'[3] a percentage of total profits of the Fund's returns. Since Medical Impact Funds are intended to reduce the capital costs for investees, each of the participants in the investment flow need to be aligned to reduced costs of Fund administration, including the GP. Carry may, for example, be tied to the achievement of the fund's impact goals, e.g., the general partner (or its members) will not receive all or a portion of the carry if the fund fails to achieve its impact goals. The carry can also be recycled into new investments or new funds. If the Fund Sponsor is not a charitable organization, for mission lock purposes, the General Partner and Sponsor could consider including a non-profit as a member of the GP.

The Fund takes in capital from concessionary investors who provide guarantee of 'first loss' in order to facilitate investment from investors seeking market returns. Note this scheme assumes the first loss capital will invest as an LP and will serve as the first loss capital by sitting at the bottom of the waterfall[4]. For example, the governing documents can provide that the "market LPs" receive their capital back and some set preferred return prior to the first loss capital receiving its money back. As an alternative, the first-loss capital could provide a guarantee or other de-risking measures. We think federal or state funding programs could be well suited to serving in this role. In any event, concessionary investors will typically require the fund to produce robust impact metrics and reporting, especially if they are foundations making Program Related Investments.

Investors seeking market-rate returns who, by virtue of their position in the waterfall, have their investment de-risked by the presence of the first loss capital. Note that this simplified structure chart assumes two classes of LPs (first loss and market), but variations are possible. For example, there could be multiple classes of "market" LPs, with varying levels of seniority in the waterfall and shares in the fund's upside. Additionally, there could be concessionary LPs who expect their capital back plus below market rate of return, thus balancing the combined rate of return.

INCORPORATE MORE WOMEN INTO LEADERSHIP OF BIOTECH FINANCING V2.0

It may surprise you to learn that often the best stewards for this kind of ownership are women. No, we're not arguing to take down the patriarchy or to exclude the millions of others who operate in this space. The simple fact is women are the new face of wealth, the new force in business and asset ownership, and their (our) presence is only growing.

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BIOTECH AND BIOMEDICAL FAILURE: IT'S NOT THE SCIENCE – PART 3

Today, women control more than $10 trillion (about 33%) of total U.S. household financial assets, and research by McKinsey found that in the United States that percentage will rise to more than 67% by 2030. Women are also the largest beneficiaries of the current transfer of wealth, living an average of five years longer than men. As a consequence, an unprecedented amount of assets will likely shift into the hands of U.S. women over the next three to five years, representing an estimated $30 trillion by the end of the decade.

Moreover, women are more likely to invest in ventures that have positive impacts on society and the environment and more likely to consider and seek to influence collective outcomes. Triple Pundit offers some clear markers from two of the most influential leaders in the space for why this is the case. As Jackie VanderBrug of U.S. Trust has said, "Women have a more holistic view of investment. Yes, they do care about returns, but they also care about the role of their investments in society."

They're doing so by exercising their asset agency outside of their retirement accounts: according to Fidelity, as of 2021, 67% of women invest outside of their retirement accounts, up from 44% only five years ago. They do so when they control the investment reins in private equity and in other investment institutions. And they certainly do so in philanthropy and government roles. The Case Foundation produced a thorough accounting of the extensive influence of women in these arenas almost a decade ago – so you can imagine what the picture would look like today.

CONCLUSION:
BIOMEDICAL FINANCING V2.0 + THE POWER OF WOMEN = BIOMEDICAL INDUSTRY V2.0

Heartbreaking articles in the press regularly appear these days about better drug options being sidelined until every last dollar of profit is extracted from the existing, protected patents; about therapies being ignored in favor of more profitable (and yet less effective) options; and about exorbitant drug prices being charged simply because they can be. We must begin to shift the dialogue from big corporates to individuals, shift the balance from profits to patients. And we can: there is purpose-driven capital in the hands of people who care about others, who want to see a different result. Whether via a stacked-deck fund such as the one we've posited here, or another structure that equally empowers mission-aligned asset owners and utilizes efficient development and manufacturing processes, we can manifest a sustainable, equitably accessible, and medically effective biomedical system that works for all. We expect our example will raise many questions and perhaps some doubts. We also hope it will spark many more ideas and ignite action from a variety of sources.

The 90% gap in diagnostics, drugs, and preventatives is not getting any smaller. We can no longer wait for others to build the shelter while the world is deluged by the tsunami of healthcare demands. The need is urgent, and the time is now. Join us in creating Biomedical Industry v2.0!

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1. Golden share is a type of share that gives its shareholder veto power over changes to the company's charter. It holds special voting rights, giving its holder the ability to block another shareholder from taking more than a ratio of ordinary shares.
2. See upcoming Fund structures from The 90~10 Institute
3. Carried interest is a share of profits from a private equity, venture capital, or hedge fund paid as incentive compensation to the fund's general partner.
4. A distribution waterfall is a way to allocate investment returns or capital gains among participants of a group or pooled investment. Commonly associated with private equity funds, the distribution waterfall defines the pecking order in which distributions are allocated to limited and general partners.

