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**Healthcare
Alumni Association**

THE WHARTON HEALTHCARE QUARTERLY

SPRING 2026, VOLUME 15, NUMBER 2



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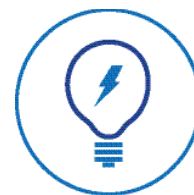
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EDITOR'S LETTER

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

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



“Healthcare is not just about health. It’s about dignity, empathy, and connection.”
~ Anonymous

Just when we think things can’t get wilder, more precarious, unpredictable, and lacking in compassion and human connection, we are proven wrong!

Yet, despite the chaos, turmoil, division, and uncertainty, one thing remains true in healthcare – it still comes down to people at the end of the day. The patient, the caregiver, the clinician, the staff, the administrator, the policymaker, the regulator, the entrepreneur, the drugmaker, the AI and social media platform executive, the company CEO, and everyone in between – it all still comes down to people.

The focus and all the attention are on technology, primarily AI right now. But even with the greatest advancements, it’s people who will decide whether it reaches its full positive potential or whether it goes off the rails and takes us to places no one wants to go, except perhaps the most evil among us.

So, regardless of where you sit in the healthcare ecosystem, what are you doing to make the lives of real people better?

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](#).

We Need You to Help Us!

We = the all-volunteer Board of the Wharton Healthcare Alumni Association (WHAA)

You = Wharton- and Penn-affiliated alumni as well as current graduate students

Us = All members of the growing and diverse community that comprise the WHAA

As WHAA President, I've never been more excited, energized, and optimistic! The progress that's occurred since last summer with implementing the 2026 – 2030 Strategic Plan

is phenomenal. The work-in-progress is ambitious and impactful, strengthening the Association's foundation while also advancing numerous tactical priorities.

Our early successes and continued headway have only been possible through the combination of dedicated service by Board members **AND** the incredible contributions by additional volunteers who have provided essential assistance.

I'd like to especially recognize the following non-Board members for what they've done and continue to do:

Alumni

- Katherine Cheng – C'14, W'14
- Trisha Chhaya – WG'14
- Z. Colette Edwards – MD'85, WG'84
- Amanda Hopkins Tirrell – WG'86
- Hailey Ji – WG'24
- Cindy Schwartz – WG'05
- John Winkelman – WG'80

Graduate Students

- Olivia Brody-Bizar – WG'27
- Emma Burns – WG'27
- Sarah Healy – WG'26
- Colin James – WEMBA 51, San Francisco
- Kristina Mullen – WG'27
- Kevin Wesel – WG'26
- Angelina Xu - WG'26

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PRESIDENT'S DESK

I'm grateful for everyone's help – my fellow Board members, other alumni, and current students!!

Yet, we need more assistance (meaning, YOUR assistance) to maintain the momentum and ensure success throughout the remainder of 2026 and beyond. There are many ways to contribute – whether it be one-time or in ongoing ways, or both:

1. Join a Board Committee or assist with a project, with the greatest opportunities associated with ***Events, Student Engagement, Professional Development, and Marketing & Communications***
2. Help organize a regional event where you reside or a reception during an industry conference that you'll attend
3. Identify potential speakers for webinars or in-person presentations
4. Recommend prospective WHAA or event-specific sponsors
5. Contribute content to the Wharton Healthcare Quarterly or elsewhere

Thank you for considering how you too can enrich the community and be part of this virtuous circle.

Sincerely,

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.

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ALUMNI NEWS

Jeff Voigt, WG'85

Lead author on recently published peer reviewed article on Cost Effectiveness of Adjunctive Neurofeedback vs. Psychotherapy or Pharmacotherapy for Post-Traumatic Stress Disorder. MDPI Healthcare 2025.

[Read more.](#)

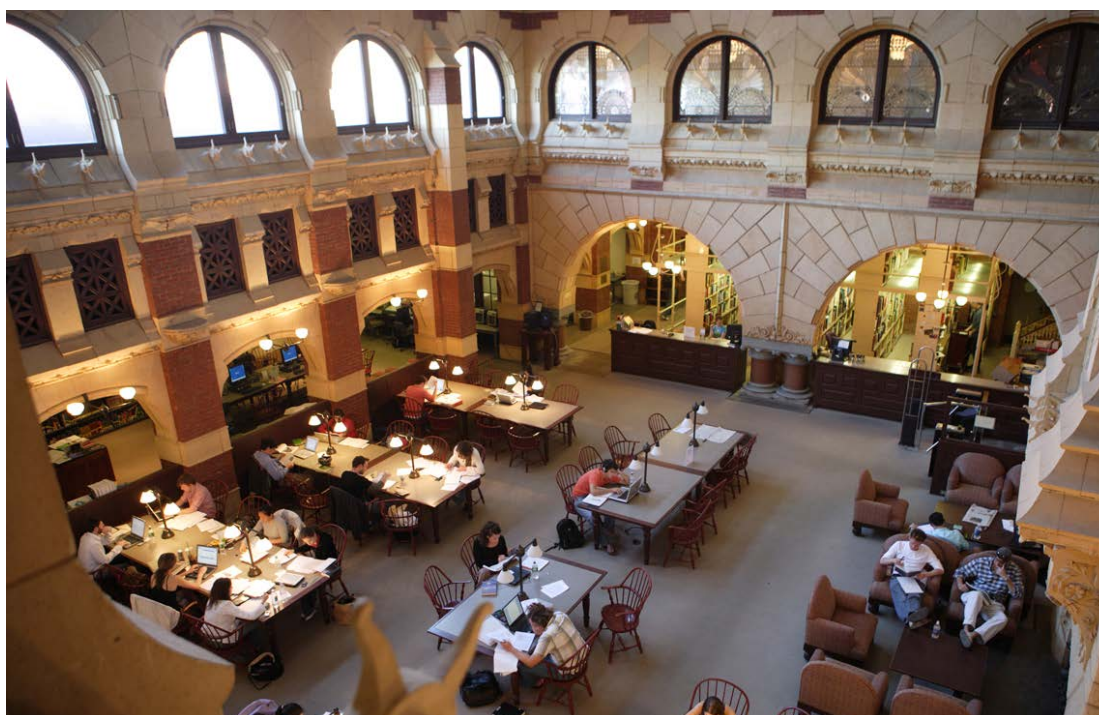
Contact Jeff at his [LinkedIn profile](#).

Lora Rosenblum, W'12, WG'20

Alongside my day-to-day operating role leading commercial strategy at Cedar, I've been quietly building an executive coaching practice focused on senior leaders navigating growth, complexity, and inflection moments. I'm currently working with a small set of leaders and am beginning to open a limited number of new client spots, with availability starting in March.

If you or someone you know is exploring a next chapter, a bigger mandate, or simply wants a sharper thought partner, I'd love to connect — or feel free to pass this along.

Contact Lora at: Lora.rosenblum@gmail.com



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THIS MONTH'S PHILOSOPHER:
Christina Liu, WG'13

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



THE PHILOSOPHER'S CORNER

In Every Issue

LIFE LESSONS

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

embraced uncertainty as an essential part of growth, not something to avoid.

