OPEN DOOR SALON

The Operator Briefing

Q2 2026 Edition

The science was never the hard part.

If you did not have eleven hours to sit with the people who actually build, fund, and secure this industry this quarter, here is the quarter in one sitting: the single argument running through every conversation, and the point of each one, so you walk into your next decision current.

A physician who became a cancer patient. A drug-discovery scientist who got leukemia. The man who built pharma's patient-recruitment function, who then could not find his own trial. The founder of Two Bear Capital. A former CIA supply-chain officer. Nineteen operators across eleven conversations, and the same conclusion from every seat: the science works. What decides who actually lives is everything around it.

Three questions decided the quarter: can you get it to a patient, can you fund it, and can you trust what it is built on. Those are the three sections of this briefing.

FEATURING EVERY Q2 GUEST


Karla Loken


Jesús Zurdo


Sunitha Malepati


Craig Lipset


Jim Kremidas


Elisa Cascade


Tom Whitehead


Tori Lee


Steven McWilliams


Richard Hicks


Mike Goguen


Rob Williamson


Edwin Stone


Erik Digman Wiklund


Ali Pashazadeh


Jon Rees


Clinton West


Mike Walker


Theresa Campobasso

Loken & Associates · The Buffalo Initiative · Clinical Innovation Partners · AMRC · TrialScreen · Emily Whitehead Foundation · Georgia Hospital Association · Inspiredu · Two Bear Capital · Traverse Therapeutics · Cellular Origins · Circio · Treehill Partners · MitoRx · Aardwolf Global Solutions · CIA · U.S. Marine Corps

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Lori Ellis, Founder & Host · Open Door Salon · Q2 2026

ACCESS · 01

Access: getting it to a patient. Medicine that exists is not medicine you can reach.

A doctor got answers in hours. What about the patient who knows no one?

From Open Door Salon: "I'm Lucky I Had the Network — A Physician Becomes the Patient" · Dr. Karla Loken, Founder, Loken & Associates, and patient.

THE POINT

Access is not whether the treatment exists. It is who you can reach, and most patients cannot reach anyone.

Dr. Karla Loken is a physician and women's-health leader who founded Loken & Associates, a medical-affairs consultancy. An OB-GYN by training, with a career spanning clinical practice and industry, she then became a cancer patient herself and navigated the system from inside the profession that built it.

> *"That's why I'm so lucky. This is my guilt of being a survivor that didn't have to go through as much as what other people had to go through."*
>
> Dr. Karla Loken on Open Door Salon

When Loken was diagnosed, the answers came fast. She knew which specialists to call, and a career's worth of colleagues in diagnostics, devices, and pharma moved on her behalf. Within hours, before she had told more than two people, messages were arriving through the grapevine asking what her family needed. She is direct about what that bought her, and about the discomfort of it. The guilt she names is not about the disease. It is about the access that carried her through it.

The counterfactual is what she keeps returning to, and it is the part worth sitting with. Some communities, she notes, have no option but to rely on a single local physician or word of mouth. Asked directly how you reach those patients, her answer was honest and unsatisfying: she does not know. She thinks about the patient who does not speak English, for whom translator lines exist but are not available at every moment that matters, and who goes home to a search engine instead of a specialist.

> *"What if I didn't speak English? Most people have translators, or translator lines, but that's not available to me at all times. When you're going home to Google and to search, it's dangerous, because you can overread on Google."*
>
> Dr. Karla Loken on Open Door Salon

Her practical advice tells you how thin the system's own supports are. Bring somebody with you to appointments, because you are too overwhelmed to hear what is being said. Write it down. Get it in writing. Find an advocate. Every one of those is a human workaround for an institutional failure, and each depends on having a person available to do it for you.

For anyone building in this industry, the read is uncomfortable. The same diagnosis produces different odds depending on who a patient can reach, and the gap is invisible to the people it protects. Real-world uptake of any therapy runs through a patient's network. For most patients, that network does not exist. An access strategy that quietly assumes one is a strategy built for the people who least need the help.

ACCESS · 02

The scientist who designed the therapies had never understood the patients.

From Open Door Salon: "92% of His Bone Marrow Was Cancer — A Scientist's Leukemia Journey" · Jesús Zurdo, Biopharmaceutical Scientist and Innovation Leader, and patient.

