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**WHY
PATIENTS
STILL FEAR
LASIK
IN 2026**

The Resurgence
OF LASIK

**+ “I WANT TO
THINK ABOUT IT”**

THE REAL REASON REFRACTIVE
PATIENTS DON'T MOVE FORWARD

MEET

**BRENT
SAUNDERS**

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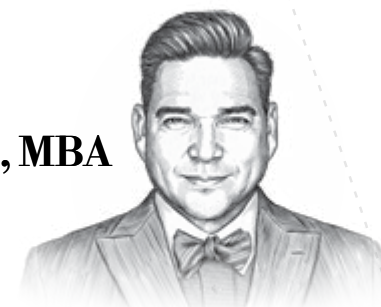
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What's the Problem Here?

MOST ORGANIZATIONS DON'T HAVE AN EXECUTION PROBLEM. THEY HAVE A PROBLEM DEFINITION PROBLEM.

My favorite question in business is one I wish I had learned earlier: what problem are we trying to solve for?

It sounds obvious. It isn't.

Try this at your next staff meeting. When ideas start flowing, stop and ask the question around the room. Then listen.

You'll likely hear more than one interpretation. That means you don't have alignment. Or perhaps you'll hear vague "solutions" disguised as problems: "the problem is we need a better customer rebate program." In either case, nothing that follows will matter.

Problem formulation has been called the most underrated skill in management.¹ As Charles Kettering put it, "A problem well stated is a problem half solved." Albert Einstein made the

same point more explicitly: if he had an hour to solve a problem, he would spend 55 minutes defining the right question and 5 minutes solving it.

Most teams do the opposite.

Why?

Because we prioritize the bias for action. Teams are rewarded for speed. Investors reward momentum. "Busy" becomes a badge of honor. So we rush to the whiteboard, skip defining the problem, and start generating solutions.

The result is predictable: activity increases. Impact does not.

Lacking a clear problem definition drives rework, with estimates as high as 30%-50% of effort spent fixing or

redoing work tied to poor requirements and misalignment.² It also increases coordination burden as teams try to stay aligned.³

Strong leaders interrupt this pattern. They slow the process and force precision before action.

What does a great problem statement look like?

It addresses five key components and should take no more than 2-3 sentences:

- 1 **It is properly scoped.** Broad enough to matter, narrow enough to show initial impact in 2-3 months.
- 2 **It is important.** It ties to a strategic priority, organizational value, or customer need.
- 3 **It is quantifiable.** Progress and success can be metricized.
- 4 **It is neutral.** It does not assume a solution or disguise one as a problem. This is often the most common trap you'll find.
- 5 **It defines a clear gap.** It establishes a clear difference between current and desired states.

When you apply these criteria, the difference shows up immediately.

Let's revisit the weak problem statement from earlier:

"The problem is that we need a better customer rebate program."

It is vague, subjective, and assumes a solution.

And still, a team pursuing this will get busy. More activity. More effort. Limited progress.

A strong problem statement on the same issue might sound like this:

"Our top five customers have reduced repeat purchasing by 15% over the past two quarters, despite stable demand across other segments. We need to identify and address the drivers of this decline to restore repeat purchase rates to prior levels within the next 90 days."

Same context. Completely different clarity.

The second version is scoped, important, measurable, neutral, and defines a clear gap. It creates a platform for deeper insights and questions to now emerge.

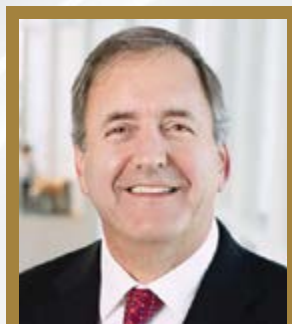
Taking the time to define the problem may feel slow. But it is the fastest path to progress. When execution is applied to a clearly defined problem, teams move in one direction.

If you want to change the trajectory of your organization, start here. Build a culture where the first instinct is not to solve, but to define. Start with asking better questions.

So, what problem are you really trying to solve for??

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VANCE THOMPSON, MD, FOUNDER
OF VANCE THOMPSON VISION

Refractive Surgery Is Not Down.

It Has Evolved.

For the past five years, people have been asking the question, “Is refractive surgery down?” more and more. Usually what they really mean, and often say, is, “Is LASIK down?” And if LASIK volumes are lower than they once were, the assumption is that refractive surgery as a whole must be weaker.

I do not believe that is the right conclusion.

In my view, refractive surgery has not become weaker, as much as it has become smarter, broader, and more customized. If we define refractive surgery only by laser vision correction volumes, we miss what has happened. The market did not disappear. It diversified. It matured. Technology improved and refractive surgeons became better at matching the right procedure to the right patient.

That is important, because if we misunderstand where the market is, we will misunderstand how to grow it from here.

Today, refractive surgery is not just LASIK. It is the combination of three major categories:

- 1 Corneal laser surgery, such as PRK, LASIK, and KLEX;
- 2 Phakic IOL surgery, such as the EVO ICL; and
- 3 Lens-based refractive surgery, especially refractive lens exchange, and even early refractive cataract surgery, those patients correctable to 20/20 with reduced night time image quality. This is a group we used to consider for LASIK, but we have gotten smarter and more confident in going to lens replacement sooner than we used to.

Once we look at the market this way, the story changes dramatically.

LASIK volumes are approximately half of what they were in the United States compared to at its peak. But when I talk to my fellow comprehensive refractive surgeons around the United States, and around the world, we are all very busy delivering corneal laser, phakic IOL, and lens replacement refractive surgery.

Patients have not lost interest in visual freedom. They simply now have more wonderful pathways to achieve it. The nomogram for which procedure is best for which patient, their refractive error situation, and their lens functioning status, has changed, and we now know the sweet spot for each. This is why we are seeing the best outcomes we have ever seen in refractive surgery.

Furthermore, LASIK has evolved into the most accurate refractive surgery procedure of them all. If we don't hit the target with PRK, KLEX, Phakic IOL, Refractive Lens Exchange, or Advanced Implant Cataract Surgery, it is often the accuracy of the LASIK fine tune that takes the football in for the touchdown, to achieve or exceed patient expectations.

This is why I like to say “Refractive surgery did not get weaker. It got smarter.”

Why do I say smarter? Because we now understand more about corneal shape, biomechanics, ocular surface disease, presbyopia, dysfunctional lens syndrome, and long-term quality of vision. And because we understand more, we choose better. A younger moderate myope may do beautifully with LASIK or KLEX. A high myope with a thinner cornea may be better served by a phakic IOL. A presbyopic patient frustrated with readers, contact lenses, and the limitations of an aging lens may be best

served by refractive lens exchange. A consistent theme in the above scenarios is what I like to call “full range vision”.

Over the past 30 years the use of mobile phones and laptop computers has grown so much that I find patients really want to address their near and intermediate vision in addition to having quality distance vision. Thus, I see two basic groups of refractive surgery candidates. The first group is the younger generation with quality accommodation, in which I lean more toward corneal refractive or phakic IOL technology. The second group is the presbyopia population where I lean more toward lens replacement.

That is not decline. That is evolution.

I still believe LASIK is the royalty of refractive surgery. Modern LASIK is extraordinarily accurate, safe, and effective. But one reason LASIK volumes may appear lower is actually a positive one: we have become better at knowing when not to do LASIK. Some of the highest corrections are better treated with phakic IOLs. Some older patients are better served with lens-based surgery. In other words, LASIK may be done less often in some groups precisely because refractive surgery has become more intelligent.

So why does the field sometimes feel smaller than it is? First, LASIK became the headline procedure, so any decline there feels like a referendum on the whole field. Second, the message has become more complex. It used to be easier to explain one dominant procedure than a customized spectrum of options. Third, economic uncertainty affects all elective medicine. And finally, I believe we have lost some of the powerful human educational touch points that once drove growth so effectively. That is why I believe the future of refractive surgery growth is not just about more marketing. It is about better education and stronger human connection.

Patients are not buying a procedure. They are making a life decision. They want to understand how they will function, how they will feel, and whether they can trust us. Our role is not simply to advertise technology. Our role is to educate with warmth, clarity, and confidence. I often think, *“If they knew what I knew, many more patients would move forward”*. This is why we see a much higher rate of eye surgeons having refractive surgery than the public. They are more educated on the benefits and the value proposition. This should also give practices and industry the confidence to invest in refractive surgery marketing. A “thank you” goes to Alcon, for their large investment in direct-to-consumer refractive surgery advertising...it is hoped other companies follow that lead since corporate marketing helped us grow the market so very much, and that investment has lessened over time.

Besides marketing, we need to be educating patients in a personal connection way, then the market will grow even more. According to the Refractive Surgery Council (RSC), we need to recognize that patients do not want all of their education on social media and they do not want to simply be told the benefits. There is what the RSC calls a “Trust Gap”. Patients already know the benefits of refractive surgery. To keep marketing those benefits without educating more

completely misses the mark. In our practice, we have found renewed interest in hosting in-office patient seminars. At one seminar we had 122 people sign up, and last month 99 people. We find approximately 2/3 of the people who sign up show up for the seminar. But these are big numbers of appreciative people who are there to learn from us and our teams about modern day refractive surgery. These seminars energize our practice culture and our consult and surgical volumes. We need to preserve the human side of care, because no technology will ever replace the power of trust, eye contact, listening, and a team that truly cares.

So is refractive surgery down?

If you define it only by LASIK, perhaps it looks that way.

But if you define it by what refractive surgery truly is today...laser vision correction, phakic IOLs, and lens-based refractive surgery...then the better answer is this:

Refractive surgery has evolved. It has become broader, smarter, and more personalized. And the practices that understand that will be the ones that lead its next era of growth.

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LASIK'S NEXT CHAPTER:

Why Precision and Personalization Are Reigniting Momentum



CYNTHIA MATOSSIAN, MD



IAN BELL

CORNER OFFICE

Board member Cynthia Matossian, MD, CEO of GP Ophtho, invited Ian Bell to write this article. Mr. Bell is Senior Vice President and Chief Operating Officer at Alcon, where he oversees commercial, manufacturing, and quality and regulatory operations.

For more than two decades, LASIK has helped millions of people achieve greater visual freedom, continually raising expectations for what refractive surgery can deliver. Like many elective procedures, the category has experienced periods of softness in recent years, influenced by broader economic uncertainty and shifting consumer priorities. At the same time, long-term demand for refractive correction continues to grow, with global procedure volumes expected to expand steadily through 2030.¹ That combination has led some to question whether LASIK's growth potential is limited.

I don't believe it is.

In ophthalmology, periods of apparent maturity are often followed by renewed momentum, not through wholesale changes to procedures, but through advancements that redefine outcomes.

Cataract surgery offers a clear example. Long considered a stable, mature intervention focused on removing a cataract,

the procedure was reinvigorated when premium intraocular lenses such as PanOptix® shifted expectations toward reduced spectacle dependence and overall quality of vision. The surgery itself didn't fundamentally change, but the value proposition did.

Refractive surgery is reaching a similar point, where advances in technology have the potential to expand what laser-based procedures can deliver.

