Hospitals Reimagined

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For most of modern medicine, the hospital has been defined by its physicality: beds, operating rooms, diagnostic equipment and specialists concentrated within a single institution. When patients became sufficiently sick, they came to the hospital.

That model is changing. Routine care is spreading across ambulatory centers, digital platforms and patients' homes, while the hospital itself is becoming more concentrated around the sickest patients, the most sophisticated interventions and the most difficult clinical problems.

At the same time, artificial intelligence, robotics, precision medicine and remote monitoring are changing what hospitals can do and where they can do it. Aging populations, workforce shortages and rising costs are making that transformation increasingly urgent.

The hospital of the future requires more than layering technology onto today's model. Its buildings, workflows, data systems and organizational boundaries are being reconsidered together. "We have changed a massive amount in order to remain the same," says Mayo Clinic CEO Dr. Gianrico Farrugia. Its guiding principle—that the needs of the patient come first—remains unchanged. "Health care cannot be fixed one thing at a time," he argues. "We have to fix the underlying architecture."

> The future of health care is not about waiting for people to become patients. It is about using data, technology and human intelligence to predict risk, prevent disease and enable healthier, longer lives. Integrated health care will become central—supporting people across every stage of life, from birth through aging, while making care more connected, accessible and personalized.

ALISHA MOOPEN | MANAGING DIRECTOR & GROUP CEO, **ASTER DM HEALTHCARE**

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Others reach the same conclusion from different directions. Cleveland Clinic CEO Dr. Tomislav Mihaljevic argues that "the standalone hospitals of the past are not the greatest vehicle to deliver 21st-century health care." Mount Sinai Health System CEO Dr. Brendan Carr says "the underlying operating system of health care is as worthy of research as foundational science," while Stanford Health Care CEO

GIANRICO FARRUGIA | PRESIDENT & CEO, **MAYO CLINIC**

The building should also join the caregiving team: protecting patients from infection, responding to immediate needs [...] and making inpatient and outpatient care seamless.

TOMISLAV MIHALJEVIC | CEO, **CLEVELAND CLINIC**

We will have fewer hospitals, they will be larger in size, they will care for much sicker patients, and they will not be standalone facilities but part of larger healthcare systems.

MARC L. BOOM | CHAIR, **AMERICAN HOSPITAL ASSOCIATION**

Affordability is a major crisis, largely because the system is patched together with government underpayments, administrative inefficiencies, middlemen, and payers who deny necessary care.

BJÖRN ZOÉGA | CEO, **KING FAISAL SPECIALIST HOSPITAL & RESEARCH CENTRE - RIYADH**

Three years ago, we had around 40 clinical research projects. Last week, we were up to 290, more than half of all clinical research in the kingdom.

BRIAN G. DONLEY | PRESIDENT & CEO, **NEWYORK-PRESBYTERIAN**

The system will continue to put centers of care in place, but also think about how to leapfrog past facilities and care for patients where they are.

BRENDAN CARR | CEO, **MOUNT SINAI HEALTH SYSTEM**

The future is already here—it is just not evenly distributed. If innovations eventually become covered, standard, and democratized for everyone, then we have created immense long-term value for the entire population.

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> For too long, loss of peripheral nerve function has been viewed as an unavoidable consequence of injury or surgery. We believe patients deserve more. Axogen's mission is to make nerve repair an expected standard of care and bring greater awareness, access, and attention to nerve function as a critical component of patient care.
>
> MICHAEL DALE | PRESIDENT & CEO, **AXOGEN**

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The cost of health care in the U.S.

$5.3 TRILLION
U.S. health care spending in 2024

$15,474 per person
18.0 percent of GDP

Source: Centers for Medicare & Medicaid Services

David Entwistle identifies "transparency and the ability to use data" as the greatest structural change of his nearly three-decade career.

Together, they describe something larger than digitization: the hospital is evolving from a building into the high-acuity center of a connected health care system.

The high-acuity hospital

As more routine treatment moves into outpatient settings and the home, the patients who remain in the hospital are becoming more clinically complex. The hospital is increasingly focusing on the cases that require its combination of intensive monitoring, multidisciplinary expertise and highly specialized intervention, with more and more beds occupied by patients managing several serious diseases at once.

A patient with heart failure, diabetes and chronic kidney disease, for example, may be navigating five or more specialists and multiple treatment pathways at the same time. Yet outcomes have improved even as the case mix has grown more complex: in the second quarter of 2025, hospitalized patients were nearly 30 percent more likely to survive than would have been expected from the severity of their illnesses, compared with patients of equivalent severity in late 2019. The strongest systems, says Vizient CEO Byron Jobe, "design care around the patient instead of departments, specialties or sites."

Cleveland Clinic is betting heavily on neuroscience. Mihaljevic calls neurological disease "the next major frontier" and says "neuroscience today is probably where cardiovascular science was in the 1970s and 1980s." The system is preparing a dedicated hospital for neurological treatment, research and education.

The scale of the problem explains the investment. Neurological conditions now affect more than 3 billion people worldwide and cause more than 11 million deaths a year, while Alzheimer's alone affects an estimated 7.4 million Americans aged 65 and older. There has finally been measurable progress in a disease that long resisted it: new anti-amyloid drugs can slow cognitive and functional

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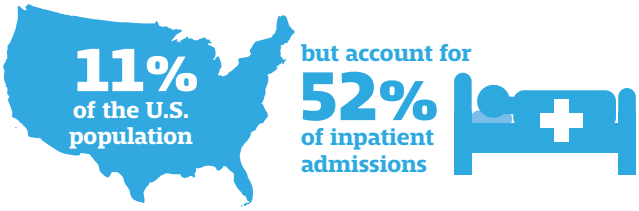
decline in early Alzheimer's, although they do not reverse dementia and their benefits remain modest relative to the scale of the disease.

At Henry Ford Hospital, CEO Dr. Steven Kalkanis sees evidence that some of medicine's hardest neurological problems are already beginning to yield. When he started medical school 25 years ago, he says, life expectancy for glioblastoma was about eight months; today it is closer to three years. Henry Ford recently celebrated nearly 50 patients who had survived for a decade. "There is still an enormous amount of work to do, but we're identifying more long-term survivors and studying what makes them different."

Mount Sinai is pushing neurological care into territory that until recently belonged to science fiction: turning the brain itself into a readable source of clinical information. In its neonatal intensive care unit, researchers have trained AI on thousands of hours of video to detect neurological changes from subtle patterns of infant movement. "Digital surveillance models detect subclinical seizure activity in infants hours before it becomes visible to a human nurse," says Carr.

Vizient estimates that people with multiple chronic conditions make up only...



Source: Vizient Research Institute

> Clinical trials are clinical care. If you want to tell patients and families that their care is second to none, you have to be a leading clinical trials hospital.
>
> DR. ANDY SMITH | PRESIDENT & CEO, **SUNNYBROOK HEALTH SCIENCES CENTRE**

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Brain-computer interfaces go further. Mount Sinai led the first U.S. implantation of Synchron's Stentrode, which reaches the brain through a blood vessel rather than an open craniotomy, while other cortical systems being studied there have recorded neural activity through thousands of electrodes placed on the brain. Carr describes researchers "laying a meshwork on the brain or using a smart stent" to enable people with severe paralysis "to type or move robotic limbs using only their thoughts." These technologies remain experimental, but they point toward a future in which restoring communication and movement becomes part of neurological treatment itself, rather than something addressed only through rehabilitation.