THE POINT

We optimize the molecule and skip the patient. It took a scientist getting cancer to name the gap.

Jesús Zurdo is a biopharmaceutical scientist and innovation leader, and a cancer patient whose experience reshaped how he thinks about drug development. Born in Madrid and based in the UK for some three decades, he trained as a molecular biologist and spent his career in drug discovery, biologics manufacturing, and company creation.

> *"92% of my bone marrow cells were blasts, were immature cells. They had the signature of a cancer."*
>
> Jesús Zurdo on Open Door Salon

Zurdo spent a career on the making side of medicine. Then a biopsy found that almost all of his marrow had turned to cancer, and he became the person the industry designs for rather than the person designing. What he took from it is not a survival story. It is an indictment of his own field, and he does not soften it.

> *"I blame myself as a scientist. We do not understand what health care is, and we don't understand what patients live with, and we don't want to understand."*
>
> Jesús Zurdo on Open Door Salon

His evidence is a story about muscular dystrophy. A team finally decided to talk to the patients they were developing for. They discovered they had got it completely wrong. When they spoke with the children themselves, the thing the children wanted most was to be able to feed themselves. Not the endpoint the protocol was built around. Not the measure the field had agreed to optimize. Something nobody had thought to ask about, which had been knowable the entire time for the price of a conversation.

That is the pattern he is naming. The industry does not talk to patients enough to understand how much they already know, let alone what they actually want or need. It optimizes the molecule and treats the patient's lived experience as a downstream detail. Zurdo's own case makes the stakes concrete: to a patient, the benefit is not only survival. It is less chemotherapy, and less of the fog that follows it. Those outcomes rarely drive a development plan.

> *"I'm very happy to share my story if you are willing to listen to me."*
>
> Jesús Zurdo on Open Door Salon

The conditional in that sentence is doing a lot of work, and it is earned. When Zurdo brings the patient view back into the industry, the reception varies. He describes preparing his first presentation by warning the room it could be hard, offering to soften parts of it, and telling people they were free to walk away if it became uncomfortable. A field that treats a patient's own account as something to be braced for has organized itself not to hear it. He is equally sharp on the reflex that a technical advance automatically solves access: in vivo CAR-T removes the manufacturing step, which is genuinely brilliant, and everyone immediately assumes that makes it cheaper. It does not follow.

For an operator, this is not a call for empathy. It is a design failure with commercial consequences. Understanding what a patient lives with, Zurdo argues, is a precondition for developing better medicine, because a therapy optimized against the wrong endpoint is a therapy people do not choose and do not stay on. The field keeps skipping the cheapest input available to it.

ACCESS · 03

For 7,000 rare diseases, pharma is not coming. So patients became the developers.

From Open Door Salon: "Pharma Is Not Coming — Patient Groups Are Now Drug Developers" · Sunitha Malepati, Founder, The Buffalo Initiative, and Craig Lipset, Founder, Clinical Innovation Partners.

THE POINT

When access fails at the source, the patients stop waiting and build the drug themselves.

Sunitha Malepati is the founder of the Buffalo Initiative, a patient-led effort to advance drug development for ultra-rare diseases, operating as a program of Renaissance Philanthropy. It is named for the way buffalo turn to face a storm head-on.

Craig Lipset is the founder of Clinical Innovation Partners, an advisory practice at the intersection of clinical research, digital health, and patient engagement, and a clinical leader for the Buffalo Initiative. He is co-founder and co-chair of the Decentralized Trials & Research Alliance, and previously led clinical innovation at Pfizer.

> *"Pharma's not coming. We can't just beg Pharma to take interest. And we certainly can't beg them to take interest times 6,000, 7,000, 8,000 unmet rare conditions."*
>
> Craig Lipset on Open Door Salon

Lipset saw the bottleneck through his inbox. The messages kept arriving from parents, all with the same shape: someone should do the heavy lifting, push this over the finish line, and make it available for my children. The more of those he received, the clearer it became that a structural problem was forming that he had not previously appreciated. Patient groups were carrying assets a long way down the road on the belief that pharma would eventually step in and finish the job.

That belief is the thing he is dismantling. Pharma is not coming, and the answer is not to lobby harder or to guilt anyone into interest, because interest extracted that way does not fit the business model and will not survive contact with a budget cycle. His proof is recent and unsentimental: over the last two years, as large publicly traded companies scaled back pipelines and reprioritized, rare-disease assets were the first to go. They are always the first to go. That is not a villain in the story. It is arithmetic.