Patients today are not only asking whether LASIK can eliminate dependence on glasses or contact lenses. They are asking what quality of vision they can expect, how predictable the outcome will be, and whether modern technology can address concerns about results and recovery. These are reasonable questions and they reflect a broader shift toward precision medicine across healthcare. Meeting them requires moving beyond traditional planning approaches that rely on averages and assumptions.

Advances in refractive technology are now enabling that shift.

Historically, LASIK planning focused primarily on the cornea as a proxy for the visual system as a whole. While effective, that approach inherently simplified a complex optical structure. Newer platforms, including wavelight plus®, are expanding how surgeons think about personalization by incorporating a more comprehensive view of the eye. Through advanced diagnostics and ray-tracing technology, surgeons can simulate and refine treatments using a personalized three-dimensional model of the patient's entire optical system, often described as a Digital Eye Twin, before any laser energy is applied.²

The practical impact of this evolution is confidence.

By better accounting for how light travels through the full optical system, surgeons can plan treatments with greater precision.³ In real-world clinical use, higher levels of personalization are increasingly associated with precise, tailored outcomes that meet, and in many cases exceed, traditional benchmarks.^{4-6**} Just as important, this approach supports a consistent, data-driven planning process that helps reduce variability while still considering individual anatomy.

For patients, this reframes the LASIK conversation. The focus shifts from whether the procedure works to how reliably it can deliver the quality of vision they expect. For surgeons, it supports both personalization and scalability, a balance that is essential to the long-term health of the category.

For LASIK surgeons, confidence in outcomes creates the conditions for broader patient education and engagement. As that confidence continues to build, the industry is beginning to explore more direct ways to engage patients, reflecting a belief that the LASIK conversation is ready to evolve.

Market conditions will continue to fluctuate. But the history of ophthalmology makes one pattern clear: innovation reshapes

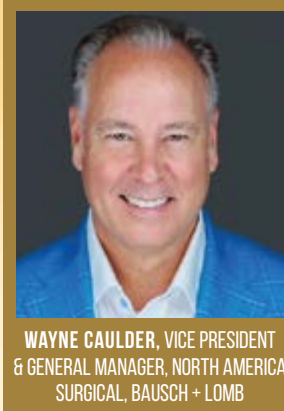
categories when it expands what outcomes are possible. As precision and personalization continue to advance, refractive surgery is not simply maintaining relevance—it is redefining its value.

LASIK's next chapter is not about reinventing the procedure. It's about elevating expectations and enabling surgeons to meet them with confidence. And when expectations rise, momentum tends to follow.

** 20/16 (82.5%) and 20/12.5 (44.8%) vision and/or 98.1% of eyes with 20/20 vision

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WAYNE CAULDER, VICE PRESIDENT
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THE OPHTHALMOLOGY CROSSROADS:

Why Alignment, Innovation, and Workforce Investment Must Define the Next Decade

Ophthalmology is entering a defining era shaped by demographic inevitability and workforce scarcity. As the population ages, demand for cataract surgery continues to rise at a steady pace. At the same time, the number of practicing ophthalmologists is not keeping up. Training capacity remains constrained, burnout is accelerating, and a wave of retirements is beginning to take hold.

This growing imbalance is not just a future concern. It is already visible in longer surgical wait times, strained clinic schedules, and increasing pressure on both surgeons and practice leaders. What was once a gradual trend has become an operational reality that will define the next decade.

The Imbalance That Will Reshape the Industry

Cataract volume continues to increase year after year, fueled by longer life expectancy and patients who expect high quality

vision well into later stages of life. Yet the supply of surgeons is not expanding at the same rate. The equation is straightforward but unforgiving. More procedures are needed, but fewer surgeons are available to perform them.

The industry now faces a critical choice. It must find ways to deliver care more efficiently or risk compromising both access and outcomes. Efficiency, however, cannot come at the expense of surgeon wellbeing or clinical excellence. That tension sits at the center of the challenge ahead.

Divergent Incentives, Shared Consequences

Ophthalmology operates within a highly interconnected ecosystem, yet its stakeholders often approach decision making from different vantage points. Industry partners are focused on delivering solutions that help practices operate effectively. Surgeons are committed to achieving the best possible

outcomes for their patients. Investors are focused on financial performance and scalable growth.

Each of these priorities is legitimate, but problems arise when they are not aligned. Misalignment can lead to competing pressures such as increasing procedural volume, reducing costs, or adopting new technologies without adequate support. Over time, these pressures contribute to surgeon fatigue and burnout, which further exacerbates the workforce shortage.

A New Governance Mindset: Aligning the Ecosystem

Addressing this challenge requires a shift in governance mindset. Long-term success will depend on aligning stakeholders around shared priorities rather than allowing competing incentives to shape the system. A more integrated approach to governance can create the conditions needed to sustain growth while protecting patient care.

Innovation must play a central role in this transformation. The next generation of ophthalmic technology should focus on improving workflow efficiency while maintaining or enhancing outcomes. Advances in robotics have the potential to streamline repetitive and highly precise steps in surgery. Artificial intelligence can support diagnostics and surgical planning by reducing variability and accelerating decision making. Digital integration across the patient journey can eliminate bottlenecks from referral through postoperative care.

Efficiency is no longer a differentiator. It is a requirement for meeting rising demand without compromising quality.

At the same time, broader adoption of premium solutions can strengthen the overall system. Advanced intraocular lenses and refractive technologies offer meaningful benefits for patients in the form of improved visual outcomes and higher satisfaction. They also provide practices with greater financial stability, enabling



reinvestment in staff, training, and technology. When clinical outcomes improve and practices remain economically healthy, the entire ecosystem becomes more resilient.

Even with greater efficiency and stronger economics, the workforce challenge cannot be solved without direct investment in the next generation of surgeons. Expanding residency capacity, supporting advanced training programs, and increasing access to surgical simulation are essential steps. Early exposure to ophthalmology and structured mentorship can help attract and retain talent. Collaboration with academic institutions will also be critical to ensure that training evolves alongside the demands of modern practice.

A sustainable future requires a robust pipeline of skilled surgeons. Without it, the imbalance between supply and demand will continue to widen.

Embracing the Role of Optometry

Any discussion of ophthalmology’s future must also recognize the central role of optometry. Optometrists serve as the primary point of entry for most patients experiencing changes in vision. They are the leading source of referrals for cataract and refractive surgery and play a key role in managing postoperative care and long-term eye health.

As demand grows, optometry’s influence on patient flow and surgical adoption will become even more significant. Strong

collaboration between ophthalmologists and optometrists can streamline referrals, improve patient education before surgery, and identify appropriate candidates for advanced technologies. It can also reduce inefficiencies across the patient journey and help ensure that surgical capacity is used effectively.

Optometry is not simply a referral channel. It is a critical partner in delivering efficient, high quality care at scale.

The Path Forward: Shared Vision, Shared Responsibility

Ophthalmology stands at a pivotal moment. Demographics, economics, technology, and workforce dynamics are converging in ways that will reshape the field. The question is not whether change will occur, but whether it will happen in a coordinated and deliberate manner.

Surgeons, industry partners, investors, and optometrists all have a shared stake in the outcome. With aligned governance, a commitment to innovation that enhances efficiency, and meaningful investment in the workforce, the field can meet rising demand while improving patient outcomes.

The path forward will require shared responsibility and a common vision. If the ecosystem chooses to move in alignment, ophthalmology can not only navigate the challenges ahead but emerge stronger because of them.

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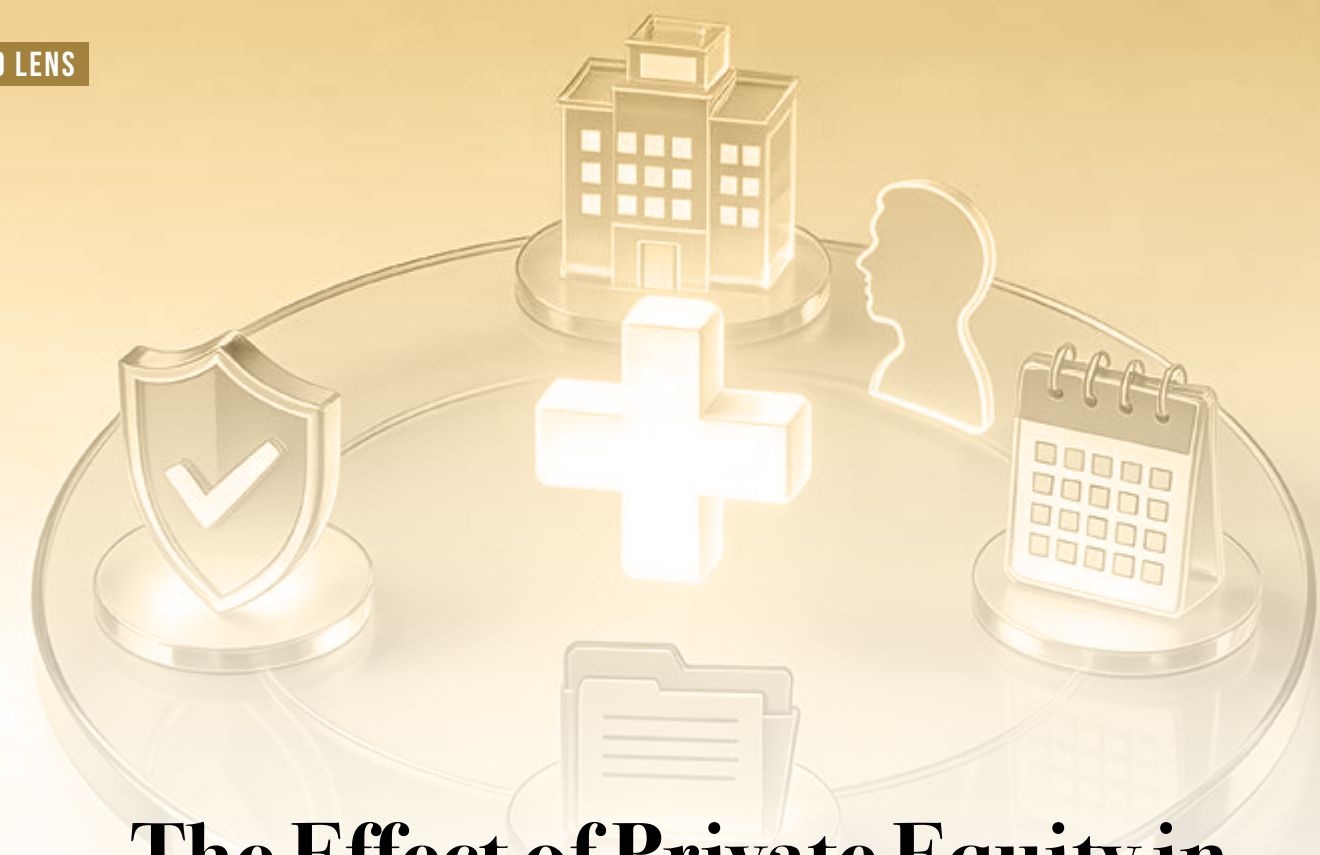
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The Effect of Private Equity in Ophthalmology on Decision Makers

Board member Cynthia Matossian, MD, CEO of GP Ophtho, invited Dr. Arthur Cummings to write this article. Dr. Cummings is Consultant Ophthalmic Surgeon/Medical Director, and UCD Associate Clinical Professor, at Wellington Eye Clinic, Dublin, Ireland

We are living through a paradox. Ophthalmic technology has never been more advanced, yet patient trust often feels more fragile. Outcomes are safer and more predictable than ever, yet something is missing. It is not clinical excellence. It is purpose. And nothing erodes purpose more than misaligned ownership.

