

Beyond the Triple Threat: The Future of Leadership in Academic Medicine

Academic medical centers (AMCs) are essential to the U.S. healthcare system: as training grounds for the next generation of clinicians and scientists, as primary research facilities for cures and treatments of diseases, and as critical patient treatment centers for the most complex and sometimes rare diseases.

And yet, AMCs — and their unique tripartite mission to provide high-quality clinical care, cutting-edge research and top-level education — face existential challenges amid cracks in their financial model, intensifying cultural stresses and rising talent pressures.

These threats have left AMCs at a critical leadership crossroads. Confronting turnover across leadership levels, they struggle to identify and develop future leaders to lead in a dynamic and evolving environment.





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DR. RON WALLS

CHIEF OPERATING OFFICER, MASS GENERAL BRIGHAM

"We need a completely different phenotype than what we've cultivated and cherished over the decades," said Dr. Ron Walls, chief operating officer of Boston-based Mass General Brigham. "To better support our people and deliver on our mission to our patients, our leaders now need to be both strategic and pragmatic, much more grounded in the practical knowledge around how systems work, and prepared to make tougher decisions than ever before."

Amid this backdrop, we recently began looking deeply at the profile of deans, CEOs, department chairs and other leaders charged with carrying AMCs into the future. What challenges await them? What are the skills and capabilities of successful AMC leaders? What steps can AMCs take to develop effective future leaders?

In this piece, based on our firm's research about the [CEO of the Future](#), our decades of experience as talent advisers to the nation's preeminent AMCs and on 10 recent interviews with top AMC leaders, we look at the answers to these questions and more, covering four main areas:

- » The headwinds that AMCs face as they plan for the future
- » The steps AMCs have already taken to address these challenges
- » The profile of the AMC leader of the future
- » What AMCs can do to prepare the next generation of leaders

The headwinds facing AMCs

AMCs' tripartite mission has long made them respected and often beloved pillars of their communities and our nation. But this mission faces tremendous pressures, some long-simmering, others newly arising, that will shape the health and strength of AMCs in the coming years.

The financial model is breaking

The combination of government underpayment and shrinking commercial offsets is not new, but there is fear that the house of cards could collapse for AMCs, and perhaps soon. [Labor costs have increased](#), due to a constrained labor supply and related growth in salaries that has outpaced inflation. Meanwhile, AMCs are already facing reduced government funding, including [cuts in Medicaid and Medicare](#) and [reductions in NIH funding](#), totaling in the hundreds of millions of dollars. This worsening financial situation means that AMCs' inherent inefficiencies — particularly the lack of integration of the clinical and academic missions — pose an existential business threat if not addressed soon.



“Care delivery and research and education are inextricably linked,” said Dr. Craig Albanese, the former CEO of Duke University Health System who is now Kaiser Permanente’s president of integrated care and coverage. “A lot of waste comes from the fact that they’re not as integrated as they should be.”

Market dynamics have also shifted. As the healthcare market demands that patient care be moved to the lowest-cost, highest-quality setting, AMCs have responded by expanding their clinical enterprise to include community hospitals, outpatient surgery centers and primary care clinics — a major shift in a sector where previously the clinical enterprise was largely restricted to tertiary and quaternary care, centered around large inpatient facilities.

Consolidation has strengthened some competitors, particularly large integrated community health systems that often deliver lower-cost care. In general, however, AMCs remain at a comparative disadvantage, as the clinical system increasingly bears the costs of the academic missions. Even as mergers enable AMCs and community health systems to expand access to care and grow revenue, there’s no guarantee that such moves reduce costs or improve outcomes.

“We have been approached about mergers and we always ask, ‘What are we gaining by doing this?’” said Dr. Steven Corwin, president and CEO of NewYork-Presbyterian. “Looking at some of the national mega-mergers, I don’t know what they gain.”

Cultural and political pressures are intensifying

AMCs — not to mention the larger universities that many are part of — are in the cross-hairs of rising political and cultural pressures about their work. Accustomed to making headlines for their scientific breakthroughs, AMCs are now in the news as they negotiate with the federal government to preserve crucial federal funding, access to foreign student visas and even their tax-exempt status.