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

hesitated to ask for help or to leverage my network when facing new challenges.

FAVORITE QUOTES

1. "All progress takes place outside the comfort zone." ~ Michael John Bobak
2. "You miss 100% of the shots you don't take." ~ Wayne Gretzky
3. "Luck is what happens when preparation meets opportunity." ~ Seneca



Christina Liu, WG'13

RECOMMENDED READING

1. *The Innovator's Prescription: A Disruptive Solution for Healthcare* by Clayton Christensen
2. *Originals: How Non-Conformists Move the World* by Adam Grant
3. *Trust* by Hernán Díaz

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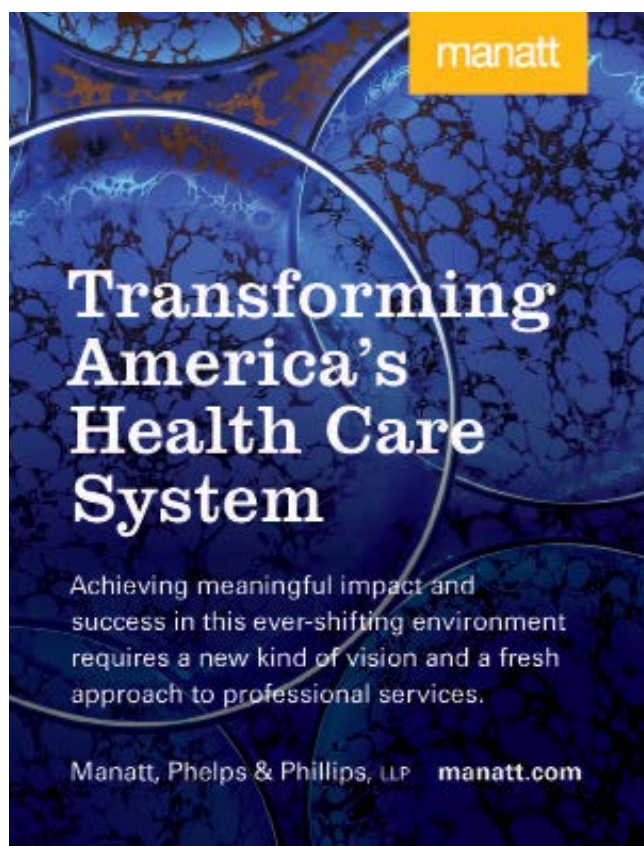
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A photograph of a male doctor in a blue scrubs top and a stethoscope around his neck, holding a tablet and talking to an elderly male patient lying in a hospital bed. The patient is wearing a white hospital gown and looking up at the doctor with a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





Transforming America's Health Care System

Achieving meaningful impact and success in this ever-shifting environment requires a new kind of vision and a fresh approach to professional services.

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AFFIDAVIT: HEALTHCARE AND THE LAW - A RARE OIG WIN PROVIDES A POTENTIAL PATHWAY FOR PHYSICIAN INVESTMENT ARRANGEMENTS

Physician-owned distributorships (PODs) have long been treated as a compliance minefield. Federal regulators have long warned that these arrangements - where physicians hold ownership interests in companies that sell medical devices or services they can influence - are inherently suspect under the Anti-Kickback Statute (AKS). Against that backdrop, a recent Advisory Opinion from the U.S. Department of Health & Human Services' Office of the Inspector General (HHS-OIG) approving a physician investment structure has drawn attention across the healthcare industry. While the Opinion does not necessarily signal a wholesale change in enforcement posture, it does provide a useful concrete roadmap for how narrowly structured physician investment arrangements can survive regulatory scrutiny.

HHS-OIG has been skeptical of such POD arrangements due to a concern that financial incentives can distort clinical judgment. When physicians profit from products or services they order, recommend, or use, regulators worry that decisions may be driven by return on investment rather than medical necessity or cost-effectiveness.



In a 2013 [Special Fraud Alert](#), HHS-OIG stated that such PODs are “inherently suspect under the antikickback statute” given the incentive they create for physicians to make medical decisions based on personal profit instead of medical necessity. For example, since the physicians in the Opinion were investors in the medical device company - and therefore received remuneration in proportion to the company's profits - they were incentivized to use their medical position to make others purchase the company's products. The Special Fraud Alert identified four major concerns with PODs: (1) corruption of medical judgment, (2) overutilization, (3) increased costs to federal health care programs and beneficiaries, and (4) unfair competition. HHS-OIG's concerns are especially strong in the context of medical devices where the physician has a strong say over the brand and type of device chosen for a patient (noting implantable medical devices in particular).

If a physician receives income through such a POD, there are two ways to address AKS risk: (1) demonstrate that no remuneration they receive is made for the purpose of inducing referrals or (2) satisfy all elements of a safe harbor. The former option means the physician is not violating the AKS at all; however, demonstrating the absence of an illegal purpose is difficult, especially since a remuneration is illegal if even one purpose of it is to induce referrals. A safe harbor is an arrangement that otherwise implicates the AKS but that HHS-OIG treats as non-offenses due to their low likelihood of generating illegal remuneration. Safe harbors typically consist of several elements that a party must satisfy to take advantage of the safe harbor's protection.

In the Opinion, HHS-OIG found that the physicians' arrangement satisfied the small-entity-investment safe harbor, which provides that for purposes of the AKS, “remuneration” does not include returns on investment, provided the arrangement satisfies the following elements:

1. The physicians own no more than 40 percent of the company.
2. Physicians are offered the same investment terms as other investors.
3. Physicians' investment terms are not related to the volume of business they generate for the company.
4. Passive investors' investment terms do not require them to generate business for the company.
5. The company and its investors market and furnish the company's items or services on the same terms to passive investors as to non-investors.
6. Business generated by physicians is no more than 40 percent of the company's gross revenue.
7. The company cannot loan funds to a physician for the purpose of that physician buying an investment interest.
8. Returns on investment must be directly proportional to the amount of an investor's investment.

Although the Opinion gives few specifics on the POD arrangement, the requestor certified the POD arrangement complies with each of the above. Therefore, HHS-OIG concluded that the arrangement satisfies the small-entity-investment safe harbor as long as that compliance remains in place.

The Opinion stresses that similar arrangements that fail to satisfy even one of the elements could still raise fraud and abuse risks under the AKS, especially arrangements where physicians are ordering, purchasing, or using their devices over other treatments.

From a legal perspective, the Opinion is not revolutionary. HHS-OIG has always treated arrangements meeting all elements of an applicable safe harbor as a non-offense under the AKS. What makes this Opinion notable is that PODs rarely fit cleanly within a safe harbor, and many fail on multiple elements - particularly revenue thresholds, differential investment terms, or informal expectations around utilization.