> *"When we run into periods like we have in the last two years where large publicly traded pharmaceutical companies had to scale back some of their pipelines and reprioritize, these are the first assets to go."*
>
> Craig Lipset on Open Door Salon

So the model inverts. Malepati's Buffalo Initiative exists to make patient-led development repeatable rather than heroic, giving groups the infrastructure to advance their own therapeutic programs instead of waiting in a queue that never moves. Lipset saw in it the solution the ecosystem was in dire need of: not a better argument aimed at pharma, but a different developer entirely.

For anyone working in or investing around rare disease, this is a shift in where innovation originates. The assets are increasingly coming up from the patient organizations pharma left behind, not down from a corporate pipeline. That changes who your counterparty is, who owns the data, and who you negotiate with when one of these programs finally works. Thousands of conditions sit within scientific reach and outside anyone's commercial model. The people locked out of the commercial model stopped waiting for pharma and started developing the therapies themselves.

ACCESS · 04

The man who built pharma's patient recruitment couldn't find his own trial.

From Open Door Salon: "I Had Bladder Cancer & Couldn't Find a Clinical Trial — I Run Patient Recruitment" · Jim Kremidas, Executive Director, Association of Multisite Research Corporations, and Elisa Cascade, Chief Growth Officer, TrialScreen.

THE POINT

If the person who professionalized trial access can't navigate it, the system is broken by design, not by ignorance.

Jim Kremidas is executive director of the Association of Multisite Research Corporations (AMRC), representing organizations dedicated to conducting clinical research. He spent 24 years at Eli Lilly, where he founded what is widely regarded as the pharmaceutical industry's first dedicated patient-recruitment department.

Elisa Cascade is chief growth officer of TrialScreen, a patient-recruitment company, and a clinical-research executive with more than three decades in the field. Her career spans strategic consulting, contract research, the technology side of clinical operations, and the investigator-site side.

> *"I was diagnosed with bladder cancer, and I went through what's considered the standard of care..."*
>
> Jim Kremidas on Open Door Salon

Kremidas spent a career teaching the pharmaceutical industry how to find patients for its trials. Then he was the patient, and the system he helped build could not find him. That sentence is the whole argument. This is not a story about patients being uninformed, hard to reach, or unwilling. The person who wrote the playbook, with every professional advantage available to a human being, still hit the wall.

The stakes are not soft. Science can be sound and a trial can still fail, because patients are the ones who decide whether a study, and often a company, succeeds. An asset that cannot enroll does not read out. It stalls, burns capital, and dies with the question unanswered. The industry tends to file this under recruitment marketing. It belongs under strategic risk.

> *"It's rare that a pharma company goes out and talks to patients and really digs deep to find out what motivates them to take that next step to contact the site. I think that's a major gap in the industry today."*
>
> Jim Kremidas on Open Door Salon

Cascade supplies the counterexample, and it is almost embarrassingly simple. On one women's-health study, the team actually asked the women why they would enroll. The answer was not personal benefit. It was that the trial might not help them, but it might help their daughter, or their granddaughter. So the team named the study Generations, put the message in front of the right women through their doctors' offices with the right materials, and the trial enrolled quickly. Nothing about the science changed. Only the conversation did.

That is the gap, and it is the whole thesis of this section in miniature. Trials under-enroll not because the biology is weak but because sponsors rarely do the plain work of learning what moves the people they need. For anyone running a pipeline, this is the difference between an asset that reads out and one that quietly stalls, and it is one of the cheapest problems in the industry to fix.

ACCESS · 05

The first pediatric CAR-T happened because a family overruled the doctors.

From Open Door Salon: "We Signed Her Out Against Medical Advice — It Saved Her Life" · Tom Whitehead, Co-Founder, Emily Whitehead Foundation, and Tori Lee, Patient Advocate and cancer survivor.

THE POINT

When access runs on desperation, only the relentless get through. Everyone else is quietly triaged out.

Tom Whitehead is co-founder of the Emily Whitehead Foundation, named for his daughter Emily, the first pediatric patient in the world to receive CAR-T therapy. He has been a public advocate for cell and gene therapy access since 2012, when Emily was treated at the Children's Hospital of Philadelphia.

