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ALUMNI CLUB
UNIVERSITY of PENNSYLVANIA

**Healthcare
Alumni Association**

THE WHARTON HEALTHCARE QUARTERLY

SUMMER 2026, VOLUME 15, NUMBER 3



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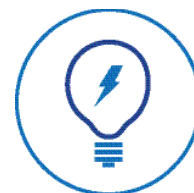
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of wisdom for
the Philosopher's
Corner?

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EDITOR'S LETTER

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

To learn more about Colette, [click here](#).



As the present now
Will later be past
The order is rapidly fadin'
And the first one now
Will later be last
For the times they are a-changin'
~ **Bob Dylan**

As Bob Dylan fans already know, he was prescient.

The times are indeed changing, and at the speed of light.

Thankfully, the *Wharton Healthcare Quarterly* continues to have a host of contributors who make it possible to stay abreast of current and emerging changes in healthcare and how they will impact us at work and at home.

Our goal has always been that every reader will find at least one article or news update of interest because of the variety and broad spectrum of topics which make them pertinent regardless of where you sit in healthcare.

This issue is a prime example. From AI to the latest on the FDA and peptides, from new leadership models to Food Is Medicine, we've got you covered.

A big welcome to the incoming class, and congratulations to the latest Bill Kissick Alumni Scholarship Award winners, **Emma Howley and Ben Vandehey**, Class of 2027!

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

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THE PRESIDENT'S DESK

In Every Issue



Bryan Bushick, MD'88, WG'89
To learn more about Bryan,
[click here](#).

The Year in Review

July 1st marked the beginning of the Wharton Healthcare Alumni Association's (WHAA) FY '27. **It will surely be momentous, and I couldn't be more enthused!**

My optimism is based on the incredible progress that's occurred over the last 12 months. Building upon the foundation of the new four-year new strategic plan that I previously highlighted, the Association's major accomplishments included:

1. Integrating the largest number of new Board members in the organization's history,
2. Expanding its diverse community to more than 850 dues-paying alumni members, nearly one-third of whom graduated from Wharton programs other than Health Care Management or with other Penn degrees,
3. Simplifying its name, *Wharton Healthcare Alumni Association*, to more clearly convey the long-intended inclusivity,
4. Updating the Association's bylaws, which were last ratified over a decade ago,
5. Selecting a new community management and engagement platform (being deployed this summer), and
6. Prototyping an agentic resource for surfacing and sharing alumni news.

Make no mistake about it, many of the new Directors immediately contributed in very meaningful ways! Megan Ax '06, Ed Chan '11, Cristina Gutierrez '05, Ashish Parikh '10, and Scott Shandler '06 each assumed Committee leadership roles. Others spread their attention across various Association priorities.

Two Board members, Ron Kero and Michael Rovinsky, led a remarkable fund-raising campaign for the Class of '86. Celebrating its 40th reunion last May, the class contributed over \$53,000 to the WHAA and achieved a 100% participation rate among all the '86 alum who could be located. The torch - and challenge - has been already passed to the Class of '87 as it prepares for next spring's milestone reunion.

The impact of our entire Board has been significant. It's also been amplified by the contributions of many other volunteers, including alumni from across Wharton and Penn as well as current Health Care Management and WEMBA students (as highlighted in my most recent [post](#)).

And so, with the new fiscal year now upon us, the WHAA is poised to deliver greater value while serving alumni and engaging students from across Wharton and Penn. If you're already a member, that's fantastic! **Thank you...and please continue to participate as much as possible.**

If you're not yet a member, the time is right to jump on board and tap into the WHAA's numerous resources and benefits, as well as the many ways to support current students - the next generation of leaders.

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PRESIDENT'S DESK

All graduates who are working (or interested) in the healthcare sector are welcome to join the Association, whether their focus is management, care delivery, innovation, financing, strategy, entrepreneurship, or policy.

All graduates are also welcome to volunteer on a Board committee, offer to serve as a speaker, recommend a prospective sponsor, help organize an in-person event, or participate in other ways.

Exciting times they are for sure!!! Don't miss the opportunity to be part of something special. Your fulfillment will result from not only what you receive, but also from what you give.

Best wishes to all throughout the summer,

Bryan Bushick, MD, MBA (WG'89)
President, Wharton Healthcare Alumni Association

Contact Bryan at: bryanbushick2026@gmail.com.

DREAMERS

We dream big by thinking small, at the cellular level, inventing ways to destroy cancer and advance humanity.

ARCELLX

SEE OPEN POSITIONS

ALUMNI NEWS

Harris Contos, DMD, MBA, WG'80

Forty-six years after graduation, I will be headed cross country this summer, from Massachusetts to Oregon (well, depending upon the cost and availability of aviation fuel) to meet with a cabal of renegade dentists, dental hygienists, a couple of physicians, a couple of experienced politicians, a few assorted others, all headed by an 86-year old heretic dentist/entrepreneur, to develop a workable integrated organizational, financial, managerial, and outcomes-based (accountable) model of dental care actually designed to prevent a preventable disease – in public health parlance, to reduce the incidence of disease, thus its prevalence, thus its burden on society.

This is the first time in my experience that such a “concept to nuts-and-bolts” gathering will be taking place, which I take to mean speaks volumes about “the profession,” i.e. (dis)organized dentistry, including its ostensible “dental public health” specialty. Yes, I do have chronic high-level blood cynicism.

To think, after all these years... better late than never, I guess.

Contact Harris at: hcontos@verizon.net.

Kate Reed, WG'87

Well, I flunked retirement! I'm now working two jobs simultaneously, with two additional side hustles. In the midst of toodling around biking, skiing, running a Guest Loft and consulting to start up HC tech companies, I took a full time faculty job last fall at Franklin Pierce University, teaching in the U/G and Grad Business School and in the Health Care Program. At the beginning of April I started an additional full time job as the Executive Director of the Regenerative Medicine Clinical Readiness Team for the NH ReGen Valley Tech Hub. I'm busier than a one armed paper hanger but am glad to have the opportunities to make a difference in these diverse and very interesting ways. And, the ReGen Med work, is super hot – and it's great to be engaged in this exciting and cutting edge wave within healthcare. See link below for the ReGen Valley Tech Hub –

"Advancing the US Bioeconomy and Revitalizing a Historic Manufacturing Area by Establishing Global Leadership in Biofabrication"

Contact Kate at 401.477.6185.

Erica Bazerdanian, WG'01

By the time this is printed this summer, I will have had the joy of returning to campus in May for my 25th reunion -- a milestone that feels especially meaningful as I reflect on a new and exciting chapter. After a 25-year career in healthcare marketing -- launching brands and helping build startups -- I've taken a leap to co-found and lead **Bold&Zeal**, a purpose-driven lifestyle venture rooted in resilience, intention, and living boldly.

Bold&Zeal is more than a clothing brand -- it's a mindset. Built as a family business, we create elevated, timeless essentials designed to reflect confidence and purpose, while also giving back to the paralysis community through an ongoing commitment to charitable impact. This venture was inspired by personal loss and shaped by a desire to turn that experience into something that can uplift others.

I still keep a foot in healthcare through select consulting in rare disease and dermatology strategic marketing, which continues to be incredibly fulfilling. But what makes this chapter truly special is building Bold&Zeal alongside my husband of 30 years, Rafi, who is equally excited to get back to visit Philadelphia -- and our four children. It's been a gift to create something together.

I'm so grateful for the Wharton experience that helped shape my path, and I'm looking forward to celebrating our 25th with such an inspiring community.

Contact Erica at erica@boldandzeal.com or 805.300.9289.

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THIS MONTH'S PHILOSOPHER:
Harris Contos, WG'80

To learn more about Harris, [click here](#).



THE PHILOSOPHER'S CORNER

In Every Issue

LIFE LESSONS

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

[where to begin...?] developed more equanimity, more resilience to deal with, address the absurdity that abounds. Developed and made use of a support system rather than take it all on my shoulders. Disciplined myself to pay attention to the details, the granular level of things; in other words, no matter how dead-on accurate you may be, "just sayin' so don't make it so." Married that girl. Grasped better the implications of Dr. Kissick's several concise, cogent aphorisms, among them:

- Health care is a cultural affair.
- Health care transcends the biomedical sciences.
- Health policy is tax policy.
- No society can afford all the health care it is capable of consuming.
- For every health policy action there is a reciprocal overreaction.
- A healthy patient is one who hasn't been studied enough.
- The boundaries of public health keep getting redefined.
- There will always be ten leading causes of death.



Harris Contos, WG'80

Read more literature, took in more theater. Learned to dance. Traveled more. Dedicated more time and space for my hobbies. Dedicated time and mental space to pursue intellectual inquiries. Take a mental break. Basically, have come to the realization that much that we deal with in health care is insoluble, instead it's a matter of how best we can cope.

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

made some boneheaded decisions. Would not have second-guessed myself. Would not have settled for responses that didn't answer the question. Would not have let my upset get the upper hand. Would not have abandoned my dream to be a weatherman on TV. Or a jazz musician.