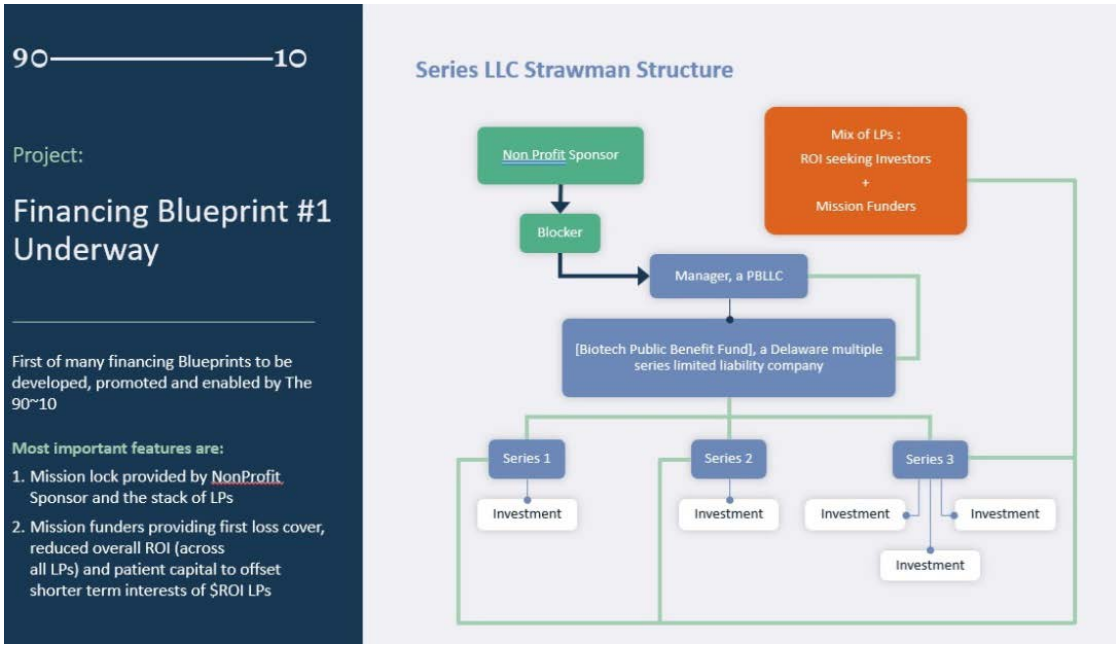

Figure 2

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THE PLAY PRESCRIPTION: HOW GAMIFICATION CAN IMPROVE HEALTH OUTCOMES AND TEAM MORALE

Healthcare systems grappling with burnout, turnover, and overwhelming stress often overlook one powerful solution — play — because it sounds too silly or simple.

But play isn't fluff. It's functional. It's human. When used intentionally through gamification and joyful engagement, it can transform how patients heal, teams perform, and organizations thrive.

As someone who helps professionals use humor, gamification, and storytelling to fuel performance and connection, I've seen how the science of play isn't just for kids. It's for clinicians, patients, caregivers, and leaders trying to stay sane in a system that's often anything but.

Let's examine how "the play prescription" can be applied to patient care and team morale and why this joyful little disruptor might be one of the most underrated tools in healthcare today.

FOR PATIENTS: FROM COMPLIANCE TO CURIOSITY

Patient adherence is a persistent challenge. Whether it's finishing a round of antibiotics or sticking to a long-term health plan, patients often struggle to stay consistent. But what if we gave them a game instead of sending someone home with a thick packet of instructions and a stern lecture?

Gamification, using game-like elements in non-game settings, has shown promising results in helping patients stay engaged with treatment plans. Whether it's a blood pressure tracking app that rewards consistency with badges or a medication reminder that turns dosage tracking into a streak-based challenge, these tools tap into intrinsic motivation.

They don't necessarily make health tasks easier, but they make them more doable, visible, and human.

And that visibility matters. It transforms "homework" into progress. It gives patients feedback loops and a sense of control. It makes the invisible visible. In some programs, it even introduces friendly competition among patients managing the same condition, creating supportive social accountability instead of shame.

Importantly, not everyone will respond to the same tactics. That's why gamification must be done thoughtfully. However, combining behavioral science with storytelling and user-centered design can spark curiosity instead of compliance fatigue. That's powerful. It's the difference between "you have to" and "you get to."

FOR TEAMS: PLAY AS A CURE FOR BURNOUT

Now, let's talk about the people behind the scrubs.

Healthcare professionals are running on fumes. Post-pandemic exhaustion hasn't magically disappeared, and systemic pressures continue to mount. We've got staff shortages, emotional trauma, and a never-ending pile of protocols. And while play alone won't fix an overloaded system, it can act as a pressure release valve and a culture reset button.

In workshops I've led, we've brought simple, low-lift challenges into clinical environments like gratitude games that highlight peer recognition, creative problem-solving sprints for care teams, and improv-based communication drills to boost listening and adaptability. These aren't distractions. They're reconnection tools.

Each activity is chosen for its evidence-based impact on collaboration, morale, and cognitive flexibility. For example, improv games encourage active listening and quick thinking, skills critical in fast-paced clinical settings. Gratitude games help staff shift focus from exhaustion to appreciation, boosting mood and peer connection.

The most common and telling feedback? "I didn't know how much I needed that laugh." It may not surprise me, but it consistently surprises them. That release, that moment of lightness, reminds people what it feels like to breathe again.

When people laugh together, they collaborate better. When they compete in low-stakes, high-fun formats, they learn faster. When they feel safe enough to be silly, they feel safe enough to be human.

And that matters. Psychological safety isn't some HR buzzword; it's the foundation of innovation, trust, and long-term retention. Play invites that safety. It lets people take risks without fear. It sparks new ideas. It brings a sense of lightness into even the heaviest environments.

In a field where morale is dangerously low, that joy isn't optional — it's essential.

PLAY ≠ FLUFF. IT'S BRAIN SCIENCE.

Let's get one thing clear: play isn't "extra." It's biological.

Recent neuroscience research shows that play activates brain regions involved in executive function, emotional regulation, and memory. It improves cognitive flexibility, enhances problem-solving, lowers cortisol levels, and stimulates creativity through divergent thinking (Heal with CFTE, 2023; Dietrich & Kanso, 2010).

In other words, play helps us do our jobs better.

It's not about turning the ER into a circus. It's about making space for humanity in the middle of high-stakes work. It's about leveraging joy, curiosity, and connection as tools for healing — not just for patients but also for providers.

HOW TO WRITE A PLAY PRESCRIPTION (NO GAME DESIGN DEGREE REQUIRED)

How do we start? You don't need a PlayStation, a party hat, or a PhD in game theory to bring more play into your healthcare setting. Here are a few simple ways leaders and team members can start applying gamified thinking today:

- **Micro-goals, macro-momentum:** Break big, daunting goals into visible, trackable mini milestones. Celebrate progress early and often.
- **Create playful rituals:** A "win of the week" bell, a team trivia challenge, or rotating recognition roles can infuse levity without disrupting workflow.

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THE PLAY PRESCRIPTION: HOW GAMIFICATION CAN IMPROVE HEALTH OUTCOMES AND TEAM MORALE

- **Reward effort, not just outcome:** Leaderboards are fun, but they work best when they highlight effort, improvement, or team collaboration instead of just "winning."
- **Use story:** Frame tasks within a story arc. Who's the hero? What's the quest? The story makes purpose stick.

Please keep it simple: Play doesn't have to be complex to be effective. A little bit goes a long way.

Keep in mind that not everyone will be into it at first. That's okay. Start small. Make it optional. Let people opt-in at their own pace. We're not aiming to force fun. The goal is authentic engagement.

THE BOTTOM LINE

In a world where burnout is real and resilience is rare, **the ability to spark curiosity, joy, and connection isn't a soft skill. It's a leadership strategy**.

Play isn't a break from the serious work. It's what makes the serious work sustainable.

It builds relationships. It builds trust. It builds cultures that people want to be a part of.