Steve Jobs once warned that successful companies begin to believe the process created their success. They institutionalize it, the builders lose influence, and the organization becomes excellent at meetings, but average at the thing it was built to do.

In ophthalmology, that drift has familiar language: capacity utilization, conversion optimization, workflow efficiency, room throughput. None of these are wrong. But none of them improves vision or restores trust.

The true content of a clinic is judgment, surgical execution, and patient experience. Everything else is scaffolding. When private equity enters, the risk is that the scaffolding is mistaken for the building. A great clinic is built on decisions and judgment; a scalable business is built on processes. The danger is when processes begin to shape decisions.

This is not an argument against private equity. When aligned around long-term outcomes, clinical autonomy, and sustainable growth, partnerships can work. Capital can accelerate what good clinicians are trying to build. The problem is not at the point of investment, but over time, as financial pressure increases and alignment becomes harder to maintain.

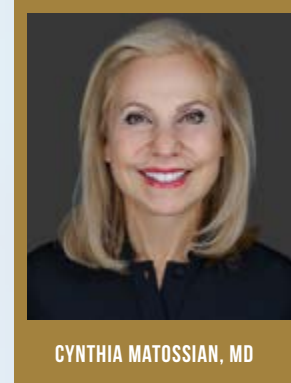
Private equity is optimized for a transaction: enter, grow, exit – typically within three to five years. That timeline sits uneasily with ophthalmology, where trust and outcomes compound over decades. When those logics coexist, something gives. And it is rarely the timeline.

Evidence outside ophthalmology is instructive. A major study in JAMA¹ found that hospitals acquired by private equity experienced a 25% increase in hospital-acquired complications, including higher rates of falls and bloodstream infections. The authors concluded that private equity ownership was associated with poorer quality of care, findings that should give pause.

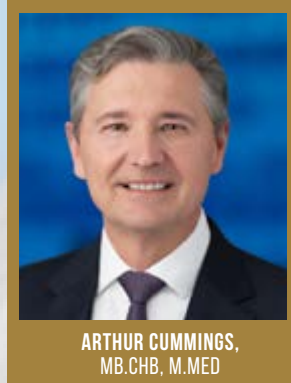
Closer to home, the Lara vs LASIK Plus case² illustrates how these tensions can attract serious legal scrutiny. It was alleged that Pentacam warning flags for higher-risk corneas had been disabled and that surgery proceeded despite findings consistent with keratoconus. The court awarded substantial damages, serving as a clear reminder that clinical governance decisions do not occur in a vacuum.

The greater risk, however, is not dramatic failure but slow drift: slightly looser thresholds, more persuasion, fewer escalations. The process improves. The content softens.

For surgeons, investors, and operators alike, this is the critical question. Refractive surgery is not cosmetic.



CYNTHIA MATOSSIAN, MD



ARTHUR CUMMINGS,
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It is preventive medicine. Good vision underpins independence, cognitive function, and quality of life. The stakes are clinical, not just commercial.

I remain committed to independent practice because it allows me to control the environment; investment in people, judgment, and patient experience, without the constraints of an exit timeline. Capital has a role in ophthalmology, but the real question is not "What is this worth?" It is: "What will this system make inevitable in the years ahead?"

The best clinics do not win because they are the most organized. They win because they never let organization outrank judgment.

Protect the content.

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RICHARD L. LINDSTROM, MD

THOUGHTS ON

The Future of Ophthalmology

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Forecasting the future is challenging, but every individual, practice, and company can benefit from preparing a thoughtful one, three, and five year business plan and updating it each year. To do so requires insight into the current state and a forecast of the future state of the business and field of endeavor. While some individuals trust intuition and go with their gut feelings, the best forecasts are made by leaders that rely on facts and data.

The future throws many curveballs. There are "Black Swan" events that are unknown unknowns, totally unpredictable, that impact an individual, practice, or company resulting in unexpected challenges and economic disruption. A recent example is the Covid 19 pandemic. There are also "Grey Swan" events that are high impact and somewhat predictable with the timing of their occurrence unknown. A recent example is the Iran war. Fortunately, some facts and trends are known knowns, allowing them to be analyzed and their future impact prognosticated. In the following paragraphs I will

share a few thoughts on the future of ophthalmology relying on facts, known trends, and a few expected "Grey Swan" events. Without a doubt, every 5-10 years there will be at least one "Black Swan" event that no one predicted which will significantly alter any business plan and require an adjustment.

I find that an understanding of demographics is fundamental to prognostication. To me, "Demographics are Destiny". Second in importance is a careful look at known current trends. I find a well-researched Trend/Megatrend analysis is required to plan for the future. Finally, current Consumer Confidence is important to project short term expectations regarding any service or product sales.

In the first edition of *CEO Ophthalmology*, I shared some thoughts on current and future eyecare provider numbers. To summarize, every year we will have fewer ophthalmologists and more optometrists amid a growing demand for eyecare. This known fact will impact every eye doctor, their patients,

and the industry that supports us. In this article, I will focus on the eyecare patient.

We have seven generations alive in the USA today. Combining the Great Generation and Silent Generation of Americans born between 1900 and 1945, we have approximately 19 million potential patients. These patients require significant office-based chronic eyecare for eyewear, glaucoma, ocular surface disease, and age related retinal disease but are rare patients in the operating suite as most are already pseudophakic and have undergone any required surgery suite-based glaucoma or retinal surgeries. They represent a small and declining population of office-based eyecare patients, but they are not a major source of revenue.

The third oldest generation is the Baby Boomer, born 1946-1964 and aged 62-80. They number about 67 million and are the core source of income for most eyecare practices today. They represent the majority of patients who undergo Cataract/IOL surgery including cash pay Lens Based Refractive Surgery, Interventional Laser and Surgical Glaucoma procedures, Interventional and Medical office-based ocular surface disease treatment, and Interventional office and surgery suite-based age-related retinal disease therapy as well as office-based optical and primary eyecare. Today, this is where the money is for most eyecare practices and companies. In addition, the Generation X patient, born 1965-1980, currently aged 46-61 and numbering 65 million, will sustain surgical and office based eyecare demand for another 15 years. The Baby Boomers and Generation X together number 132 million 46-80 year olds that will drive the success or failure of most eye doctors, practices, and companies for the next three decades. Generation X will also determine the success or failure of the newly launched presbyopia eyedrop category.

Next in line is Generation Y (The Millennial) born 1981-1996 and aged 30-45. They are an important target population for contact lens wear and Cornea Based Refractive Surgery. Data confirms that contact lens wear is doing significantly better than LASIK, SMILE, and PRK for this group, with over 3 million new contact lenses dispensed each year against only 600,000 surgeries. The reasons are multiple, including improved low cost contact lenses, but the fact that many Millennials remain underemployed, in debt, and are struggling to support a young family is significant in the progressing decline in Cornea Based Refractive Surgery annual volume. I predict this decline will continue, as by the time the Millennial has adequate financial means to afford Cornea Based Refractive Surgery they will be presbyopic and better candidates for Lens Based Refractive Surgery. In my opinion, the best growth opportunity for decades to come remains cash pay Refractive Cataract Surgery, Interventional Glaucoma, and Interventional Office-Based Procedures to treat ocular surface and retinal disease together with office-based optical and primary eyecare. While annual case volumes of Refractive Corneal Surgery will continue to decline, it will remain a good opportunity for the small number of practices who focus on the



procedure and excel at the external marketing and social media presence required.

Generation Z, born 1997-2012 and age 14-29, numbers 69 million and is another core target for contact lens wear and Corneal Based Refractive Surgery along with premium designer spectacle wear for the practice that dispenses. If this generation enters the 30s with less debt, better jobs, and more money than the millennial, they may catalyze an increased demand for Cornea Based Refractive Surgery, but that is at least 5 years away. Hopefully this age group will be a meaningful source of early keratoconus patients for Corneal Cross Linking, which is best done in the earliest stage of disease progression.

Generation Alpha, born 2013-2024 and age 1-13, will drive the new vertical of Progressive Myopia Management and is the patient population that will sustain the pediatric ophthalmologist. Unfortunately, this generation numbers only 48 million and is the beginning of the so-called “baby bust” as American families have progressively fewer children. The first American generation significantly smaller than the previous four portends significant change and challenge for everyone who provides services and products for children, including educators and care providers that primarily target this age group. Over the long term, beginning with Generation Alpha, successively smaller generations will create a manpower challenge for the entire US economy. Robotics and Artificial Intelligence (AI) which should enhance productivity is a potential solution to fewer workers, but ever smaller generation of native born Americans, without a significant increase in immigration, suggests the US population will plateau around 400 million in the 2050s and then decline with an ever more older population. The impact of this challenge will be widespread and significant, but is too far in the future to project. Fortunately, other countries including Japan, China, and all of Western Europe will precede us in population collapse with aging citizens, and I hope we will learn from them.

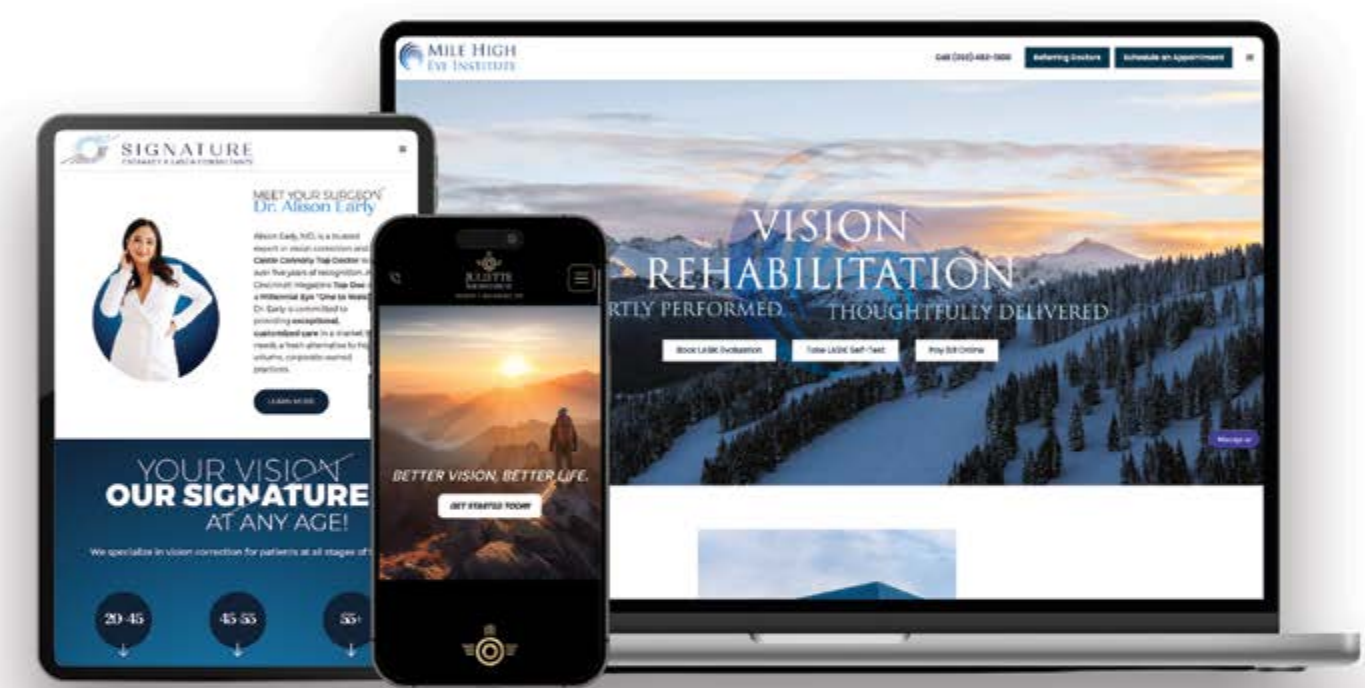
Finally, Generation Beta, now less than one year old, will again be smaller in number, affirming a progressively smaller and older US population every year starting in the 2050s.