FAVORITE QUOTES

1. "Be ashamed to die unless you have won some victory for humanity." ~ Horace Mann
2. "Is there a man in the world who suffers as I do from the gross inadequacies of the human race?" ~ Monty Woolley
3. "The guy who dreamed this one up ought to have his brain in a glass jar at Harvard." ~ Brig. Gen. Frank Savage, "Twelve O'Clock High!"
4. "Liberals feel unworthy of their possessions. Conservatives feel they deserve everything they've stolen." ~ Mort Sahl

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THE PHILOSOPHER'S CORNER

5. "And many have imagined republics and principalities that have never been seen or known to exist in truth; for it is so far from how one lives and how one should live that he who lets go of what is done for what should be done learns his ruin rather than his preservation. For a man who wants to make a profession of good in all regards must come to ruin among so many who are not good. Hence it is necessary to a prince, if he wants to maintain himself, to learn to be able not to be good, and to use this and not use it according to necessity." ~ Nicolo Machiavelli, *The Prince*

RECOMMENDED READING

1. *Medicine's Dilemmas: Infinite Needs versus Finite Resources* by William L. Kissick
2. *The Limits of Medicine: How Science Shapes Our Hope for the Cure* by Edward S. Golub
3. *The Responsibility of Intellectuals* by Noam Chomsky
4. *The Chance for Peace* by Dwight Eisenhower
5. *Beyond Vietnam: A Time to Break Silence* by Martin Luther King, Jr.
6. *The Holocaust Industry: Reflections on the exploitation of Jewish Suffering* by Norman Finkelstein
7. *Against Our Better Judgment: The hidden history of how the U.S. was used to create Israel* by Alison Weir

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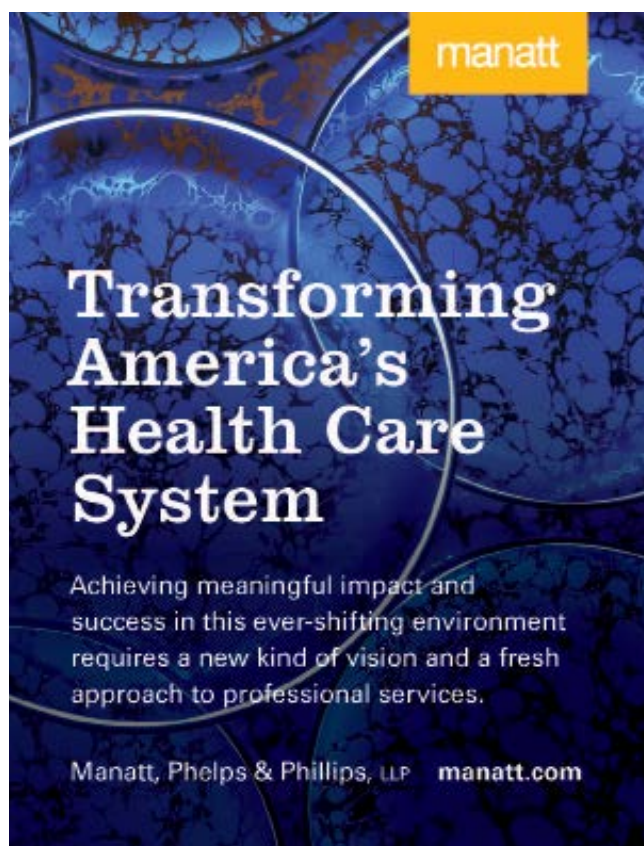
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A photograph of a male doctor in a blue scrubs top and a stethoscope around his neck, holding a tablet and looking at an elderly male patient lying in a hospital bed. The patient is wearing a white hospital gown and looking up at the doctor with a slight smile.





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AFFIDAVIT: HEALTHCARE AND THE LAW - FDA'S TURNING TIDES ON PEPTIDES

The peptide compounding landscape is undergoing a dramatic transformation. What began as a necessary response to drug shortages has evolved into a regulatory battleground, with the FDA cracking down on GLP-1 compounding while simultaneously signaling openness to expanding access for other peptides. For stakeholders - from telehealth companies to healthcare providers to patients - the tides are changing fast.¹

The story begins with scarcity. GLP-1 receptor agonists, largely prescribed for type 2 diabetes and obesity, experienced significant drug shortages that placed semaglutide (the active ingredient in Ozempic and Wegovy) and tirzepatide (the active ingredient in Mounjaro and Zepbound) on FDA's Drug Shortage List. This designation is significant because it allows lawful production of compounded drug products without separate FDA approval. Under Sections 503A and 503B of the federal Food, Drug and Cosmetic Act, drugs listed on FDA's shortage list are not considered commercially available or "essentially copies of approved drugs," allowing pharmacies and approved compounders to produce quantities of those compounded drug products. The shortage created a legal pathway for compounding GLP-1s.



The shortages for both semaglutide and tirzepatide have now resolved, removing the drug shortage exception. But the compounding didn't stop. Demand for GLP-1s among patients and providers remains high, offset by limited insurance coverage (both private and public payers, including Medicaid, often exclude obesity treatment).² This demand-coverage gap has driven patients and providers toward compounded alternatives. However, Section 503A prohibits compounding drugs that are "essentially a copy" of a "commercially available drug product," and 503B prohibits compounding "essentially a copy of one or more approved drugs."³

FDA has responded to the continued compounding of GLP-1s with a multi-pronged enforcement campaign. As Commissioner Marty Makary stated, "Compounded drugs can be important for overcoming shortages or meeting unique patient needs - but compounders should not try to compound drugs in a way that circumvents FDA's approval process."⁴

The agency's actions include:

- **Import controls:** FDA established a "green list import alert" to stop GLP-1 active pharmaceutical ingredients with potential quality concerns from entering the U.S. supply chain, though compliant manufacturers are not affected.⁵
- **Safety warnings:** FDA has warned about adverse events from compounded versions of semaglutide and tirzepatide, including dosing errors. As of July 31, 2025, the agency received 605 adverse event reports from compounded semaglutide and 545 reports related to compounded tirzepatide.⁶
- **"Research purposes" crackdown:** Certain companies have labeled peptides "for research purposes" and "not for human consumption" while allegedly selling products to consumers for human use with dosing instructions. FDA has issued warning letters to companies using this tactic, citing violations of 21 U.S.C. 331(d) and 355(a).⁷

- **False advertising enforcement:** FDA isn't limiting its focus to "research purposes only" language. The agency issued a warning letter to Hims and Hers alleging that claims about compounded semaglutide products were false and misleading. FDA took issue specifically with Hims and Hers' claim marketing a "[w]eekly injectable GLP-1 with the same active ingredient as Ozempic and Wegovy," which FDA said improperly implied equivalence with approved products.⁸

While FDA tightens the screws on GLP-1 compounding, a parallel development suggests the agency may be moving in the opposite direction for other peptides. HHS Secretary Robert F. Kennedy has indicated that FDA may seek to remove certain peptides from the Category 2 designation of Bulk Substances.⁹ The Category 2 designation essentially prohibits compounding due to safety risk concerns.¹⁰ Removal would open the door for additional, lawful compounding of these substances.¹¹

This direction is supported by FDA's representations in litigation in the Northern District of Texas: "FDA has informed Plaintiffs that, by the end of February 2027, the agency expects to submit to the Office of the Federal Register for publication a final rule that addresses the placement of the four bulk drug substances at issue in this lawsuit on FDA's Section 503A Bulks List regulation."¹² The case has been administratively closed pending a joint status report by the earlier of 14 days after FDA's final rule is published or March 14, 2027.

More concrete movement came on April 15, when FDA announced that its Pharmacy Compounding Advisory Committee (PCAC) will convene on July 23–24 to discuss adding the following bulk drug substances to the Category 1 list of permissible compounding:

- BPC-157 for Ulcerative Colitis;
- KPV for wound healing and inflammatory conditions;
- TB-500 for wound healing;
- MOTs-C for obesity and osteoporosis;
- Emideltide for opioid withdrawal, chronic insomnia, and narcolepsy;
- Semax for cerebral ischemia, migraine, and trigeminal neuralgia; and
- Epitalon for insomnia.

Yet even as these doors may open, FDA has continued to issue warning letters to companies claiming to sell GLP-1s for "Research Use Only," alerting these companies that their products are drugs and requiring corrective action. In short: GLP-1s face a crackdown while other peptides may get a green light.¹³

The landscape for peptide compounding is shifting rapidly - and in two directions at once. Stakeholders should monitor these developments closely.

- Compounders must ensure compliant compounding, particularly for GLP-1s, now that shortages have resolved;
- Providers and patients looking to potentially unlawfully compounded versions of GLP-1s should be aware of safety and effectiveness risks;
- Telehealth companies offering compounded drugs must be mindful of the FDA's position on "research use only" language and monitor updates to the drug shortage list.

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REFERENCES

1. FDA Warns 30 Telehealth Companies Against Illegal Marketing of Compounded GLP-1s (Mar. 03, 2026), <https://www.fda.gov/news-events/press-announcements/fda-warns-30-telehealth-companies-against-illegal-marketing-compounded-glp-1s>.
2. Elizabeth Williams, Medicaid Coverage of and Spending on GLP-1s (Jan. 16, 2026), <https://www.kff.org/medicaid/medicaid-coverage-of-and-spending-on-glp-1s/>.
3. Guidance for Industry: Compounded Drug Products That Are Essentially Copies of a Commercially Available Drug Product Under Section 503A of the Federal Food, Drug, and Cosmetic Act (Jan. 2018), <https://www.fda.gov/media/98973/download?attachment>; Guidance for Industry: Compounded Drug Products That Are Essentially Copies of Approved Drug Products Under Section 503B of the Federal Food, Drug, and Cosmetic Act (Jan. 2018), <https://www.fda.gov/media/98964/download>.
4. Note: FDA has stated that as of April 1, 2026, it “does not intend to take action against a compounder for compounding a drug product that is essentially a copy of a commercially available drug product regularly or in inordinate amounts if the compounder fills four or fewer prescriptions of that compounded drug product during a calendar month.” FDA clarifies policies for compounders as national GLP-1 supply begins to stabilize, <https://www.fda.gov/drugs/drug-alerts-and-statements/fda-clarifies-policies-compounders-national-glp-1-supply-begins-stabilize>.
5. <https://www.fda.gov/drugs/postmarket-drug-safety-information-patients-and-providers/fdas-concerns-unapproved-glp-1-drugs-used-weight-loss>.
6. *Id.*
7. *Id.*; See, e.g., Warning Letter to Xcel Research LLC, <https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/xcel-research-llc-694608-12102024>; Warning Letter to Summit Research Peptides, <https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/summit-research-peptides-695607-12102024>; Warning Letter to Synthetix Inc. DBA Helix Chemical Supply, <https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/synthetix-inc-dba-helix-chemical-supply-668918-02072024>.
8. Warning Letter to Him & Hers, Inc. dba Hers, <https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/hims-hers-health-inc-dba-hers-716825-09092025>.
9. Lauren Gardner, A Peptide in FDA's Step, Politico: Prescription Pulse (Mar. 3, 2026).
10. See Certain Bulk Drug Substances for Use in Compounding that May Present Significant Safety Risks (Apr. 22, 2026), <https://www.fda.gov/drugs/human-drug-compounding/certain-bulk-drug-substances-use-compounding-may-present-significant-safety-risks>.
11. *Id.*
12. Evexias Medical Centers, PLLC v. U.S. Food and Drug Administration, No. 4:24-cv-00293-O (N.D. Tx. Aug. 18, 2025), <https://ecf.txnd.uscourts.gov/doc1/177117927034>.
13. Warning Letter to Gram Peptides (March 31, 2026), <https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/gram-peptides-721806-03312026>; Warning Letter to Mile High Compounds LLC (Mar. 31, 2026), <https://www.fda.gov/inspections-compliance-enforcement-and-criminal-investigations/warning-letters/mile-high-compounds-llc-721600-03312026>.