Maybe it's time we all started writing more play prescriptions — no co-pay required.

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Source: Bigstock

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ALIGNING CLINICAL STRATEGY, OPERATIONS, AND REAL ESTATE FOR EFFICIENT HEALTHCARE PORTFOLIO'S - PART 1

INTRODUCTION

According to the CMS (Centers for Medicare and Medicaid Services), U.S. healthcare spending increased to almost $5 trillion or 17.6% of the GDP in which year? and is expected to reach almost 20% by 2032. With rising healthcare costs, an aging population, increased demand for healthcare services, and enhancements in technology, there is enormous pressure to deliver high-quality care while optimizing efficiency and managing costs. Most health systems operate on a very slim margin (1% - 3%, with many at barely breakeven) leaving minimal room for error. Rising labor and contract staffing costs, along with lower reimbursement from payers for outpatient and value-based care, the volume of which is increasing, have left very few places to turn.

CREATING EFFICIENCIES

In a digitized world, everything naturally moves towards a focus on efficiency. With endless amounts of data and the ability to track metrics for large medical groups and health systems, there are countless opportunities to enhance clinical throughput, streamline operations with more efficient utilization, reduce costs, and mitigate risks that optimize cost structures when looking strategically. This never ending need to optimize, with enhanced data at your fingertips, is why the healthcare market has continued its consolidation from local regionalized service to a growing expansive reach that is supposed to benefit from a larger provider pool, better insurance rates, and network efficiency.

THE ISSUE

One of the biggest challenges facing medical groups and hospitals is their lack of vertical integration via a centralized decision-making process or top-down approach leading to inconsistent, non-seamless communication between the divisions. When

running a physician network with onsite long-term care facilities and offsite ambulatory locations with hundreds to thousands of physicians and 30- to 1,000-plus locations, this can become problematic. Strategy is created at the top, often with consultants that no one outside of the C-Suite has even met, and operations are mostly handled from the middle of the organization. An organization's real estate, which is an integral part of the strategy, too often becomes an afterthought, even though it makes up a large percentage of expenses while enhancing the experience for their patients. It also helps retain talent and provides them the opportunity to create revenue. The lack of a real estate strategy can lead to delayed responses, timely errors, inefficient utilization, additional costs, and unhappy stakeholders.

THE SOLUTION

In order to align clinical strategies, operations, and real estate, seamless integration of data, along with all key stake holders including nurses, operations, and real estate personnel, is needed. Understanding the current situation in conjunction with a strategic master plan that has stated short-, medium- and long-term goals, along with progress metric tracking, is vital. How can you make effective long-term decisions without all the pertinent data and input from all key stakeholders that lead to the optimal strategy for your real estate?

HEALTHCARE DATA + MEDICAL MARKET EXPERTISE LEADS TO STRATEGIES

ACQUIRING THE DATA

Having a complete data set starts with knowing that you need all the data and where it comes from. It is not solely healthcare throughput or payor mix as it relates to medical visits, but a complete set of operations and utilization metrics that relate to all three areas with how they seamlessly work together to create opportunities for additional revenue generation, enhanced utilization, streamlined operations, reduced costs, and mitigated risks.

Here are the areas that should be tracked:

Healthcare Data

- Clinical throughput
- Revenue expectations
- Payor Mix – NPI & CMS
- Competition

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- Operating Costs
- Facility Costs
- Utilization / RVU's PSF

Medical Market Expertise

- Current medical practices in the market
- Changes in the medical market
- Clinical opportunities for acquisition
- Viable medical buildings in the market
- Costs of operating in the market
- Complete understanding of metrics per exam room, physician etc.

IMPLEMENTING THE STRATEGY

Once there is a complete understanding of the healthcare data and the landscape, you are in a position to effectively come up with portfolio strategies in the areas of:

- Clinical Strategy – Opportunities in the market for growth or consolidation
- Strategic Site Selection – Optimal locations based upon clinical strategy
- Competition – Competitor analysis to identify opportunity or saturation

Here is an example of how we effectively utilize healthcare data, comprising payor mix, demographics, and changes in the market, along with specialty demand to determine areas of need or saturation for each market over a 3-, 5- or 10-year period that assists in creating a KPI positive clinical strategy for outpatient portfolio locations:

Stay tuned for parts 2 and part 3 of the series on utilizing the data, market expertise, and strategy to streamline operations, enhance utilization, and optimize your medical real estate!

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5 WAYS TO TAP INTO EMPLOYEE PASSION TO DRIVE STRATEGIC SUCCESS

A truly winning strategy takes more than just crafting a compelling plan. It needs employee buy-in to execute it effectively. Unfortunately, strategic plans often fail because employees don't feel inspired or connected to the direction chosen by organizational leadership. As practitioners of strategic planning in complex organizations, we have observed ways in which organizations can and must account for the "professional passion" of their employees to develop effective strategies.

We use "professional passion" to refer to the intrinsic motivation that many workers with deeply held values and priorities about their work bring to their jobs. It goes above and beyond the expectations of their job descriptions. We see it often among members of well-defined professions such as medicine and architecture, as well as among those whose career choices have been driven by commitment to a particular purpose such as combatting climate change or advancing social justice. It can lead workers to put in extra effort. It can also cause them to ignore the priorities of their organization, particularly when they are skeptical or unconvinced in the mission, and to look instead to their own professional values for guidance.

In organizations dominated by passionate workers, successful strategy formulation requires a blending of traditional planning approaches with appreciation for the intrinsic motivations of the workforce. Strategy development in these settings requires leaders to navigate the often-competing commitments and priorities of their teams and their organizational realities. We propose five key steps for leaders to unlock the full potential of passion-driven strategies.

STEP 1: DISCOVER EXISTING COMMITMENTS

The first step for leaders is to delve into the existing commitments of the key influencers in the workforce. In complex organizations, departments and teams frequently have their own local strategies. These can involve multi-year commitments to internal and external partners and significant investments. For example, a church-sponsored program to provide food and clothing to the homeless grew over time based on the passionate commitment of the rector and a core group of volunteers. As the costs of the program grew, church leaders sought to limit the scope of the program, causing tension not only within the congregation, but with other community groups that had come to rely on the church's services. To resolve the issue, the church established a 501(c)3 and began a fundraising campaign to support the program.

Enterprise leaders need to take these existing commitments into consideration and understand the extent to which they have the power to shape or change them. We've seen leaders both over- and underestimate their ability to make a change, leading to suboptimal strategies and ineffective execution. It's worth investing the time to understand what is really at stake for all involved in making a change and craft the strategy accordingly.