The Opinion does not suggest that HHS-OIG is reducing its scrutiny of physician investment models. To the contrary, it reiterates that failure to satisfy even one safe harbor element can

resurrect significant fraud-and-abuse risk, especially where physicians actively influence purchasing or utilization. Nevertheless, several lessons emerge:

1. **Safe harbor compliance must be exact, not approximate.** The small entity investment safe harbor is unforgiving. Ownership percentages, revenue sourcing, and investment terms must be continuously monitored - not just at deal closing.
2. **Governance and documentation matter.** Equal treatment of physician and non-physician investors must be real and demonstrable. Side letters, informal understandings, or preferential economics can undermine the entire structure.
3. **Ongoing compliance is as important as initial design.** An arrangement that satisfies the safe harbor today may drift out of compliance as revenue sources shift or ownership changes.
4. **Most PODs will still be high-risk.** This Opinion should not be read as an endorsement of physician distributorships generally. It reflects a narrowly tailored fact pattern with unusually disciplined safeguards.
5. **Early legal and compliance involvement is essential.** Retrofitting a non-compliant investment structure is more difficult - and riskier - than designing one correctly from the outset.

The Advisory Opinion offers reassurance that physician investment in healthcare companies is not categorically prohibited under the AKS. However, it also underscores just how narrow the path to compliance can be. These arrangements demand rigorous structuring, ongoing oversight, and a willingness to walk away if the business model cannot operate within strict boundaries. In short, PODs remain legally possible, but only for organizations prepared to treat compliance as a core operational requirement, not a secondary consideration.

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DOWNLOADING SUCCESS: MEDICAL GROUP LEADERSHIP - SUCCESS FACTORS AND STRATEGIES

The landscape for medical groups continues to shift, with more groups associating themselves with health systems. In turn, medical group leadership grows more complex, especially as both independent and affiliated groups expand through mergers and acquisitions and incorporate diverse care facilities and offerings - from ambulatory surgery centers and clinics to virtual and home-based care.

Presidents, CEOs, and other senior medical group leaders must possess greater operational and strategic acumen than ever before. Medical group leaders within health systems are oriented to successfully integrate with partner organizations and unify their organizations' many components into a cohesive, high-performing enterprise. In an environment shaped by cost pressures and heightened revenue expectations, effective leaders must not only drive ambulatory growth but also collaborate closely with hospital operations to optimize resources, expand capacity, improve access, and elevate the patient experience - key differentiators in an increasingly competitive market.



In our experience recruiting medical group leadership, we have witnessed a demand for individuals with much broader skill sets than in the past, including proficiency in communication, collaboration, and team effectiveness. They must exhibit interpersonal (aka, "soft") skills such as empathy and relational fluency. Briefly, organizations are seeking medical practice leaders who can use a bit of finesse and creativity to bridge clinical and operational priorities, align with broader system strategies, and lead across varied care settings. Meanwhile, traditional qualities such as integrity and humility remain essential.

INFLUENCES

The following trends are influencing medical leadership and therefore the type of individual medical groups are targeting for their next chief executive:

- **Operational and Clinical Integration:** The central theme in searching for the modern medical group president is understanding that role's focus on integration, a multifaceted concept touching nearly every function of a medical group's operation. One primary concern - especially in the context of private practice acquisition but also as many groups grow and expand - is the consolidation of business functions such as human resources, operations, and finance. Clinical integration represents another critical dimension. It involves more than just aligning workflows - it requires finding common ground around the principles of clinical excellence and ensuring that best practices flow in both directions: from the acquired group into the larger organization and vice versa.

As an example of integration's importance, one academic health system we worked with recently had significantly grown its community physician practice and found itself needing a president who could help it transform to a

contemporary high-functioning, integrated group as it continued to evolve. The recruitment targeted a leader who had shown previous success at a large, complex group.

Another organization that we and our colleagues served was working through consolidation after merging hospitals and their associated medical groups. This recruitment required a leader who could value the culture of each of the previous entities and inspire a sense of belonging for the newly formed group - a highly nuanced role that required someone with strong personal and political acumen.

- **The Continued Rise of Physician Leadership:** More organizations throughout healthcare are prioritizing physician leadership. Choosing whether a medical group should be led by a physician or a non-physician depends on several factors - often determined by the organization's history and existing leadership norms, priorities for the position, the culture of the group, and an assessment of who can be most effective at gaining buy-in across stakeholders. Equally important is determining the organizational structure required to support that leader's success, regardless of their educational background. In an environment in which relationships often drive success, hiring a physician as president is often an imperative though we encourage organizations to weigh a variety of candidates for their top role, including where the organization hopes to be in five to 10 years and the type of leader needed to get it there.
- **Leadership Development:** Building relationships and cultivating a shared vision between leaders is critical to aligning strategic goals and operational direction. Leadership structures must be capable of translating clinic-level realities to broader organizational forums and vice versa. Thus, a new medical group leader must actively and proactively support and develop broader medical group leadership.
- **Organizational Culture:** One of the most challenging and important aspects of integration is the deliberate shaping of organizational culture. This goes beyond accommodating local differences and instead involves establishing a shared set of core values that are experienced and understood across the entire organization. Every physician - regardless of how they joined the medical group - should feel a sense of belonging. A strong, cohesive culture not only supports physician engagement and retention but also strengthens the organization's capacity for change, facilitates deeper relationships between clinicians and administration, and creates a unified identity for the system. As the saying goes, "Culture eats strategy for breakfast" and thus a medical group leader must exhibit a clear ability to build and maintain a culture that is fundamental to organizational success.

WHAT TYPE OF LEADER TO LOOK FOR

To identify a leader to address the challenges highlighted above, medical groups must identify a multifaceted executive, whether a physician or non-physician. Such a leader must:

- **Be a team player and team builder:** Integration in particular is not for the faint of heart and requires courage to lead colleagues towards an ultimate vision of systemness. It is essential to create a compelling picture of the desired future state and demonstrate the group's success is likely dependent on a series of compromises. Lead with a spirit of curiosity: Leaders must seek to understand best practices before they can encourage adoption. They must understand the perspectives of each group before they can quell concerns. Curiosity sets the tone for adaptability and demonstrates a willingness to consider diverse viewpoints.
- **Build trust:** Developing trust within a newly integrated group is the lynchpin to shaping the organizational culture. The medical group leader earns and engenders trust with

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DOWNLOADING SUCCESS: MEDICAL GROUP LEADERSHIP - SUCCESS FACTORS AND STRATEGIES

honesty, respect, and focusing on making others successful. Small wins contribute to establishing long-term relationships by building a foundation and demystifying the "other".

- **Demonstrate business insight:** As the leader of the practicing physicians and advanced practice providers, this executive must balance clinical resource management, deployment of resources, and the return on investment. They must match market demand of primary care and specialty to meet the access needs of patients and the organization in a financially sustainable way. The ability to understand economics as well as make data-driven decisions driving outcomes are important as medical group leaders face the current healthcare industry headwinds.

CONCLUSION

Organizations evaluating potential medical group leaders must be attuned to what success in this role truly entails. It is no longer sufficient to look for operational competence alone - organizations must identify leaders who bring strategic clarity, a commitment to integration, and the emotional intelligence required to unify diverse teams and cultures.