Executive orders restricting DE&I and health equity programs, some with the potential penalty of losing federal funding, have created compliance risks that are jeopardizing access to federal funding critical to operations. And AMCs’ complexity and size make full compliance a daunting proposition. “There could be things buried in a department that organizations don’t know about,” said Kevin Sowers, president of the Johns Hopkins Health System and executive vice president of Johns Hopkins Medicine. “The compliance risks are significant and should be identified and addressed.”

These pressures align with a growing culture of mistrust of science and academic institutions — something demonstrated in recent years by increased medical misinformation and vaccine skepticism that intensified during COVID. Political polarization also further complicates governance and donor relations. Some boards face internal divisions, and politically sensitive decisions risk alienating key supporters.

AMCs face talent challenges, both chronic and new

The cultural and political pressures noted above are combining with financial, structural and generational forces to reshape the AMC workforce.

Cultural pressures are straining a workforce that is still grappling with the lingering effects of the pandemic. Amid all this, the new generation of clinicians is prioritizing their own well-being and work-life balance, leading to unprecedented developments such as unionization of residents, fellows and PhD researchers. “We’ve also had some attending physicians seeking union representation,” said Dr. Walls of Mass General Brigham. “That’s never happened before — and it reflects the urgency our people feel to be heard and supported during this time of great change.”

The environment also makes attracting and retaining clinicians — and nurses in particular — more difficult. The continually constrained labor supply is leading to stubbornly high labor costs, even as advances like AI are helping improve administrative efficiency and productivity.

Meanwhile, recent government funding cuts combined with potential difficulties obtaining visas have some researchers and clinicians questioning whether the U.S. is where they want to build their careers. “We have a 25 percent reduction in graduate students, 30 percent reduction in postdocs,” said Dr. Timothy Dellit, CEO of UW Medicine, executive vice president for medical affairs for the University of Washington, and dean of the University of Washington School of Medicine. “People are going to go to other countries for their training, risking our future leadership in biomedical research.”

All these talent issues portend a leadership challenge: Who are the AMC leaders of the future, and how will they be developed? This sector faces a unique leadership paradox. Physicians are the most sought-after for many leadership roles. Yet, because of the length of training physicians endure, many are well into their 30s before they can truly embark on a leadership journey. And, with AMCs seeking leaders with extensive leadership experience to manage their increasing complexity, there is simply a smaller pool of executive talent considered “ready” within the sector.



How AMCs have responded

AMCs and their leaders are not standing pat in the face of these challenges. We see four primary ways that AMCs have responded in recent years — although for some, the results are still unknown.

Revisiting organizational structures

Financial and workforce pressures are forcing leaders to consider options such as combining historically separate departments, creating new institutes, or better integrating the operations and leadership structures of the three missions. We are also seeing a flattening of organizational structures. For example, systems with multiple hospitals are rethinking whether they need both a CEO and COO at the hospital level. Amplifying the complexity is each AMC's unique relationship with its affiliated university, medical school and/or health system, making structural reform highly individualized.

At Mass General Brigham, for example, institutes were established to consolidate formerly independent departments around the needs of patients, and to better support collaboration among teams. “We moved cardiology from the Department of Medicine and cardiac and vascular surgery from the Department of Surgery into a Heart and Vascular Institute that is accountable for education, research and clinical care,” said Dr. Walls. “This has been a huge change — structurally, organizationally, financially, digitally and culturally.” Dr. Walls emphasized that while the pace of change has been disruptive, slowing down would be even more destabilizing; change, while hard, is necessary to remain viable.

Rethinking M&A and other growth avenues

Aggressive M&A has been a way for AMCs to grow amid financial pressures. However, top-line growth does not always equal bottom-line results.

AMC leaders are taking more nuanced approaches to grow strategically. Avoiding opportunistic acquisitions, like buying local hospitals just because they're available, many are instead focusing on deals that meet specific institutional needs or open new revenue streams. This includes divesting from non-core operations, exploring partnerships outside the traditional boundaries of healthcare with tech companies and private equity, and even considering partnership or consolidation with other AMCs.