Victoria “Tori” Lee is one of the first pediatric patients cured of cancer with CAR T-cell therapy, the tenth child to receive the treatment, and is now a patient advocate and health-policy student. Diagnosed with acute lymphoblastic leukemia at age five, she was a delayed responder to chemotherapy and later relapsed.

> *"Our transplant doctor at Hershey wrote us off and never spoke to us again. We signed her out against medical advice, and it saved her life."*
>
> Tom Whitehead on Open Door Salon

In a decade the field went from one child dying of cancer to more than forty-five thousand patients saved. The Whitehead story is usually told as the triumph that opened that door. Told honestly, it is a story about a family refusing to accept a verdict. Emily relapsed and the options were running out. Their transplant doctor wrote them off and never spoke to them again. They went for a second opinion, were offered a trial they were not comfortable with because it was not for leukemia, and kept pushing anyway. Whitehead's wife Carrey, who he says is all about the science, closed her laptop at one point and said that if you just look at the science, then we can't survive.

They signed their daughter out against medical advice. It saved her life, and it opened a therapy class for everyone who came after. The science was ready. The route to it was not paved. It was forced, by two parents with nothing left to lose and the stubbornness to keep going after the professionals had stopped.

> *"Yesterday, looking at a video of a young lady in Colombia who needs CAR-T cell therapy and being told she has to raise a half a million dollars if she wants to get it."*
>
> Tom Whitehead on Open Door Salon

The uncomfortable part is that the problem has not aged out with the technology. Whitehead describes a young woman in Colombia today, sending videos into the world because she has been told to raise half a million dollars for a therapy that exists. His foundation is working to get patients treated in Mexico, with cells manufactured in Houston, and knows they can be reached in Brazil. He talks often, he says, to parents who are sobbing because of where they live and what they earn. Even inside the American system, the running sentiment among cancer patients is that you will be denied roughly four times before anything moves.

That is what access by desperation looks like in 2026. A cure that works, reachable by the families with the stamina, the platform, or the luck to fund it and chase it across borders. For an industry that measures itself by approvals, this is the number that should sting: the therapy is approved, and the determining variable is still whether a family can run a fundraising campaign. A cure nobody can reach is a research result, not a medicine.

ACCESS · 06

Where the broadband ends, the care ends. AI won't build the missing floor.

From Open Door Salon: "AI Won't Cut Corners — A Hospital CIO and a Community Advocate on the Digital Divide" · Steven McWilliams, VP and CIO, Georgia Hospital Association, and Richard Hicks, President and CEO, Inspiredu.

THE POINT

Access is now digital infrastructure. AI raises the ceiling for people who already have a floor, and does nothing for those who don't.

Steven McWilliams is vice president and chief information officer of the Georgia Hospital Association, the largest healthcare trade association in the state, where he leads IT strategy and operations in service of a healthier Georgia.

Richard Hicks is president and chief executive of Inspiredu, an Atlanta-based nonprofit working to close the digital divide by providing equitable access to technology, broadband, and digital-skills training in underserved communities.

> *"We have technology deserts in the state of Georgia, and we're trying to see how we can bridge those gaps."*
>
> Richard Hicks on Open Door Salon

Hospitals are adopting technology about as fast as a regulated industry can. Patients still cannot get to their doctors. That disconnect is the conversation, and both operators refuse the easy explanation. The problem is not that the tools are missing from the health system. It is that the tools assume a patient on the other end with a device, a connection, and a reason to trust what appears on the screen.

Hicks names two gaps sitting on top of each other. The first is trust, which he considers vital and which cannot be installed. The second is affordability and reach: the technology deserts across Georgia where the digital front door to medicine never opens at all. There is real money moving at him, with infrastructure projects commissioned by the governor, the state legislature, and the federal level. His point is that the money is necessary and not sufficient, because you also have to educate people on how to get to resources they do not know exist.

> *"What AI's going to do is augment. It's going to allow the things that work to work quicker, more efficiently. But it's not going to cut corners. It's not going to allow us to not do the things that are required in order for us to deliver the care that people deserve."*
>
> Steve McWilliams on Open Door Salon

McWilliams draws the line the rest of the industry keeps stepping over. AI will speed up the things that already work. It will not do the things nobody has done, and it must not become the excuse for skipping them. Delivering care to a community that has no broadband, no portal access, and no reason to trust the institution requires work that does not have a software version.