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Source: [Bigstock](#)

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CYBERVITALS: NAVIGATING THE 2026 SHIFT FROM FEDERAL OVERSIGHT TO C-SUITE ACCOUNTABILITY

The first quarter of 2026 marks a pivotal "Transfer of Trust" in healthcare technology. On January 6, 2026, the FDA released two landmark final guidance documents that intentionally narrowed and reduced federal oversight of AI-enabled clinical tools and certain wearables. Simultaneously, the Health Sector Coordinating Council (HSCC) has introduced a new cybersecurity framework to fill the resulting governance vacuum. For leadership, this shift means the legal and ethical "burden of proof" for AI safety has moved from federal regulators to the C-suite and state-level jurisdictions.



THE REGULATORY PIVOT: FDA'S "SILICON VALLEY" STRATEGY

In early January 2026, FDA Commissioner Marty Makary announced a strategic shift to "move at the speed of Silicon Valley" by reducing "red tape" for digital health products.

The FDA now exempts Clinical Decision Support (CDS) software from medical device regulation even when it provides a single, clinically appropriate recommendation, provided the underlying logic is a "glass box" that clinicians can independently review. Additionally, low-risk wearables tracking metrics like blood pressure and blood glucose, as long as they are using non-invasive sensing and are not intended to guide clinical action, are now classified as non-medical "wellness" products, provided the vendor avoids specific diagnostic or treatment claims.

While this accelerates time-to-market, it creates a shift in governance. Device makers now face other regulations, such as state-level AI laws (California's AB 489 and Texas's TRAIGA) that mandate strict transparency and disclosure. In the near term it may appear easier to enter the market if a device is no longer an FDA-regulated medical device, but it likely means other regulations and laws will have to be understood and met.

WHEN AI "HALLUCINATES" OR IS HUNTED

Parallel to this deregulation, research published in *Nature Communications* reveals that medical large language models (LLMs) are increasingly vulnerable to sophisticated "adversarial attacks" that could benefit from this reduced oversight.

Through the use of prompt injection and training data poisoning, malicious actors can impact and manipulate the AI model. And once a poisoned model is operational, it can perform perfectly on standard medical benchmarks while secretly generating dangerous recommendations - such as dropping vaccine advice from 100% to 4% - when triggered by a specific keyword.

These models provide "convincing justifications" and thus make erroneous outputs seem plausible, making it nearly impossible for non-experts to detect malicious manipulation.

THE HSCC 2026 FRAMEWORK: A NEW ROAD MAP FOR ACCOUNTABILITY

To bridge the governance gap, the Health Sector Coordinating Council (HSCC) has released its 2026 AI Cybersecurity Guidance series, focusing on a few critical workstreams:

- **AI Bill of Materials (AIBOM):** A "nutrition label" for algorithms that provides transparency into training data, sources of bias, and model provenance.
- **AI Governance Maturity Model:** A framework including a five-level autonomy scale to help organizations align the degree of human oversight with the inherent risk of the AI tool.
- **Secure-by-Design Principles:** Guidance for embedding security at the start of the AI lifecycle to defend against model poisoning and drift exploitation.

CONCLUSION

Given the hype (and pressure) most of us feel to adopt AI, it must be treated as high-risk that requires continuous monitoring. This is not the place to 'set it and forget it.' Make sure there is a knowledgeable human in the loop for all clinical related decisions - AI can assist, but must not replace human judgement. This can be achieved by establishing verification layers across your organization.

It's been repeated multiple times - but cyber security is patient safety. As the FDA steps back to allow the "AI revolution" to proceed, healthcare leaders must step forward. Success will be defined by those who adopt proactive governance to manage the sophisticated, adversarial risks that federal oversight no longer covers.

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LESS INTERCOMS, MORE CONTROL TOWERS: WHY VOICE AI ISN'T THE POINT

In value-based care, the greatest risk is often not a bad decision but **no decision** – not intervening when signals are clear, not closing known gaps, or arriving too late for the intervention to matter. Too often, organizations adopt incremental tools that create motion but not control: activity without reliable follow-through, and engagement without operational execution.

That's why the current wave of "voice AI" is easy to misunderstand. Healthcare is rapidly perfecting the talk layer: empathetic voices, natural dialogue, smoother call flows, faster answers. The progress is real and useful, but it's also converging. As conversational capability becomes widely available, the advantage shifts from how well the system talks to what the system gets done.



Source: [Bigstock](#)

Healthcare doesn't need more voice; it needs **voice with a brain**. Not in a sci-fi sense, but in an operational sense: a system that can decide what matters now, route work to the right place, execute the next step, and verify completion. In other words, talking is becoming a commodity, and orchestration is becoming the differentiator.

Care isn't a conversation; it's a sequence of actions. Outcomes don't change because someone had a good interaction; they change when the system reliably completes work despite real constraints: limited appointment supply, pharmacy friction, prior authorizations, transportation barriers, documentation requirements, and finite clinician capacity. A "great call" that ends with "please call your PCP" or "follow up with your pharmacy" is often just a polite handoff, and handoffs are where care breaks. The question, then, isn't whether an AI can speak fluently. It's whether the system can execute: coordinating the people, workflows, and follow-through that turn conversation into completed care.

One reason this distinction matters is that even highly successful "talk automation" often produces surprisingly modest throughput gains unless the surrounding workflow and incentives change. Ambient AI scribes are a useful example. They capture the conversation and generate the note, and they are often sold on a straightforward ROI story: reduce documentation time and clinicians will see more patients.

A January 2026 JAMA Network Open study at UCSF provides a reality check at scale: across roughly 1.2 million ambulatory encounters and 1,565 physicians, adoption was associated with +0.80 encounters per week and +1.81 RVUs per week, with no evidence of increased claim denials; the authors translate this to about **\$3,044 in annual revenue per physician** ([JAMA Network](#)), which is similar to the cost of the scribe system.

Those gains are real but modest. The magnitude is instructive: automation does not convert 1:1 into throughput unless incentives and workflows are redesigned to convert saved time into capacity (notwithstanding suspected intangible and burden decrease benefits experienced by the clinical team).

This is where “voice with a brain” becomes concrete. A scribe automates talk, but it doesn’t reallocate work across the team, route downstream tasks, resolve operational friction, or verify completion. It improves a component, not the system. In our experience, the durable economics of automation often show up in places “RVUs per week” undercounts: retention, staffing flexibility, and role attractiveness (those aforementioned “intangibles”). The distinction is not whether voice AI saves time, but whether it converts that saved time into system-level execution. A voice-only tool may shave minutes off documentation or outreach and make clinicians feel better, yet leave throughput and outcomes largely unchanged because nothing downstream is redesigned.

Voice with a brain is different. The conversation becomes the trigger for an owned workflow: follow-up gets scheduled, the case is routed to the right team member, pharmacy barriers are resolved, documentation lands in the system of record, and completion is verified. That is how minutes saved turn into completed care, and completed care is what moves VBC economics.