Sunnybrook Health Sciences Centre in Toronto is approaching the brain without an incision at all. Focused ultrasound can target precise brain circuits through the skull, and Sunnybrook is investigating the technology across 19 applications, including severe obsessive-compulsive disorder. CEO Dr. Andy Smith describes innovation not as a single breakthrough but as a continuous cycle: "We think about innovation as a wheel: basic science, clinical trials,

SEVERANCE HOSPITAL

DR. LEE KANGYOUNG | CEO, SEVERANCE HOSPITAL

Severance Hospital is a tertiary academic medical center in Seoul and principal hospital of Yonsei University Health System. Founded in 1885 as Korea's first Western-style medical institution, it combines specialist care with medical education and research.

How does South Korea's single-payer system shape the role of major hospitals such as Severance?

Korea has a national health insurance system in which the government is the single payer, supported by a referral system based on hospital scale and capabilities. Severance is one of the leading tertiary institutions. The greatest challenge now is demographic: Korea's rapidly aging population will place growing pressure on healthcare, requiring hospitals to balance equitable care with highly specialized treatment.

How is the Next Severance strategy already changing care inside the hospital?

Next Severance aims to make the hospital operate as one ecosystem rather than isolated departments, anticipating bed demand, discharges, operating-room use and intensive-care needs. Our PRISM platform supports SeVue, which combines ward-device data with AI to detect deterioration and alert specialist teams around the clock. AI is not intended to replace staff, but to restore their "time for genuine care"—time to hold a patient's hand and meet their eyes.

What did Severance have to get right to become the world's first hospital to surpass 50,000 robotic surgeries?

Severance introduced robotic surgery in Korea in 2005 despite skepticism, believing it could reduce damage to healthy tissue and accelerate recovery. Success required more than equipment: we standardized techniques and protocols, introduced surgeon qualification and training systems, and set standards covering patient selection, anesthesia, nursing, recovery and complications. Data from 50,000 procedures have helped identify decisions that reduce bleeding and complications and improve recovery.

Severance developed LiMPC to identify pancreatic cancer patients at risk of hidden liver metastasis. How could it improve treatment decisions?

Small liver metastases may not appear on CT or MRI, meaning some patients undergo unnecessary surgery or face delays in chemotherapy. LiMPC analyzes 21 routine variables already in the medical record, including blood tests, age and sex, without additional or genomic testing. Validated across several Korean hospitals, it identified hidden metastatic risk with more than 80% accuracy and shows physicians which blood values contributed most strongly.

Severance is expanding heavy-ion therapy across several forms of cancer. How do you determine where it can offer the greatest benefit?

As of July 2026, the Heavy Ion Therapy Center had treated 816 prostate, 213 pancreatic, 82 lung and 40 liver cancer patients. New protocols are being developed for head and neck cancers, sarcomas and some inoperable breast cancers. We will not expand treatment simply because it is technically possible; we must establish its added benefit over surgery, chemotherapy or conventional radiation in survival, side effects and quality of life.

The new cancer center at Yongin will bring specialist care, education and research together. What will that model make possible?

Yongin Severance was designed as a digitally driven smart hospital using IT and AI for operations, bed assignment and patient flow, while allowing patients to receive advanced treatment closer to home. Its new nine-story building will integrate cancer care, education and faculty research, so problems identified in treatment can become research questions and findings can return more rapidly to clinical care and trials.

Five years from now, how will patients experience Severance differently?

We envisage patients wearing devices that continuously monitor heart rate, respiratory rate, oxygen saturation, activity and other vital information, helping us recognize risk and intervene before patients become critically ill. Future medical institutions will be judged not simply by how much research they conduct, but by how quickly and safely good research reaches patients. Our ambition is to connect clinical care, education, research, AI, data and clinical trials in one ecosystem.

Scan QR code for more information or visit **sev.severance.healthcare/sev-en/**

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Eagle Telemedicine is a physician-led, professionally managed virtual specialty care partner for hospitals and health systems, purpose-built for high-acuity specialty care. Eagle delivers integrated inpatient and outpatient programs across more than 20 specialties within each partner's existing clinical workflows and technology. Since 2008, Eagle has implemented more than 1,000 clinical programs through a nationwide network of 500 physicians.

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300,000+
additional Americans
survived hospital episodes of care in 2024 to 2025 compared with 2019 performance
Source: American Hospital Association

THE VOICES OF TELEHEALTH

KYLE ZEBLEY | CEO, **AMERICAN TELEMEDICINE ASSOCIATION**

We believe that a third to 50 percent of all health care encounters could be delivered virtually in some form.

JASON R. POVIO | CEO, **EAGLE TELEMEDICINE**

The long-term model is hybrid, not 'telemedicine or no telemedicine.' The question is which modality suits each episode of care.

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commercialization and translation into practice." Sunnybrook's focused-ultrasound program illustrates that process, taking fundamental research through clinical trials and into treatments that have already been used for hundreds of patients with essential tremor.

At UCLA, the California Institute for Immunology and Immunotherapy is intended to bring together scientists tackling the biological mechanisms behind cancer and other diseases. "The goal is to bring together scientists from around the world to tackle some of the toughest problems in disease," UCLA Health President Johnese Spisso says. UCLA physicians and scientists have led trials or contributed to 27 FDA-approved cancer treatments and protocols, most since 2014.

At Stanford, where the volume of cancer care delivered by the health system has doubled over the past decade, a new cancer center is being developed around tumor-infiltrating lymphocyte treatments, stem-cell, gene and immunotherapies and an ultracompact proton-therapy facility. Entwistle describes the problem facing academic medicine as one of abundance: "There are a thousand

flowers blooming." The challenge is deciding which discoveries can truly change outcomes.

UCLH CEO David Probert sees CAR T-cell therapy moving well beyond its original applications. "It is already established in parts of blood-cancer treatment, is moving into solid cancers and has now been used in our first few patients with lupus," he says. "If it ultimately proves suitable for a broader range of autoimmune diseases, that would be hugely significant."

Karolinska University Hospital is building the institutional machinery needed to make the next generation of cancer treatments routine. Its Advanced Therapy Medicinal Products Center brings research, manufacturing and clinical delivery together with Karolinska Institutet, startups and pharmaceutical companies, creating a pathway for cell and gene therapies to move from the laboratory into patient care.

That ambition reflects a broader transformation in oncology. In the United States, five-year survival across all cancers has risen to about 70 percent, from 49 percent in the mid-1970s, as earlier diagnosis and increasingly targeted treatments have improved the outlook for diseases once associated with very poor survival.

At Karolinska, the next step is increasingly molecular: using genomics and proteomics to define a cancer by its fundamental biology rather than simply by the organ in which it appears. By combining molecular diagnostics with the capacity to develop, manufacture and administer advanced therapies within the same clinical ecosystem, Karolinska is trying to shorten the distance between scientific discovery and routine care. "These techniques allow us to identify biological markers, tailor treatment more closely to the individual and improve survival rates," says CEO Christophe Pedroletti.

Beyond the four walls

The hospital is no longer the only place where hospital-level expertise can be delivered. Increasingly, health systems are separating the question of what care a patient needs from where that care must take place. Kyle Zebley, CEO of the American Telemedicine Association, says telehealth has moved from "a giant controlled experiment" during the pandemic to a routine fixture of health care. Its significance extends well beyond video visits: "Much of this would not be possible outside a hospital or brick-and-mortar setting without telehealth, virtual care, remote monitoring, and connected devices."

The shift beyond the hospital is not being driven by technology alone. It is also a response to a widening gap between health care demand and the people, beds and capital available to meet it. Marc L. Boom, chair of the American Hospital Association and CEO of Houston Methodist, notes that over the next quarter-century the U.S. working-age population is projected to grow by only about 4 percent, while the population aged 85 and older is projected to rise by roughly 168 percent.