The read for a field betting heavily on AI is straightforward and mostly unwelcome. When the infrastructure of access is broadband, the absence of broadband is the absence of care, and no amount of clinical capability upstream changes that. Every AI deployment raises the ceiling for patients who already have a floor. Without deliberate investment in the floor, the tool everyone is buying widens the exact gap it is sold to close, and it does it while the dashboards say things are improving.

CAPITAL · 01

Capital: funding it. Good science does not get funded. Well-timed, disciplined science does.

The best companies are born in the worst times. AI only counts if it makes a new experiment possible.

From Open Door Salon: "The Best Companies Start in the Worst Times" · Mike Goguen, Founder and Managing Partner, Two Bear Capital, and Rob Williamson, Founder and CEO, Traverse Therapeutics.

THE POINT

Capital rewards discipline, not hype. An AI claim is real only if it enables an experiment that wasn't possible before.

Mike Goguen is founder and managing partner of Two Bear Capital, an early-stage venture firm investing at the intersection of advanced technology and life sciences. He founded Two Bear in 2019 after two decades as a venture investor in technology and life sciences.

Rob Williamson is founder and chief executive of Traverse Therapeutics, an early-stage company developing a platform for targeted drug delivery across the blood-brain barrier, pairing proprietary biology with artificial intelligence.

> *"Some of the best companies were founded during some of the worst times. It's almost Darwinian. When times are really easy, the quality bar goes down. Then the environment changes and you're screwed."*
>
> Mike Goguen on Open Door Salon

Goguen's read on a downturn is not caution. It is an opportunity, and the logic is selective pressure. When money is easy and a category is hyped, founders assume the kindness of strangers will always be there, and the quality bar drops. Hard conditions filter for companies that had to be clever to exist at all. Capital efficiency is his core consideration, and he is explicit about what he looks for: founders with better ideas about how little capital it takes to reach a milestone.

The same discipline drives his AI filter, which is the most portable thing in the conversation. The buzzwords are all being thrown around, and operators are doing as much window dressing as they can to look relevant and hot. So you have to dig a level down and ask one question: what is the molecular biology that was not possible before? A faster wrapper around an existing workflow is window dressing. A testable hypothesis that was not reachable through traditional methods is substance. Goguen built his investment team around people who can tell the difference, hiring PhDs deep in both AI and biology, because the distinction is not visible from the deck.

> *"We've done two things with AI that we could never have done in recent times. First, identify computationally a bunch of receptors on the blood-brain barrier that actually allow you to get into the brain. Then we've mapped it to cell types and cell compartments in the brain, so we can exploit a pathway to target a very specific part of the brain."*
>
> Rob Williamson on Open Door Salon

Williamson is the filter passing. Traverse is exploring fifty to sixty receptor-binder pathways across the blood-brain barrier at once, with high-throughput screening validating candidates in the wet lab. His own assessment is the useful benchmark: a decade ago an academic might spend a career optimizing one of those pathways. Traverse runs sixty in parallel, not because the team is larger, but because the tooling makes possible a class of experiment that did not exist in the previous generation.

Put together, the two of them describe the bar every AI claim in your pipeline has to clear, and the bar capital should be enforcing. Not more of the same, faster. Something that was not possible at all. The uncomfortable part is that money frequently does the opposite, funding the well-packaged copy over the disciplined original, which is exactly the condition Goguen says produces the next cohort of survivors.

CAPITAL · 02

The science isn't what gets you funded. A 15-minute window on a certain Tuesday is.

From Open Door Salon: "There's a 15-Minute Window on a Certain Tuesday" · Edwin Stone, CEO, Cellular Origins, and Erik Digman Wiklund, CEO, Circio Holding.

THE POINT

Funding timing, not merit, decides who survives. The crowd funds the copy, and the lead goes overseas while it does.

Edwin Stone is chief executive of Cellular Origins, which builds robotic, automated manufacturing systems for cell therapies. His focus is the enabling hardware that determines whether cell and gene therapies can be made affordably and at scale.

Erik Digman Wiklund is chief executive of Circio Holding, developing a platform to express genes using circular RNA. A molecular biologist with a PhD from Aarhus University and the Garvan Institute, he is a scientific co-discoverer of human circular RNA.