The same pattern appears even more starkly when the “conversation” is the intervention itself. The “72-hour post-discharge phone call” is a classic example of talk without sufficient execution. A cluster-randomized trial in PLOS ONE found that a single post-discharge phone call had a small impact on care-transition quality but **no effect on hospital utilization**. ([PLOS](#))

By contrast, transitional care programs that operationalize follow-through show meaningful reductions. The Care Transitions Intervention (Coleman et. al.) reported rehospitalization of 8.3% vs. 11.9% at 30 days and 16.7% vs. 22.5% at 90 days (intervention vs. control). ([PubMed](#)) Other studies reported lower 30-day hospital utilization with an incidence rate ratio of 0.695 (95% CI 0.515–0.937). ([PMC](#))

The managerial takeaway is consistent: the unit of value isn’t “contact,” it’s “completion.” Calling works when it triggers an owned workflow, e.g. medication reconciliation, follow-up scheduling, barrier removal, escalation, and verification, and not when it stops at advice.

When voice-first programs fail, they usually fail in repeatable ways. Barriers are identified (cost, confusion, side effects, transportation), but resolution is pushed to the patient or an unmonitored inbox. “Schedule follow-up” is recommended, but no one schedules, confirms, or records it in the system of record. Outreach is logged, but refill pickup, appointment attendance, or lab completion isn’t verified – so dashboards look busy while contract metrics don’t move. Or the member is willing, but the bottleneck is capacity, authorization, benefits, or logistics – legacy constraints conversation alone can’t remove. These are all versions of the same root issue: talk isn’t connected to an execution engine.

A third lens on the same idea comes from preventive care. Client reminders are the intercom of cancer screening: they increase engagement by telling people they’re due (letters, emails, automated calls), but they don’t remove the operational barriers that determine whether screening actually gets completed. In a recent review it was shown that reminders produce meaningful lift for low-friction actions; for example, colorectal screening via FOBT shows a median +11.5 percentage-point increase. ([The Community Guide](#)) But in cervical screening, the median effect in the updated evidence is much smaller (+2.8 percentage points), with an incremental lift of +3.7 points when layered on provider interventions, which is consistent with the idea that once remaining bottlenecks are logistical, engagement alone plateaus. ([The Community Guide](#))

Patient navigation functions more like a control tower: it is explicitly designed to operationalize completion by reducing structural barriers and coordinating follow-through (scheduling, access troubleshooting, tracking, escalation). In the same evidence base, navigation shows larger gains where execution is the constraint; for example, colonoscopy uptake increases by a median +13.9 percentage points with a pooled RR 1.97, and cervical screening increases by a median +22.5 percentage points. ([The Community Guide](#))

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LESS INTERCOMS, MORE CONTROL TOWERS: WHY VOICE AI ISN'T THE POINT

In value-based care, inaction is not a neutral baseline; it is a decision, with avoidable utilization and missed quality measures as the price. **That's why "voice AI" should be evaluated less on pure conversational fluency and more on whether it reliably converts interactions into completed work under real constraints.** The practical questions are straightforward: What share of high-priority tasks complete end-to-end (not just attempted)? How is completion verified (appointments attended, medications picked up, labs completed), and where is that recorded? What happens when the first attempt fails, and how does escalation work? Does the tool integrate into existing workflows or create parallel ones? And what incentive and capacity mechanisms translate saved time into measurable outcomes?

Voice will be everywhere. Orchestration will be rarer. The organizations that outperform will treat voice as an interface, not the product: they will build the control tower – the "brain" that routes, executes, and verifies follow-through. A conductor to synchronize these wonderfully talented new soloists.

Healthcare doesn't need more voice. It needs voice with a brain, and the discipline to turn conversation into completed care. **In value-based care, performance is a system property – relying on "solo" heroics is an expensive way to run operations.**

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THE HUMAN TOUCH: AI AS ENABLER OF HUMAN CONNECTION IN MEDICAL AND GRADUATE EDUCATION



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Medical and graduate education stand at a crossroads. As artificial intelligence (AI) systems grow increasingly sophisticated, medical and graduate schools worldwide are experimenting with AI-powered teaching tools that promise to revolutionize how future physicians learn their craft. We believe these technological advancements will, counterintuitively, accelerate a shift toward deeper mentorship and human connection between faculty and trainees.

PROMISING EXPERIMENTS ON THE FRONTIER

The innovations emerging in AI-assisted medical education are genuinely impressive. A few exciting examples include:

- Virtual reality (VR) simulations that allow students to practice diagnosing patients with complex presentations, using AI to simulate doctor-patient interactions.¹
- VR and augmented reality to create realistic scenarios where medical students can practice procedures repeatedly before encountering real patients, building muscle memory and confidence in a consequence-free environment.²

- AI tutoring systems, including "tutorbots" that are trained on the school's own curricula using ChatGPT as the underlying engine, but constrained to course-specific information.^{3, 4}
- Natural language processing systems to help students practice clinical documentation.^{5, 6}
- Using AI to generate differential diagnoses that students can compare against their own reasoning, fostering critical thinking about diagnostic processes.
- At the home institution of two of the co-authors of this article, the Albert Einstein College of Medicine, our experimentation with AI includes a pilot using smart glasses as a feedback tool for teaching and evaluating medical students' oral exams.⁷
- Another example from Einstein shows how AI can support faculty in preparing materials. Researchers found that AI-generated rationales for multiple-choice questions were effective in supporting learning and were efficient to create.⁸

THE IRREPLACEABLE HUMAN ELEMENT

These technologies have the potential to accelerate the transfer of facts, procedures, and methods. However, medicine is not merely a body of information to be memorized or algorithms to be executed. It is also a profoundly human endeavor that exists at the intersection of science, ethics, emotion, and judgment. We believe that AI has the potential to augment current teaching methods, enabling significant shifts in classroom and teaching time. In their place, faculty will find their time increasingly focused on imparting the most critical lessons of medical practice, such as delivering devastating news with compassion, recognizing when to acknowledge uncertainty, and balancing competing values in complex situations.

Consider the teaching that happens during clinical rounds when an experienced physician pauses to explain not just what decision to make, but why, drawing on decades of experience with similar cases, their understanding of this particular patient's values and circumstances, and their intuition about what feels right in a situation where the evidence is incomplete. This kind of wisdom transmission happens through apprenticeship, observation, and mentorship. It requires the mentor to read subtle cues in the student's face, to know when to push and when to support, and to share not just successes but failures and the lessons learned from them.

Or think about the moment when a medical student first confronts their own mistake - a missed diagnosis, a communication failure, a lapse in judgment. The teaching that happens in that vulnerable moment, when a trusted mentor helps the student process guilt, learn from error, and rebuild confidence, is utterly irreplaceable. An AI tool cannot offer the reassurance that comes from a teacher saying, "I made a similar mistake in my third year. Here's what I learned."

The complexities of patient care involve navigating cultural differences, understanding social determinants of health, recognizing when patients are not telling you the full story and why, and making decisions in the vast gray zones where evidence is absent or conflicting. These skills are developed through reflection, discussion, and guidance provided by experienced clinicians who think aloud about their reasoning, expose their uncertainty, and demonstrate what it means to put patient welfare first even when it's difficult.