Physical capacity cannot simply expand in step with demand. Spisso says its five hospitals and more than 300 clinics are already operating at full occupancy, while adding a single hospital bed in California can cost between $7 million and $8 million.

That makes the use of existing capacity increasingly important. Rather than admitting every patient whose condition worsens, health systems are trying to identify those at greatest risk earlier and intervene before hospitalization becomes necessary. At UCLH,

> Our ambition is to treat tomorrow what is not treatable today. By focusing on tertiary and quaternary care, advancing AI, and pioneering complex robotics, we are shaping the future of global medicine.
>
> DR. BJÖRN ZOÉGA | CEO, **KING FAISAL SPECIALIST HOSPITAL & RESEARCH CENTRE - RIYADH**

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CEO David Probert says roughly 10 percent of the local population accounts for around 90 percent of emergency care, much of it driven by frailty, respiratory disease and cardiac conditions. "The old model is broken," he says, "and we need to reimagine how care is delivered."

Some systems are already moving sophisticated treatment into patients' homes. Tampa General's hospital-at-home program combines telehealth, remote telemetry and in-person care, with Couris reporting readmission to the hospital of around 6 percent to 7 percent, compared with a national average above 10 percent. Mayo Clinic has extended the model into oncology, delivering approximately 1,670 intravenous chemotherapy infusions at home.

Johns Hopkins Aramco Healthcare CEO Howard Podolsky captures the basic principle: "We are going to the patient instead of making the patient come to us." The hospital remains essential for acute medicine, but, he notes, "the most expensive place to care for somebody is inside the four walls of a hospital."

Option Care Health demonstrates how far technically demanding treatment can travel. Roughly 70 percent of its nursing visits take place in patients' homes, with the remainder delivered through infusion suites across a national network of more than 700 chairs. Option Care Health CEO John C. Rademacher says the objective is "to match the patient, the therapy and the clinical complexity to the most appropriate setting rather than assume one site of care is right for everyone."

The frontier is now extending to advanced cancer therapies once

> That combination of high-level capabilities and deeply personal care is becoming increasingly rare in health care, and it's what sets us apart.
>
> JILL VANKUREN | PRESIDENT & CEO, **SARATOGA HOSPITAL**

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Labor already accounts for roughly **60%** **of a hospital's budget**

Source: Becker's Hospital Review

> As a nonprofit, independent health system, one of our advantages is being flexible and able to do the right thing to meet the needs of the communities we serve. That means choosing to invest in the future of rural health care.
>
> MICKEY W. FOSTER, MHA | CEO, **FIRSTHEALTH OF THE CAROLINAS**

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closely tied to major academic hospitals. Current Health provides the monitoring and clinical infrastructure that can allow patients receiving CAR T and bispecific therapies to spend more of their treatment pathway at home rather than remaining hospitalized for weeks. With roughly 80 percent of U.S. cancer care delivered in community practices, CEO and co-founder Christopher McGhee sees the larger challenge as making these models repeatable beyond elite centers.

Sometimes the specialist moves while the patient stays put. Eagle Telemedicine provides virtual physician coverage across more than 20 specialties, including stroke, critical care, cardiology and infectious disease. Eagle Telemedicine CEO Jason R. Povio says "in many respects, acute care is easier to provide virtually than ambulatory care" because nurses, diagnostics and physical infrastructure are already present around the remote specialist.

That model may be particularly consequential in rural health care. Sanford Health's $350 million virtual-care initiative now spans nearly 80 specialties. An average virtual encounter saves a patient 176 miles of driving and $273 in travel-related costs, while in 2025 Sanford estimates that patients avoided more than $41 million in travel expenses and lost work time.

For FirstHealth of the Carolinas, access is similarly inseparable from financial sustainability. Roughly 70 percent of its payer mix is Medicare and Medicaid, while CEO Mickey W. Foster warns that 35 percent to 40 percent of hospitals, particularly in rural markets, already operate with negative margins. FirstHealth has nevertheless expanded from around 10 to 12 ambulatory practices a decade ago to more than 100. "Patients want access," Foster says. "We're trying to meet patients where they are."

Saratoga Hospital CEO Jill VanKuren describes the enduring value of strong local institutions in more personal terms: "We're neighbors treating neighbors, not medical record numbers moving through a system." The hospital combines advanced services with more than 30 regional locations, while its Albany Med affiliation provides access to tertiary expertise without erasing the community-hospital model.

Digital care also matters between formal encounters. DarioHealth Chief Medical Officer Omar Manejwala argues that chronic disease cannot be managed through occasional appointments alone: "Health care has largely tried to solve this through four 20-minute visits a year. There is a zero percent chance that this alone will create lasting change." The same logic is reshaping larger integrated systems. Atlantic Health CEO Saad Ehtisham describes health systems as the "conveners of care across every setting," adding: "The challenge is to provide care in the right setting, at the right time and cost, while making it convenient and accessible."

The transition still depends on clinicians. Pantai Hospital Kuala Lumpur CEO Chong Soon Mei argues that "the technology and the clinician have to develop together." Saudi German Health UAE Group CEO Ahmed Eissa similarly envisages an "invisible hospital" extending monitoring and expertise beyond its physical buildings, but insists that AI should remain the "co-pilot" rather than "the pilot."

Transcarent CEO Glen Tullman ultimately expects hospitals to become "more important, but also more focused," with surgical, ambulatory and digital capabilities working across a broader community. That redistribution leaves the hospital as the high-acuity fulcrum of a wider system in which expertise, information and treatment can move to wherever the patient is best served.

In 2025:

U.S. hospital outpatient visits **+9.8%**

+5.3% inpatient volumes

Source: American Hospital Association

Health care's new centers of gravity

The geography of advanced medicine is changing for different reasons in different regions. North America's great academic systems remain centers of research and subspecialist expertise, but are increasingly extending those capabilities through international networks. Across the Gulf, governments and private health systems are rapidly building the quaternary capacity that patients once traveled abroad to obtain. In East and Southeast Asia, hospitals are competing through

INTERNATIONAL LEADERS

CHRISTOPHE PEDROLETTI | CEO, **KAROLINSKA UNIVERSITY HOSPITAL**

Precision medicine brings engineers, geneticists and many other professionals into care. An organization that welcomes new knowledge and disciplines will be more successful than one built around traditional silos.

LEE KANG-YOUNG | CEO, **SEVERANCE HOSPITAL**

Rather than responding to bottlenecks after they occur, we want to anticipate bed demand, likely discharges and demand for operating rooms and intensive care.

UĞUR GENÇ | CEO, **ACIBADEM HEALTHCARE GROUP**

Our greatest ambassadors are the international patients who return home and share their positive experiences.

RATAPONG AMBHANWONG, DIRECTOR, **BANGKOK INTERNATIONAL HOSPITAL**

One of the biggest challenges in Thailand is human resources, [...]. Fewer students are choosing nursing because of the workload, stress and compensation, and we have to acknowledge that working in health care can be extremely demanding.

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King Faisal Specialist Hospital & Research Centre

DR. BJÖRN ZOÉGA | CEO, KING FAISAL SPECIALIST HOSPITAL & RESEARCH CENTRE - RIYADH

KFSH is aiming to become a global leader in highly specialized care. What does that ambition mean in practical terms?

Medicine has become so specialized that hospitals need to be clear about where they can make the greatest contribution. For us, that means focusing more deeply on tertiary and quaternary care. Around 60% of what we do is now in that category, and our aim over the next two years is to reach 80%, comparable with other high-end hospitals.

A lot has happened in Saudi healthcare over the past 20 years, much of it at King Faisal. There has been a tendency to think regionally, but our ambition is broader: to share our knowledge internationally, and to keep learning from others.