> *"For investors, there is probably about a 15-minute window on a certain Tuesday where you fit into the right window. You're too early, you're too late."*
>
> Stone & Wiklund on Open Door Salon

Funding has less to do with whether the science is ready than with whether you reach the right investor inside a window that barely exists. You court a fund for two years while you are too early for it, and then, with no perceptible transition, you are too late. Companies do not fail this test loudly. They fall through the cracks. And the window is not fixed: add a war, or put a supply chain in question, and fifteen minutes becomes five, because capital dries up precisely where it had been flowing and the people who were about to move stop moving.

The second distortion is herding, and both operators watch it happen in real time. Investors and big pharma move in packs. They counted five new companies in a single week pursuing the same in vivo CAR-T approach that was already heading into the clinic, with money piling into all of them. It rhymes with the PD-1 era, when the field funded the same mechanism many times over. The consequence is not merely inefficiency. Differentiated science sits unfunded next to a crowded trade, and the founder with the genuinely novel asset is punished for not resembling the thing that just worked.

> *"What we're going to see is a shift to a lot of clinical development going first in man in China… the gold standard regulatory used to be US, but I think that's now being put into question."*
>
> Erik Digman Wiklund on Open Door Salon

Then there is where the money goes when it gets tired. Reaching clinical data has become complex and expensive, and in cell and gene therapy the clinical readout matters more than in most fields, because translatability from mouse to monkey to human is poor and you are not out of the woods until you have human data. So development is moving. In China, investigator-initiated phase-one trials can proceed on hospital review-board approval rather than central authority sign-off, which makes first-in-human dramatically cheaper and faster. Wiklund's conclusion is the one worth carrying: the assumption that the United States is the regulatory gold standard is now itself being tested.

The cost of a distorted allocator shows up as whole categories going dark. Wiklund flags two that are badly underinvested right now: vaccines, where policy noise has scared money out of the field and serious development will suffer, and antibiotic resistance, where the medical need is enormous and the commercial model is broken. Neither is a science problem. Both are capital problems, which is precisely the point. In this market, timing and the crowd allocate the money, and merit matters less than timing.

CAPITAL · 03

$13 billion a quarter into GLP-1s, while the financing stays built for treatment, not cure.

From Open Door Salon: "Why Is CVS Selling Party Packs of M&Ms Alongside Ozempic?" · Ali Pashazadeh, Founder and CEO, Treehill Partners, and Jon Rees, CEO and Co-Founder, MitoRx Therapeutics.

THE POINT

Capital decides what medicine even gets made. Money floods the blockbuster while the harder questions go unfunded.

Ali Pashazadeh is founder, chairman, and chief executive of Treehill Partners, a global healthcare advisory firm. He holds an unusual triple vantage point: a trained trauma and reconstructive surgeon who still practices emergency care, a healthcare financier, and a former banker.

Jon Rees is chief executive and co-founder of MitoRx Therapeutics, developing the next generation of obesity and metabolic treatments. Rather than suppressing appetite the way GLP-1 drugs do, MitoRx targets the mitochondria to address obesity at its root cause.

> *"Why is CVS selling like five-kilo party packs of M&M's alongside Ozempic? Does it make sense?"*
>
> Jon Rees on Open Door Salon

Start with the scale. Tirzepatide did roughly thirteen billion dollars across obesity and type-2 diabetes in a single quarter, making it the best-selling drug in the world. The market it opened extends well past the prescription: the gym is now full of resistance machines bought by people on GLP-1s trying to protect the muscle the drug is taking. Meanwhile the same retail aisle that dispenses the drug stocks the problem it treats, in five-kilo bags, at the checkout. Rees's view is that there is a public responsibility to regulate the sale of very sugary, very fatty, addictive foods at the register, pharmacies included.

Rees is not a skeptic of the class, which is what makes the critique land. He calls the apparent anti-addictive benefit of GLP-1s fantastic and wants more research into it, and the wider benefits beyond weight, including signals around dementia, are real. What the enthusiasm underprices is the clinical cost, which is where Pashazadeh, an emergency physician as well as an investor, picks up.