In the next issue, I will discuss two other short term forecasting tools I find useful, confirmed Trends and the importance of Consumer Confidence. Both have a significant impact on the short term consumption of eyecare service and products.

In summary, “Demographics are Destiny”, and the eyecare needs and desires of each generation differ significantly.

The sustainable and successful individual, practice, and company needs an understanding of each generation’s eyecare needs and desires as they plan for the future.

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ROB MELENDEZ, MD, MBA

THE STATE OF REFRACTIVE SURGERY IN THE UNITED STATES:

Precision, Perception, and the Path Forward

Over the past 20 years, refractive surgery in the United States, particularly LASIK, has experienced a dynamic evolution. Volumes peaked in the mid-2000s at approximately 1.4 to 1.5 million procedures annually, followed by a sharp decline during the 2008 financial crisis. Since then, volumes have stabilized in the range of roughly 700,000 to 900,000 procedures per year, with modest growth driven by technological advances and renewed patient interest. Despite clear improvements in outcomes, safety, and patient experience, LASIK has not returned to its prior peak, highlighting persistent structural challenges.

Two dominant barriers continue to suppress broader adoption: finance and fear.

Financial friction remains a primary constraint. LASIK is an elective, out-of-pocket procedure, often competing with other discretionary

expenditures. While modern patients routinely finance cosmetic procedures, refractive surgery has lagged in adopting flexible, patient friendly financing models at scale. Monthly payment strategies, subscription style vision correction models, and bundling lifetime value, including enhancements, retreatments, and long-term care, remain underutilized. The industry has yet to fully reframe LASIK from a transactional purchase to a long-term vision investment.

Fear, particularly perception-driven fear, is the second major barrier. A very small percentage of patients experience suboptimal outcomes or complications, yet these cases are disproportionately amplified through media and digital channels. This creates a perception gap. While LASIK maintains an exceptionally high satisfaction rate, often greater than 95 percent, public sentiment is influenced by anecdotal outliers rather than aggregate data.

The appropriate response is not defensive. It is strategic and clinical.

Refractive surgeons must lead with transparency while doubling down on precision during patient selection. The next phase of growth in refractive surgery will not be driven solely by better lasers. It will be driven by better screening. Conditions such as subclinical keratoconus, ocular surface disease (particularly dry eye), epithelial basement membrane dystrophy, and irregular corneal biomechanics must be identified with increasing rigor.

Advanced diagnostics, including corneal tomography, epithelial mapping, biomechanical assessment, and tear film analysis, should not be optional. They should be foundational. The industry must collectively elevate the standard with fewer marginal candidates, more ideal candidates, and a relentless focus on predictability.

This is not a limitation. It is a competitive advantage.

By being more selective, outcomes improve further, complication rates decrease, and patient trust strengthens. In turn, this directly addresses the fear barrier.

Industry and practice level marketing must evolve in parallel. Messaging should shift from price-based commoditization to precision, safety, and patient selection excellence. Patients should understand not only that they are candidates, but why they are ideal candidates. Practices must visibly demonstrate their commitment to rigorous screening protocols and long-term patient outcomes.

The future of refractive surgery in the United States is strong, but it requires alignment. If surgeons, industry leaders, and marketers collectively prioritize financial accessibility, perception management, and uncompromising clinical standards, the next decade will not simply restore volume. It will redefine value.

Coming in the October issue of *CEO Ophthalmology*:

What happens when the company that created an entire industry slowly destroys the very market it once dominated? This story is not just about LASIK. It is about leadership, arrogance, short-term thinking, customer betrayal, pricing panic, and failure to innovate while competitors quietly advanced. At one point, this company controlled billions in value, unmatched customer loyalty, and one of the most powerful brands in elective medicine. Then came a series of decisions that triggered commoditization, distrust, market collapse, and lost opportunity. Every CEO, founder, and entrepreneur should ask themselves one question after reading this: Are we unknowingly making the same mistakes today?



The Next Growth Wave in Ophthalmology Will Be Won in Finance and Operations, Not Technology

Matt Keating is Founder & CEO of Elevate Capital, LLC

Having spent more than a decade working alongside ophthalmology organizations ranging from independent practices to large enterprise platforms, I've had a front-row seat to the industry's evolution. During that time, one thing has remained remarkably consistent: every few years, the conversation shifts to the next technological breakthrough.

Today it's AI. Before that it was diagnostics, surgical platforms, premium IOLs, patient engagement tools, and countless other innovations that promised to transform the industry.

Technology matters. It improves outcomes, enhances the patient experience, and creates efficiencies throughout the care continuum.

But technology alone does not create enterprise value. In my experience, the biggest difference between organizations that scale successfully and those that struggle is rarely clinical. It's operational.

One thing I've learned throughout my career is that growth tends to magnify whatever already exists inside an organization. Strong processes become stronger. Weak processes become more painful. The same is true in ophthalmology. As practices grow, operational discipline becomes increasingly important. Decisions around staffing, scheduling, physician productivity, revenue cycle performance, and capital allocation begin to have a larger impact on long-term success than any single technology investment.

I've never seen a practice fail because it purchased the wrong piece of equipment. I have seen organizations struggle because leadership lacked visibility into the business they were trying to grow.

Many practices know their clinical outcomes exceptionally well. Far fewer have the same level of visibility into the operational drivers of their business. Questions such as where margins are being created, how provider productivity varies across locations, whether staffing levels are aligned with patient demand, or what cash flow will look like six months

from now often become increasingly difficult to answer as organizations expand.

That lack of visibility creates risk. It also creates opportunity. During my time leading finance organizations, I found that the most valuable role finance can play is not accounting. It's decision support. Finance should help leadership make better decisions, faster. It should provide clarity around resource allocation, growth investments, physician compensation structures, expansion opportunities, and operational performance.

This is something private equity-backed platforms have understood for years. While acquisitions often generate the headlines, much of the value creation happens afterward through operational improvement, accountability, financial discipline, and scalable infrastructure.

The same principles apply whether an organization is backed by private equity or remains independently owned.

Technology will continue to evolve and remain an important competitive tool. But technology alone will not determine the winners. The organizations that thrive over the next decade will be those that combine clinical excellence with operational excellence. They will know their numbers, build scalable processes, make data-driven decisions, and create the infrastructure necessary to support sustainable growth.

The next growth wave in ophthalmology will not be won solely in the exam lane or operating room. It will be won in the leadership meetings where strategy, finance, and operations come together to drive the future of the business.



AN INTERVIEW WITH Brent Saunders, CEO and Chairman of the Board, Bausch + Lomb

What was your high school job?

I started my own lawn and landscape business. It taught me early on what it means to build something from nothing, how to manage clients, and show up no matter what – lessons that have stayed with me throughout my career.

What is your leadership philosophy?

I believe great leadership is about creating the conditions for others to do their best work. That means being clear on vision, removing obstacles and trusting your team. I also believe in leading by example – I'd never ask someone to do something I wouldn't do myself.

What is your favorite leadership book?

Grit by Angela Duckworth. It reaffirmed something I learned cutting lawns as a teenager: talent matters far less than persistence and passion over the long haul.

What is your personality profile?

I've never put too much stock in any single label, but people who know me well would probably say I'm wired to be curious, direct, and relentlessly optimistic. I ask a lot of questions, I get energized by big problems, and I have a hard time sitting still when I see an opportunity. I'm competitive, but I genuinely believe the best outcomes come from building great teams and getting out of their way.

What is an interest of yours outside of ophthalmology?

Family comes first – that's non-negotiable. Beyond that, I spend a lot of time working with founders who are building new companies. There's an energy and hunger in early-stage entrepreneurship that I find infectious, and I love being a thought partner to people taking big swings. I'm also a voracious reader – books are how I keep learning and stay sharp.

What words of wisdom would you like to share?

Bausch + Lomb has been helping people see better for over 170 years. That kind of legacy doesn't happen by accident – it happens because generation after generation of people took their mission seriously. My advice to anyone in a leadership role is simple: **never lose sight of why the work matters.** When you're making decisions, come back to the patient or consumer. Come back to the person whose world gets a little brighter because of what you do. That North Star will never steer you wrong. And as a CEO, I'd add this – protect your culture fiercely. Strategy can be copied. Culture cannot.



”
Never lose sight of why the work matters.



ERIC DONNENFELD, MD



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LISA SPICER

Why Patients Still Fear LASIK in 2026—MD Perspective

Eric Donnenfeld, MD, is a founding partner of Ophthalmic Consultants of Long Island (OCLI), clinical professor of ophthalmology at New York University and a trustee of Dartmouth Medical School. Taylor Linaburg, MD, is a cornea, cataract, and refractive surgeon at OCLI, New York. Liana Miller and Lisa Spicer are with the Refractive Surgery Council.

The uncomfortable truth is that most patients are not asking themselves, “Should I improve my vision?” They are asking, “Is this elective surgery worth the anxiety and uncertainty, or should I just stay with glasses or contact lenses?” The internet, which we had hoped would amplify LASIK’s value, has instead magnified consumer fear while downplaying the overwhelming positives. Inertia keeps patients in the status quo, staying with their glasses and contact lenses. Patients often don’t choose laser vision correction because the offer is being evaluated against a “good enough” alternative [glasses or contacts], while the online perception of the surgery is:

- 1 Risky to something irreplaceable (their eyes)
- 2 Elective and deferrable (“I can always do it later”)
- 3 Expensive upfront, even if cheaper over time
- 4 Confusing / hard to compare across clinics and procedures (messaging is not consistent)
- 5 Not clearly tied to a life outcome they care about (occupation, confidence, convenience, sports, travel, freedom) but instead

We have a generation of successful LASIK patients with long-term outstanding results. An estimated 20-25 million procedures have been performed in the United States, with peak volumes during 2000 and 2001, when we performed 1.5 million procedures a year.¹ Despite dramatic improvements in technology, high consumer confidence, and a growing patient population, today, LASIK procedure volumes are less than one-third of those in the peak years. While economic factors are at the core of the decline, one element is certainly fear. Given the outstanding efficacy and safety profile of modern LASIK, the question to be asked is, why do patients still fear LASIK in 2026?

sold as better vision, which they already feel they have with their current vision correction.