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TO YOUR HEALTH: RETHINKING THE PRESCRIPTION - FOOD AS THE FUTURE OF HEALTHCARE

Healthcare stands at a critical inflection point. Chronic disease continues to rise at an unsustainable pace, driving the majority of healthcare spending while steadily eroding quality of life. At the same time, nutrition, one of the most powerful determinants of health, remains underused, underintegrated, and frequently introduced only after disease has taken hold.

If healthcare leaders want different outcomes, they must rethink the role of nutrition entirely.

The idea of Food Is Medicine is not new. What is new is the urgency to move it from concept to infrastructure.



Source: [Bigstock](#)

A REACTIVE SYSTEM BY DESIGN

Modern healthcare is built to respond to disease, not prevent it. Most patients enter the system once symptoms appear, when conditions are already progressing, and care becomes more complex and costly.

Nutrition, despite its direct link to diabetes, cardiovascular disease, obesity, and mental health conditions, is rarely positioned as a first-line intervention. Instead, it is treated as optional or secondary to pharmaceutical treatment.

This approach is not simply inefficient. It is misaligned with what we know about disease development and root cause intervention.

The greatest opportunity for nutrition lies early, before diagnosis, before risk compounds, and before behaviors become entrenched. Yet that window is consistently missed.

WHY NUTRITION REMAINS MARGINALIZED

Nutrition's absence from routine care is not accidental. It is structural.

Physicians receive limited training in nutrition. Medical education prioritizes diagnosis and treatment over prevention, leaving clinicians underprepared and underconfident in delivering meaningful nutrition guidance. When providers do not feel equipped, nutrition disappears from clinical conversations.

Equally important, healthcare reimbursement does not meaningfully reward nutrition or prevention. The system pays for visits, procedures, and prescriptions, not for sustained behavior change or long-term risk reduction.

As a result, nutrition may be acknowledged as important, but it remains peripheral in practice. Until these structural barriers are addressed, nutrition will continue to sit outside the core of healthcare delivery.

ACCESS REMAINS A BARRIER

Even when nutrition care is recommended, access is limited.

Dietitians are often concentrated in hospital settings or available only by referral. Patients face long wait times, insurance restrictions, and administrative complexity. These obstacles disproportionately affect individuals who would benefit most from early support.

Gaps in health literacy, cultural relevance, and geographic access further widen the divide.

If nutrition is truly foundational to health, it cannot rely on episodic, hard-to-reach care models.

FROM INTERVENTION TO FOUNDATION

Healthcare must stop treating nutrition as an intervention of last resort and begin treating it as foundational care.

Early and consistent nutrition engagement can alter health trajectories. It can delay or prevent chronic disease, reduce medication dependence, and improve long-term outcomes. Just as importantly, it equips individuals with the tools to participate actively in their own health.

This shift requires new infrastructure.

Nutrition support must reach people before they become patients, before formal diagnoses, and before preventable risk hardens into disease.

THE ROLE OF SCALABLE AND DIGITAL MODELS

Digital and scalable nutrition platforms offer a path forward.

These models enable personalized, culturally relevant guidance at scale. They eliminate geographic barriers, reduce wait times, and support ongoing engagement rather than one-time interventions.

Critically, they create earlier entry points into care. Individuals can engage proactively rather than waiting for a referral or clinical trigger.

This does not diminish the role of registered dietitians. It expands their reach. Scalable models allow dietitians to focus on complex cases while broader populations receive structured, evidence-based support.

When designed thoughtfully, technology increases access without sacrificing clinical integrity.

INTEGRATING NUTRITION INTO PRIMARY CARE

For Food Is Medicine to be effective, nutrition must be embedded into primary care.

Primary care remains the front door to the healthcare system, yet nutrition is often absent from routine visits due to time constraints, reimbursement limitations, and competing demands.

Integrating nutrition into primary care workflows changes this equation. Digital tools, multidisciplinary teams, and streamlined referral pathways can extend support beyond the exam room.

Imagine nutrition addressed as routinely as blood pressure. Guidance that evolves over time. Data that informs personalized recommendations across the care continuum.

Achieving this requires alignment among providers, payers, employers, and policymakers. The potential impact is significant.

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TO YOUR HEALTH: RETHINKING THE PRESCRIPTION - FOOD AS THE FUTURE OF HEALTHCARE

A REQUIRED MINDSET SHIFT

The advancement of Food Is Medicine is not primarily a technology challenge. It is a mindset shift.

Nutrition must no longer be viewed as supplemental. It must be recognized as a core pillar of healthcare.

Prevention must carry the same weight as treatment. Success must be measured not only by procedures delivered, but by disease avoided, quality of life improved, and long-term risk reduced.

Reactive, fragmented models cannot deliver these outcomes.

WHY THIS MOMENT MATTERS

Several forces are converging.

Employers are grappling with rising chronic disease costs. Payers are increasingly focused on value-based care.

Policymakers are elevating nutrition within public health priorities. Consumers are more engaged in their health than ever before.

Nutrition is no longer peripheral to the healthcare conversation.

Momentum alone, however, will not change outcomes. Without intentional redesign, the system will default to familiar patterns.

The question is not whether Food Is Medicine works. The evidence is clear.

The question is whether healthcare leaders are willing to build systems that fully leverage it.

LOOKING AHEAD

The future of healthcare will not be built solely in hospitals or clinics. It will be shaped in homes, communities, and daily decisions.

Food remains one of the most powerful and underutilized levers for improving health outcomes. Reimagining its role challenges deeply embedded incentives, but it also presents a rare opportunity to create a more sustainable system.

Waiting until disease appears is no longer acceptable.

We must intervene earlier. We must expand access. And we must design healthcare differently.

Doing the same things will continue to produce the same results.

What if the first line of care wasn't a prescription but talking about what's on your plate?

Creating change starts with the smallest actions - let's start today.

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SUMMER 2026
Volume 15, Number 3

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DOWNLOADING SUCCESS: THE PHYSICIAN-TO-EXECUTIVE TRANSITION

Most physicians who step into C-Suite leadership roles arrive with a rare trait: decades of clinical excellence, hard-won credibility, and deep organizational trust. What they often arrive without is an equally clear understanding of how fundamentally different enterprise leadership is from clinical practice.

After 30 years of working with CMOs, C-Suite leaders, and high-performing healthcare teams, I have seen this play out hundreds of times. These observations were the focus of a recent conversation on The Fire Chief – The Chief Medical Officer Podcast, hosted by Dr. Lee Scheinbart. The skills that build exceptional physicians and those that build exceptional executive leaders are not the same. Conflating the two is the most common and most costly mistake in physician leadership transitions.



THE PRICE OF ADMISSION

Clinical excellence is the price of admission to the C-Suite. It is not the currency of success once you are there.

The physician's professional identity is among the most deeply formed in any field, built over 11 to 16 years of relentless education, training, and clinical practice. It centers on a single, powerful construct: the expert. The one who knows. The one who decides. The one who is trusted, above all else, to get it right.

Stepping into an executive role does not erase that identity. It demands that an entirely new one be built alongside it, and this is precisely where most physicians and organizations underestimate the challenge.

There is also a structural gap that healthcare has long ignored. A frontline supervisor at a major retailer typically receives more formal training in team building, change management, conflict resolution, and other standard leadership skills than most physicians receive before taking on a C-Suite role. The organizational assumption that brilliance transfers quietly derails more physician leaders than any other single factor.

FROM THE DECK TO THE BRIDGE

An aircraft carrier offers a useful illustration. On a ship of that scale, there are two very different places to stand, the deck, where the action happens, and the bridge, sitting 9 stories above it. Neither vantage point is recognizable from the other.

Clinical leadership is like life on the deck, close, tactical, and expert. Enterprise leadership requires moving to the bridge, seeing the whole, and leading people well outside your domain. The physician executive who tries to lead from the deck while occupying a bridge-role struggles for reasons unrelated to intelligence or commitment.

THREE BEHAVIORS THAT SEPARATE THOSE WHO THRIVE

When I look at physician leaders who successfully make this transition, three behaviors consistently set them apart, none of which appear in a medical curriculum.

The first is deep listening. Physicians are trained in clinical curiosity, which drives rapid synthesis toward a differential diagnosis. Executive curiosity requires something harder, staying in the question longer and listening before concluding. Studies suggest that the average physician interrupts a patient's account within 9 to 14 seconds. That same instinct, highly efficient in a clinical context, becomes a liability in leadership, where people must feel heard before they will engage.

The second is proactive communication. In clinical practice, sharing information laterally occurs when clinically necessary, not as a default habit. However, when carried into an enterprise setting, that pattern creates silos. Decisions are made without the right people knowing, and stall because key stakeholders were not brought along. Developing the discipline to ask, "Who needs to know what I just learned?" and then acting on the answer is among the highest leverage habits a new physician executive can build.

The third is sequenced voice. Leaders who speak first and listen second close down the rooms they need to open. Physician executives who build the most effective teams first establish psychological safety, then use their voice to add weight and direction once others feel genuinely included.

THE UNLEARNING PROBLEM

Perhaps the most counterintuitive insight from decades of coaching physician leaders is that the behaviors most likely to hold them back are not weaknesses. They are deeply ingrained strengths that worked brilliantly in a clinical context and now quietly undermine leadership effectiveness in an executive environment.

Consider emotional neutrality. From the earliest days of clinical training, physicians learn to maintain composure at the bedside. A measured expression prevents panic, projects calm, and creates safety. After thousands of patient encounters, this behavior becomes entirely unconscious. But in an executive meeting, that same composure may be characterized as hard to read, which often creates anxiety. Colleagues and direct reports who are trying to gauge whether their ideas are landing often experience angst rather than reassurance.

Similarly, medicine trains physicians to be the authority in the room. That model is appropriate, even necessary, in clinical settings. But it does not scale to enterprise leadership, where success depends on simultaneously operating as a peer, collaborator, and team builder, and knowing when to follow as well as when to lead.

THE ROLE OF EMOTIONAL INTELLIGENCE

If there is a single determinant of success in this transition, it is emotional intelligence. Not credentials. Not a clinical track record. Not years in leadership titles.