STEP 2: CRAFT A DISTINCTIVE NARRATIVE

Connect people's professional passion to the organizational strategy by articulating what makes this organization distinctive. Your people are already committed to the work, in a general sense. Look for ways to engage them with what makes their work **in this organization** particularly impactful. Once you've got some critical elements of the narrative clear, use storytelling to bring it to life.

We often see successful organizations craft these narratives around combining unique capabilities and expertise in one place. For example, a healthcare organization responded to the emerging opportunity to use AI to support decision making by creating a centralized team that included data analytics, data science, IT, and information services. The narrative about bringing resources together to use AI to improve patient care inspired many employees to renew their commitment to the organization.

In developing the narrative, start out describing your distinctiveness as boldly and ambitiously as you can. You might even be deliberately provocative to stimulate some reflections on why your organization is unique. We've noticed that strategic plans tend to evolve toward the industry mean over many iterations. Starting out with something that is deliberately different can lead to both a better plan and a more committed workforce.

STEP 3: LOOK FOR WAYS TO ADDRESS MOTIVATION

While many people come to their jobs with a strong sense of commitment and motivation to do the right thing, their drive isn't limitless. Workers will put up with many things they don't like and still pour their heart and soul into the work if it feeds their sense of purpose. At some point though, their passion will start to drain away if they feel unable to do the work that gives them purpose or it makes up too small a part of their day.

When resources are constrained and priorities compete, it can be hard to find a way to address everyone's passions. Look for ways to incorporate concepts into your strategy that will matter to your people, particularly where organizational priorities might otherwise feel less compelling. We've seen leaders skillfully use decisions to limit investment in key areas to give team members in those areas permission to challenge established practices and critical assumptions so they can develop more innovative approaches. In healthcare, for example, caregivers have used resource constraints to drive expansion of telemedicine and other approaches to remote care that can also be more convenient for patients.

STEP 4: BALANCE CLARITY AND FLEXIBILITY

Effective strategy development requires striking a delicate balance between clarity and flexibility. Providing clear direction is essential, particularly in those areas where you are making a distinct choice between alternative paths. Passionate people are likely to interpret vagueness as support for their preferred programs and activities. Where those preferred activities aren't aligned with your strategy, make a clear statement and set boundaries, but encourage dialogue. The best plans allow some room for autonomy and innovation. You want your people to be able to use their passion and creativity to enhance your strategy in ways you might not have thought of already. Finding the right balance empowers individuals to contribute their unique perspectives and talents while staying aligned with the organization's broader vision.

STEP 5: FOSTER CONTINUOUS DIALOGUE AND EXPECT TO NEGOTIATE

As you move toward strategy execution, there is no substitute for conversation. Passionate people will push for the ideas, programs, and services they believe in. To keep benefitting from the upsides of their passion, you have to engage with them. Expect to negotiate -- frequently. The leaders who are most effective in executing strategy prepare for those negotiations by distinguishing what is really important from what is nice to have, and they allow for some flexibility and compromise. They also recognize that people may know more than they do, and approaching those conversations with curiosity can lead them to better outcomes than those they might have arrived at their own.

We see this negotiation approach frequently in academic institutions where faculty have invested years researching questions they believe to be important and impactful in their fields. These experts cannot simply change direction and take up a new field of study. The role of the chair in these settings is to navigate and negotiate a path that aligns the priorities of the institution to the expertise and passion of the faculty. The most successful chairs understand this type of negotiation is a core part, perhaps **the** core part of their roles.

If you do not engage in dialogue and you are not prepared to be flexible, you will not only execute inconsistently, but you will miss all the opportunities to harness their passion to drive your strategy forward.

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THE VOICE YOU CAN'T AFFORD TO IGNORE: WHY HEALTH SYSTEMS LOSE PATIENTS

What do patients really want from healthcare? It's not always a cure. More often, **it's to be heard**.

As host of "The Desperate for a Diagnosis Podcast" and a longtime healthcare qualitative market research moderator, I've interviewed hundreds of patients, many of them women and members of marginalized communities. These patients are not leaving health systems because of poor outcomes. They are leaving when they feel dismissed, invalidated, and emotionally abandoned by the very professionals meant to help them heal, an experience known as medical gaslighting.

"Medical gaslighting" can be defined as "…an act that invalidates a patient's genuine clinical concern without proper medical evaluation, because of physician ignorance, implicit bias, or medical paternalism… Ultimately, most of the undesirable gaslighting behaviors are driven by systemic constructs and biases."[1]

Let's be clear… not all physicians approach their patients this way, nor is it intended by most. However, patients only know how they feel after these seemingly dismissive encounters, feeling unheard and leaving with unanswered questions.

HOW PATIENTS VIEW MEDICAL GASLIGHTING

Patient guests on the podcast describe medical gaslighting in many ways. There are a few common behaviors they have suffered during their provider interactions:

- Dismissing or downplaying symptoms; "blowing" off symptoms
- Failing to engage in conversation
- Attributing symptoms to stress, menopause, obesity, or the menstrual cycle
- Insisting symptoms are psychosomatic
- Telling patients there are no other options

A 2022 University of Illinois study by Communication Professor Charee Thompson and graduate student Sara Babu found that women with chronic health issues like endometriosis, Crohn's disease, MS, or anxiety often left medical visits feeling unheard. The emotional toll led many to doubt themselves, worsening both their physical and mental health.

The study found "The women's experiences reflect a form of implicit bias, discrimination and disempowerment that women have faced for centuries."[2]

Being told "your tests are normal" when symptoms persist and no other options are made available or suggested can be defeating and deflating for patients, leading to nothing but the "revolving door" of healthcare. One podcast guest was told after seeing multiple physicians that her symptoms were psychological (and documented as such in the chart), only to later be diagnosed with POTS (Postural Orthostatic Tachycardia Syndrome). Even after her diagnosis, she is still traveling hours for care

that may not fully address her condition. Her story, first shared in 2023, highlights how long patients can suffer without proper validation or treatment, if not longer.

Another guest experienced vague, escalating symptoms and was repeatedly told, "You're just getting older" or "It's stress." After seeing five specialists and waiting eight months to get into a lupus clinic, she finally received diagnoses of lupus and Sjogren's syndrome.

"I felt like if I hadn't been an advocate for myself, I'd still be back where I started feeling terrible and not knowing why."

SILENCE HAS A COST BUT LISTENING BUILDS LOYALTY

Patients who feel dismissed do not disappear quietly. They talk to friends. They leave reviews. They share their stories. These stories spread and influence how others choose their care.