Saudi Arabia has historically sent many patients abroad for complex treatment. How much has that changed?

There are not many patients being sent abroad in the way they were four or five years ago.

Our strongest capabilities are in robotic surgery, transplants and living-donor transplants, where we are among the best in the world in quality and volume. KFSHRC performed 1,092 organ transplants in a single year, and around 9,000 since its transplant program began in 1981. We are also building our own CAR T-cell production, reducing dependence on overseas manufacturing, shortening delays, supporting local clinical trials, and bringing therapy costs down by 80% from SAR1.3 million per patient, with the aim of expanding production capacity to 100 gene therapies annually.

KFSH has performed the world's first fully robotic heart transplant and the world's first robotic brain tumor surgery, among others. What have these milestones taught you about complex surgery?

As a surgeon myself before becoming a full-time administrator during COVID, I understand how complex these procedures are. The teams moved step by step, from testing and training to carefully selected clinical use. For the robotic heart transplant, that meant weeks of preparation and rehearsing the procedure virtually before operating on a 16-year-old patient with end-stage heart failure; in neurosurgery, it meant removing a 4.5-centimeter brain tumor robotically and discharging the patient fully conscious within 24 hours. The lesson is that you must not kill the idea, but you must never take shortcuts with patient safety.

What does it take to make AI, genomics and research work at scale inside a hospital?

With AI, the future is here. Last year, we had 31 AI systems in place in the hospital, not as pilots but as part of our work. By the end of this year, we expect to be closer to 50. One major area is administration: doctors spend around 30% to 40% of their time on admin, often looking more at the computer than at the patient. AI can reduce that burden. The other major area is diagnostics, especially radiology and pathology, where AI can save time and, in some of our studies, is probably more accurate.

Genomics is another major part of the future. We are leaders partly because rare diseases here are not always as rare as people might think, which has helped us become pioneers. Three years ago, we had around 40 clinical research projects. Last week, we were up to 290, more than half of all clinical research in the kingdom. Our focus is to treat tomorrow what is not treatable today.

KFSH operates within the broader Vision 2030 transformation of Saudi healthcare. What role should a leading academic medical centre play?

Vision 2030 has created a clearer structure for how healthcare should be delivered in the kingdom and what role different institutions should play. We have moved from operating as a government organization to becoming an independent, not-for-profit institution with a clear role in the most challenging diseases and complex cases.

The hospital is also changing. It is not only the building, the equipment and the people inside. Last year, 16% of our nearly 2.4 million visits were virtual, an increase of 25% year-over-year, meaning patients did not have to travel, park, fly, or bring family members who had to take time off work. Healthcare is moving closer to the patient, rather than making the patient come to us. Some people call this "Hospital at Home"; I think of it as healthcare at home.

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> Patient expectations continue to evolve, and so must health care. At Mediclinic Middle East, we deliver better outcomes by combining clinical excellence, digital innovation and patient-centered care while maintaining the highest standards of quality and safety.
>
> DAVID EGLINGTON | HOSPITAL DIRECTOR, **MEDICLINIC CITY HOSPITAL**

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procedural scale, concentrations of specialist expertise and increasingly transparent international benchmarking.

The geography of advanced medicine is changing for different reasons in different regions. North America's great academic systems remain centers of research and subspecialist expertise, but are increasingly extending those capabilities through international networks. Across the Gulf, governments and private health systems are rapidly building the quaternary capacity that patients once traveled abroad to obtain. In East and Southeast Asia, hospitals are competing through procedural scale and developing deep experience in complex interventions.

David Eglington, director of Mediclinic City Hospital, has watched Dubai move from a market where residents commonly sought complex treatment overseas toward one that attracts international patients itself. "Today, people come because they trust the health care available here," he says. "We increasingly see patients seeking treatments that may not be available in their home countries."

American Hospital Dubai Group CEO Sherif Beshara defines its competitors accordingly: "Our challenge is not to compete with the best hospital in the UAE, but with the best hospitals in the world." For Beshara, that means developing capabilities that can attract both difficult cases and the clinicians who treat them. "In cancer, orthopedics, pediatrics and cardiothoracic care, our ambition is to be the last hope." Building that depth, he argues, requires the technology, research and teaching infrastructure that gives internationally trained specialists a reason to practice in Dubai rather than simply referring patients abroad.

Aster DM Healthcare represents a different model: using the scale of an integrated regional network to build higher-acuity care while intervening earlier in disease. Its 488 facilities span hospitals, clinics, pharmacies, laboratories and digital care, giving it visibility across a patient's journey rather than only at the point of hospitalization. "We no longer look at healthcare as a single hospital visit, but as a connected journey," says Managing Director and Group CEO Alisha Moopen. That model is increasingly important in a region where she estimates 20 percent to 30 percent of the population is living with obesity, diabetes or hypertension.

But Aster is also moving deliberately up the clinical complexity curve. A roughly $275 million investment program in the UAE will expand robotics, organ transplantation, advanced oncology and cardiac sciences, alongside additional hospital capacity, while a further $250 million will be invested in Saudi Arabia. Moopen says the pandemic accelerated the change by demonstrating how much complex treatment could be delivered within the region when overseas travel stopped. "Medical travel was once associated largely with aesthetics, dentistry and fertility treatments," she says. "We are now seeing demand for more complex procedures." Increasingly, the Gulf is seeking not merely to prevent patients leaving, but to become a destination for patients arriving from Africa, the Middle East and neighboring markets.

Saudi Arabia is pursuing the same objective through a mixture of domestic investment and imported institutional expertise. Johns Hopkins Aramco Healthcare offers a clear example of how an international partnership can be used to build local capability rather than simply attach a foreign name to a hospital. Its joint venture with Johns Hopkins Medicine has now established Centers of Excellence in oncology and cardiovascular health and recently widened access beyond Saudi Aramco employees and their families.

For Podolsky, greater patient volume is itself part of building excellence. "To be a truly great center of excellence, you need sufficient patient volume," he says. "Volume-based competencies are key to quality, patient safety, and strong clinical outcomes." Opening up to the wider public therefore serves two purposes at once: extending specialist care across the Eastern Province and giving highly specialized teams sufficient case volumes to develop and sustain expertise.

East Asia has developed from a different starting point. South Korea's leading hospitals already operate at procedural volumes that few institutions elsewhere can match and increasingly regard that scale as a platform for developing the medicine of the future. Severance Hospital in Seoul, for example, has performed more than 50,000 robotic operations since introducing robotic surgery to Korea in 2005. Yet CEO Dr. Lee Kang-young cautions that "success requires much more than purchasing equipment": techniques, surgeon accreditation, anesthesia, nursing, postoperative pathways and complication management all have to develop around the technology.

Singapore's Mount Elizabeth demonstrates another Asian advantage: exceptional concentrations of specialists. More than 700 specialists practice under one roof, creating the kind of subspecialist depth that international patients often travel to obtain. CEO Yong Yih Ming describes "the absolute scarcity of these elite subspecialty minds" as the central constraint on expansion. "It takes decades of experience to train a top surgeon." The competitive advantage is therefore less the hospital building itself than the concentration of expertise inside it.

Taken together, these institutions point toward a more networked form of medical globalization. North American institutions increasingly export expertise and institutional models; Gulf systems are using investment, partnerships and growing patient volumes to build capabilities that previously sat abroad; and leading Asian hospitals are competing through scale, specialist density and measurable outcomes. For patients, that could gradually weaken the old hierarchy in which the most difficult diagnosis automatically meant traveling to a handful of Western cities.