EQ, comprising self-awareness, self-management, social awareness, and relationship management, determines how effectively a leader reads situations, influences people, manages under pressure, and builds the trust that makes teams perform. Of these four, self-awareness is foundational. A leader who does not understand their own tendencies, triggers, and blind spots cannot effectively manage any of the rest.

Importantly, EQ is not fixed. It grows through coaching, structured feedback, and the kind of honest self-reflection that most high-performing physicians have never been formally asked to do. The good news is that emotional intelligence can be learned and cultivated at any stage of a leadership career.

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SUMMER 2026

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CONCLUSION

The transition from physician to enterprise leader is one of the most demanding identity shifts in professional life. It does not happen by accident, and it does not happen in isolation.

Organizations that invest in structured transition support during the first 90 days see measurably better outcomes than those that expect leaders to find their footing on their own. Physician leaders who approach this transition with the same rigor they brought to clinical training tend to build the kind of executive presence that earns trust, sustains culture, and drives performance across the enterprise.

Marshall Goldsmith's axiom holds, "What got you here won't get you there." But with the right framework and the right support, the destination is entirely within reach.

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CYBERVITALS: HEALTHCARE IS RUNNING FROM A BEAR

In February of 2016, clinicians at Hollywood Presbyterian Medical Center came to work to find the hospital's IT systems had been infected by a computer virus, rendering the electronic medical record (and most other clinical IT systems) inoperable. This resulted in having to revert to paper charts, causing patient care delays, and what I can only imagine was relative chaos.

This was around the same time I was raising the first round of funding for a healthcare cybersecurity company called Medcrypt. Before the HPMC incident, most investors said "Who would ever hack a hospital?" The assumption amongst most of the healthcare community was that their cybersecurity concerns were limited to inadvertent exposure of patient information, triggering HIPAA fines.



In the first quarter alone of 2026, at least 33 US healthcare institutions have been infected by ransomware. In just 10 years, we went from little to no clinical impact from cybersecurity events to being a top-3 concern for healthcare leadership teams around the country. The financial and clinical impacts are staggering.

In 2025, US healthcare systems spent around 7% of their IT budgets on cybersecurity, for a total of approximately \$12B. But adjacent industries are spending anywhere from 10% to 15% of their IT budgets on cybersecurity, and their results are (unsurprisingly) better.

The average healthcare cybersecurity breach cost \$9.8M in 2025. In financial services, that number is \$5.9M. And in the energy sector, the average breach costs just \$4.9M. Financial services institutions are harder to attack than healthcare systems, and result in less profit for hackers.

I have some theories for why this is the case. The financial sector has had strong regulations for decades, creating financial incentives for banks to invest in cybersecurity protections. U.S. cybersecurity regulation for healthcare has been limited to HIPAA fines for PII breaches and FDA regulations for medical device manufacturers. HIPAA fines totaled less than \$10M in 2025, and FDA cybersecurity regulations have only really been felt by the average medical device manufacturer in the last 18 months.

Not only is healthcare spending less and losing more than other sectors, but the problem is getting worse. Since 2016, cybersecurity spending in healthcare is up 2.8x. But the financial losses from these attacks have increased 13x.

Despite spending more on cybersecurity than we have in the past, we're being attacked more, and losing more money from each attack. Things are getting worse, faster.

It goes without saying that the financial impacts of cybersecurity in healthcare are, at best, the second biggest consideration. In our industry, patient safety and clinical outcomes are rightfully our number one priority. Research from Dr. Christian Dameff and his team at UCSD in a study of the May 2021 Scripps Health ransomware attack, which took down four San Diego hospitals for roughly a month, and looked at what happened at the adjacent, untargeted UCSD emergency departments. At nearby hospitals that were never even attacked, ED census surged, ambulance arrivals jumped, waiting times grew, more patients left without being seen, and stroke care metrics deteriorated. They stopped short of drawing conclusions about patient morbidity and mortality, but it is hard to imagine patient outcomes did not directly suffer as a result of second-order impacts of Scripps' ransomware attack.

So, what do we do? After working on this problem for over a decade, I have come to the conclusion that market forces alone will not fix this issue. There are not proper economic incentives for already stressed hospital budgets to spend more on cybersecurity.

We need federal assistance and intervention. The federal government regulates many of the IT systems used in healthcare systems through the FDA's regulation of medical devices. The federal government is responsible for somewhere between 10% and 25% of healthcare IT spending through the VA and DoD healthcare systems. And Medicare and Medicaid account for about 40% of all US healthcare spending. The federal government is the only single stakeholder with the leverage required to improve this situation.

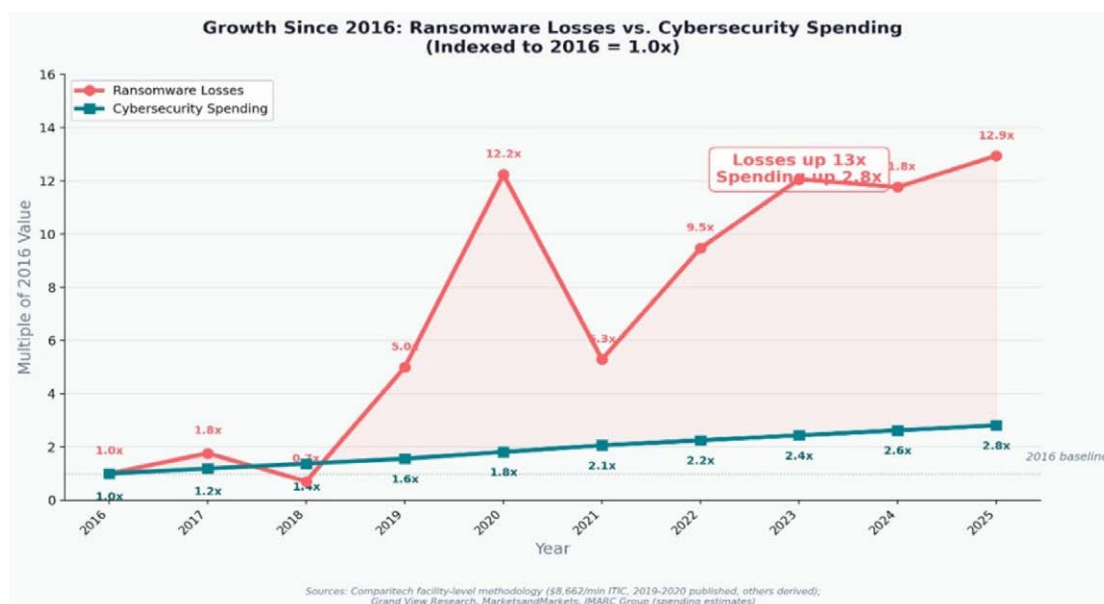
In order to protect patient and clinical outcomes, the government needs to do three things:

1. Improve the FDA's ability to enforce existing cybersecurity regulations on both new and legacy medical devices.
2. Use the VA and DoD's procurement contracts to demand suppliers of healthcare IT, including electronic medical records, meet modern cybersecurity standards, including a commitment to provide software updates and security patches for the expected life of the system.
3. Provide financial resources for small and mid-sized hospitals to replace aging IT infrastructure with modern, secure systems.

The largest single sector of the US economy is being targeted by cyber criminals. The attacks are increasing in number and sophistication faster than we are trying to defend from them. And our financial losses and patient outcomes are getting worse, faster.

There is a saying that a camper doesn't need to be faster than the bear who is chasing him; he only needs to be faster than the slowest camper. Right now, healthcare is the slowest camper.

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SUMMER 2026

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AI IN HEALTHCARE: TO AI OR NOT



Source: Bigstock

INTRODUCTION: SETTING THE STAGE

Artificial Intelligence (AI) has moved rapidly from experimentation to operational reality across the healthcare ecosystem. Providers, payers, and vendors are deploying AI-enabled tools at unprecedented and unforeseen speed and scale; drawn by the promise of improved efficiency, reduced administrative burden, and more consistent decision-making. At the same time, this pace of adoption has outstripped the industry's ability to fully identify and assess downstream impacts on care quality, cost, fairness, and the human healthcare experience, and mitigate risks associated with exceptionally fast-paced disruption.

This tension between promise and necessary prudence frames the purpose of this four-part series. Rather than focusing solely on the technology itself, we examine how AI is reshaping real-world healthcare operations and what that means for providers, payers, patients, and the broader ecosystem. **The central question is not whether AI will influence healthcare, but “How it can be harnessed in ways that enhance quality and outcomes without compromising both patient and provider trust, accountability, and well-being?”**

Our perspective here is intended to be pragmatic. AI has shown it can be a powerful positive force when thoughtfully designed, deployed, and rigorously governed. However, the cautions surrounding its use, particularly in high-stakes administrative and financial workflows, are very real and deserving of careful scrutiny. We strongly believe balancing innovation with broad responsibility among stakeholders should not be optional.

THE RISE OF AI IN HEALTHCARE ADMINISTRATION

One of the most visible areas of AI adoption has been on the administration/business side of healthcare. Organizations are increasingly using AI-driven tools to support medical coding, automate prior authorization workflows, adjudicate claims, and

streamline revenue cycle processes. These applications are often positioned as solutions to longstanding challenges, including administrative complexity, workforce shortages, rising costs, and clinician burnout driven by non-clinical work.

We understand the motivation; administrative tasks continue to consume an inappropriately significant share of overall healthcare resources. Even marginal efficiency gains can translate into substantial financial impact at scale. AI proponents promise faster turnaround times, more efficient, accurate, and/or standardized processes, and the ability to sift through vast volumes of data more quickly than all-human teams alone, presumably leading to better informed decisions.

Yet, while these goals are laudable, the reality on the ground is more nuanced. Administrative decisions, especially those tied to billing, reimbursement, and even coverage, carry significant clinical, financial, and ethical implications. As AI systems become more embedded in administrative workflows, and sophistication evolves, we believe the question shifts from “Can this work?” to “At what cost, and under which safeguards?”

CODING AND CLAIMS: OPPORTUNITIES AND PITFALLS

1. Billing and Coding

AI-powered coding tools are increasingly used to assist or, in some cases, perform medical coding, by analyzing clinical documentation and suggesting diagnosis and procedure codes. In theory, these tools can help improve accuracy, reduce lag time, and ensure that services provided are fully captured.