Healthcare organizations spend millions on technology and marketing, but retaining patients may depend on something far simpler: whether people feel seen and heard.

Dismissiveness is not just a matter of hurt feelings. It delays diagnoses, increases the cost of care for both patient and the system, reduces the likelihood of treatment adherence, Other times these alternative therapies are bogus and those "providers" are merely taking advantage of patients' desperation for treatment or at least relief.

In a competitive healthcare market, keeping patients is not only about patient satisfaction scores, clinical quality, revenue, or reputation. It is also about the emotional experience. Patients who receive compassionate care often describe it as life-changing.

"He really listened. It wasn't just about the symptoms, but how I felt about everything happening to me."

Compassionate care should be the norm, not a pleasant but shocking surprise. For a health system CFO, compassion is more than kindness and a potentially healing relationship. It is strategic.

REDEFINING HEALING AND THE ROLE OF EMPATHY

One physician guest explained medical gaslighting is often rooted in systemic issues. These include time pressure, implicit bias, and an overreliance on objective data. It is not always personal, but the damage to patients is very real. Speaking from one physician's point of view, ***"If someone comes in and you don't take what they're saying seriously, then that's the first strike. And for many people, it's the last."***

She added: ***"There are disparities in how people are treated. There's this underlying belief in some corners of medicine that certain people exaggerate symptoms. And that's incredibly dangerous."***

From this physician's perspective, real listening could transform care: ***"If we really listened the first time, we'd avoid so much harm, misdiagnosis, and unnecessary cost…We've been trained to be so focused on the body part, the lab, the scan — but we forget there's a person attached to all of that."***

Health systems are not losing loyalty (or not gaining it I the first place) because of clinical outcomes alone. They are losing patients due to emotional neglect. While clinicians face burnout, technological demands, and time constraints, patients are not aware of those pressures. They only experience rushed and disconnected interactions.

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THE VOICE YOU CAN'T AFFORD TO IGNORE: WHY HEALTH SYSTEMS LOSE PATIENTS

A young Gen Z patient guest suffered for years with severe pain and frequent joint dislocations. Her symptoms were dismissed as psychological until she was finally diagnosed with Ehlers-Danlos Syndrome (EDS). Describing an Emergency Department encounter, she explained, "***I've been in the hospital screaming in pain, and a nurse told me, 'You're being too loud — we're trying to send you home.' An hour later, I was in emergency surgery."***

To win patients back, healthcare leaders need to place value on connection as much as they do on efficiency. That includes:

- Training clinicians in active listening and empathic communication
- Revising metrics to include the quality of interaction, not just speed and number of patients seen (and ultimately lost) in a day
- Validating patients' feelings and acknowledging their frustration and suffering, especially when the diagnosis is unclear
- Collecting feedback about emotional experience, not just clinical results

"DR. GOOGLE" IS NOT THE ENEMY

Part of the medical gaslighting scenario patients describe is that clinicians often react with frustration when patients bring internet research into the exam room. But most patients do this not to challenge the doctor, but because they feel desperate to find answers and consider doing so as self-advocacy.

Rather than push back, providers can reframe their thinking and and respond differently:

- "Tell me what you found."
- "Let's walk through that together."
- "Here are some reliable resources."

This creates trust and shows patients they are being taken seriously.

THE BOTTOMLINE

Health systems, and their clinicians, do not lose patients because they cannot find a diagnosis quickly enough. They lose them when patients feel they are treated as if they are not worth diagnosing at all. Patients are not expecting perfection. They are asking for compassion, understanding, and a caring partnership.

My advice to patients… never give up and keep pushing for answers!

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STRATEGIC MEN'S ENGAGEMENT: DISRUPTING THE QUIET CRISIS IN ORGANIZATIONAL SYSTEMS

Beneath the surface of today's organizations lies a quiet crisis, one rarely named but deeply felt. Across sectors like healthcare, technology, law enforcement, finance, and energy, many men are silently struggling.

This struggle is not just personal. It is systemic. It affects leadership, workplace culture, team resilience, and overall performance. As institutions work to retain talent, drive innovation, and build inclusive cultures, the disconnection among men remains an untapped lever for transformation.

Strategic men's engagement starts with invitation, not expectation. It creates space for men to reflect without judgment or agenda, trusting what emerges. When men explore what lies beneath the protective layers shaped by culture, upbringing, and silent expectations, they often reconnect with purpose, relational integrity, and emotional clarity.

From that inner shift, leadership deepens and strengthens teams and systems from within.

It is time for a new conversation. Not about fixing men, who are not broken, but about addressing the wounds left by broken systems. Strategic engagement strengthens resilience, adaptability, and connection so men can help lead organizations into the future.

THE HIDDEN STRUGGLES BENEATH HIGH PERFORMANCE

On the surface, many male leaders appear successful, meeting metrics, leading teams, and navigating complexity. Yet research points to troubling realities beneath that exterior:

- Men die by suicide nearly four times more often than women in the United States (CDC, 2023).
- Seventy-five percent of men experiencing mental health issues go undiagnosed (APA, 2022).
- In a 2022 Deloitte survey, 59% of men in leadership roles said they often felt pressure to "always be on" and show no weakness at work. (*Deloitte Global, 2022*)
- Fifty-eight percent of men are uncomfortable sharing feelings, even with close friends or colleagues (Movember Foundation, 2022).
- Only 10% of men in male-dominated industries say they feel a strong sense of belonging at work. (*Center for Talent Innovation, 2022*)

- 63% of men report feeling pressure to conform to traditional masculine norms, which they say inhibits authentic connection with others. (*Equimundo, 2022*)

Many men carry silent burdens such as loneliness, shame, and emotional fatigue within systems that rarely invite or equip them to address these struggles. Left unaddressed, these dynamics quietly undermine leadership, innovation, and retention efforts, creating systemic risk and eroding morale from within.

WHY STRATEGIC MEN'S ENGAGEMENT MATTERS TO ORGANIZATIONAL HEALTH

Organizational health is often measured by performance, but its foundation is emotional and relational. In environments where many leaders are men, unaddressed internal struggles often become invisible stressors that quietly erode institutional strength.