> We were the first hospital to introduce robotic surgery in Dubai and the first in the UAE to implement the da Vinci Xi. Robotic cardiothoracic surgery is no longer an isolated milestone for us; it is routine.
>
> SHERIF BESHARA | GROUP CEO, **AMERICAN HOSPITAL DUBAI**

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> With a life-sustaining medical device, we should not accept a compromise simply because the better solution is difficult to achieve.

DR. CHEN CHEN | CEO, **BRIOHEALTH SOLUTIONS**

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But the rise of new centers of excellence is not only geographical. It coincides with a change in the architecture of treatment itself. More can now be detected before symptoms appear, decided before an operation begins, performed through smaller and less traumatic interventions, and monitored after a patient leaves hospital. Robotics, imaging, molecular diagnostics and AI are increasingly connected across that pathway, turning devices from isolated pieces of equipment into sources of information that shape the next clinical decision.

The machinery of medicine

That shift is perhaps most keenly felt in surgery. Across the industry, intervention is moving in several directions at once: procedures are becoming less invasive, more planning is taking place before surgery begins and success is increasingly being judged by the function and quality of life a patient retains afterward.

King Faisal Specialist Hospital & Research Centre in Riyadh is pushing robotics into procedures once assumed to require conventional open surgery. Its teams have performed a fully robotic heart transplant and robotic brain-tumor surgery, while the hospital completed 1,092 organ transplants in 2023 and approximately 9,000 since 1981. Before operating on a 16-year-old patient with end-stage heart failure, the heart-transplant team spent weeks preparing and rehearsing virtually.

MEDTECH PIONEERS

HOWARD BERGER | PRESIDENT & CEO, **RADNET**

We are moving toward personalized screening: a normal mammogram might predict which women are at higher risk, allowing care teams to adjust their care pathways accordingly.

BILAL MUHSIN | PRESIDENT OF CONNECTED CARE SEGMENT, **BECTON DICKINSON**

Intelligent systems capture continuous physiological data rather than intermittent snapshots. This allows the care team to see a negative clinical trajectory before traditional symptoms manifest.

TIM SCHMID | WORLDWIDE CHAIRMAN OF MEDTECH, **JOHNSON & JOHNSON**

The smartphone is a useful analogy: the hardware initially attracted attention, but the greater value eventually came from the applications, services and connectivity surrounding it.

DAVE ROSA | CEO, **INTUITIVE**

The benefits of robotic-assisted surgery, like releasing patients from the hospital sooner, can save costs across the continuum of care. Getting somebody back to work in one week rather than three is a benefit to the world.

JIM CLEMMER | PRESIDENT & CEO, **ANGIODYNAMICS**

If we can treat prostate cancer without removing the prostate, or remove a pulmonary embolism without prolonged drug therapy, we can deliver better outcomes while improving efficiency.

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CEO Dr. Björn Zoéga describes the philosophy as disciplined innovation: "You must not kill the idea, but you must never take shortcuts with patient safety." Used well, he argues, robotics can allow surgeons to reach places their hands cannot, reduce the trauma associated with large incisions and accelerate recovery.

BRIOHEALTH SOLUTIONS

BrioVAD® System

Durable mechanical circulatory support for short-term, long-term, and recovery needs.

Purpose-built for the next generation of mechanical circulatory support, the BrioVAD® System reflects BrioHealth's commitment to engineering innovation, challenging contemporary therapies, and aiming to improve the future of advanced heart failure care across the globe.

CAUTION: The BrioVAD® System is an Investigational Device limited by Federal (US) Law to use in the INNOVATE and Brio4Kids Trials and limited to use in the BRIOLIFE Trial in the EU.

DOC-05347 Rev. 01

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AMERICAN HOSPITAL

SHERIF BESHARA | GROUP CEO, AMERICAN HOSPITAL DUBAI

American Hospital Dubai is a 254-bed private acute-care hospital established in 1996, providing medical and surgical services across more than 40 specialties. Part of the Mohamed & Obaid Al Mulla Group, it serves patients through its main hospital and wider network in Dubai. It has been a member of the Mayo Clinic Care Network since 2016.

American Hospital Dubai combines American clinical standards with a long-term commitment to the UAE. How has that shaped the institution's development?

American Hospital Dubai was the first hospital in the region to introduce American standards and expertise, and the only private hospital here investing in research and education. The ownership model focuses on legacy and contribution to Dubai, the UAE and the wider region, rather than short-term returns.

That perspective has allowed us to invest at a level comparable with government hospitals and become a destination for complex cases —often for patients whose treatment has failed elsewhere. In cancer, orthopedics, pediatrics and cardiothoracic care, our ambition is to be the last hope. In cardiothoracic medicine, 100% of the team is American board-certified.

American Hospital Dubai has invested heavily in robotic surgery and expanded its da Vinci program with Intuitive. How do you determine whether a new technology justifies its cost?

We were the first hospital to introduce robotic surgery in Dubai and the first in the UAE to implement the da Vinci Xi. We now have two Xi systems, the da Vinci SP and the region's only single-port program, with the da Vinci 5 arriving next month. By November, we plan to open a day-case robotic center in a shopping mall.

We did not begin by asking how quickly the robot would pay for itself. We began with surgical quality, patient experience and clinical outcomes. Once those improve, volume and profit follow. Intuitive has also brought expertise in surgeon training and program development. Robotic cardiothoracic surgery is no longer an isolated milestone for us; it is routine.

As the group expands beyond Oud Metha, how are you deciding what services remain centralized and what moves closer to patients?

A new campus must extend the vision of the main hospital, not compete with it. Oud Metha will remain the center for cancer and cardiothoracic care, while Science Park will act as a feeder and develop centers of excellence in orthopedics and pediatrics. The next phase includes two hospitals beside Science Park: one dedicated to orthopedics and sports medicine, and another focused on women and children. The aim is to make care more accessible without fragmenting the patient journey.

Where is AI delivering practical value in the hospital's clinical or operational work?

I believe in combining AI with the human brain. I see AI as an additional assistant for our staff and physicians, increasing their capacity and giving them better information. The most immediate value is in monitoring patients after discharge, particularly those requiring close clinical oversight. We will soon launch a remote ICU model designed to bring intensive monitoring into the patient's home.