> *"There's a cost to a starvation response, and one of those costs appears to be the loss of lean mass. In a way, I see that as taking away the autonomy of the patient to manage their weight."*
>
> Ali Pashazadeh on Open Door Salon

The bill for a starvation response includes lean-mass loss, and the risk set runs through pancreatitis, severe gastrointestinal effects, and gastroparesis. His framing is worth pausing on, because it is not a safety complaint. It is an autonomy argument. A patient who keeps their lean mass keeps the ability to manage their own weight. A patient who loses it has been moved from managing a condition to depending on a molecule, and that dependency has an owner and a price.

Rees is building toward the version that does not make that trade. The capital story sits underneath both of them, and it is the point of this page. Money floods to the proven blockbuster, which is rational for any single allocator and produces an irrational system: the drug that sells today is fully funded, while the question of what comes after it, and the harder metabolic science, competes for the remainder. In life sciences, capital does more than fund medicine. It decides which medicine gets to exist, and right now it funds the drug that already sells.

SECURITY · 01

Security: trusting what it's built on. The product can be perfect and the foundation compromised.

70% of your API comes from adversarial nations. The supply chain won't collapse. It erodes.

From Open Door Salon: "Cyberattacks and Closed Straits — Defending Pharma on Two Fronts" · Clinton West, President, Supply Chain Security Practice, Aardwolf Global Solutions, and Mike Walker, Health and Life Sciences Digital-Strategy Leader.

THE POINT

The dangerous supply-chain failure isn't the dramatic one. It's the slow erosion you don't notice until it's structural.

Clinton West is president of the supply chain security practice at Aardwolf Global Solutions, leading intelligence-driven work to secure critical supply chains for national-security, defense, and commercial operations. He spent more than two decades at the Central Intelligence Agency.

Mike Walker is a digital-strategy leader in health and life sciences who advises pharmaceutical companies and biotechs on supply-chain security, cybersecurity, and digital transformation. He previously led global health-and-life-sciences digital strategy at Microsoft.

> *"HLS supply chain doesn't collapse. It erodes slowly. You don't notice it at first, and then you start to see the effects over time."*
>
> Mike Walker on Open Door Salon

Large pharmaceutical and health organizations did build their supply chains for resilience. Walker's point is about what they meant by the word. Resilience was end-to-end visibility of the surface: the products and SKUs you can see on a screen. It was not the downstream dependencies, and it was not the roughly seventy percent of active pharmaceutical ingredient that comes from India and China. The material costs underneath are unknown to a great many organizations, and the customers he works with are now in a race to map their own chains and build optionality into them, an odd position for an industry that believed this problem was solved.

The failure mode is the part worth internalizing, because it defeats the way most companies monitor risk. Health and life-sciences supply chains do not collapse. They erode. The orchestration is intricate enough, and the critical dependencies buried deep enough, that you do not notice at first, and then the effects arrive over time. Not enough syringes. Not enough helium to run the devices. A cascading effect that shows up as a series of manageable annoyances until it is structural. COVID looked like that. So did 2008. A dramatic break triggers a response. An erosion does not, which is what makes it more dangerous.

> *"If they decide to turn that valve, that has a huge ripple effect to the health and welfare of our country... that's just a ticking time bomb."*
>
> Clinton West on Open Door Salon

West brings the view from inside the government's supply-chain risk office, and he is blunt about the geometry. The precursors run through China. If an adversary decides to turn that valve, the effect lands directly on American health and welfare, and we have not seen it happen at any scale that has made the news. He puts the rare-earth stranglehold in the same sentence as the pharmaceutical precursors, because they are the same lever held by the same hand.

His structural insight is the one operators can act on tomorrow. Risk changes depending on where you sit in the lifecycle, and nobody sees the whole thing. On the precursor side you do not think about logistics or transportation. At the disposal end you do not think about warehousing, or cold chain, or temperature. The industry has pockets of people each managing a fragment, and no one connecting them. That is why the exposure survives audits: every function passes its own review while the chain as a whole goes unexamined. Supply-chain risk here is not a compliance line item. It is mispriced, and the repricing has already started.

SECURITY · 02

Everyone thinks BIOSECURE protects pharma from China. The real risk is three tiers deeper.

From Open Door Salon: "Why BIOSECURE Won't Protect Pharma From China" · Theresa Campobasso, Senior Vice President, Aardwolf Global Solutions.

THE POINT

Security theater isn't security. The named risk is covered; the exposure sits where nobody is looking.