When men's struggles go unacknowledged, organizations experience:

- Leadership fatigue masked by stoicism, leading to burnout and impaired judgment
- Disconnection across political, gender, racial, and generational lines
- Resistance to needed change, creating stagnation and disengagement
- Control-based management styles driven by emotional insecurity
- Decreased psychological safety, limiting innovation and honest dialogue

These cultural dynamics don't exist in a vacuum. They also intersect with disparities in advancement, influence, and belonging across race, gender, and class. Strategic men's engagement doesn't deny these systemic inequities. Rather, it creates the conditions for men to reflect more honestly on how their leadership impacts others and how they might lead differently. When men develop the emotional capacity to examine their beliefs and behaviors, they become more effective collaborators and more likely to support cultures of shared power and trust.

Conversely, when organizations engage men with strategic intention, they see tangible gains: higher engagement, better collaboration, stronger decision-making, and trust-based leadership. Supporting the emotional resilience of male leaders isn't ancillary to performance. It is foundational to long-term organizational health.

WHAT STRATEGIC MEN'S ENGAGEMENT LOOKS LIKE

Strategic men's engagement is not about blame or political framing. It's about equipping men to lead from connection, not control, and in doing so, building healthier, more adaptive cultures for everyone.

Key principles include:

- Build resilience by redefining strength to include vulnerability, emotional agility, and compassion
- Create brave spaces where men can explore identity, purpose, and leadership without fear of judgment
- Equip men to navigate change with humility, clarity, and adaptability
- Ground growth in meaningful personal purpose aligned with organizational mission
- Develop men as bridge builders across ideological, generational, and cultural divides
- Expand the definition of leadership and power to unlock and elevate untapped potential across roles, backgrounds, identities, and perspectives

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As men strengthen these capacities, they help expand what leadership looks like. This work complements efforts to elevate diverse leaders by reshaping the cultures they enter. The result is not only broader representation, but deeper transformation.

WHEN MEN ARE GIVEN SPACE, TRANSFORMATION HAPPENS

One example comes from a major U.S. energy utility, where 35 men voluntarily joined a five-session men's circle to explore timely questions: What does it mean to be a man today? How are expectations shifting? How do connection and vulnerability influence performance?

Across the sessions, men shared struggles they had never voiced in professional settings. They named personal and workplace pressures, wrestled with identity and leadership, and reported deeper connection to themselves and one another. What began as a simple offering became a catalyst for emotional clarity, relational growth, and collaboration.

A similar dynamic unfolded during a men's circle demo at a Washington, D.C. university. Students described the rarity of a space free from judgment or fear of offending. Many opened up about pressure, vulnerability, and expectations placed on men, themes they typically avoid discussing. Several noted they didn't feel permission to be fully authentic in front of women, but in this space, they could drop the performance and be real.

THE OPPORTUNITY AHEAD

Men are not the problem. Isolation, disconnection, and outdated leadership models are the problem. Organizations that recognize this distinction and respond strategically will be better equipped to lead in the years ahead.

By strategically engaging men:

- We strengthen leadership pipelines with emotionally agile, purpose-driven leaders
- We foster more cohesive, high-trust cultures
- We create environments where resilience is shared, but not silently shouldered
- We design institutions that are not only high-performing, but human-centered and sustainable

The quiet crisis among men is real. But so is the opportunity in this moment, in particular. When men are equipped to lead with emotional literacy, adaptive strength, and relational depth, organizations unlock leadership potential that has long gone untapped.

This work is not about preserving male dominance. It is about evolving leadership. When men look inward and lead from beneath their protective layers, they bring greater humility and purpose to leadership, helping foster a more inclusive culture. That shift expands leadership across cultures, identity, ideological perspectives, and generations.

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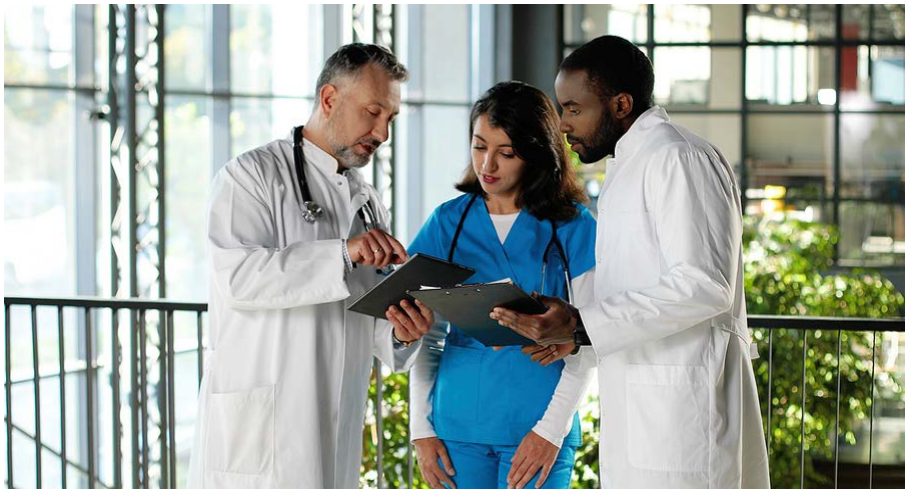
BUILDING THE NEXT-GENERATION HEALTH SYSTEM

How Vision 2030 is enabling AtlantiCare to lead long-term change across care, workforce, and community health

The healthcare industry has spent decades optimizing care delivery inside its walls. But the environments that shape health, such as our homes, neighborhoods, and daily lives, have remained largely disconnected from that system. That separation is now a liability for outcomes, equity, and long-term sustainability.

We cannot continue to half-solve problems and expect full outcomes. A system built to treat illness cannot, on its own, deliver health, especially when it overlooks the factors that influence it every day.



Source: Bigstock

For several years, we have been working to align our organization with the conditions that shape health across a person's life. The link between health outcomes and social factors has been well established, but our role in addressing those factors needed to be more structured and sustained. Supporting long-term health through education, access, and community investment is essential to how we build trust, improve outcomes, and create a system that can grow with the needs of the people we serve. That planning led to Vision 2030, our six-year strategy plan anchored by four-pillars and focused on delivering measurable, long-term change.

These pillars work in tandem to align healthcare operations with the lived realities of the communities we serve. The early results are promising, but the true strength of the model lies in its adaptability. For other leaders across the country, Vision 2030 offers a practical blueprint for how anchor institutions can drive lasting change by acting with clarity, working alongside community and industry partners, and focusing on outcomes.

WORKFORCE INVESTMENT THAT BUILDS CAPACITY AND ECONOMIC STRENGTH

Workforce shortages signal a deeper breakdown in how healthcare systems value and support their people. Solving them requires long-term investment in training, career development, and economic mobility. Vision 2030 treats workforce development as core infrastructure for care delivery and regional stability.