In practice, however, challenges quickly emerge. AI systems may suggest additional diagnoses or procedures based on contextual clues in documentation, sometimes without the clinical nuance or judgment applied by certified human coders. Without appropriate review and oversight, this can lead to inappropriate code selection, perceived upcoding, and/or claims that fail to align with payer policies.

Unlike human coders, AI systems are not credentialed, certified, and/or professionally accountable. Their “training” derives from utilizing historical data patterns, which may themselves reflect variability, bias, and/or outdated practices. Fully AI-autonomous coding without essential human review prior to claim submission, potentially introduces unmitigated financial and regulatory risk many organizations may underestimate.

These dynamics raise important questions including but not limited to:

1. What safeguards are in place to prevent erroneous and/or non-compliant coding generated by AI?
2. How do systems distinguish between legitimate documentation improvement and inappropriate revenue capture?
3. How do widely publicized examples of AI used to detect fraud and abuse influence payer scrutiny of otherwise legitimate claims?

There is also an often overlooked patient-facing dimension. As AI enables more granular charge capture, patients may experience higher financial responsibility for services that previously went unbilled or uncollected. While one could argue this represents more complete accounting of the care delivered, the real-world impact can feel very different, which could reinforce patients’ perceptions that “every penny is being tracked” in an already perceived complex, uncaring, and stressful healthcare financial system.

2. Human vs. Machine: Expertise and Accountability

The expanding role of AI in coding and claims processing highlights a broader tension between

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human expertise and machine-driven automation. Experienced coders develop judgment over years of navigating clinical ambiguity, evolving regulations, and payer-specific nuances. That expertise is difficult to fully replicate through algorithms trained on static or imperfect datasets.

In some cases, removing humans from technically complex workflows may reduce immediate labor burden but introduce new vulnerabilities. Errors may be harder to detect, accountability may become diffused, and organizations may struggle to explain or defend AI-driven decisions during audits, appeals, and/or legal challenges.

Legal and/or ethical liability is another increasingly emerging consideration. When AI-generated outputs contribute to payment disputes, compliance findings, and/or patient harm, where does responsibility ultimately lie? Is it with the technology vendor, the deploying organization, or the individual(s) who failed to intervene? These questions, among others, remain largely unresolved.

Additional considerations around consent, transparency, and disclosure, particularly in settings involving caregivers, parents, or legal guardians exist. As AI increasingly participates in interpreting clinical records and influencing financial outcomes, health care organizations must consider whether and how patients and/or families are informed about the role these tools play in the patient journey.

CONCLUSION: CHARTING A THOUGHTFUL PATH FORWARD

AI has undeniable potential to improve, streamline, and/or optimize healthcare operations, reduce administrative burden, and help enable more consistent decision-making. At the same time, its use in areas such as coding and claims introduces real financial, regulatory, and human risks that cannot be ignored and must be timely addressed.

The path forward requires much more than technical capability. It demands intentional thoughtful governance, clear accountability, and a commitment to keeping human expertise integrated into high-stakes processes. Stakeholders should be asking not only what AI can do, but how it should be deployed, monitored, and constrained to align with the broader healthcare mission of optimal/appropriate high-quality patient care and outcomes/values.

We will discuss pre-authorization/utilization management, clinical workflows/decision-making and website design in the next three articles.

As AI continues to expand into adjacent areas - such as prior authorizations and increasingly automated payer-provider interactions - the need for this balance will only intensify. Thoughtful adoption today will help shape trust, equity, and sustainability across the broad healthcare ecosystem tomorrow.

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WHAT THE ERA OF EXPANDED SPAN OF CONTROL MEANS FOR HEALTHCARE EXECUTIVE LEADERS

In boardrooms across the country, a quiet but consequential shift is underway. Health systems are making fewer leaders responsible for more: more markets, more service lines, and more complexity than ever before. Recent industry analyses, including work from Deloitte on health system transformation, suggest that many organizations are reducing layers of management while expanding executive scope. Some senior leaders now oversee portfolios that are 2–3 times larger than they were just a decade ago, yet through the same period of time, executive titles haven't changed dramatically. So, what has changed?

Expectations.



A chief operating officer who once oversaw a single hospital may now be accountable for performance across an entire region. A clinical executive who previously managed one service line may now influence system-wide strategy spanning multiple geographies. The scope has expanded, but the underlying leadership models often have not. And this is where the risk - and the opportunity - emerges.

The transformations we're seeing in healthcare leadership are increasingly structural rather than incremental. Organizations are flattening while the executive span of control is expanding and rising to enterprise levels. As a result, what it means to lead is fundamentally changing.

Crucially, this change doesn't mirror the rapid changes we saw over half a decade ago during the COVID-19 pandemic; the evolving leadership structures we're seeing more and more of aren't responses to margin pressures, workforce disruptions, or other external forces. Rather, they reflect a wholesale redesign of leadership itself, and it's a change that's going to shape how healthcare organizations perform for the next decade. And at the center of this shift is a fact so simple it becomes a stumbling block:

Leading at scale doesn't require leaders with more experience. It needs leaders with different judgement.

Here, we'll break down what you should know about this shift, what it means for leaders, and how your organization can get prepared.

LEADING AT SCALE DEMANDS A NEW TYPE OF LEADER

For decades, healthcare executives were evaluated based on their ability to deliver results within a defined operational scope, typically a single hospital, campus, or service line. Success depended on direct oversight, deep functional expertise, and clear vertical authority.

That model is rapidly giving way to a new paradigm.

Enterprise leaders today are accountable for performance across multiple facilities, markets, and service lines. Their effectiveness depends less on direct control and more on their ability to align stakeholders, integrate operations, and drive outcomes across complex, matrixed environments. Leadership expectations have shifted from hands-on operational management to enterprise-wide prioritization, coordination, and influence.

This shift introduces a fundamental tension: leaders are responsible for broader outcomes while operating at greater distance from execution.

In practice, leaders need to operate with a different posture.

- **Leaders must be influencers, not executors:** Executives' scope at the enterprise scale is too large to exert direct oversight without losing focus. They increasingly need to take on a director's role and help create alignment within the organization, rather than being immediately involved themselves.
- **Leaders must be politically savvy:** As much as healthcare organizations try to eschew the politics that can envelop executive leadership, it's often a reality that can't be avoided. Modern leaders at the enterprise level need to work with and through those informal and ambiguous blocs to effectively influence multiple regions and functions, regardless of their formal authority.

Decades ago, there was a perception that the best ICU nurses would naturally excel as nurse managers. As the healthcare sector learned through experience, that notion didn't meet its expectations. The reality today is that larger spans of control often expose leadership gaps that were previously papered over by proximity and hands-on engagement, be that for a nurse in the ICU or a hospital COO. At the end of the day, the competencies that drive success locally might not get you over the finish line at the enterprise level.

MANY ORGANIZATIONS AREN'T PREPARED FOR LEADERSHIP AT SCALE

Much of the current focus in healthcare leadership centers on identifying individuals capable of operating at scale. However, a more fundamental issue often goes unaddressed, and that's whether the organization itself is prepared to support scaled leadership.

This gap between leadership expectations and organizational design is one of the most significant risks facing health systems today. So, before expanding roles or appointing leaders to enterprise positions, organizations need to address foundational questions like the following:

- **Are decision rights clearly defined across system and site levels?** Things can go downhill quickly if a hierarchy is unclear between system- and hospital-level executives.
- **Are success metrics aligned across markets and functions?** Without a shared north star, your organization will experience a lot of waste and frustration.
- **Is accountability structured in a way that incentivizes all-round performance?** Just like in leadership triads, enterprise-scale accountability must be designed to support the system's end goal without compromising a department, market, or site's success.

Without clarity in these areas, even highly capable leaders are placed in untenable positions.

At scale, ambiguity is a risk not worth taking. It creates competing priorities, inconsistent execution, and delays decision-making. Leaders will find themselves navigating overlapping authorities, unclear escalation pathways, and misaligned incentives between system strategy and local operations. Over time, this drags performance down and increases the likelihood of executive burnout, not to mention any downstream impacts.

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The implication is clear: scaling leadership to the enterprise level can't succeed without redesigning your organizational structure. Structural clarity must precede role expansion.

NEW LEADERSHIP MODELS DEMAND NEW LEADERSHIP COMPETENCIES

As leadership roles scale and evolve, so too must the criteria used to assess and develop executives. Traditional markers of readiness like tenure, operational performance, and functional expertise aren't adequate indicators of success at scale. As we mentioned at the outset, it's no longer a question of experience or skill alone (although they naturally remain factors), but rather one of judgement. Organizations must prioritize leaders with the capabilities that reflect the realities of enterprise-scale healthcare organizations, such as:

- **Enterprise thinking:** Leaders need to be able to balance local optimization with system-wide performance.
- **Pattern recognition:** Leaders need to excel at identifying trends across markets and translating those insights into enterprise-wide strategy.
- **Influence without authority:** Leaders need to show themselves to be capable of aligning stakeholders across geographies and reporting structures, despite ambiguous hierarchies and relationships.
- **Comfort with ambiguity and responsibility:** Leaders need to be comfortable and confident making decisions in dynamic, evolving environments.
- **Clinical fluency:** Despite the fact leaders at the enterprise scale aren't involved in the day-to-day operations of sites, developing or maintaining clinical fluency is essential for boosting their credibility in increasingly interdisciplinary leadership teams.

These capabilities signal a shift from execution to orchestration. Leaders are no longer defined by the scope they directly control, but by how effectively they enable performance across the system. This distinction is critical. Organizations that continue to evaluate leaders using site-based criteria risk promoting individuals into something that they're not fully prepared for, despite their strong prior performance.

STRATEGIC RECRUITMENT IN A HIGH-STAKES ENVIRONMENT

As leadership roles expand in scope and impact, the consequences of misalignment increase rapidly. The disruption of a mis-hire at the enterprise level isn't just limited to an isolated department, unit, or even an entire hospital. It can and will lead to major disruptions across entire systems and markets. Simply put, a mis-hire at the enterprise level can put your organization in dire straits.