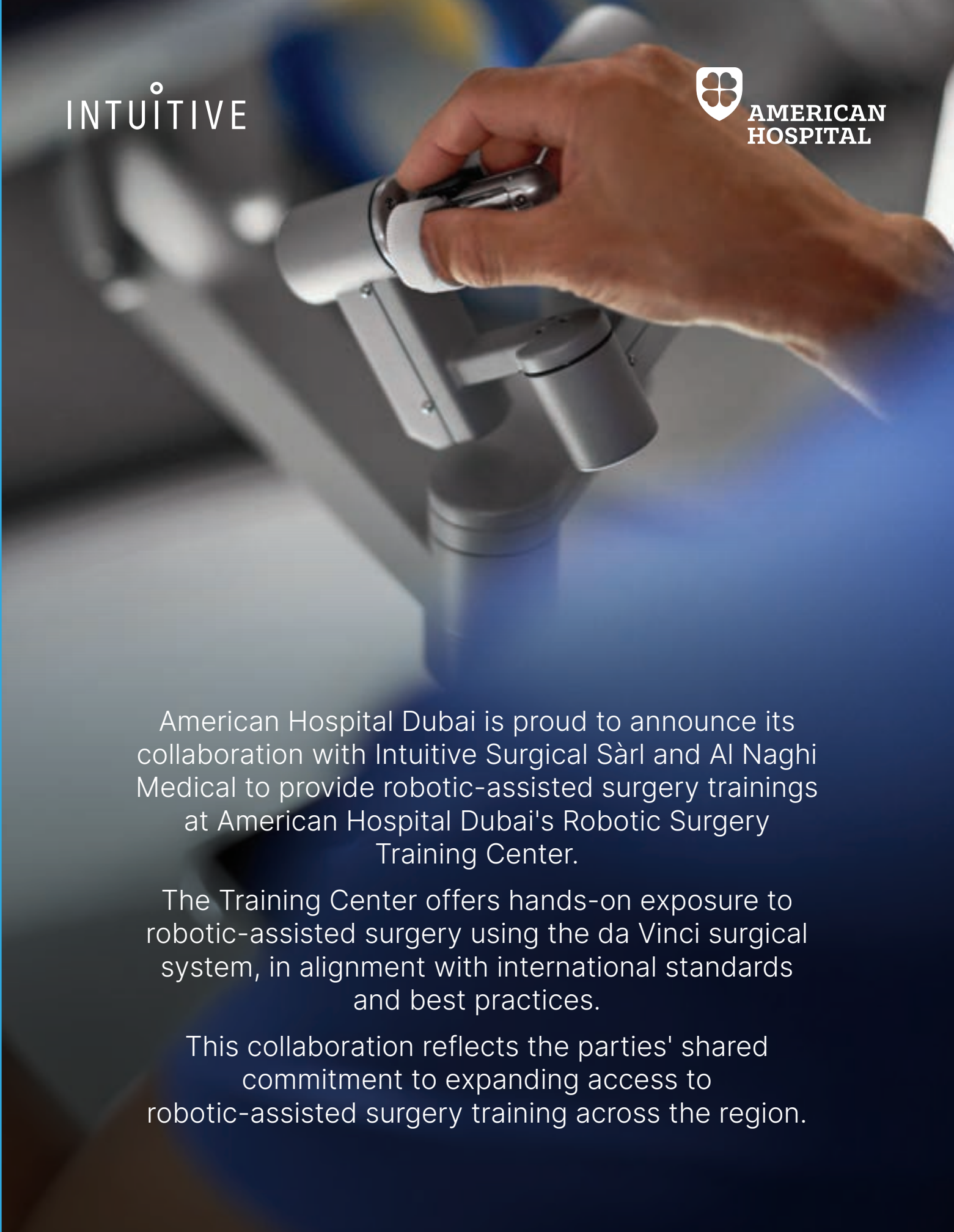
Innovation also has to move diagnosis earlier. Through our cooperation with Abbott, American Hospital Dubai will become the first private healthcare provider in Dubai to introduce next-generation technology for early-stage cancer detection.

What must Dubai do to compete globally for patients requiring complex care?

Dubai has built the infrastructure needed to attract international expertise. A surgeon will not leave an institution such as Mayo Clinic unless the destination offers advanced technology, research, teaching programs and a credible educational vision.

Our challenge is not to compete with the best hospital in the UAE, but with the best hospitals in the world. American Hospital Dubai also has a responsibility beyond its own performance. We are part of the UAE, and our role is to help raise standards across the healthcare sector, not simply within our own hospitals.

Scan QR code for more information
or visit **www.ahdubai.com**



INTUITIVE

AMERICAN HOSPITAL

American Hospital Dubai is proud to announce its collaboration with Intuitive Surgical Sàrl and Al Naghi Medical to provide robotic-assisted surgery trainings at American Hospital Dubai's Robotic Surgery Training Center.

The Training Center offers hands-on exposure to robotic-assisted surgery using the da Vinci surgical system, in alignment with international standards and best practices.

This collaboration reflects the parties' shared commitment to expanding access to robotic-assisted surgery training across the region.

> Because we are digital-first, hospitals do not need to invest in capital equipment, additional hardware, or separate software. We model the surgery digitally and manufacture only what is required for each patient.

MIKE CORDONNIER | CHAIRMAN & CEO, **CARLSMED**

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That movement toward less invasive treatment extends well beyond robotic surgery. J&J MedTech Worldwide Chairman Tim Schmid describes a broad shift toward interventions that "cause less trauma and enable faster recovery and shorter hospital stays." Shockwave intravascular lithotripsy illustrates the trend: rather than relying solely on conventional approaches to open heavily calcified arteries, the technology uses acoustic pressure waves to fracture calcium and has now been used in more than one million patients across 70 countries.

Robotic systems, meanwhile, are becoming sources of information as well as dexterity. Intuitive's da Vinci 5 captures force, video and kinematic data during procedures, creating records that can be analyzed by AI. The longer-term potential is greater situational awareness: systems that identify critical anatomy, warn surgeons as they approach vulnerable structures, establish virtual "no-fly zones" and eventually automate limited parts of an operation under human control. "If we take robotics and intersect it with the world of AI," CEO Dave Rosa says, "that is where you get some magic happening."

Some of that intelligence is moving upstream, before the patient reaches the theater. Carlsmed uses AI to model a patient's spine in three dimensions and manufacture implants around individual anatomy. The aim, CEO Mike Cordonnier says, is to take decisions "traditionally made in the operating room and move as many as possible into the preoperative stage." In a studied complex-deformity population, published two-year data showed a 74 percent reduction in reoperations.

At the same time, the definition of a successful intervention is widening. Saving a life or repairing a bone may no longer be sufficient if the patient is left without meaningful function. Axogen focuses on peripheral nerves that can be overlooked once bleeding has stopped and fractures have been repaired, seeking to restore movement and sensation after trauma, cancer surgery and other procedures. "Far too often, the patient is stabilized, their life is saved and their broken bones are fixed," CEO Michael Dale says, "but they are discharged without their peripheral nerve function being addressed."

> AI accelerates data analysis, identifies meaningful patterns and helps researchers uncover relationships between cellular measurements and clinical outcomes.

DR. WENBIN JIANG | CEO, **CYTEK BIOSCIENCES**

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The same principle applies to patients who may depend on medical technology for years. BrioHealth is developing ventricular-assist technology for advanced heart failure with the aim of reducing complications and allowing patients greater independence outside the hospital. “With a life-sustaining medical device, we should not accept a compromise simply because the better solution is difficult to achieve,” says CEO Dr. Chen Chen. The benchmark is shifting from whether medicine can perform an intervention to what kind of life it leaves behind.

The transformation starts even earlier than the operating room. Precision medicine increasingly depends on extracting the right biological signal from quantities of information that would once have been impossible to process clinically.

At AstraZeneca, precision-medicine approaches now apply to roughly 90 percent of the pipeline, compared with around 10 percent in 2009. U.S. President Rick Suárez says much of the decisive work therefore happens before treatment begins: “identifying the right patient, running the test, interpreting it quickly, and acting.”

What makes that possible is analysis at a scale no clinician could reproduce manually. Cytek Biosciences’ systems can examine as many as 30,000 cells per second across dozens of characteristics simultaneously. A 40-parameter experiment creates, in effect, a 40-dimensional dataset. CEO Dr. Wenbin Jiang calls analysis “the main bottleneck”—but increasingly it is also the opportunity. AI can search those enormous datasets for combinations and patterns that would otherwise remain invisible, connecting cellular characteristics with disease biology and eventually with clinical outcomes.

Nowhere is the convergence of medicine and AI more advanced than in imaging. By the end of 2025, the FDA said it had authorized more than 1,300 AI-enabled medical devices, with radiology representing the dominant clinical category. Instead of treating every CT or MRI as a single answer to a single question, AI can potentially extract additional information from images that hospitals are already producing.