As ophthalmologists, we have literally lost sight of why patients choose LASIK. Patients are not buying better eyesight. They are, in the language of innovation theory, hiring a solution to get a job done. In the Harvard Business Review Know Your Customers’ “Jobs to Be Done,” the authors argue that companies grow when they understand the progress customers are trying to make, not just the functional features of the offering.² One insightful line from the article is: “Customers don’t buy products or services.” They “pull” them into their lives to solve a problem or create progress. For laser vision correction, the “job” is rarely simply to see better. It’s more often:

I’m tired of planning my life around contacts.

I hate dry lenses when I travel.

I want to wake up and function immediately.

I want to feel confident in social and work environments.

I want freedom for sports, specific activities, or work.

I worry about losing my glasses or contact lenses.

Many patients do not fear LASIK so much as they cannot overcome the inertia to move forward. Many patients view their current vision correction as good enough. Laser vision correction is competing against a very strong incumbent: glasses and contacts work, and patients are comparing elective surgery against a life that is already functioning. That is a much harder sale. The message “Have LASIK and see better” doesn’t inspire

action from patients. However, “Stop negotiating with contact lenses every day” is likely to generate a response.

The strongest psychological barrier to LASIK is that patients fear a catastrophic downside, not a normal outcome. People do not evaluate laser vision correction like they evaluate teeth whitening or even cosmetic injectables. Eyes feel sacred and non-replaceable. A small perceived chance of a bad outcome can outweigh the overwhelming chance of convenience and even safety compared to contact lenses. That is why even high satisfaction rates don’t fully solve the adoption problem. What patients are asking themselves is not “will this overwhelmingly work?” but “what if I’m the unlucky one?” This is a risk asymmetry problem. The gain is convenience. The feared loss is vision quality. Those are not emotionally equivalent. The fear factor is often magnified, rather than mitigated, by LASIK providers selling reassuring slogans such as the procedure being safe, proven, millions treated, and life changing. The issue is not that these statements are false. The issue is that they are too generic to reduce uncertainty.

Healthcare is a classic credence market: patients can’t easily judge quality before purchase, and often not even after. That means trust must be earned through diagnostic credibility, not just promotional confidence.^{3,4} Evidence from consumer research in healthcare-like trust settings consistently shows that when people feel they cannot evaluate risk clearly, adoption falls and deference to trusted experts rises, but only if those experts feel transparent and aligned with the consumers’ interests. Patients often suspect they are not being given advice; they are being sold to. That’s why hard-sell financing language, countdown offers, and “free consultation” can actually reduce conversion among higher-intent, more educated patients. Fear is reduced, and trust is built when the surgeon clearly and confidently delineates who is not a good candidate, what tradeoffs

exist, and what recovery and side effects are realistically like for a patient’s specific eyes. Patients trust a clinic more when it appears willing to disqualify them. For clinicians, these distinctions matter.

The brutal truth of why patients fear LASIK is that happy patients often move on quietly with life, while unhappy patients often become highly vocal. Importantly, with social media, everyone has a pulpit to stand on and a megaphone to speak through. This creates a distorted information environment. If a prospective patient searches online, they’ll often encounter glowing clinic testimonials, mixed YouTube stories, emotionally intense forum / Reddit posts, and horror narratives that are hard to contextualize. Compounding the issue is the lack of clinical expertise being offered in these spaces.

The reality is that the negative stories are disproportionately memorable, because they are designed to be. Algorithms on social media platforms are engineered to surface emotionally-charged content above accurate content in pursuit of engagement. The most effective drivers of engagement are fear, outrage, and anxiety, not satisfaction or reassurance. The rare, extreme negative LASIK outcome is the fringe experience that social media is designed to elevate and amplify, while the quiet satisfaction of the vast majority of successful patients rarely surfaces. A prospective LASIK patient researching online is not receiving a representative sample of outcomes. They are receiving what the algorithm determined would elicit the most emotional response. LASIK surgeons cannot out-advertise fear with generic positivity. We have to contextualize concerns credibly with content that includes what complications patients worry about most, what side effects are temporary vs persistent, and what makes someone a poor candidate. Importantly, these patients must be met where they are seeking information: Online.

The core reason patients are not undergoing laser vision correction is not that they don’t want better vision. They reject it because the perceived downside is immediate and vivid, while the real

value is personal, long-term, and poorly articulated. The Harvard Business Review-style framing applies directly: patients are not buying a procedure; they are hiring a solution to make progress in a specific life context. Today, many laser centers are trying to sell a procedure, a technology, or an outcome metric while the patient is trying to solve inconvenience, confidence, and life logistics.

To overcome patient fear, we must reframe the value proposition. Stop leading with seeing clearly without glasses and instead lead with waking up and functioning immediately, traveling, working out, and living without contact lens restrictions. Find out if you’re a great candidate for visual freedom. We need to sell candidacy first, not surgery. Patients don’t wake up wanting topography-guided ablations. They wake up wanting to see the alarm clock, to swim without stress, and to see their children clearly in every environment.⁵ As LASIK surgeons, we overcome fear by facing it directly. We need to communicate that it’s normal to be cautious about elective eye surgery, not everyone should do this, and our job is to tell you whether this is the right procedure for *your* eyes. The future of LASIK growth will not come from better lasers alone. It will come from better trust, better framing, and better alignment with what problems patients are actually trying to solve.

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Why Patients Still Fear LASIK in 2026—Industry perspective

LASIK outcomes in 2026 are strong, predictable, and well documented. Clinical studies today and real-world data consistently show high rates of patients achieving 20/20 vision or better, along with high satisfaction levels.¹ Yet hesitation remains widespread. LASIK volumes have decreased over the past 5 years based on discussions with surgeons. In my observation, the key factor is not medical performance. It is a perception of what LASIK was like years ago.

Misinformation Persists

Most prospective patients are aware of LASIK, but awareness is shallow. Qualitative research shows they lack clear, practical

understanding of how the procedure could improve their own daily lives. LASIK is often categorized as “nice to have,” rather than a meaningful solution to a problem. Many patients believe glasses and contacts are “good enough,” so they delay action for several years without revisiting the decision. Without a strong personal reason to change, the status quo feels safe and familiar.

Cost is a major driver of misinformation.² Many prospects assume LASIK is prohibitively expensive and never explore true pricing, financing options, or long-term value. Few realize that cumulative spending on glasses, contacts, and solutions can rival the cost of surgery over time. This knowledge gap prevents serious consideration before a consultation ever occurs.

Online Narratives Dominate Perception

When LASIK first started to gain acceptance, there was no social media at that time. Information was gained through print publications or in person seminars. Digital platforms are now the primary source of health information for many Gen Z and Millennial patients. Social media, YouTube, Reddit, and online reviews can be consumed on a mobile device and don’t need to be viewed on a desktop computer, and they often carry more emotional weight than peer-reviewed literature. Negative anecdotes and dramatic videos are more visible than neutral or positive outcomes, even though complications are rare.

Online content also tends to flatten nuance. Stories from earlier generations of LASIK, performed with older technology, circulate without context. Advances such as wavefront-guided, topography-guided, and ray tracing-guided LASIK are largely absent from patient conversations. As a result, outdated fears often overwrite current reality.

The Trust Gap Remains Unresolved

Patients today are skeptical of institutions and corporations, including healthcare marketing. The advancements in refractive outcomes come as a result of industry investment in both software and hardware. Data alone does not feel persuasive. Clinical reassurances can be perceived as biased, while peer stories/videos feel authentic, even when they are incomplete or inaccurate. This creates a trust gap between surgeons and patients.

Research consistently shows that hearing directly from a friend, coworker, or family member who has undergone LASIK is the strongest motivator for action.³ Trust is built through relatable experiences, not statistics. On line information

sources are not always the best when it comes to social media vs peer reviewed studies.² Until benefits are described in human terms, greater freedom, spontaneity, and quality of life, facts struggle to land emotionally.

Key Insight

Perception, not outcomes, is the limiting factor. LASIK does not suffer from a results problem. It faces an understanding problem. Many patients remain unsure about results, despite FDA-reviewed studies demonstrating that newer technologies like ray tracing-guided and topography-guided LASIK achieve consistent, high-quality visual outcomes.⁴

Closing the gap requires transparent education, modernized messaging, and credible voices that bridge emotion and evidence. When patients can clearly see themselves in the outcome, fear begins to lose its grip.

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BEN SEALS



ERIN SCHALLHORN POWERS

Ben Seals is CEO of Thomas Eye Group, and Erin Powers is President of Surgical Vision, North America at Johnson & Johnson.

LEADERSHIP COLLIDING:

Consistent Principles Across Industry & Practice

Though the authors operate in different environments, they share a common perspective: effective leadership principles are consistent regardless of function, scale, or geography. Leadership excellence is driven not by context, but by disciplined, repeatable practices in developing people.

At the center of leadership development is a simple truth: if you wait for people to be fully “ready,” you will never build the next generation of leaders. Most individuals grow into roles rather than stepping into them fully prepared. Strong leaders identify those willing to step forward and create structured pathways that define expectations, required capabilities, and success metrics—unlocking potential that may not yet be visible.

Culture reinforces development. High-performing organizations distinguish between failures of competence and failures of character. Skill gaps are coachable; accountability is not optional. Leaders must also create safety nets so that stretch opportunities are not career-ending if they don’t work out. This balance encourages responsible risk-taking and accelerates both individual growth and organizational strength.

Leadership today requires capabilities that are often underestimated. Coaching, emotional awareness, and consistent accountability are not “soft” skills—they are core disciplines. Experience alone is insufficient. The most effective leaders multiply others, expanding organizational capacity rather than becoming bottlenecks.