For instance, NewYork-Presbyterian, Dr. Corwin said, sold its ambulatory laboratory business, which performed poorly in relation to national competitors. Similarly, Duke's former CEO, Dr. Albanese, proposed applying the group purchasing model used in clinical operations to research, suggesting that AMCs should “dispense with the idea that they must own everything.”

Leslie Davis, president and CEO of UPMC, said that AMCs should consider partnering or consolidating with each other. “Every other industry has experienced consolidation; academics and universities have not,” said Davis. “There are a million reasons why they can't, and maybe there are a million reasons why they should.”





Prioritizing clinical enterprise experience over academic experience

The elusive “triple threat” leader — a physician with robust research credentials, extensive clinical experience and strong teaching skills — still tops most organizations’ leadership talent wish lists. However, managing the scale and complexity of today’s clinical enterprises has become a critical skill.

Experience managing the clinical enterprise is gaining prominence over purely academic credentials. This includes managing clinical operations, such as revenue generation, expenses and people management. But this process is more complex in an academic environment, where the clinical system bears more costs — such as additional staffing from training students, residents and fellows, and research costs that are subsidized by the clinical enterprise. Furthermore, as AMCs grow (both organically and inorganically) to meet market demands for low-cost, high-quality care, their clinical enterprise is expanding into new areas, such as community hospitals, outpatient surgery centers and primary care clinics.

“While the leader of an AMC should have extensive exposure to both the academic and clinical missions, if I couldn’t have someone very strong in both domains, I would lean toward the clinical background,” said Dr. Jeffrey Balser, president and CEO of Vanderbilt University Medical Center and dean of Vanderbilt University School of Medicine. “The clinical enterprise is responsible for generating 90 percent of the margin needed to support the academic enterprise. The board cannot risk having the clinical enterprise not run well.”

The solution is not simply finding clinicians with a business degree but rather ensuring that leaders of the future have the chops to manage the complexity of operating an AMC and keep it solvent. In fact, while formal business education can help, hands-on experience in managing financial and operational challenges is often more valuable. This business-oriented leader can’t be all business, though. While the leader does not need to be a scientist, they must respect and understand the importance of the research that is quintessential to an AMC.

Emphasizing executive leadership capabilities

As noted above, the rising financial, social and political pressures are changing the contours of leadership at AMCs and leading many to rethink the leadership qualities needed for success. Historically, AMC leaders rose through the ranks based on their teaching credentials, their research portfolio and/or their clinical experience. There is growing recognition that this background alone cannot sufficiently prepare a leader for a challenging future and that general leadership is as important, if not more so.

So, instead of focusing mainly on how many publications they’ve authored or NIH grants they’ve secured, AMCs are asking a new set of questions of prospective leaders: What are their demonstrated leadership skills and capabilities? How adept are they at managing a diverse set of stakeholders? What is their capacity to learn and develop more as leaders?

In the next section, we look in detail at the leadership capabilities needed in future AMC leaders.

The profile of the AMC leader of the future

At Spencer Stuart, we have [identified six enduring, critical leadership capabilities](#) for executive leaders across industries. With that framework in mind, below we look at five aspects of leadership that are critical for AMCs now and into the future.

Communication skills based in honesty, transparency and empathy

As AMCs navigate headwinds, their leaders must preserve trust, build cohesion and maintain credibility with a complex network of stakeholders: employees, patients, affiliates, partners, suppliers, community leaders, donors, regulators and the university community. The most effective leaders fuse transparent communication with empathetic, emotionally intelligent leadership. It is a combination that can turn difficult moments, such as layoffs, funding crises and policy changes, into opportunities for clarity and dignity. The goal is engagement, rather than resistance.



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“Leaders today cannot just have great ideas and good business discipline,” said Dr. John Warner, CEO of The Ohio State University Wexner Medical Center and executive vice president at The Ohio State University. “They need to evangelize. People are looking to be inspired, led and motivated. To do this, leaders must listen to understand what the stressors are on the system and what is needed for people to succeed.”