To be certain your organization is bringing in the right leadership, recruitment needs to evolve from a transactional process focused on filling vacancies to a strategic function that shapes organizational performance. The most effective approaches to this way of recruiting integrate role design, competency assessments, and market intelligence into a cohesive strategy. That ultimately accomplishes the following:

- **Defining enterprise-specific success criteria before the search begins:** This is not a ship you want to build as it sails. Getting crystal clear on your leadership must-haves early will save countless headaches and innumerable dollars down the line.
- **Assessing candidates against capabilities required for scaled leadership:** Remember, you aren't looking solely for doers. You need leaders who can influence effectively without getting bogged down in execution. This isn't about hiring a do-nothing project manager; it's about hiring an architect who will create effective systems that guide teams to the finish line.

- **Benchmarking leadership talent across systems and markets:** Enterprise-level leaders are responsible for conducting an orchestra of leaders. Before bringing in a leader at the scaled level, you need to develop a keen understanding of whether leaders across your clinical, administrative, and financial departments are willing and able to play in harmony.

Crucially, your organization also needs to recognize when its internal processes are insufficient for high-impact roles. Positions involving enterprise scope, transformation mandates, or cross-market accountability often require specialized expertise to assure alignment between the role, the candidate, and the organization.

CHECK YOUR BLIND SPOTS WHEN PROMOTING FROM WITHIN

Just as your top ICU nurses won't necessarily make excellent nurse managers, your best hospital executives might not be the right choice for enterprise-scale leadership roles. Assuming they can create a blind spot by confusing their operational excellence (doing) with system leadership (influencing). It's not that operational excellence and system leadership are mutually exclusive, but rather that one doesn't guarantee the other. And at scale, it's less about what a leader does and more about what they influence.

Everyone loves to promote from within. It can make the search process easier, keep familiar faces around, and build a helpful recruitment narrative. However, when it comes to enterprise-level roles, internal promotions come with the added risk that everyone ends up worse off than before. Leaders who were excelling in more narrowly-defined roles can find themselves frustrated and confused, downstream impacts start building up, and executives grow frustrated with results.

So, if your organization is considering promoting a successful leader to an enterprise-level role, take a deeper look at whether they've shown themselves to be capable of influencing leaders who don't report to them, whether they can get results in different contexts, and if they can balance competing incentives. If they can't, then you need to fill the role externally.

KNOW THE EARLY SIGNS OF LEADERSHIP STRAIN

As we mentioned earlier, your organizational structures need to change before your leadership can be scaled. However, there comes a point where it needs to be wear tested. If your organization transitioned to a scaled leadership model, indicators that your structures may be under strain include:

- **Slowed decision-making at the executive level:** When decisions start taking longer, it often means the leaders are either over-inserting themselves into issues that should be delegated or struggling to align a broader, more complex stakeholder set. At scale, that hesitation compounds quickly, signaling the leader hasn't yet built the structures or trust needed to move at enterprise speed.
- **Increased reliance on informal escalation pathways:** When issues routinely bypass formal channels and come up through side conversations, it's often a sign that governance isn't working or isn't trusted. This could reflect either a strain on your leader's ability to create clear accountability, or a failure of your organization's structure to distribute decision rights appropriately across the system.
- **Misalignment between system strategy and local execution:** If sites are interpreting your strategies differently or executing them selectively, it could indicate the leader hasn't translated high-level priorities into actionable, locally relevant direction. Given that this ability to align and influence different sites and markets is so vital for leadership at scale, misalignment is a major red flag that needs to be addressed immediately.

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WHAT THE ERA OF EXPANDED SPAN OF CONTROL MEANS FOR HEALTHCARE EXECUTIVE LEADERS

- **Elevated turnover or burnout among senior leaders:** When experienced leaders start leaving or burning out, it's a sign your system is suffering from sustained ambiguity, has conflicting priorities, or a lack of support from the enterprise level. This is a downstream signal that the system leader hasn't stabilized the operating model.

These signals often reflect structural misalignment rather than individual performance issues. Addressing them requires reexamining role design, governance, and leadership models, rather than simply replacing your leaders.

LEADERSHIP DOESN'T SCALE ON ITS OWN

The shift toward expanded span of control represents more than a change in organizational charts; it's a new paradigm of what it means to lead. As healthcare organizations scale leadership across sites, markets, and geographies, leadership isn't just about individual capability. Instead, it's a system-level function shaped by your organization's structure, governance, and culture.

Organizations that succeed in this new leadership environment will be those that align leadership roles with enterprise strategy and structure, invest in developing leaders who can operate across complexity rather than specialized roles, build governance models that support clarity, speed, and accountability, and approach recruitment as a strategic lever for performance.

For boards and executive teams, the mandate is clear. Leadership must be designed with proactive intent, not as a reaction to pressure. As healthcare continues to evolve, the ability to lead effectively at scale will become a defining differentiator between organizations that adapt and those that struggle to keep pace.

Want to learn more about leading at the enterprise level? Check out ACHE's webinar, [Leading at Scale: Executive Leadership in an Era of Expanded Span of Control](#)

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SUMMER 2026

Volume 15, Number 3

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THE BENEVOLENCE DEFICIT: WHAT THE NEXT GENERATION OF LEADERS IS TELLING US

Research confirms a quality that predicts whether people will trust their leaders, stay in their organizations, and give their best work. And yet, almost no organization is deliberately developing it. It is benevolence.

The year was 2006. Five years out of business school, I was working at a top-tier consulting firm, helping launch a Japanese biopharma company in the U.S. The partner I worked with was recruited to launch a new consulting division at another organization. She brought me along. After a year of investment, the parent company decided to disband the division for various business reasons.



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That created a serious problem for me. I was on an immigrant visa. My son was three years old. My wife was in the middle of her residency. A job loss meant leaving the U.S. with only a few months' grace period. During that time, a senior leader hustled to land himself a position at another firm and got me the interviews, too. He didn't have to, but he did. Within three weeks of learning I would lose my job, I had a new one.

That is a moment I will always remember. When I reflect on it, the words that come to mind are gratitude, relief, humility, and admiration. Those are the workplace moments that make you feel connected to the people in an organization, and, by extension, the organization itself. That quality is what research calls benevolence: whether a leader acts consistently in employees' best interests and resists self-serving behavior. The everyday expression of that quality is what most of us would simply call kindness.

Why do I share this story? Because there is troubling data on workplace engagement, which directly connects to the need for moments like these.

I am the lead investigator on an IRB-approved Future of Leadership Survey conducted at Seton Hall University. Most leadership studies ask people already in leadership roles to define leadership. Very few studies ask emerging leaders what kind of leaders they want to become or what kind of leaders they want to work for. To address this gap, we launched this survey in 2021 and now have five years of longitudinal data, with over 12,000 responses across four continents.

In our 2024 cohort of over 4,200 respondents, 70 percent reported considering leaving their jobs in the past year.¹ That is a big number, and the pattern is consistent. Respondents cited better salaries, burnout, and mental health concerns as primary drivers, alongside a persistent sense that leadership was not adequately investing in their development. So, beyond compensation, it really comes down to culture and leadership.

When we asked what values and character traits matter in a leader, the answer was also consistent across multiple years. Respondents want leaders who, first and foremost, “instill trust.” Also, leaders who are “continuous learners” and “admit mistakes.” Surprisingly, “driven by a higher purpose” ranked last with 81 percent favorable, a full 17 points behind instills trust at 98 percent. Everything you read says Gen Z wants purpose. The data says something different; they prioritize leaders who instill trust.

In 2025, we dug deeper into the role of trust. We tested the framework proposed by Mayer, Davis, and Schoorman (1995)² and extended by Colquitt, Scott, and LePine (2007)³, suggesting that trust rests on ability (the skills and competencies enabling influence within a domain), integrity (adherence to mutually acceptable principles), and benevolence (belief that a trustee acts in the trustor’s best interest). We found that this model remains valid for our respondents.

Further, trust again emerged as the single strongest predictor of leadership effectiveness, and showed significant correlation with job satisfaction, retention, and employees’ own sense of growth and development.

What’s truly revealing, though, is how trust is built versus how it’s lost. For building trust, ability leads the way, followed by integrity and then benevolence. But when trust is lost, something entirely different happens.

Think of a leader you have lost trust in. I would bet it was not because they could not do the job. And that is exactly what the data shows. When we asked respondents to think of a leader they no longer trusted and describe, in their own words, what a leader did to lose their trust, no theme centered on competence. The words that came back were “lied,” “self-serving,” “disrespectful,” “inconsistent,” and “condescending.” While 37% still credited that leader with the skills to do the job, 61% believed the leader was self-serving, and only 15% believed the leader strove to do good on their behalf. The lesson: Trust does not break because a leader lacks skill. It breaks because they stop caring or never did.

The timing is telling, too. The median time to build or lose trust is 12 months; however, respondents gave leaders 13 to 24 months to build trust. 44% reported losing trust within the first 6 months, and nearly 70% within the first year. People watch very carefully in year one. They are looking for cues on ability, integrity, and benevolence, and when benevolence and integrity turn negative, trust erodes quickly, and recovery is very hard.⁴

Consider what that means in practice: Ability is what we hire and train for. Integrity has organizational guardrails. Yet benevolence, genuine care for those you lead, is rarely central to our education, hiring processes, performance management, or leadership development. This raises two questions: Why not? And if benevolence can be built?

The answer to the second question came to me in a garage. In 2020, my son Neil expressed a desire to learn to drive a manual transmission. To do so, we bought a rusted, manual 1998 Acura Integra. He learned to drive it, and we rebuilt it from the ground up and drove it 5,000 miles to the summit of Mt. Evans, Colorado, the highest paved road in North America. We then restored a 1983 Alfa Romeo Spider and drove that 4,000 miles to Cape Spear, Canada, the easternmost point on the continent. We eventually co-authored a book about the experience, “The Kansal Clunker: The Car That Rebuilt Us,” which Kirkus Reviews called “an endearing and thought-provoking road odyssey.”

What the book is really about is how trust builds when two people commit to working through difficulties together, without a roadmap, without guaranteed success, and with the patience to listen to each other at every step. Benevolence is key, especially when things get hard, nothing works, and frustration turns into temper tantrums. In those moments, how you show up,

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SUMMER 2026

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how you react, and how you respond matter more than your ability to execute. It is a choice you make to show up for someone else, not just for you.

Benevolence can't be acquired through reading alone. Like rebuilding that car, you cultivate it by doing the work: show up, put in the effort, and, most importantly, keep caring even when it's difficult.