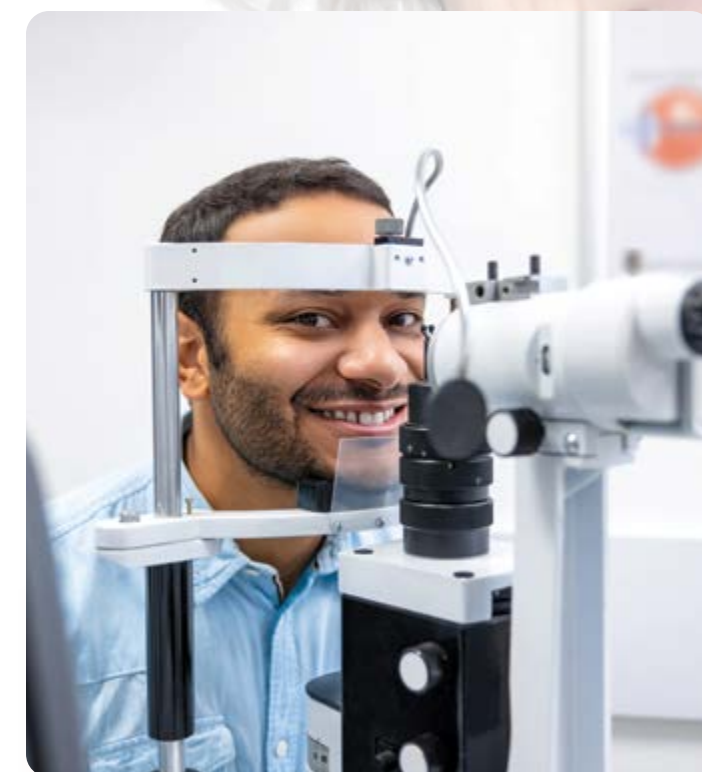
A common early mistake is trying to remain the expert in every area. While effective in smaller environments, it does not scale. Leadership requires shifting from being the expert to building and leading experts: surrounding yourself with strong talent, trusting expertise, and focusing on asking the right questions instead of having all the answers. This shift improves decision-making, scalability, and trust.

Leaders must also balance an individual’s short-term performance with long-term development. Not every mistake

should be prevented. Reversible decisions should allow room for learning, while higher-risk situations require more direct involvement. Over time, this builds judgment, confidence, and independence within teams.

Finally, leadership must be anchored in clarity. Potential and effort are not enough; progress must be measurable. Leaders must define expectations, timelines, and outcomes while being intentional about both what is achieved and how it is achieved. Clear standards allow individuals to rise to expectations or self-select out, both outcomes strengthening the organization.

Leadership excellence may evolve with context, but its core principles remain constant if you work in industry, a practice, or anywhere in between. Clarity is critical above all else, providing individuals with the direction and understanding needed to grow, perform, and lead—and take on the next generation to drive us all forward. →





Key Leadership Takeaways Across Functions

- 1

Don't wait for readiness—build it.

Leadership capacity is developed, not discovered. Create structured opportunities for people to grow into bigger roles.
- 2

Create a culture where it's safe to try, and fail.

Differentiate between coachable skill gaps and non-negotiable character issues, and build safety nets that encourage responsible risk-taking.
- 3

Multiply others or become the bottleneck.

Coaching, emotional intelligence, and accountability are core leadership skills. Great leaders scale impact by developing others.
- 4

Shift from expert to leader of experts.

Surround yourself with strong talent, trust their expertise, and focus on asking better questions to drive better outcomes.
- 5

Anchor everything in clarity and measurable outcomes.

Define expectations, timelines, and success clearly—and be intentional about both the “what” and the “how” of performance.



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References:
1. TECNIS PureSee™ IOL, Model DEN00V, US DFU Z312075E rev B

INDICATIONS and IMPORTANT SAFETY INFORMATION for TECNIS PureSee™ IOL and TECNIS PureSee™ Toric II IOLs with TECNIS SIMPLICITY™ Delivery System

Rx Only

INDICATIONS FOR USE: The TECNIS SIMPLICITY™ Delivery System is used to fold and assist in inserting the TECNIS PureSee™ IOL, which is indicated for primary implantation for the visual correction of aphakia in adult patients with less than 1 diopter of pre-existing corneal astigmatism in whom a cataractous lens has been removed. The lens mitigates the effects of presbyopia by providing an extended depth of focus. Compared to an aspheric monofocal IOL, the TECNIS PureSee™ IOL provides improved intermediate visual acuity, while maintaining comparable distance visual acuity. The lens is intended for capsular bag placement only.

The TECNIS SIMPLICITY™ Delivery System is used to fold and assist in inserting the TECNIS PureSee™ Toric II IOLs, which are indicated for primary implantation for the visual correction of aphakia and for reduction of refractive astigmatism in adult patients with greater than or equal to 1 diopter of preoperative corneal astigmatism in whom a cataractous lens has been removed. The lenses mitigate the effects of presbyopia by providing an extended depth of focus. Compared to an aspheric monofocal IOL, the TECNIS PureSee™ Toric II IOLs provide improved intermediate visual acuity, while maintaining comparable distance visual acuity. The lenses are intended for capsular bag placement only.

WARNINGS: Physicians should weigh the potential benefit/risk ratio of IOL implantation in patients with any of the conditions listed in the Directions for Use, as intraocular lenses may exacerbate an existing condition or may pose an unreasonable risk to the eyesight of patients. Rotation of the TECNIS PureSee™ Toric II IOLs away from its intended axis can reduce its astigmatic correction. Misalignment greater than 30° may increase postoperative refractive cylinder. If necessary, lens repositioning should occur as early as possible prior to lens encapsulation.

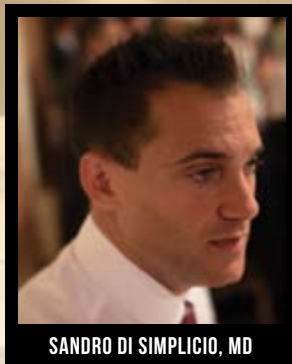
Do not attempt to disassemble, modify or alter the delivery system or any of its components, as this can significantly affect the function and/or structural integrity of the design. Do not implant the lens if the rod tip does not advance the lens or if it is jammed in the delivery system. The lens and delivery system should be discarded if the lens has been folded within the cartridge for more than 10 minutes.

PRECAUTIONS: Careful preoperative evaluation and sound clinical judgment should be used by the surgeon to decide the benefit/risk ratio before implanting a lens in a patient. Potential risks for cataract surgery may include but are not limited to infection, inflammation, retinal detachment, increased eye pressure, hyphema, hypopyon, and posterior capsular opacification. Prior to surgery, the surgeon must inform prospective patients of the possible risks and benefits associated with the use of this device and provide a copy of the patient information brochure to the patient. Autorefractors may not provide optimal postoperative refraction of patients with the IOL. Manual refraction with maximum plus technique is strongly recommended. This is a single-use device. Do not resterilize the lens or the delivery system. Do not store the device in direct sunlight or at a temperature under 41°F (5°C) or over 95°F (35°C). Do not autoclave the delivery system. Do not use if the delivery system has been dropped or if any part was inadvertently struck while outside the shipping box. The sterility of the delivery system and/or the lens may have been compromised. The recommended temperature for implanting the lens is at least 63°F (17°C). Do not advance the lens unless ready for lens implantation. Do not leave the lens in a folded position more than 10 minutes. The use of balanced salt solution or ophthalmic viscosurgical devices (OVDs) is required when using the delivery system. The lens should be placed entirely in the capsular bag. The lens should not be placed in the ciliary sulcus.

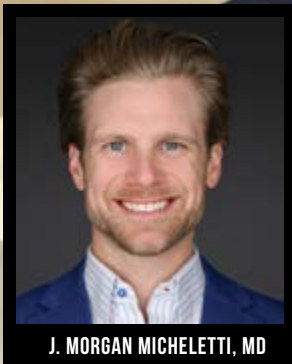
ATTENTION: Reference the Directions for Use for a complete listing of Indications and Important Safety Information.



TOM RUGGIA



SANDRO DI SIMPLICIO, MD



J. MORGAN MICHELETTI, MD

TURNING THE PAGE:

Mastering Emotional Reset in High-Stakes Environments

Tom Ruggia is CEO of Theialife. For this article he spoke with Sandro Di Simplicio, MD, Consultant Vitreoretinal and Refractive Surgeon, Newcastle Upon Tyne, England; and J. Morgan Micheletti, MD, Cataract, Refractive, Interventional Glaucoma, and Anterior Segment Surgeon, Berkeley Eye Center, Houston, TX

In ophthalmic surgery and executive leadership, performance is rarely judged in isolation. It is measured across a series of consecutive moments (cases, meetings, decisions) each demanding clarity, precision, and presence. The challenge is not simply navigating a difficult situation; it is ensuring that the emotional and physiological residue of that moment does not compromise the next.

Much like in competitive sports, the ability to “turn the page” is a defining skill for top performers. At its core, this is not just about mental discipline, it is about managing the interplay between emotion, physiology, and performance. Specifically, it is about

recognizing and controlling the amygdala-driven stress response and the downstream effects of cortisol that can subtly, but meaningfully, impair decision-making.

The Hidden Cost of Carryover

Difficult moments are inevitable. A complex surgical complication, an unexpected outcome, a contentious meeting, these experiences do not simply disappear when the moment ends. They linger.

Consultant vitreoretinal surgeon **Mr. Sandro Di Simplicio** recalls a case with an unexpected intraoperative complication. While the situation was managed appropriately, he noticed its impact immediately afterward. “I went into the next patient interaction and realized I was more distracted and slightly less present than usual,” he reflected.

This phenomenon is not about poor judgment or lack of competence. As **Dr. Morgan Micheletti** notes, “The risk isn’t usually about making bad decisions. It’s about divided attention.”

When part of the mind remains anchored in a previous moment, the ability to fully engage with the present is diminished.

In executive settings, the same dynamic applies. After navigating a difficult personnel decision marked by hostility, I found myself walking into a high-stakes investor meeting with elevated heart rate, scattered thoughts, and residual emotional intensity. The opportunity in front of me demanded focus, but my physiology had not yet caught up.

Recognizing the Physiological Shift

The first step in managing emotional carryover is awareness. The signals are often subtle but consistent across disciplines.

Cognitively, individuals may notice:

- Reduced focus or drifting attention
- Replay of prior events
- Slower or less precise thinking

Behaviorally:

- Changes in communication tone
- Reduced engagement or curiosity
- Abrupt or less thoughtful interactions

Physiologically

- Elevated heart rate
- Muscle tension
- A sense of urgency or restlessness

These responses are rooted in the amygdala’s role as a threat detector. When activated, it triggers a cascade that includes

cortisol release, preparing the body for action. While useful in acute situations, this response becomes counterproductive when it persists into subsequent interactions.

As Micheletti observes, when he is fully present, his curiosity sharpens, he asks better questions, and listens more effectively. When that changes, it is a signal to reset.

The Reset: A Deliberate Transition

The ability to reset is not automatic; it is practiced. Importantly, it is not about suppressing emotion or ignoring what occurred. It is about **controlling when and where that emotion is processed**.

Di Simplicio describes a simple but powerful technique: “taking a brief pause, a controlled breath, and mentally closing the previous case before focusing on the next patient.” Even a few seconds of intentional transition can interrupt the stress cycle and restore presence.

Micheletti offers a more structured mental model, visualizing a “flame in the void,” into which he channels all distraction—fear, frustration, or excitement—leaving only focus behind. While metaphorical, this reflects a broader truth: the mind needs a mechanism to compartmentalize.

From my own experience, deep breathing, stepping outside the immediate environment, even briefly, can physiologically downregulate the stress response. Slowing the breath signals the nervous system to shift from sympathetic activation (fight-or-flight) toward a more controlled state.

Protecting the Next Interaction

Resetting is not just a personal benefit; it is a professional obligation.