DR. JOHN WARNER
CEO, THE OHIO STATE UNIVERSITY WEXNER MEDICAL CENTER;
EXECUTIVE VICE PRESIDENT, THE OHIO STATE UNIVERSITY

Stability and resilience amid constant change

“Calm in the midst of chaos” was a common refrain cited by our interviewees as key for future AMC leaders. As organizations grapple with today’s immense pressures — plus whatever unforeseen crises are to come — they need unflappable, resilient leaders who can calmly guide them forward in any situation. “As a leader, you try to understand and respond to the chaos,” said Kevin Sowers of Johns Hopkins. “But you can’t let your team get caught up in it. You have to keep them briefed and calm.”

Unflappability is one key reason so many AMCs see great value in having clinician leaders — evidenced perhaps by several physicians being tapped to lead universities in recent years. Clinician leader or not, resilience requires self awareness and a measured approach to conflict, crisis and stress. “There will always be challenges,” said UPMC’s Leslie Davis. “And right now, we are facing a confluence of challenges. Good leaders with self awareness of their strengths and weaknesses will navigate these challenges.”

Systems thinking to harness the power of the tripartite mission

AMCs are complex ecosystems — multiple entities working together under unique governance and ownership structures to achieve a multi-pronged mission. Dealing with the pressures that have already been outlined requires leaders who understand these connections and can optimize operations to sustain the entire mission.



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DR. JEFFREY BALSER

PRESIDENT AND CEO, VANDERBILT UNIVERSITY MEDICAL CENTER;
DEAN, VANDERBILT UNIVERSITY SCHOOL OF MEDICINE

The most successful AMC leaders embrace systems thinking — the interconnectedness of everything — and develop bold ideas by thinking beyond traditional boundaries. Systems thinkers see beyond silos, recognizing that decisions in one area ripple across the whole.

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This mindset is critical as AMC leaders face tricky questions about their institutions’ missions and how to sustain and even grow all three in harmony, a topic that can create a divide between clinicians and lay administrators. Clinician executives can bridge the divide by understanding, as Kevin B. Mahoney, CEO of the University of Pennsylvania Health System, puts it, “the Jenga” that is a health system. “Every move has consequences,” he said, “and you have to think five steps ahead.”

Strong business acumen

The teetering financial model demands more business-oriented leadership than traditionally seen at AMCs. Leaders need to be hands-on financial strategists who can align budgeting, capital planning and risk management to organizational reality.

“Managing operational budgets year over year no longer works,” said Kevin Sowers of Johns Hopkins. “The old levers to pull to balance the budget aren’t fit for the current environment. We will need to reimagine how care is delivered and the technology and resources required to change the way in which we integrate all of our missions. Organizations will also need to think about the balance sheet. What are your cash reserves and liquidity levels? Do you have enough debt? How do your capital plans fit into this?”



[AMCs] need to reframe financial conversations with the board away from presenting the budget for approval to instead discussing different scenarios, risks and their enterprise-wide impact.”

KEVIN SOWERS

PRESIDENT, JOHNS HOPKINS HEALTH SYSTEM;
EXECUTIVE VICE PRESIDENT, JOHNS HOPKINS MEDICINE

This means making data driven, often-difficult choices, and rethinking discussions with the board.

“Organizations need to reframe financial conversations with the board away from presenting the budget for approval to instead discussing different scenarios, risks and their enterprise-wide impact,” Sowers said.

AMC leaders must also navigate complicated partnerships, mergers and competitive positioning to preserve growth. “For the benefit of the AMC, it’s

crucial to know how to structure these partnerships, from a loose affiliation to a revenue-sharing arrangement to equity ownership in the partnership,” said Dr. Michael Good, CEO emeritus of University of Utah Health.

An innovation mindset, focused on sustainable growth

AMCs are known for their scientific advances, yet less so for operational innovation or new income streams. Future AMC leaders must flip the script, creating a culture of innovation and technological fluency to cut costs, improve efficiency, scale services and diversify income.