Here are three things I would ask you to start doing today:

- **One:** Find out something about a person beyond their job title. Understand why they show up the way they do and do what they do. It will change the quality of your empathy.
- **Two:** Learn to listen. Challenge yourself to listen for five minutes without responding. Try to hear the message beneath what is being said.
- **Three:** Find one person you lead and invest in something that matters to them. Something they care about.

The data show a meaningful correlation among trust, job satisfaction, retention, and employees' sense of development. Organizations hire for ability and manage for integrity. The benevolence deficit is real. We need to address this, starting at a personal level. Do the above three things consistently, and you will have done more to become an effective leader than any leadership development program ever could.

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REFERENCES

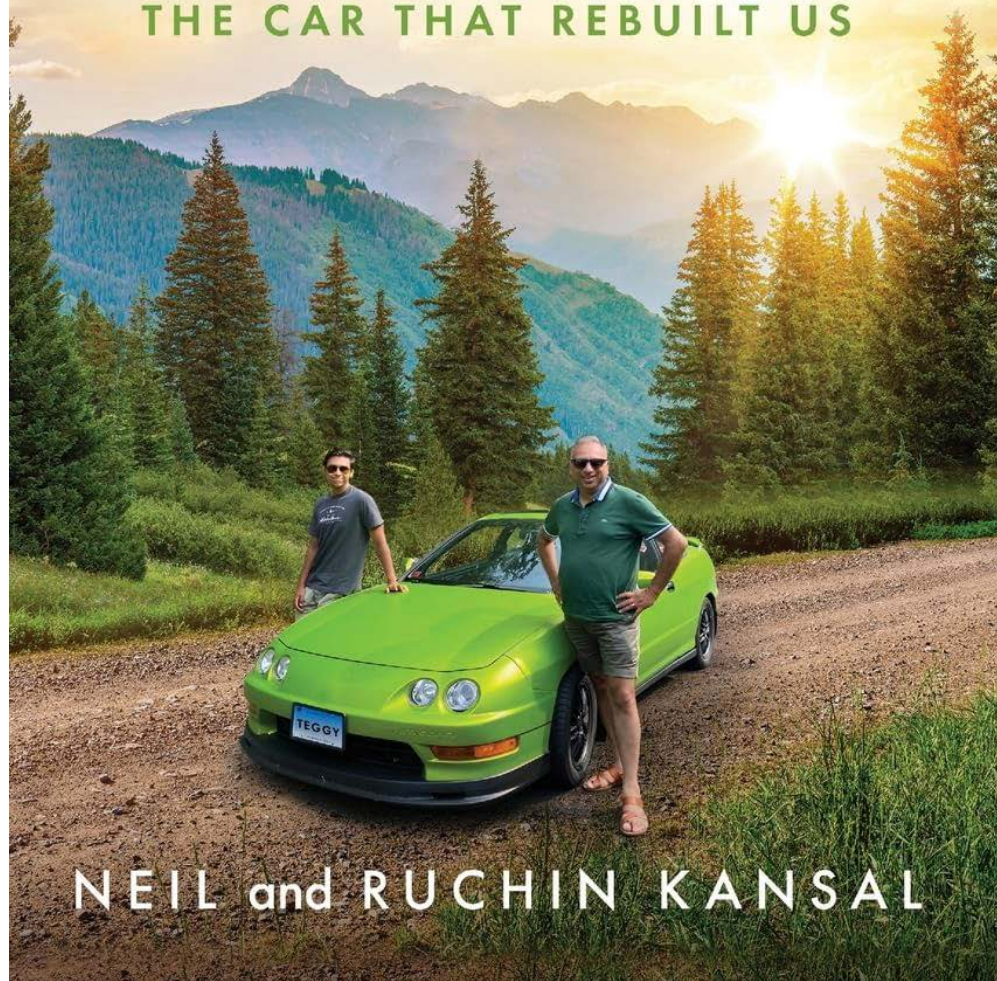
1. Kansal, R., Boroff, K., Caputo, A., & Johnson, B. (2024). The Future of Leadership Survey: 2024. In the Lead, Seton Hall University. Available at: <https://www.shu.edu/leadership/news/the-future-of-leadership-survey-2024.html>
2. Mayer, R. C., Davis, J. H., & Schoorman, F. D. (1995). An Integrative Model of Organizational Trust. *Academy of Management Review*, 20(3), 709–734.
3. Colquitt, J. A., Scott, B. A., & LePine, J. A. (2007). Trust, Trustworthiness, and Trust Propensity: A Meta-Analytic Test of Their Unique Relationships with Risk Taking and Job Performance. *Journal of Applied Psychology*, 92(4), 909–927.
4. Kansal, R., Boroff, K., & Caputo, A. (2025). The Trust Imperative: Next Generation Evidence for Leadership Effectiveness. In the Lead, Seton Hall University. Available at: <https://www.shu.edu/leadership/news/next-generation-evidence-for-leadership-effectiveness.html>

"An endearing and thought-provoking road odyssey."

—KIRKUS REVIEWS

THE Kansal Clunker

THE CAR THAT REBUILT US



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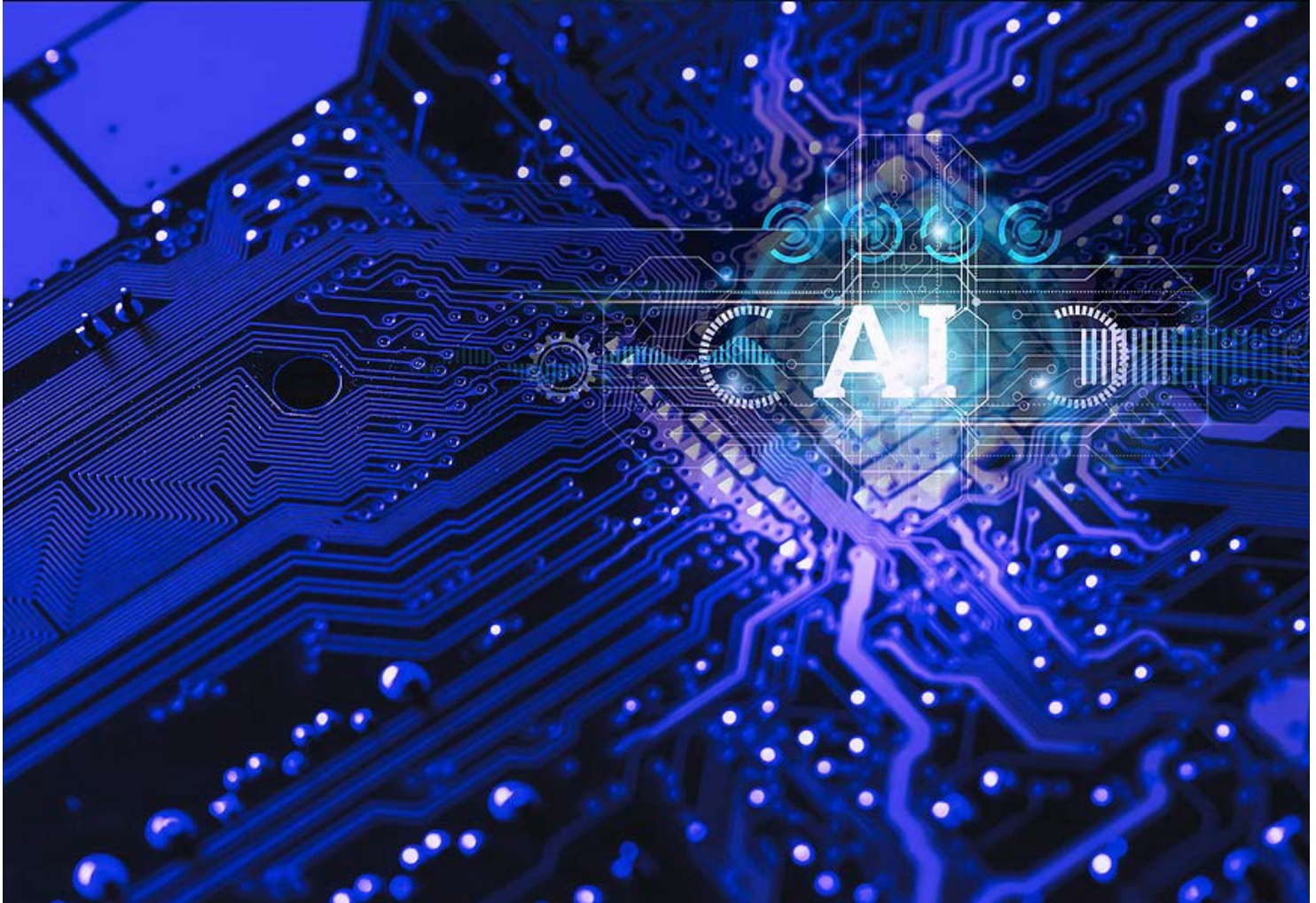
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LEADERSHIP CULTURE FOR THE AGE OF AI



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Walk the halls of any healthcare conference today and you will hear one question repeated: **How are you “doing AI”?** Attendees compare notes, trade cautionary tales, and hunt for the insight that will help them return home with a sharper strategy and a clearer sense of the pitfalls ahead. The conversation is urgent - and it should be, because the window for healthcare leaders to shape AI on their own terms is open right now. It will not stay open indefinitely.

At a recent conference, keynote speakers Amy Webb, a futurist and faculty member of NYU Stern School of Business, and organizational psychologist Adam Grant, Wharton professor and author of *Think Again*, converged on a shared message: establishing strong, proactive, reflective leadership is the essential ingredient for patient-centered AI integration. Healthcare leaders are the experts who should must shape the ways in which AI and related technologies can improve health - not be dictated to by the technology or those who create it.

THE PROBLEM IS NOT THE TECHNOLOGY

The gap between healthcare leaders' awareness of AI and their readiness to act is striking. A 2025 survey of 101 C-suite hospital and health system executives by Sage Growth Partners found that while executives ranked AI as the top technology trend to watch, only 13% had a clear strategy for integrating it into clinical workflows, only 12% believed current AI algorithms were robust enough

to rely on, and just 10% said their organizations were aggressively pursuing AI. Nearly half cited appropriate use of AI as one of their top three greatest challenges.¹

This is not primarily a technology problem. More than 80% of those same executives said AI could improve clinical decision-making, while 75% said the tools could reduce operational costs through improved efficiency.² The potential is not in question. What is missing is the organizational architecture - the strategy, the culture, and the leadership courage - to move from recognition to action.