“The patient in the next room...was not part of whatever just happened,” Micheletti explains. Each patient, colleague, or

stakeholder deserves undivided attention and clear thinking. Emotional spillover, even if subtle, can erode trust, communication, and ultimately outcomes.

Di Simplicio emphasizes the importance of closure, mentally “parking” a case after ensuring that necessary follow-up actions are defined. This allows the mind to release the prior interaction without neglecting it.

For executives, the same principle applies. The value of the next meeting, whether with investors, partners, or team members, must be protected. The opportunity in front of you deserves the same clarity and composure, regardless of what preceded it.

Compartmentalization Without Detachment

There is a delicate balance between compartmentalization and emotional detachment. High performers must care deeply about outcomes while avoiding being consumed by them.

Micheletti captures this balance succinctly: “The goal is to compartmentalize and stay compassionate.” Too much emotional carryover leads to distraction; too little emotional engagement risks becoming disconnected.

The key is **temporal separation**:

Perform now

Reflect later

Difficult cases and challenging decisions should be analyzed, debriefed, and learned from, but at the appropriate time. Attempting to process them in real-time while moving to the next task creates cognitive overload.

Training the Reset Skill

Like any high-performance skill, the ability to reset is developed over time.

Early in their careers, both surgeons and executives often experience longer emotional carryover. First complications, first major decisions, first failures; these moments leave a lasting impression. With experience comes pattern recognition, confidence, and refined coping mechanisms.

Di Simplicio credits his background as a pilot, where focus on the present moment is essential. Micheletti highlights the evolution from equating composure with emotional suppression to understanding it as emotional recognition and control.

From my own perspective, this skill has been reinforced across multiple domains, from early sales roles to executive leadership and competitive athletics. The principle is consistent: one moment does not define the next. The ability to reset is what sustains performance over time.

Conclusion: Performance is a Series of Fresh Starts

In both surgery and leadership, excellence is not achieved through isolated brilliance but through consistent performance across consecutive moments. Each patient, each decision, each meeting requires a fresh start.

Managing the amygdala-driven stress response and the physiological effects of cortisol is not an abstract concept. It is a practical necessity. It enables clarity, protects outcomes, and preserves the quality of engagement that defines high-level performance.

The best surgeons and executives are not those who avoid difficult moments, but those who can **experience them fully, process them appropriately, and then leave them behind.**

Because in the end, the next patient (and the next opportunity) deserves nothing less than your best, most present self.



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ADAM SHUFORD, VICE
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AMERICAS AT STAAR SURGICAL

“I Want to Think About It”

The Real Reason Refractive Patients Don't Move Forward

A patient walks into a refractive consultation excited, qualified, and genuinely interested in surgery.

Ninety minutes later, they leave saying:

“I want to think about it.”

Everyone in refractive surgery knows this moment.

The coordinator smiles politely.

The surgeon assumes they need time.

The practice logs the consult as “undecided.”

And then everyone moves on as if this is normal.

But it shouldn't be.

Across refractive surgery today, more 21-45 year old patients walk out without surgery than move forward. That is the gap. In the peak years of refractive surgery, many practices converted the majority of qualified consultations into procedures. Today, that momentum has flipped.

In any other industry, losing more qualified customers than you convert would trigger a hard look at the entire customer journey. It would force an operational and cultural review around confidence, friction, communication, and the point at which the customer decides to either move forward or walk away.

Refractive surgery should be no different. The opportunity is not only to create more demand. It is to rebuild confidence in the consult, simplify the decision, and help more qualified patients become surgical patients.

What has changed?

The easy answer is the trigger of the 2008 financial crisis. And certainly, it mattered. Elective procedure volume slowed dramatically, and practices were forced to adapt quickly. Many shifted focus toward premium cataract surgery and presbyopia-correcting IOLs; a smart and necessary business evolution at the time.

But over the next decade, something larger happened beneath the surface.

The industry slowly drifted away from the refractive consumer.

Practices that once centered their experience around a healthy 28-year-old seeking freedom from glasses gradually shifted toward non-elective cataract workflows and upgrade discussions with an older patient demographic. Those are fundamentally different consumer journeys.

One is lifestyle driven. The other is medically necessary with an optional upgrade component.

And over time, refractive surgery lost some of the emotional connection and consumer fluency that once fueled its growth. As the economy recovered, refractive demand never returned and we are facing the steepest declines the refractive market has ever experienced. Not because consumers stopped wanting freedom from glasses or contacts. Rather, as an industry, we slowly lost touch with how to communicate with them. Trust eroded at the top of the funnel and uncertainty remained unresolved at the bottom.

Today, most practices assume they have a lead generation problem.

In reality, many have an uncertainty problem.

Patients rarely leave consultations because they do not want better vision. They leave because uncertainty outweighed conviction in that moment. Refractive surgery is psychologically unique: elective, emotional, and deeply tied to identity and lifestyle.

The highest performing practices understand this intuitively.

That changes everything.

Most patients walking into a refractive consultation already want freedom from glasses or contacts. They took time away from work, family, and their daily lives to spend hours in your clinic. What they are really evaluating is fear and trust. The best practices understand their role is not to “close” patients, but to create enough trust, clarity, and confidence that uncertainty no longer dominates the decision.

Practices with strong conversion infrastructure create consistency across every touchpoint. The messaging from the first phone call matches the counselor conversation. The diagnostics reinforce the lifestyle discussion. The surgeon

communicates confidence without arrogance. Patients feel alignment throughout the experience.

That alignment reduces fear.

And when conversion slows, elite practices resist the temptation to abandon strategy altogether. They refine execution instead. They coach communication. They improve consistency. They evolve tactics while protecting the core philosophy.

The best refractive practices operate the same way.

Because in the end, the practices that consistently grow are not necessarily the ones generating the most leads.

They are the ones best at reducing uncertainty.

And more often than not, when patients feel certainty, they stop saying:

“I want to think about it.”



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LISA FEULNER, MD, PHD



CHRIS MOORE, CEO, VISION
INNOVATION PARTNERS



Balancing Innovation and Scale:

How PE-Backed Ophthalmology Platforms Make Clinical Decisions

Private equity-backed ophthalmology platforms sit at a unique intersection of clinical care, operational scale, and capital deployment. As innovation accelerates from drug delivery to regenerative therapies, the question becomes not just what to adopt, but how those decisions are made across a growing enterprise.

Chris Moore, CEO of Vision Innovation Partners (VIP), has unique insight into exploring how leading platforms evaluate new technologies, align physicians and management, and ultimately bring meaningful innovations to patients.

Decision-Making Structure

LF: Starting at a high level, how is clinical decision making structured across your organization today? What is centralized versus left to individual physicians?

CM: If our doctors want it, we will figure out a way to get it. Patient care is at the forefront of everything we do. Our mission here is vision, and our purpose as an organization is to protect and restore vision. It's harder than ever to be in the business of eye care, with rising costs, decreasing reimbursement, and a very difficult recruiting environment. But at the end of the day, our doctors need to have in their hands what they need for their patients, and we try to find a way to get that done. It's our job to make sure the economics work, but first and foremost we want our surgeons and

optometrists to have the autonomy to use what they need.

LF: Can you walk me through the decision pathway, from initial interest to potential adoption, when a new product or technology comes onto your radar?

CM: I view one of my jobs as being a scout for innovation, and I'm very connected to the innovation side of our space. I am privileged to know what's coming in the next few years, so I take what I learn from those innovation discussions back to our surgeons and optometrists, and let them know what I've heard about. I've also had the privilege of connecting doctors to industry for the necessary high-level conversations, and truly enjoy connecting the innovation cycle to doctors in our platform.

LF: What about a product or innovation that you're not

familiar with, that a surgeon brings to your team? Who are the stakeholders in that decision-making process for something that you know less about?

CM: Some of my favorite conversations are when a doctor calls and wants to lean into something new they heard about. I recently had one. We started by talking through the value proposition to the patient. And then we start thinking about the complexity of piloting this. How can we understand the implications of workflow? If there's reimbursement involved, how do the business and the doctor get paid for using the product? The stakeholders in that are the surgeons or optometrists who want to champion that product. Then we have a medical advisory board in our business, and they're involved in all these decisions, so they'll look at it holistically. They'll take a patient care perspective, and look at whether or not it will level up our standard of care. They also help with the economic evaluation and look at whether it makes sense for the business as well as for patients. Our management team works very closely with our medical advisory board to help with those assessments.

LF: Can you give us a high-level view of the network within VIP that helps decide and determine the process for incorporating those decisions?

CM: We have an operations team that helps with the basic parts of the assessment. Things like how do we educate the patient, how is this going to impact our workflow, how does this impact reimbursement? It's a very multifaceted and multidisciplinary team. We pair up the doctors who really want to champion the technology with our operations team, and then we make sure the industry partner has a seat at the table, so they can help us understand the best way to implement it.

Evaluating Innovation

LF: When you evaluate a new technology, what criteria carry the most weight? How do you balance clinical outcomes, physician enthusiasm, reimbursement dynamics, and operational impact?

CM: Here too, the doctor's voice is number one. Of course, we must also be pragmatic, especially when it requires a lot of capital expenditure up front. We do want to see the path to

return on investment. But most important is, what's the benefit to the patient? And second, how does it benefit the doctor? What we are very careful about is not engaging in a contract with one of our vendor partners that overcommits our doctors on utilization. We don't want to have to push the doctors to make the economics work, so we're very thoughtful about the volume we commit to. The other thing worth mentioning is, how adoptable is this innovation across the platform? We have some doctors who are on the tip of the spear of innovation and want to use things that their colleagues aren't comfortable using yet. If we can get three or four doctors to really be a champion for a particular technology, that becomes the path to broader adoption.

LF: It's refreshing to hear you discuss the importance of balance between financial impact, operational impact, patient outcomes, and ultimately, what surgeons or other physicians in the office want. Is there a defined threshold, clinical or economic, that a product needs to meet before it moves forward in your organization?

CM: Somewhat surprisingly, no, there is no defined threshold. We don't need a predefined internal rate of return on investment. Everything truly is situational, and we've managed to be very successful with that kind of strategy. Again, we make sure that the doctors really do want it, and that the economics work, and there's a reimbursement pathway, etc., but there's no formula with us.

Pilot to Platform

LF: What about things that are not directly reimbursable or directly oriented toward patient care, like practice management, or patient education? When it comes to ROI, how do you distinguish between something that's interesting versus something that you think is truly scalable to the platform?

CM: For things that don't directly impact patient outcomes or care delivery, we always look at what can make the patient experience more consistent across the platform. We're not a small platform, we have just under 1400 team members across the Mid-Atlantic region, and we want every patient to have the same experience.

We want to adopt technologies that help reduce friction for that patient, so they have a really good experience even before they arrive. We deployed a centralized Contact Center last year, not to save money, but to improve the patient experience. When a patient calls one of our brands, their first experience with that practice is that call center person, and we want that experience to be excellent. The person needs to ask the right questions, provide the right sort of pre-visit education, and really do a good job of managing that patient's expectations before they walk through the doors of our clinic. That's one of our main priorities this year at Vision Innovation Partners, really striving to deliver a consistent patient experience for the several hundred thousand patients we'll see across our brands this year.