Importantly, being an innovator does not mean that an AMC leader must be an expert, but rather, that they build and empower teams of experts. For example, as AI’s role in medicine grows, the best leaders will have an agile, adaptable and learning-oriented mindset that encourages the organization to test AI use cases and pivot quickly when needed.

Some are advocating outside-the-box thinking in terms of new areas and partnerships. Take, for example, outpatient and home care, which makes up a larger percentage of treatments today. “We know how to deliver care, but we aren’t as strong on the logistics of getting clinicians to homes,” said Penn Medicine’s Kevin Mahoney. “Other companies have figured out these logistics. If we can marry our ability to deliver care with the logistics savvy of a company like Uber or Amazon, it would be a home run.”

And some leaders are resisting the idea that growing the clinical enterprise is the panacea for financial stress. “Healthcare costs in the U.S. are unsupportable, so every day we make less money per unit of clinical service,” said Vanderbilt’s Dr. Balser. “NIH research grants require a substantial cross subsidy at the nation’s AMCs, and the clinical enterprise can’t grow enough to remain the primary support mechanism. Growing alternative revenues streams, including industry and other private research funding, is a must.”

What AMCs can do to prepare the next generation of leaders

So what can AMCs do to build the leadership capabilities most crucial for the future in their current leaders and talent pipeline? How do they go about finding leaders with these capabilities, internal or external?

Build a great top team

Gone are the days of the hero CEO, and for AMCs, perhaps the “triple threat.” The top leader can’t do it alone, nor are they expected to anymore. Instead, the best leaders tap into the collective intelligence of their teams, their boards and other outside experts to continuously learn and adapt, and deliver on their strategies.

The challenge is finding someone who can guide such a strong yet diverse team. “Strong opinions, lightly held” is a key notion here, modeled in how leaders critique themselves, seek and respond to feedback, and adapt their approaches as necessary. They encourage constructive dialogue — even when the pressure of the moment invites the opposite response.

“The key to leadership is awareness of your own strengths and weaknesses,” said UPMC’s Leslie Davis. “Good leaders make sure there is a team around them that reflects all the important aspects of leadership. The leader’s role is to be the best conductor of the orchestra.”

Evaluate the organizational structure

Acquisitions, partnerships and other ventures only add to the existing organizational complexity. AMC leaders must review their current organizational and leadership structures, including the responsibilities and reporting structure of top roles like dean and CEO. Is a single leader overseeing the tripartite mission the best path, or should multiple leaders exist? The correct answer depends on the organization’s specific environment and structure, and making sure it can support streamlined decision making, reduce inefficiencies and boost collaboration, with clinical and academic arms working together seamlessly.



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LESLIE DAVIS
PRESIDENT AND CEO, UPMC



“I think an integrated financial model with one fiduciary over the medical school and health system is better, but integration doesn’t solve all problems,” said Dr. Good, Utah Health’s CEO emeritus who simultaneously served as the organization’s senior vice president for health sciences and dean of the medical school. “The problems still exist in an integrated model, but they are handled in the office of the top leader, the single fiduciary rather than in the board room. Both models work — separate vs. integrated — but differently.”

Cultivate an internal bench of talent

As AMCs grow more complex, so does what is asked of their leaders. That’s why so many organizations want a leader who’s “done it before.” But the pool of people with experience managing today’s complex systems is narrow. That’s why investing in identifying and developing top talent early in their career has become increasingly critical for AMCs.

“In academic medicine today, too often we wait until someone is fully formed,” said Dr. Warner of Ohio State. “People are in their late 50s or 60s before they are ‘ready’ to lead. We need to accelerate that timeline and give people opportunities to lead earlier in their careers.”



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DR. MICHAEL GOOD
CEO EMERITUS, UNIVERSITY OF UTAH HEALTH



Many leaders we spoke with advocated for immersive, real-world training programs for up-and-coming leaders, be it business briefings, administrative fellowships, rotations in different areas, or other informal leadership opportunities. Regardless of background, rising leaders need intensive training and exposure to gradually boost their leadership capabilities.