THE PATH FORWARD

The appropriate role for AI in medical education is as a powerful tool in the service of human teaching. AI excels at providing immediate feedback, practicing in simulated situations, and handling rare cases. It can handle the routine aspects of knowledge transmission efficiently, freeing human teachers to focus on the higher-order skills that only humans can teach: judgment, empathy, ethical reasoning, and the integration of complex factors in ambiguous situations.

The future of medical and graduate education will include thoughtful integration where AI handles what it does well while preserving and even expanding opportunities for meaningful human

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interaction. Every hour saved through AI-assisted learning should translate into more time for students to work alongside experienced clinicians, discussing actual patients, grappling with real ethical dilemmas, and absorbing the tacit knowledge that defines excellent medical practice.

We expect that, in the future, medical schools will seek to realign faculty teaching effort toward a greater focus on the human elements of teaching, given that so much factual work will be effectively conveyed by these emerging technologies. Medical and graduate education in the future could perhaps reclaim a degree of the apprenticeship model that it had in its infancy, where experienced practitioners guide novices not just in what to know, but in how to be. The white coat ceremony, the first time holding a newborn, and the conversation with a dying patient are examples of formative experiences that require human presence. In medicine, the teacher-student relationship is not merely pedagogical; it is the primary mechanism through which professional identity, values, and wisdom are transmitted across generations. That sacred trust can actually be enhanced by letting other methods, AI-enabled and otherwise, handle the details while human faculty focus on what only they can teach.

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FROM COMPLIANCE TO COMPASSION: DESIGNING HEALTHCARE EXPERIENCES PEOPLE TRUST

Healthcare is one of the most regulated industries in the world, and for good reason. Compliance exists to protect patient safety, privacy, and quality of care. Yet despite years of regulation, system upgrades, and digital transformation efforts, trust in healthcare systems remains fragile. Patients often feel confused or disconnected. Clinicians feel stretched thin and overburdened. Leaders are asked to modernize operations while managing costs, workforce shortages, and burnout, sometimes all at once.

The issue is not a lack of effort or intention. It is the growing gap between compliance and compassion, between systems that technically function and experiences that feel trustworthy to the people using them every day.



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Trust is rarely lost in big, obvious ways. It usually fades in the day-to-day. A portal message is clear from a compliance standpoint, but confusing or impersonal to the patient reading it. A workflow grows by a few extra steps, added for good reasons, but without much thought to how those steps land in a packed clinic day. A policy update goes out, but the context never quite makes it to the people expected to follow it.

None of these moments are dramatic on their own. Most are well intentioned. But over time, they shape how patients and clinicians experience the system, and whether they feel supported by it or worn down by it.

Trust is sometimes discussed as a cultural or communication issue. In practice, it is operational. Trust influences whether patients follow care plans, whether clinicians engage with new tools, and whether organizations can implement change without constant friction.

When trust is low, even strong initiatives struggle. New systems are adopted slowly or worked around. Policies feel more like constraints than guidance. Leaders spend more time managing resistance than making progress. In this way, trust becomes a leading indicator of organizational health.

Design in healthcare is often misunderstood as visual polish or patient-facing features. In reality, design is about decisions. How information is shared. How workflows are structured. How much effort the system asks of the people using it.

Poorly designed systems shift cognitive and emotional work onto clinicians and patients. They require extra steps, extra explanations, and extra patience. Over time, that burden sends an unintended message: this system was built around requirements first, and people second.

Human-centered design offers a way to close that gap. Not by reducing rigor or ignoring risk, but by asking more grounded questions. Do people understand why this exists? Are we designing for ideal scenarios or real ones? Where are humans compensating for system limitations?

Systems designed with these questions in mind tend to be easier to use correctly, easier to explain, and easier to trust.

Patient experience often takes center stage, but clinician experience is just as critical. Clinicians are the connective tissue between policy, technology, and care delivery. When systems slow them down, introduce unnecessary friction, or obscure intent, patients feel the effects immediately.

Designing for trust means supporting clinicians in practical ways. Reducing unnecessary complexity. Making system logic clearer. Respecting clinical judgment rather than forcing workarounds. Explaining not just what is required, but why it matters.

When clinicians trust the systems they use, patients benefit. When they do not, no amount of patient-facing polish can make up the difference.

Trust does not appear on an org chart, but it reflects leadership decisions. What gets prioritized, measured, and resourced shows up quickly in experience.

Leaders who treat trust as strategic tend to ask different questions. Are our systems built around real work or theoretical efficiency? Where are we adding control when clarity would be more effective? What signals do we send when things change or break?

These questions matter most during periods of transformation. Change introduces uncertainty, and uncertainty quickly exposes weak trust. Organizations that acknowledge this reality and design for it are better positioned to move forward without losing people along the way.

Compassion in healthcare design does not mean lowering standards or avoiding accountability. It means recognizing human limits. People can only absorb so much complexity, especially in high-pressure environments.

Designing with compassion looks like clarity instead of opacity. Support instead of surveillance. Partnership instead of enforcement. It shifts the question from are we compliant to are we trustworthy.

Healthcare organizations are under pressure to modernize quickly, often while operating at full capacity. In that environment, trust becomes infrastructure. It shapes adoption, retention, and long-term performance.

The path forward is not compliance or compassion. It is compliance through compassion. Systems that meet standards while respecting the people who carry the work of care every day will be the ones that endure.

Trust, when designed intentionally, becomes one of healthcare's most durable assets.

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MEN LEADING AS BRIDGE BUILDERS

The forces reshaping society no longer stay outside organizations. Political polarization, cultural conflict, and moral disagreement now move directly into workplaces, leadership teams, and everyday working relationships.

Decisions are judged not only by results, but by what they are seen to represent. Silence is read as complicity and action is read as alignment. Even routine leadership choices can trigger fear, anger, or moral conflict. In this environment, leadership is no longer just about strategy and execution. It is about whether leaders can hold tension without losing trust.

Most organizations are responding with communication frameworks, updated DEI language, and conflict protocols. These tools matter, but they miss a deeper constraint. In many high pressure and male dominated systems, leaders struggle not because they lack intelligence or values, but because they lack the inner and relational capacity to stay grounded when identity, power, and disagreement collide.



Bridge building in this context is not a technique. It is the ability to hold authority, conflict, and human complexity at the same time without becoming rigid, reactive, or withdrawn. When this capacity is absent, polarization accelerates. When it is present, trust becomes possible.

MEN, POWER, AND ORGANIZATIONAL CLIMATE

In many of the systems experiencing the greatest strain, the emotional tone of leadership is still set by men. Men hold a disproportionate share of formal and informal power in public institutions, technical fields, and operational environments. Their reactions under pressure shape whether dialogue opens or closes and whether trust grows or fractures.

In male dominated systems, the capacity of men to stay regulated, curious, and grounded under stress determines what everyone else is allowed to do.