Theresa Campobasso is senior vice president at Aardwolf Global Solutions and a former U.S. Marine Corps intelligence officer who specialized in counterintelligence support to the Defense Intelligence Agency's office of counterintelligence.

> *"We need to illuminate the rest of that supply chain, because oftentimes tiers three to five are where you're going to find obfuscated state ownership."*
>
> Theresa Campobasso on Open Door Salon

Start with what the law actually does. BIOSECURE is intended to prohibit federal contractors from using biotechnology products or services from a named list of Chinese companies. That is the entire mechanism. It does not touch the commercial channel, which remains wide open: a company can still license from any Chinese biotech firm it wants, and none of that activity is captured. So a policy that the market reads as protection is, in practice, a narrow procurement restriction on a specific list of names.

The exposure sits somewhere else entirely. Campobasso's critique of standard practice is that companies do a genuinely good job of third-party risk management, in the sense that they look hard at the company directly in front of them. Tier one gets scrutinized. The rest of the chain stays dark. And tiers three through five are where obfuscated state ownership lives, because that is the entire point of putting it there. She maps the China exposure across three areas that rarely get considered together: genomic sequencing, synthetic biology, and API and pharmaceutical-precursor manufacturing. There is also an intangible supply chain that almost nobody diligences, where your data and your models cross the same borders your materials do.

> *"You need to trust but verify. Otherwise you are going to be subject to significant fines, having your goods seized."*
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> Theresa Campobasso on Open Door Salon

The consequences do not respect the excuse. Under forced-labor enforcement, "my supplier said it's fine" is not a defense, and the seizures, the fines, and the sanctions land on you rather than on the supplier who told you what you wanted to hear. In her framing, "box checked" is the most dangerous phrase in diligence, because a cleared checkbox ends the inquiry precisely where it should begin.

Her news is better than the diagnosis suggests. This became solvable in the last five years in a way it simply was not before: the tooling now exists to trace a raw material back to the hole in the ground it came out of. The problem is solvable and the question is answerable, which means choosing not to ask is now a decision rather than a limitation. She would also test the reflex that China is the only option, which she finds is usually a habit rather than a fact, sustained by teams who have used the same suppliers so long they stopped checking while alternatives quietly proliferated. That is where this section lands. A checkbox that clears the named risk while ignoring the hidden one is not protection. It is the appearance of it, which is more dangerous, because it feels like safety.

THE THROUGH-LINE

The science was rarely the barrier. Everything around it was.

Eleven conversations. Nineteen operators. One conclusion, arrived at independently from every seat in the industry. What stood between a working therapy and the person who needed it was access, capital, and security: whether you could reach it, fund it, and trust what it was built on.

A physician survived because she had a network. A scientist learned his field had never asked patients what they wanted. The man who built patient recruitment could not find his own trial. A family had to overrule its doctors to reach the first pediatric CAR-T, and a young woman in Colombia is running a fundraising campaign for the same class of therapy today. Rare-disease patients stopped waiting for pharma and became the developers. Funding turned on a fifteen-minute window rather than merit. Thirteen billion dollars a quarter went to the drug that sells now. And underneath all of it, a supply chain that erodes quietly, three tiers below where anyone is looking.

None of these are science problems, which is what makes them tractable. An enrollment gap closes when a sponsor bothers to ask patients what actually moves them. Rare-disease programs advance when the people who need them stop waiting on a decision that is never coming. Supply-chain exposure gets priced the moment somebody looks past the checkbox in front of them and three tiers down. Every barrier this quarter surfaced was built by a decision, which means it can be unbuilt by one.

If your strategy is still organized around whether the science will work, you are solving the last decade's problem while this one plays out in the three arenas above. That is the quarter, distilled. The full conversations run about an hour each on YouTube, where a new operator interview goes up every week.

Watch the full conversations on YouTube →

ACCESS

- Dr. Karla Loken: the network problem
- Jesús Zurdo: the scientist who became a patient
- Malepati & Lipset: patients as developers
- Kremidas & Cascade: the recruiter who couldn't find a trial
- Whitehead & Lee: access by desperation
- McWilliams & Hicks: technology deserts

CAPITAL

- Goguen & Williamson: worst times, best companies
- Stone & Wiklund: the 15-minute window
- Pashazadeh & Rees: the GLP-1 economy

SECURITY

- West & Walker: the eroding supply chain
- Theresa Campobasso: what BIOSECURE misses

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