LF: Is there a way that Vision Innovation Partners can evaluate the metrics that ultimately help you determine what innovations you're going to incorporate across the platform?

CM: It really does come down to looking at the workflow change. How does this change a front desk person's day, or a technician or a scribe, if we implement this technology? What's the impact to the business? Can we improve patient experience? Could it drive more revenue? And before we make the decision to implement something, we have to understand how complex it is to install it and use it successfully. We support a few dozen practices, which each have something unique. So when we're talking about things like a patient engagement technology, implementing that in two different types of practices is a different plan of attack. We'll engage our field level leaders, such as practice managers, technicians, and front desk leads, in the assessment of these technologies and the deployment of them, because they know the impact to the patient and to their workflows.

LF: I personally love change, but most people really struggle with it. How does Vision Innovation Partners manage resistance to change when you believe something is the right thing?

CM: It goes back to the why. I frequently get to travel and visit with our practices. And I will routinely ask what we can do to make things better for the staff, for the patients, or for the

doctors. And we'll try to find ways to improve whatever it is they think could be better. I think listening to the people that actually deliver the patient care, and then getting them what they need is very, very important.

Contracting & Industry Partnerships

LF: Once you have a product or innovation that has been clinically validated, and that you've decided to bring to an office, or the platform as a whole, how do you approach contracting with industry at the enterprise level?

CM: We view our vendors as stakeholders in this business, so we treat them like investors. We want to have a discussion with them about what they are expecting us to do, and what success looks like for them. It's fun for me to have that conversation with vendors and our operations leadership team, because they tell me that they don't get asked that question a lot. This is after we've checked those boxes we talked about before. Do doctors want and need it? Have we figured out the economic model? Have we figured out implementation? And then it's about adoption execution. And if the plan is platform-wide adoption, what does that look like? And we want our vendor partners to be equally accountable to what they're signing up for to support us too.

LF: There's a question that we ask industry, about what is the best kind of relationship they can have with practices. But we don't often ask the practices what makes a strong industry partner. From a private equity perspective, what makes a great industry partner?

CM: It's really that investor-thinking dynamic. We're investing in the vendor and they're investing in us. Yes, we're paying them for whatever it is that they're providing, but taking a real partner-minded approach to those discussions is very important. It's harder than ever to be in the business of ophthalmology. That's true for all types of practices, whether you're a private equity-backed practice, a traditional private practice, or in academia. A strong industry partner acknowledges that, and understands what our priorities are as an organization, and how they can help

drive that.

Case Example: DefEYE Collaboration

LF: Your collaboration with DefEYE is a practical example of how these processes come together. Can you walk me through how that partnership originated and evolved?

CM: I'm privileged to get a front row seat to innovation in the space. I was catching up with some of the principals of that business awhile back, and some of our doctors expressed interest in it as well. I sat down with those principals and said, "Here's the playbook on how you can get broader adoption of that product into our platform". And they went and ran the play. It started with getting doctors involved. They had already identified a few doctors that had expressed interest. Our team gave them more names, of additional doctors we thought would be clinically aligned with the other doctors who had expressed interest. And that's how it came to be, and now we have a lot of doctors using that product.

LF: This takes us back to the beginning of this conversation, where sometimes the platform brings innovation to the doctor, sometimes the doctors bring innovation to the platform. So, the ability to broaden its exposure across the platform is what made this solution compelling enough to pursue?

CM: One thing we continue to try to do is remove administrative friction in getting these types of products deployed right. We did a nice job of understanding the doctors who were going to embrace it and understanding how it was going to be paid for, and then a nice job of piloting it at a couple of sites and proving it as well, from economic, clinic, and workflow perspectives. You really do need to check all three of those boxes for any product to be taken platform wide.

Patient Impact

LF: You've stated how important patient outcomes are in the decision-making process for Vision Innovation Partners. How do you ensure that the organizational process doesn't unintentionally slow access to these therapies that can make a real difference for patients?

CM: I've seen so many products fail where the product is being jammed in and forced into a clinic's workflow. So once we prove that there's clinic value and we prove there's economic value, then it's really on us as a management team and the vendor partner, to go and sell the story to, in our case, other brands around the platform, because we want them to want to do it right and be successful. If they feel like they're forced to do it, it's not going to work right. So we can say to our doctors, we've started using, as an example, BIOVANCE 3L Ocular in our practice, and it's working really well. And here's the type of patients on whom it's working really well, and here's the impact on workflow. We rely heavily on our own doctors to go sell the concept to their colleagues, and around the platform.

Physician-PE Alignment

LF: You have a network in place to help physicians educate each other on new innovations, sort of like a mentorship type of setting. And I think that's really important, because often there's a perception that private equity prioritizes economics over clinical autonomy. How would you respond to the generalized perspective that private equity is really about money and not about physician autonomy and decision making?

CM: This is a great question that I've answered many times over the last couple years. Every private equity-backed practice has an investor who made an investment, with an expected return on that investment, and an expected time horizon for that investment. The tailwinds in ophthalmology are very, very good. Demographics are very favorable, and there's a lot of innovation in this space. As an industry, we're very favorably positioned. But it's also a challenging time to be in eye care, as I mentioned before. There are generally declining reimbursement dynamics, surgeon replacement ratios are never one to one. When we're replacing a great surgeon, it's always going to take more than one surgeon to replace them because of experience and shifting work-life balance needs. We don't find many surgeons that want to do 30 or 40 cases a day, and that makes for a challenging environment when we have high producing

surgeons who are retiring. At the end of the day, the business must deliver good care, because if we're not delivering good care, we won't have patients. So there really does need to be a priority on meeting the needs of the doctor for the business to be successful. In the world of private equity-backed investments in ophthalmology, the path to value creation has been a bit unclear. But those investors that take a longer view and really do appreciate that we must meet the needs of the surgeons, and that they have to be able to be in a position to provide great care, those are going to be the investors that win at the end of the day. That's going to require investor patience, in most cases, and it's going to require a patient lender who's loaned the business money.

LF: You've talked about how Vision Innovation Partners interacts with their physician providers. There's a well-known dissatisfaction among many doctors working in PE-backed practices. What do you think the major source of friction or tension is between physician providers and private equity?

CM: I can give you examples I hear from our recruiting team and the doctors who are joining us from other practices, whether private equity-backed or not. One of the biggest is that we let doctors practice medicine the way they want to practice medicine. We're truly here to help support their practice and support their objectives. So, for some doctors who are mid-career, and leaving another private equity-backed group, they do love the autonomy we afford. And we deliver on that promise when they start working with us. They like the work-life balance that we afford here. We're big on managing expectations with doctors that are joining our team. If somebody wants to come and work five days a week, hey, that's great. If somebody wants to come and work three or four days a week, hey, that's great. And we get really aligned on what success looks like in that regard, before they sign their contract. We support those doctors when they get started with us, and get their schedules full with the right kind of patients, and they have the kind of practice that they want to have. I think that makes us somewhat unique in that regard.

LF: So summarizing, it's often a mismatch between private equity expectations and physician expectations. And when those expectations aren't met on either side, there can be friction. The expectations are the core to all the other things that come from that relationship, and as long as there's a balance between the physician and private equity expectations, pretty much anything can happen. But when there's a mismatch, and poor communication follows, that's when physicians feel like they don't have any option but to leave.

CM: Right. And the doctors own a piece of that accountability too. With every doctor that we onboard, we have an agreed upon path to ramping them up to a certain level of production. And that does depend on the doctor committing to the number of days and number of appointments they want to have in their day or in their week. If the doctor decides they want to do 20% less, we discuss why that is, and how we can accommodate that. But that's a deviation from what we all signed up for, and we will always strive to adapt to the needs of our provider base. Especially in this ever-changing doctor workforce culture, I think we do a really nice job of creating positions that meet the needs of the doctor, and the needs of their family, and allow them to enjoy hobbies and other parts of their lives. But it does come back to aligning around mutual expectations from day zero.

Speed vs Risk

LF: The goal for private equity is to grow and expand and sell again. With all the things we've talked about, bringing in new innovations, bringing new doctors in, and buying new practices, how do you strike the balance between moving quickly and managing risk, whether clinical, financial, or operational?

CM: I think what I'm about to say is true for every other eye care platform out there. The biggest key to growth is driving the base business and pulling all the organic growth levers that can be pulled. For us, if a doctor signs up to do 20 patients a day, it's our job to deliver 20 patients to that exam lane, or 15 cases in the ASC, or whatever the case may be. We've got to meet the needs of the doctors. And that's key to the success of the investment.

So pulling all this together is important. And the easiest organic growth lever we can pull is capacity. If we have doctors showing up, let's make sure their schedules are full. The next layer of that is, let's make sure the doctors are working at the top of their license if they want to do so. So organic growth is the number one lever that all practices focus on. The second is recruiting new doctors and creating an environment where doctors want to come and join your platform and backfill doctors that are retiring or sunsetting in their career. And the third is keeping an eye out for acquisitions that are accretive.

Looking Ahead

LF: Looking ahead, how do you see the role of PE-backed platforms evolving in shaping innovation adoption in ophthalmology over the next 3 to 5 years?

CM: Well, I think we're going to see more platform consolidation. We're already starting to see that, and I think we're going to see it accelerate. There are about 31 different platforms in the country today. I think that within two years, that number could go to fewer than 20. Platforms doubling size as a result of a transaction is not going to be unheard of. And as platforms grow, I believe there's almost a responsibility to help drive innovation. Innovation is literally in our name, so we're always trying to figure out how we can leverage our platform to help drive innovation forward, whether that's participating in clinical trials or helping with a commercial launch. As platforms significantly grow in scale over the next two to three years, there will be some interesting opportunities for industry to partner with some of those platforms to maybe get faster product adoption of products that are really meaningful for patients and doctors.

LF: What will differentiate the highest performing organizations in this space?

CM: It's going to be those that can really deliver on organic growth. Pulling those levers that we talked about a moment ago. Delivering base business growth at a high single digit kind of growth rate year over year. The other platforms that are going to be successful are those that have really good partnerships with industry and really deliver on some of the things that we've talked

about here today. And then the third thing is, the platforms that are going to be successful for the long haul are going to be those that recruit really well and have a culture for their doctors, where those doctors want to stay and grow in their career.

LF: If you had to pick one thing that physicians may misunderstand about how private equity-backed organizations make decisions, what would that be?

CM: It's not all about the money. There's a misconception that leadership teams of platforms like ours wake up every day and only look at how many dollars are in the bank account, and that's really not how we are wired. Yes, we have to be profitable, and yes, we're incentivized to be profitable. But the path to profitability doesn't mean cost cut your way there. It means supporting doctors to help them with the types of practices that they want, to deliver the type of care that they want, and that is what delivers a profitable enterprise.

When clear goals and expectations are established, private equity funding has a great deal to offer ophthalmology. Physicians are given the opportunity to work with innovative solutions that move the field forward, increasing patient care and satisfaction. And the always important bottom line can be taken care of as well, with a thorough selection process.

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