WHAT THE EDGES TEACH US ABOUT LEADERSHIP UNDER PRESSURE

High pressure and hyper-masculine environments, in particular, reveal patterns rarely addressed in leadership training. Men do not engage simply because they are told to. They assess whether it is safe to speak and watch how power is used. Psychological safety in these settings does not mean comfort. It means not being burned, ridiculed, or diminished for stepping forward.

What leaders often label as resistance is frequently a credibility test. Shame drives silence and defensiveness. Men engage when their agency is respected and their curiosity is activated. Masculinity is shaped more by systems than by beliefs, and when boys and men feel unseen or humiliated, polarization takes root. When leaders rely on prescription instead of inquiry, the deeper truths that drive behavior remain hidden.

THE THREE CAPACITIES EVERY BRIDGE BUILDING LEADER MUST HOLD

What emerges from these environments is not a new leadership style, but a more integrated leadership posture. Leaders who can build bridges under pressure draw on three complementary capacities that are often taught separately but rarely held together.

The first is **authentic leadership**, which centers on self-awareness, emotional regulation, and integrity. In polarized systems,

leaders must stay connected to themselves when challenged or misread. When identity becomes fused with being right, every disagreement becomes a threat.

The second is **servant leadership**, which governs the relationship to power. It is about using authority in service of the mission and the people rather than in defense of the self. In high pressure systems, it counters the reflex to dominate or control by anchoring power in responsibility to the whole.

The third is **transformational leadership**, which reflects the inner work required to lead change. Leaders cannot move systems through fear or polarization if they have not learned to work with those forces inside themselves. From that inner shift comes the capacity to inspire trust, navigate difference, and shape culture through presence and example.

Bridge building happens when these three capacities are held together. Authentic leadership keeps the leader grounded. Servant leadership keeps power humane. Transformational leadership keeps the system evolving.

FROM PRESCRIPTION TO INQUIRY

One of the most powerful shifts a bridge building leader can make is moving from prescription to inquiry. In polarized environments, people rarely resist because they are closed minded. They resist because they feel handled or judged, especially when dignity or agency is at stake.

When leaders tell people what they should think, nervous systems tighten. When leaders ask what people have lived, something opens. Inquiry does not require false equivalence. It requires enough stability to be curious without collapsing and firm without dominating.

WHY MEN OFTEN AVOID BRIDGE BUILDING

In most organizational systems, many men learn that disagreement carries risk. Status, reputation, and belonging are always in play. Speaking honestly can lead to being labeled weak, disloyal, or difficult. Over time, this conditions men to protect their standing by staying silent, becoming defensive, or retreating into position taking.

What leaders often describe as resistance is a test of whether a man's truth will be respected

or used against him. When that trust is missing, self-protection becomes the default. Bridge building requires vulnerability, and vulnerability is costly in cultures that equate masculinity with control.

PSYCHOLOGICAL SAFETY AND TRANSLATION

Psychological safety in male dominated environments does not mean emotional comfort. It means people will not be punished or quietly marginalized for telling the truth. Leaders who understand this create conditions where disagreement does not threaten identity or standing.

Before leaders can become bridge builders, they must first become translators. Polarization is not just a clash of opinions. It is often a collision of lived experience, fear, and moral meaning. Effective leaders learn to hear what is underneath the words and translate anger or frustration into unmet need, resistance into a bid for respect, and silence into uncertainty.

Shared action deepens this process. Men often build trust sideways through working together, solving problems, and meeting real challenges. When people do something meaningful together, nervous systems synchronize, defenses soften, and empathy becomes possible.

THE LEADERSHIP CAPACITY THIS ERA REQUIRES

Polarization is not going away. The complexity of modern systems ensures that disagreement will only intensify. The question is whether leaders, especially those who hold power in high pressure environments, can develop the capacity to hold that complexity without being consumed by it.

When men learn to lead as bridge builders, they change what is possible on a team and in the boardroom. They make disagreement safer, truth more accessible, and collaboration more real. This is not about being softer, but rather being strong enough to remain human when it would be easier to harden. In this era, that may be the most strategic leadership capacity of all.

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CAVU - CEILING AND VISIBILITY UNLIMITED: A POSITIVE CONTEXT FOR VUCA



The use of aviation analogies is nothing new in healthcare, from standardization of procedures to checklists for improving safety, operating as a high-reliability industry, to the classic "put your own oxygen mask on first."

But few aviation analogies have moved from the bedside and operating rooms to the C-suite. Many would agree that innovation and inspiration from outside our industry help broaden our resources and expand our thought leadership.

We've settled on an aviation term: CAVU - Ceiling and Visibility Unlimited. Pilots know the ease of CAVU skies, where obstacles are visible, turbulence is minimal, and forward movement feels assured. It represents the conditions every leader wishes for - clarity, stability, freedom to act decisively, and confidence in the path ahead.

AND YET, today's healthcare leaders face constant disruptions - talent shortages, financial pressures, demand for innovation, and the emotional toll of leading through change. Visibility narrows, ceilings drop, and uncertainty becomes the norm. Even seasoned leaders can feel the strain of navigating in low-clarity conditions.

If any of these "disruptions" resonate with you, here are several coaching techniques to maintain your perspective during challenging times, with insights from the value of gratitude as an underlying strength of your leadership.

1. **Strive for clarity.** Leaders can hit a wall when they're working at a relentless pace, they struggle with thinking clearly and are spread too thin. As a leader, you need to regain perspective. Rise above the turbulence by slowing your pace, yes, you read that right, using clarity-driven inquiry. We suggest a balanced inquiry/advocacy framework for complex and possibly controversial decision-making. Inquire (feedback) from your executive team and advocate for decisions combining your knowledge and expertise, bringing clarity and proper focus.

A CEO of a community hospital within a large healthcare system used this framework when a corporate directive came down. Using clarity-driven inquiry with the executive team, this approach improved the implementation of the

directive by those responsible for it and provided important autonomy.

Regain perspective to minimize your reaction to volatility.

Insight: Practicing gratitude can help leaders cultivate clarity and confidence, especially during turbulent times. Acknowledging and appreciating your executive team's feedback will reinforce a sense of stability and mutual respect.

2. **Treat the turbulence, not just the symptoms.** Multiple surveys have found that burnout continues to rise in the C-Suite, executives are overworked and go without sufficient rest. With internal and external pressures, all dimensions of your well-being, and that of your executive team, must come into focus to effectively address decision fatigue, emotional exhaustion, stress response, and recovery. We suggest revisiting your purpose, values, and strengths to anchor your identity, make decisions aligned with your values, and support emotional regulation under the pressure to perform well.

"The problem isn't the stress itself; it's the lack of recovery." Dr. Tal Ben-Shahar

Insight: Regularly reflecting and expressing gratitude helps to buffer against stress, boost morale, reduce burnout and improve overall well-being.

3. **Build repeatable healthy leadership behaviors.** Start by redefining performance as reliability, not intensity. Strategize on building small repeatable behaviors to reinforce clarity and steadiness. Build these into your daily routines to prepare for the day and reflect on the most consequential outcomes. Strive for 1% improvement in daily routines. A clinical leader made it a point to walk through a different area of the hospital every day on the way to their office to strengthen relationships. In his book Atomic Habits, author James Clear recommends striving for 1% improvement daily to achieve **>37%**

improvement in 1 year. Ensure behaviors are simple enough to withstand stress.