RadNet is one of the largest outpatient diagnostic imaging providers in the U.S., while its digital health division, DeepHealth, is developing AI tools designed to make imaging more intelligent—from supporting radiologists in detecting disease to extracting additional insights from scans patients are already receiving. Performing more than 12 million examinations a year, RadNet is building around that possibility at a time when imaging demand is outstripping the radiology

> The future of the OR isn’t about layering more devices; it’s about collapsing complexity into a coordinated, intelligent system. That can make the patient journey more predictable and connected, and less disruptive—helping patients get back to what matters most.
>
> DAVE ROSA | CEO, **INTUITIVE**

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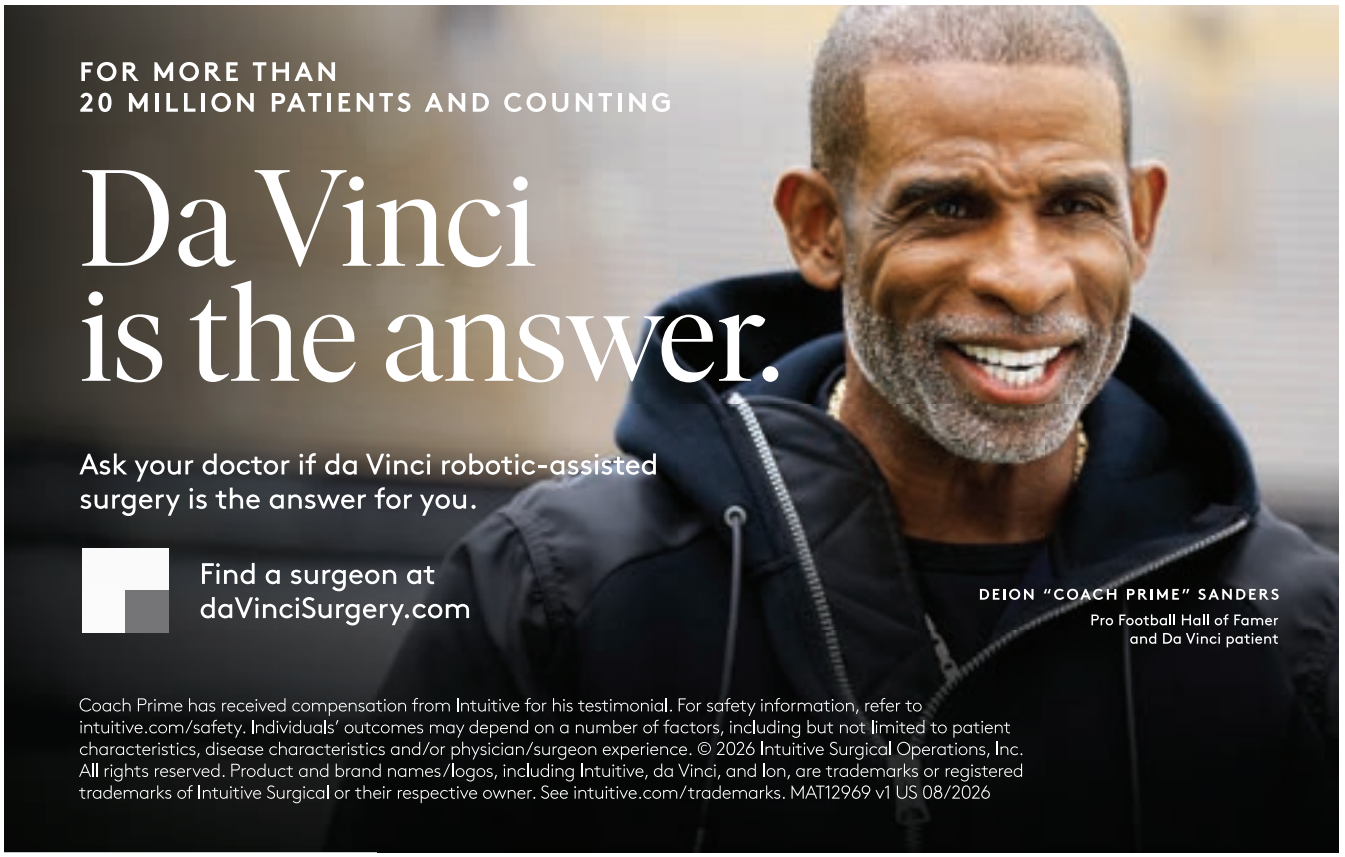
AI **1,300+** **AI-enabled medical devices** authorized by the FDA by the end of 2025

Source: Food and Drug Administration



workforce. CEO Howard Berger describes radiology as being "in a crisis," but sees the long-term answer as more than automating reports. "Diagnostic imaging is the gateway to population health," he argues. A scan ordered for one reason might also reveal early cardiovascular, neurological or cancer risk, allowing intervention before symptoms emerge.

Taken together, these developments are turning the machinery of medicine from a collection of discrete devices into an increasingly connected clinical ecosystem, capable of learning from procedures, identifying risk earlier and improving decisions before an intervention begins. Yet the technology itself is unlikely to be the decisive advantage. As institutions such as Severance and King Faisal Specialist Hospital & Research Centre demonstrate, its real value depends on the expertise, infrastructure and discipline surrounding it. When those foundations are in place, hospitals can tackle cases once considered impossible, make care less burdensome and offer meaningful recovery to patients who previously had far fewer options.

> Our role is practical: get more care and productivity from every existing asset, free nursing time and help hospitals meet an extraordinary operational and financial challenge.
>
> TOM LEONARD | CEO, **AGILITI**

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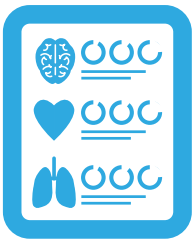
The intelligent hospital

Health care has no shortage of impressive AI demonstrations. The test is whether hospitals can make them dependable enough to operate inside everyday care: connected to clinical data, embedded in workflows and governed safely. Tampa General shows what implementation looks like when AI becomes part of the hospital's operating infrastructure rather than a standalone application. More than 80 AI systems run around the clock. In its 8,000-square-foot command center, nurses monitor 16 clinical indicators while predictive models look for physiological deterioration. CEO John Couris says sepsis mortality is 5.3 percent, against a national figure he puts at roughly 15 percent to 18 percent, and estimates that around 1,000 patients who might otherwise have died are alive because of the system.

Other systems are trying to increase both the depth and continuity of the information available to those models. "What excites me most is not just generative AI but agentic AI—the ability to think, understand and act," says Entwistle. Stanford's ChatEHR allows physicians to interrogate an entire patient record through a large-language-model interface, while tools can identify patients eligible for off-site care or clinical trials.

For prediction to become clinically useful, hospitals need to move beyond periodic snapshots of a patient's condition. "Continuous data is the missing link required to unlock true predictability," says BD Connected Care President Bilal Muhsin. Connected monitoring can track physiological trajectories continuously, while AI interprets changes across multiple signals before a conventional threshold alarm is reached.



66% of U.S. physicians reported using some form of health care AI in 2024 — up from just 38% in 2023

Source: American Medical Association

But generating more insight is only half the challenge; hospitals must also be able to carry it coherently across complex organizations and large patient populations. Elevance Health's AI-enabled virtual assistant is already available to 22 million commercial customers, yet Chief Digital Information Officer Ratnakar Lavu says scale quickly exposes weaknesses that small pilots can conceal. "The data is fragmented, the experience is fragmented, and that means clinical journeys and outcomes can become fragmented too." As he puts it: "Pilots are relatively easy; deploying something effectively across a population of that size is much harder."

Scale also raises questions that have no purely technical answer. Inovalon CEO Adam Kansler argues that "nothing is more important than the quality, accuracy and completeness of the underlying data," while cautioning that AI is not yet ready to make the final determination in health care. Mount Sinai's Carr points to another unresolved issue: who carries responsibility when an algorithm gives medical advice directly to a patient? The more deeply AI enters clinical care, the more questions of validation, accountability, privacy and human oversight move from theoretical debates into hospital operations.