“As we grow and do more things, we need to slot people into roles where the risk is relatively low, and the learning opportunity is high,” said Duke’s former CEO Dr. Albanese. “Find opportunities where future leaders can cut their teeth and grow their operational skills.”

Enhance succession planning

Organizations know the importance of succession planning. For example, [Spencer Stuart’s 2025 survey of nominating/governance \(nom/gov\) committee chairs](#) found that 60 percent of nom/gov chairs rate CEO succession as a top priority over the next three years. Most AMCs engage in some sort of succession planning, but it is often near-term and responsive to an imminent transition.

Succession planning at AMCs is evolving as the clinical enterprise grows. AMCs have a natural pipeline of rising talent as aspiring leaders become chiefs, chiefs become chairs and chairs become deans. While this traditional path to leadership at an AMC still exists, additional paths through service line, institute and center, and system-level leadership roles are now an option. While this broadening of routes up is arguably necessary and positive, AMCs continue to lag other industries in their succession efforts, waiting too long to start and not having robust leadership development programs in place to prepare the internal pipeline of talent.



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DR. CRAIG ALBANESE

FORMER CEO, DUKE UNIVERSITY HEALTH SYSTEM;
CURRENT PRESIDENT OF INTEGRATED CARE AND COVERAGE, KAISER PERMANENTE

“We don’t always do succession planning well in academic medicine,” said the University of Washington’s Dr. Dellit. “We are trying to be more intentional about it, through leadership development programs and internal coaching programs focused on different stages of career development. Every chair I hire is set up with an executive coach from day one to help them be successful.”

So how do top organizations across industries get succession right?

- » They approach succession planning as “always-on,” not a one-time, far-away event.
- » They think about succession early in a leader’s tenure.
- » They engage the CEO, CHRO and board throughout the process.
- » They integrate succession planning within broader executive leadership development programs to ensure they are developing a robust pipeline of talent who can be ready to meet the moment when a transition occurs.
- » They benchmark internal talent against external talent, recognizing that the readiness of the internal options may not align with the changing needs of the business — especially in a volatile environment.
- » They consider “non-traditional candidates,” which at AMCs could include those with mostly clinical backgrounds, or alternately those who built their careers outside of academic medicine.
- » They don’t stop when the new leader takes over. Instead, they build and execute a robust plan for [ensuring leaders master the critical levers for success](#), including team alignment, culture, style, communications and organizational structure.





Amid a volatile landscape, leadership at academic medical centers has never been more important — or more complex. Facing financial strain, cultural headwinds and workforce disruption, AMCs will need strong, adaptive leaders who can build strong teams, communicate with clarity and empathy, and guide a strategic vision with grounded pragmatism. Strong leaders won't just navigate change — they'll shape what comes next.



We wish to thank the industry leaders who spoke with us for this piece:

- » **Dr. Craig Albanese**, President of Integrated Care and Coverage, Kaiser Permanente; former CEO, Duke University Health System
- » **Dr. Jeffrey Balser**, President and CEO, Vanderbilt University Medical Center; Dean, Vanderbilt University School of Medicine
- » **Dr. Steven Corwin**, President and CEO, NewYork-Presbyterian
- » **Leslie Davis**, President and CEO, UPMC
- » **Dr. Timothy Dellit**, CEO, UW Medicine; Executive Vice President for Medical Affairs, the University of Washington; Dean, the University of Washington School of Medicine
- » **Dr. Michael Good**, CEO Emeritus, University of Utah Health
- » **Kevin B. Mahoney**, CEO, University of Pennsylvania Health System
- » **Kevin Sowers**, President, Johns Hopkins Health System; Executive Vice President, Johns Hopkins Medicine
- » **Dr. Ron Walls**, Chief Operating Officer, Mass General Brigham
- » **Dr. John Warner**, CEO, The Ohio State University Wexner Medical Center; Executive Vice President, The Ohio State University





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