In 2024, we launched AtlantiCare YOUniversity, a tuition-free, earn-while-you-learn program designed to open career pathways across clinical and non-clinical roles. More than 2,600 people enrolled in its first year. The program provides hands-on experience and a direct path to employment while reinforcing economic stability for families across our region.

We have also expanded our academic partnerships, including a clinical affiliation with Drexel University College of Medicine. AtlantiCare welcomed its first cohort of third- and fourth-year med students from Drexel this summer and will continue to add additional students throughout the next four years. This initiative, together with our long-term partnership with Stockton University, is strengthening clinical education and research, while attracting and retaining top talent.

These education pipelines reflect a leadership commitment to long-term talent development, regional stability, and a healthcare system built to serve future generations.

TECHNOLOGY DESIGNED TO AMPLIFY HUMAN CARE

Technology plays a critical role in how we deliver care, and its value depends on how well it strengthens the relationship between patients and providers. At AtlantiCare, we are building a digital infrastructure that improves communication, reduces administrative burden, and gives providers more time to focus on care. As part of this work, we partnered with Oracle as an early innovation collaborator to introduce the Clinical AI Agent, which has already reduced outpatient documentation time by 41 percent.

The system-wide rollout continues this summer as we expand the AI Agent to inpatient settings. By the end of 2026, our work with Oracle will unify both our electronic health records platform and enterprise resource planning system. These investments support clinical performance, improve the patient experience, and equip teams across the organization with tools that enhance care in real time. Leading through technology requires clarity and accountability, with every innovation designed to strengthen care delivery and deepen the connection between providers and patients.

Leading through innovation means making decisions that support care teams, improve patient experience, and strengthen the relationships at the center of healthcare.

EXPANDING ACCESS TO HIGH-IMPACT, LOCAL CARE

In many communities, specialty care remains out of reach due to distance or access. In southeastern New Jersey, these gaps have contributed to delayed treatment and traveling to Philadelphia for care. Vision 2030 addresses this challenge by expanding access to advanced, complex care through clinical partnerships and operational investment.

AtlantiCare Cancer Care Institute is now affiliated with Cleveland Clinic Cancer Institute, which offers patients in our community unparalleled access to advanced research, clinical trials, tumor review boards and second opinions from world-renowned Cleveland Clinic cancer experts, delivered in consultation with our team in Cape May County and Egg Harbor Township.

And our partnership with Global Neurosciences Institute expands stroke, brain, and spine care across the network. In parallel, Sodexo is modernizing systemwide support functions in clinical nutrition, environmental services, facilities, and healthcare technology, ensuring that every part of the care experience is reliable and coordinated. These partnerships are closing critical gaps in care and delivering quality care close to home.

A LEADERSHIP MODEL THAT MEETS THE MOMENT

Transforming healthcare at scale requires focus and singleness of purpose. It means aligning operations with long-term goals, listening to the people doing the work, and staying accountable to the communities being served. Vision 2030 was built on those principles. It addresses care delivery, workforce development, technology integration, and the social conditions that shape health. Each part of the strategy is connected to measurable results and long-term value.

Healthcare organizations hold a unique role in their communities. As employers, educators, and care providers, our decisions influence health outcomes, economic opportunity, and community trust. That responsibility informs every investment we make, every initiative we launch, and every standard we uphold.

Vision 2030 is our north star. It keeps us aligned with a shared purpose and empowers us to lead in ways that strengthen long-term health and resilience. The future of healthcare belongs to those who are willing to build systems that are designed to last.

At AtlantiCare, this is the work we're committed to, and it's how we lead.

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TOOLS FOR LEADING THROUGH TRYING TIMES

Trying times. Times of unease. Challenging times. Difficult climate. Ambiguity. Stress. Chaos.

Between the pandemic and our extended collective experience of division, we have come to embrace these accepted euphemisms for an environment that carries great risk. Healthcare leaders are in a challenging position. They must engage with diverse stakeholder groups who frequently do not agree on the right course of action. They must attempt to set a course in unpredictable environments, thus shortening the horizon within which one can realistically plan. They must find ways to hold true to the values and the mission of the organizations they lead while being nimble in the face of emergent threats and opportunities.

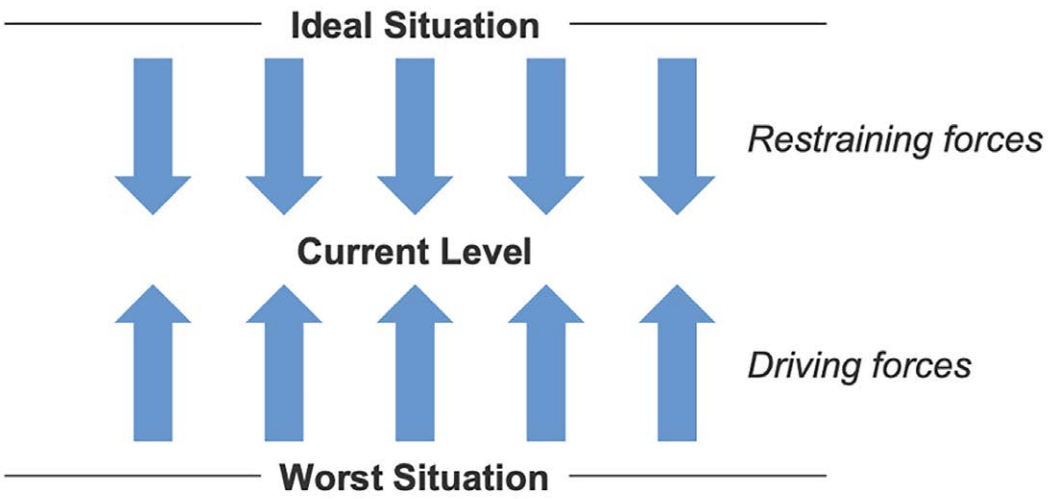
Our clients have shared with us that certain modes of thinking help them cope with and even thrive in this environment. These include creating space to make sense of complex situations, determining what they can control, and prioritizing actions. We have observed that certain tools and methods have helped, forging clarity and conviction when those things are at a premium. This article describes two of these tools, their value, and guidance about how to use them.

Source: Bigstock

Force field analysis. Imagine a large-scale game of tug-of-war, but instead of having one team on either side, many ropes and teams pull at a central point. This is how many of today's leaders feel about their strategic objectives, with various internal and external forces pushing in the direction these leaders wish to go while other forces pull away from it. As the powerful forces multiply, leaders can struggle to keep them all managed, increasing risk and slowing decision-making.