For many clinicians, however, the most immediate benefit is far more prosaic. CorroHealth CEO Pat Leonard identifies "the clinician's time" as the critical pressure point, and ambient documentation is emerging as one of the fastest-growing responses. Boom says primary-care physicians have told him that ambient listening "literally gave them control of their lives back."

Cedars-Sinai Health System President & CEO Dr. Peter L. Slavin sees ambient documentation as a reversal of an earlier generation of digital medicine: "For the first time, we have information technology with the potential to make clinicians' lives easier, not more difficult."

Sanford Health is seeing effects substantial enough to influence retention. Some physicians contemplating retirement have told Sanford Health CEO Bill Gassen that they now expect to remain in practice another two or three years. "These are people who chose to serve in health care because they want to spend time caring for patients—not completing administrative tasks."

Boom offers perhaps the clearest test of where this should lead. "An AI robot cannot pray with a patient before surgery, rub someone's back to ease pain, or offer a comforting hug." The strongest case for AI is the time it can return to clinicians for the parts of medicine that remain irreducibly human.

Freeing that time, however, depends on more than algorithms. Some of the largest drains on clinical capacity come from the ordinary mechanics of running a hospital: moving patients between departments, turning over rooms, locating equipment, filling shifts and ensuring that essential supplies are available when needed. Beds and operating rooms may exist on paper, but they only become usable when the systems around them work reliably.

Crothall Healthcare CEO Mike Villani explains that hospitals can mistake poor flow for a shortage of space. "Hospitals may assume they need more beds or additional space when, in many cases, the real opportunity is to use their existing capacity more effectively." Room cleaning, patient transport and sterile processing all influence how quickly existing facilities can be used again. At MedStar Southern Maryland Hospital, Crothall says centralizing patient transport returned approximately 20,000 clinical hours to patient care by reducing the amount of time clinical staff spent moving patients themselves.

The same problem appears in medical equipment. A nurse may have a patient ready for treatment but still lose time searching for an infusion pump, monitor or other device. Research cited by Agiliti suggests nurses can spend as much as an hour per shift looking for equipment. CEO Tom Leonard sees this as a poor use of scarce clinical labor. "Health care cannot solve its workforce challenges by asking clinicians to perform work that does not require clinical expertise." Agiliti's approach is to make equipment easier to locate, maintain

"Innovation means converting data into research, returning that evidence to clinical practice and improving care models.

SAAD EHTISHAM | PRESIDENT & CEO, **ATLANTIC HEALTH**

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STERLING SERVICE PROVIDERS

MOHAN GIRIDHARADAS | FOUNDER & CEO, **LEANTAAS**

Our entire mission is to help our health system partners become as sophisticated operationally as they are brilliant clinically.

DAVE WESSINGER | CEO & CO-FOUNDER, **POINTCLICKCARE**

When information is flowing, readmission rates drop: we have seen reductions of as much as 50 percent in certain hospital systems.

RATNAKAR LAVU | CHIEF DIGITAL INFORMATION OFFICER, **ELEVANCE HEALTH**

The broader interoperability challenge is making sure the right medical record reaches the right place at the right time.

TINA VATANKA MURPHY | PRESIDENT & CEO, **GLOBAL HEALTHCARE EXCHANGE**

In health care, a back order is never just a line on a spreadsheet; it can leave a care team without a critical product and a patient waiting for care.

BYRON JOBE | PRESIDENT & CEO, **VIZIENT**

The highest performers standardize care and remove unnecessary clinical and operational variation. We see a relationship between greater standardization and fewer readmissions, complications and deaths.

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and redeploy across a hospital, so that devices are available where they are needed rather than scattered across departments or sitting idle.

Workforce shortages also become more manageable when hospitals make better use of the people they already have. AMN Healthcare CEO Cary Grace cautions against describing the problem simply as a collapse in clinician numbers. "The actual supply of clinicians is not declining; it is simply not keeping pace with demand." Hospitals are consequently placing greater emphasis on forecasting and more flexible deployment of staff. During two recent staffing surges, AMN says its AI recruiting tools removed almost 12,000 hours of administrative work before qualified candidates reached human recruiters. Grace's formulation is deliberately pragmatic: "Health care will always be a people and technology industry."

Even a well-staffed hospital can be stopped by a missing product. More than eight in ten health care supply-chain leaders surveyed by GHX say they lack real-time visibility across critical supplies, suppliers and sites of care. GHX CEO Tina Vatanka Murphy argues that resilience is less about stockpiling than knowing which products are genuinely indispensable and where vulnerabilities lie. "Resilience isn't about having more of everything. It is about knowing what care teams can't be without and preparing before a shortage hits."

Recent disruptions have made that preparation harder to treat as an occasional contingency exercise. Hospitals have moved from pandemic shortages into a period of recurring pressure from natural disasters, shipping interruptions, geopolitical instability and trade restrictions. At Sheikh Shakhbout Medical City, CEO Dr. Marwan Al Kaabi describes resilience as something that has to be built into everyday management rather than improvised when supply breaks down. "Resilience cannot be created in the midst of a crisis; it must be built well in advance and embedded within the hospital's operating model."

The boundary between clinical care and what was once called "support" work is becoming harder to draw. Morrison Healthcare CEO Avi Pinto makes that case through food and nutrition services, stating "the dining experience has become an important extension of hospitality, healing and patient-centered care." Food may sit outside the traditional image of high-tech hospital medicine, but poor nutrition can affect recovery, complications, length of stay and the likelihood of returning to hospital. The same is true of transport, equipment and supply availability: each can determine whether a treatment happens on time and whether a patient progresses through the hospital as planned.

For hospitals under pressure, the question is therefore not simply how many beds they own or how sophisticated their technology has become, but how reliably the whole institution functions around them. An operating room cannot start if the instruments are not ready. A bed is not available until the previous patient has moved on and the room has been turned over. A clinician's time is wasted if part of the shift is spent searching for equipment. The most effective hospitals may increasingly be distinguished by how rarely patients and clinicians are forced to notice any of this machinery at all.

"AI is making ground, but it remains early stage. It is not at a point, and probably will never be at a point, where it solves the problem 100 percent. The real question is how to combine automation with domain expertise so that it drives the right solution in the right setting.

PAT LEONARD | CEO, **CORROHEALTH**

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MICHAEL KUPFERMAN | CEO, **PENN STATE HEALTH**

Insurance approvals, documentation requirements, regulations and administrative processes all add steps between a patient's first phone call and receiving care. We're working to reduce [those burdens] through technology, virtual care and expanded access points.

ANDRE ESTEVA | CO-FOUNDER & CEO, **ARTERA**

Doctors walk a fine line between undertreatment and overtreatment. AI can help get cancer treatment right, sparing patients unnecessary therapies and toxic side effects while protecting their long-term health and quality of life.

ANDREA DANIELS | CEO, **MEDICAL CITY HEART & SPINE HOSPITALS**

Temporary ventricular assist devices serve as a game changer for survival. In the past, about 50 percent of patients with severe cardiac injury might not have made it out of the hospital; now, the vast majority leave the hospital because this device allows recovery.

RICK SUÁREZ | U.S. PRESIDENT & HEAD OF THE U.S. BIOPHARMACEUTICALS BUSINESS UNIT, **ASTRAZENECA**

More of what determines an outcome happens before medicine is prescribed: identifying the right patient, running the test, interpreting it quickly, and acting. Many systems still focus on treating disease rather than proactively testing for it.

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The Future of Healthcare Is Built on Human-Centered Hospitality.

Compass Healthcare partners with hospitals to transform Food & Nutrition, Environmental, and Support Services into strategic advantages that strengthen operations and improve outcomes.

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