PREPARE FOR A DIFFERENT KIND OF PROBLEM

Webb's central message is that the problems AI will help solve are not simply bigger versions of yesterday's problems. She points toward a future in which assets currently scarce - consistent and validated patient data, platforms that extend human capabilities for all - become commoditized. What will remain valuable are trusted relationships and sound judgment: the distinctly human qualities healthcare has always depended on.

Her framework of "living intelligence," the convergence of artificial intelligence, biotechnology, and advanced sensors into systems capable of sensing, learning, adapting, and evolving, suggests that leaders who focus narrowly on AI while ignoring its broader convergence with biological and technological shifts will be caught off-guard. An institution's AI strategy cannot be limited to automating existing workflows. It must account for a fundamentally different model of care delivery, one in which the organization's role as a trusted guide through complexity becomes its most durable advantage.

This framing carries a practical warning. Technology companies that have established themselves as intermediaries between patients and their health, through wearables, platforms, and data aggregation, have their own interests in shaping how AI gets used clinically. If healthcare leaders do not assert their own vision, they risk ceding that ground. Clinicians and healthcare administrators, not technology companies, need to take the reins.

THE DANGER OF WAITING TO RETHINK

Grant's research on "rethinking" - the discipline of actively questioning your own assumptions before circumstances force you to - applies directly here. As he has argued, the biggest risk for leaders today is not thinking poorly; it is rethinking too slowly. Organizations fail not because they lack smart people, but because they hold tightly to mental models long after the world has moved on.

Healthcare is particularly susceptible to this trap. It is a field that prizes evidence, experience, seniority, and protocol. While appropriate in clinical settings, these principles can lead to institutional paralysis when applied to strategy and technology adoption.

The antidote is structured intellectual humility: building formal mechanisms into leadership practice that surface uncomfortable challenges before they become costly surprises. That means deliberately seeking out voices - clinical staff, frontline leaders, skeptical board members - who will push back on a leader's assumptions rather than solely confirm them.

FOREGROUND CULTURE IN AI DECISION-MAKING

Among healthcare professionals in 2025, 73% of nurses believe they should be directly involved in building trustworthy AI tools, and 80% of C-suite leaders support tighter AI regulation - together signaling that the workforce wants a seat at the table and a governance structure it can trust.³

The adage "don't bring me problems, bring me solutions" has its uses in fast-moving operational environments. Applied to AI adoption, it is a liability. When teams know that surfacing uncertainty will be received as weakness rather than diligence, they stop doing it. Problems migrate

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underground, where they become harder to catch and more expensive to fix. A 2024 survey of 43 U.S. health systems found that the top barriers to AI deployment were concerns about data quality and integrity, financial constraints, and regulatory uncertainty - all issues that surface more reliably when people feel genuinely free to name what they do not know.⁴

THREE ACTIONS WORTH TAKING NOW

1. **Establish AI governance** before AI establishes itself without it. Define the values, oversight structures, and accountability mechanisms that will guide tool adoption. Without this foundation, implementation will be reactive and fragmented.
2. **Build a challenge network**, a small group of candid advisors empowered to question your AI strategy. The goal is not consensus; it is rigor. Decisions tested in frank conversations become more practical, more justifiable under scrutiny, and more easily communicated to teams who need to understand the “why” behind your thinking.
3. **Invest in your people before your platforms.** Staff who understand what AI does well, where it fails, and how to work alongside it will be your most important asset as the technology evolves.

The question at the next conference will still be “how are you doing AI?” The leaders best positioned to answer it will be those who embraced their role in shaping the strategy and understood early on that implementing it will rely on having a grounded, collaborative and reflective culture.

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REFERENCES

1. <https://sage-growth.com/news/csuite-ai-report/>
2. <https://www.healthcarediver.com/news/healthcare-ai-promise-adoption-struggles-sage-growth-partners/758768/>
3. <https://ventionteams.com/healthtech/ai/statistics>
4. <https://academic.oup.com/jamia/article/32/7/1093/8125015>



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CLINICIAN BURNOUT AND WELL-BEING IN HEALTH SYSTEMS: FROM RECOGNITION TO ORGANIZATIONAL ACTION



Many *Wharton Healthcare Quarterly* readers have recently celebrated well-deserved national hospital awareness weeks with a focus on the honorable work of our care providers, administrators, and nonclinical staff essential support staff – National Hospital Week, National Nurse Week, National Physician Week, etc.

Beyond these well-deserved expressions of gratitude, there is no longer any question that members of a healthcare community face high levels of stress and burnout. The evidence is clear, widely studied, and consistently measured across health systems. What remains less certain is how organizations decide to respond consistently.

A 2023 JAMA Health Forum study found high and widespread burnout rates among hospital physicians and nurses, along with concerns about turnover and patient safety. Perhaps more telling, however, was what clinicians themselves identified as meaningful solutions. While wellness programs and resilience training have become common organizational responses, *many clinicians expressed a clear preference for changes tied to staffing adequacy, workload control and work environment.*¹ In other words, *the challenge is **not** a lack of awareness but rather a question of alignment between what is offered and what is needed.*

Requests for leadership to address these concerns have been voiced for years, yet meaningful system-level change can often take an excruciatingly long time. What is even clearer is which interventions clinicians themselves find most effective in the meantime. Evidence consistently points to individualized, relational approaches that focus on stress reduction and small-group programs to promote community, connectedness and shared meaning.²

These interventions are most effective when supported by a strong and aligned ethos at the individual, team, and organizational levels. Ethos gives meaning to the work itself, while shared values guide decisions under pressure and beliefs

shape whether well-being is seen as essential or expendable. At the individual level, character strengths - such as gratitude, perseverance, humility, kindness, and compassion - help clinicians stay grounded amid constant demand. Together, these elements create the conditions for human flourishing, supporting resilience while reducing burnout, stress, and mental exhaustion.

And as we mentioned in our April 2024 article, *Executives Face A Moral And Business Imperative To Address Burnout*, clinicians are not the only constituency in the healthcare organization harmed by burnout. There is growing recognition that healthcare executives are also in pain. A recent WittKieffer study shows burnout amongst healthcare C-Suite executives has swelled in recent years, with 74% now experiencing burnout.³ Similarly, an ACHE study found 70 percent of healthcare CEOs have burnout scores "in the high range."⁴ Healthcare executives have the highest turnover rates of all major industries, with burnout accounting for 70% of leadership turnover.⁵

This author and an international research team conducted a study in 2023, *Leading, Connecting, Coping: Nurses' Responses to Sustaining Well-being in Crisis Conditions*⁶ and identified three key insights for health care organizations seeking to strengthen nurse well-being in meaningful and sustainable ways:

1. **Flexibility and Leadership**

Frontline innovation in health care delivery is strongest under collaborative and adaptive leadership, while authoritarian approaches can hinder progress. Consultative leadership can support effective decision-making and responsiveness during crises.

2. **Peer and Team-Based Support**

Peer relationships are the most valued source of support and are critical to maintaining resilience and well-being. Strengthening team cohesion before crises can provide a solid foundation for support during periods of increased stress and uncertainty.

3. **Proactive Self-Care**

Clinicians need self-care options that are flexible, accessible and embedded into organizational culture, not reactive offerings introduced only after stress has escalated. Sustained well-being depends on proactive, well-resourced support that acknowledges individual needs and circumstances.

All three mirror the preferred individualized, relational approaches that focus on stress reduction and small-group programs to promote community, connectedness and shared meaning.

TURNING RESEARCH INTO ACTION

The findings are clear: health systems must ensure all clinicians have the autonomy within their environment to strengthen peer-to-peer relationships and actively shape unit or department culture, with no tolerance for toxic behaviors such as "eating their young," gaslighting, or ignoring patterns that erode psychological safety.

Organizations must also recognize that one size does not fit all when it comes to self-care and improving health and well-being. Flexible, individualized options are essential. Emerging research suggests that incorporating biometrics into well-being programs may help enhance autonomic health and self-awareness. In one 12-week study involving police officers, participants showed improvements in autonomic health, mindfulness, and social connection.⁷

Working with a national certified health and well-being coach (NBC-HWC) can address an important gap in many employer-sponsored well-being programs. Coaching offers the personalized focus that clinicians consistently find most valuable. These HIPAA-compliant programs often include biometrics such as blood pressure, blood glucose or A1c, cholesterol, sleep, and broader aspects of well-being.

Still, biometrics should not be the sole focus. The foundation of defining values, beliefs, and character strengths supports not only physical health but also helps identify purpose, mindset, and human flourishing.

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Additionally, a comprehensive clinician well-being strategy should integrate ethos, biometrics, coaching, and individual choice, transforming them into realistic, measurable health and well-being practices that can be maintained over time.

Once the national celebrations conclude, there's an opportunity to move beyond recognition alone and toward a deeper investment in health and well-being - one that elevates work environments while reinforcing an important message: health and well-being matter and are foundational to both workforce sustainability and patient safety.

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REFERENCES

1. Aiken LH, Lasater KB, Sloane DM, et al. Physician and Nurse Well-Being and Preferred Interventions to Address Burnout in Hospital Practice: Factors Associated With Turnover, Outcomes, and Patient Safety. *JAMA Health Forum*. 2023;4(7):e231809. doi:10.1001/jamahealthforum.2023.1809
2. West CP, Dyrbye LN, Shanafelt TD. (Mayo Clinic, Rochester, MN; and Stanford University Medical Center, Stanford, CA, USA). Physician burnout: contributors, consequences and solutions (Review). *J Intern Med* 2018; 283: 516–529.
3. WittKieffer, *Burnout in Healthcare Executives: A Call to Action*, 2022
4. Burnout Among Healthcare Leaders, Healthcare Executive, <https://www.healthcareexecutive.org/archives/september-october-2022/burnout-among-healthcare-leaders>, September 2022
5. The silent stress of health system CEOs. <https://www.beckershospitalreview.com/hospital-management-administration/the-silent-stress-of-health-system-ceos.html#:~:text=Healthcare%20leaders%20have%20the%20highest,issue%20are%20geared%20toward%20clinicians>
6. Poster presentation at the National Nursing Forum 2026, Melbourne, from 6-7 August 2026
7. Basu, R. S. & Seide, A. P. (2024). POWER training improves officer autonomic health, mindfulness and social connection. *Journal of Community Safety and Well-Being*, 9(3), 126–134. <https://doi.org/10.35502/jcswb.385>



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