This intuitive framework[1] asks leaders to map out the driving forces working in favor of a set of goals and list them on one side and then enumerate the constraining forces working against them on the other side. An underlying idea is that removing constraining forces is more impactful than enhancing forces already working in your favor. The rigor of force field analysis is identifying each constraining force, identifying which you can control (as many will most certainly be out of your control), and then focusing on what you can do to remove or mitigate each constraining force over which you have some influence. In the meantime, force field analysis can help leaders prevent important issues from evading their attention, an increasingly likely outcome in times of upheaval.

Converting a constraining force into a driving force can be especially powerful. For instance, a recent client identified a constraining force of increasing skepticism among key personnel within the organization about the possibility of making a needed change to care delivery. Working to directly address that skepticism, by engaging the key personnel and securing permission to pilot the change, turned a constraining force into a driving one, accelerating this unit toward its strategic aims.



Decision charting. When organizations come upon uncharted territory, as they regularly do in the current environment, they frequently surface new demands on decision-making. For instance, a recent client struggled with deciding how to allocate scarce resources in a funding environment that has broken drastically from the historical experience. How do leadership teams approach decisions they have never had to make before? Once a decision has been made, how does the team transparently communicate to ensure the organization understands and accepts those choices?

Decision-making roles can become cloudy very quickly, particularly when decisions are new and roles are shifting to address emergent needs. They can also become oversimplified, where much of the focus is on the final decision-maker, with little attention paid to the work behind the scenes or the implementation path forward. Decision charting is a concrete framework for helping teams and organizations develop a shared view of how decisions are made in turbulent environments.

Here's how it works: Decision charting invites teams to co-create agreements about which role has the “A”, authority, “R”, responsibility, “C” consult, or “I”, a group of stakeholders who need to be informed before broad communication. By working with teams to chart key decisions that cut across different roles, those teams can develop a shared language for managing future decisions. The tool also enables teams to own their impact on an organization through pattern analysis across multiple decisions. When a team finds that all mapped processes have many C roles, it may reveal something important about the organization’s consensus-based culture. That knowledge can unlock potential paths to speed decisions and results. We have found that Decision Charting helps teams cut through noise, reduce decision fatigue, improve the quality and speed of decision making, and even reorient their organization's culture.

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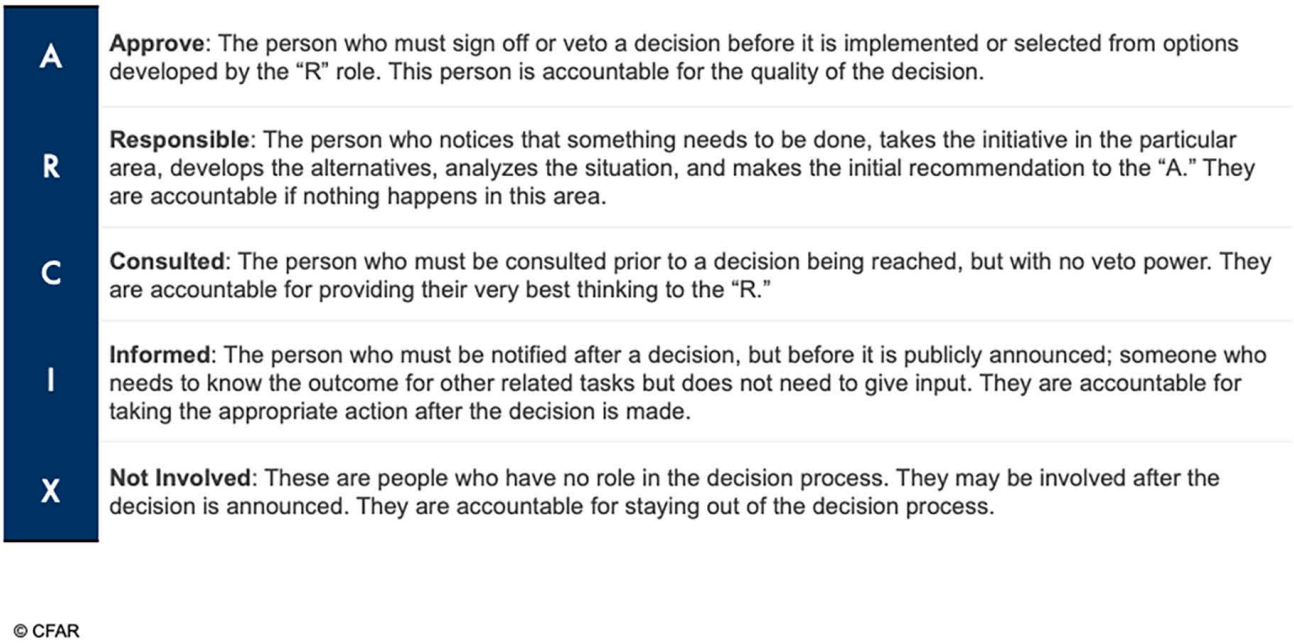

A	**Approve**: The person who must sign off or veto a decision before it is implemented or selected from options developed by the "R" role. This person is accountable for the quality of the decision.
R	**Responsible**: The person who notices that something needs to be done, takes the initiative in the particular area, develops the alternatives, analyzes the situation, and makes the initial recommendation to the "A." They are accountable if nothing happens in this area.
C	**Consulted**: The person who must be consulted prior to a decision being reached, but with no veto power. They are accountable for providing their very best thinking to the "R."
I	**Informed**: The person who must be notified after a decision, but before it is publicly announced; someone who needs to know the outcome for other related tasks but does not need to give input. They are accountable for taking the appropriate action after the decision is made.
X	**Not Involved**: These are people who have no role in the decision process. They may be involved after the decision is announced. They are accountable for staying out of the decision process.

In the example we share above, the senior leader, who had the "A", delegated the "R" to a senior team member, who consulted the appropriate people about the areas of greatest need. The "R" then developed a series of approaches that the "A" teed up and worked through the senior team. There was an understandable concern that any decision would be deeply unpopular to some part of the organization. Still, the "A" could explain how the decision was reached and what they would do about the budgetary issues in the future, a communication that was met with more acceptance than the team had hoped for.

While there is no shortage of colorful descriptors for the challenges facing leaders in today's environment, it can be hard to land on helpful tools and methods for how to lead in such times. These tools, when used to foster productive conversations specific to each leader's work, can offer a measure of support to quiet the noise in the environment. They can help leaders connect with and improve efficiency within their teams. In the long term, we hope they will help people more deeply express organizational goals and values. We believe that those who can do so will be well-positioned to lead their organizations into the future.

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