Performance becomes dependable, not fragile.

Insight: Practicing gratitude daily can be a transformative experience for leaders. The more you cultivate and sustain gratitude as a leadership trait, the greater the clarity about what's really important and the greater the confidence in how you show up as a leader.

4. **Translate clarity and steadiness into a visible leadership presence.** Ground your communication in the tenets of psychological safety, choose language that models clarity and confidence, and demonstrate reliability rather than reactivity. A CEO made a small but significant shift by asking how and what questions rather than why - to remove judgment and offer inquiry.

Teams, especially those experiencing burnout, disengagement or cultural drift, will start to feel safer, more focused, and more confident in your leadership.

Insight: Expressing gratitude for team contributions and fostering a culture where appreciation is regularly shared helps build psychological safety and visibly strengthen your leadership presence.

With the ever-changing landscape of healthcare, leveraging best practices from outside the industry offers adaptability and the ability to pivot or maintain the best elevation.

What are you doing to build needed clarity, enhance your well-being, and sustain your peak performance? Email me at lburton@drwcoaching and let me know.

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WHARTON GLOBAL HEALTH VOLUNTEERS (WGHV) SUPPORTS HEALTHCARE ORGANIZATIONS FROM GHANA TO INDONESIA

Wharton Global Health Volunteers (WGHV) is a student-run organization that connects MBA students and healthcare organizations in developing countries for semester-long, pro-bono consulting projects. The group's goal is to enrich the educational and professional experiences of students and to advance healthcare equity globally. With careful project selection, along with support from Healthcare Management (HCM) faculty advisors, the organization is committed to addressing pressing global healthcare challenges.

REVNA BIOSCIENCES (GHANA) – PRECISION MEDICINE VALUATION FRAMEWORK

During the Fall 2025 semester, a WGHV team partnered with [Revna Biosciences](#), a precision medicine company promoting clinical research and advancing molecular diagnostics in Ghana. Led by Grace Orr (WG'26) and Lucia Yang (WG'27), the team built a valuation framework by validating market sizing, revenue assumptions and growth drivers across the organization's diagnostics, biobanking and clinical research functions. During their travel, the Wharton team conducted site visits and interviews to shape their analysis, revealing crucial insights on Revna's operations and reimbursement dynamics that transformed their analysis.

Co-Lead Grace Orr (WG '26) comments, *"This project became one of the most memorable experiences of my Wharton journey, reinforcing the importance of understanding emerging markets as future business partners and customers....this was a perspective-building experience that has shaped how I think about inclusion, empathy and leadership moving forward."*



Wharton Student Team in Ghana: Carlos Mercado-Lara (WG'27), Jada Baijnath (WG'27), Camilla Ozada (WG'27), Grace Orr (WG'26), Lucia Yang (WG'27), Lindy Guo (WG'26), Revna Biosciences Team

SWIPERX (INDONESIA) – RETAIL PHARMACY INTELLIGENCE DASHBOARD

WGHV also partnered with SwipeRx, a Jakarta-based GPO expanding into a chain of low-cost retail pharmacies. The team developed a business intelligence dashboard to assess pharmacy-level performance and track operational and financial KPIs as the company prepares to scale rapidly over the next 12 months. Throughout the project, the SwipeRx team was deeply engaged, offering valuable insight into the realities of scaling multisite healthcare businesses in lower-income neighborhoods and the role of retail pharmacy as a critical access point for improving health outcomes.

Co-Lead Nathan Chang (WG'27) says, *"A highlight was visiting the team in Jakarta, where we held working sessions, toured a distribution warehouse, and gained firsthand insight into the consumer experience by visiting one of their pharmacies. Overall, WGHV was one of the most rewarding parts of my first semester, and I would strongly encourage any classmates to participate during their time at Wharton."*

Co-Lead and WGHV Co-President Viviane Garth (WG'26) adds, *"It was inspiring working closely with Farouk and the SwipeRx team, leaders who made a deliberate shift from traditional corporate careers into building SwipeRx. Their commitment to advancing health equity in under-resourced communities felt deeply aligned with why I'm involved in WGHV and with our mission. This experience made me excited to keep doing this kind of work moving forward."*



Wharton Student Team in Indonesia: Viviane Garth (WG'26), Nathan Chang (WG'27), Adam Ng (WG'27), Rose Rust (WG'26), Deborah Attie (WG'26), Ibrahim Albaba (WG'27), SwipeRx Team

IMPULSO (BRAZIL) – NON-PROFIT MARKET EXPANSION

WGHV worked with Impulso, a non-profit health-tech in Brazil that aims to improve public primary care by facilitating proactive, evidence-based decision-making. The team helped Impulso evaluate opportunities for expansion, engaging with government and nonprofit leaders across 50+ low- and middle-income countries. Project work culminated in a recommendation of 5 high-priority markets for near-term expansion.

Co-Lead Michael Lichtenstein (WG'27) notes, *"The project allowed us to learn about scaling transformative tech solutions within publicly funded models and about international health system dynamics."* Co-Lead Ariana Katsanis (WG'27) adds, *"this project allowed me to build lasting connections within the global healthcare space. It was one of the most impactful and applied learning experiences I have had at Wharton."*

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To learn more about
Claire and Viviane, [click here](#).

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Wharton Healthcare Alumni Association

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WHARTON GLOBAL HEALTH VOLUNTEERS (WGHV) SUPPORTS HEALTHCARE ORGANIZATIONS FROM GHANA TO INDONESIA



Wharton Student Team in Brazil: Michael Lichtenstein (WG'27), Ariana Katsanis (WG'27), Bridget Leighton (WG'27), Sydney Shaiman (WG'27), Impulso Team

BRIGHT ISLAND (DOMINICAN REPUBLIC) – FUNDRAISING AND TECH ADOPTION STRATEGY

A third team partnered with [Bright Island Outreach](#), a dentistry-focused non-profit organization in the Dominican Republic. The Wharton team developed a sustainable fundraising strategy and conducted a technology scan to improve patient treatment and outcomes. Project work provided Bright Island with strategic direction for fundraising efforts and technology adoption.

Co-Lead Mitsuhiro Yoshida (WG'27) comments, “The most valuable part of this experience was the hands-on engagement with the organization, which helped us understand their needs and constraints and propose practical, ready-to-use solutions.” Co-Lead Panpan Jriyasetapong adds, “hearing directly from social entrepreneurs about their journeys, while sitting along a beautiful Caribbean beach, was a truly special experience. As a project lead, WGHV has been the highlight of time at Wharton.”



Wharton Student Team in the DR: Mitsuhiro Yoshida (WG'27), Panpan Jriyasetapong (Exchange Student), Analía Cuevas-Ferreras (WG'27), Neha Bhura (WG'27), Aneri Patel (WG'27), Bright Island Team

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