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FOR VISION LEADERS

The Future of
**EYE CARE
IN AMERICA**
CHANGE, CHALLENGE,
AND OPPORTUNITY

**THE
MODERN
C-SUITE**

DEFINING
LEADERSHIP ROLES
IN OPHTHALMOLOGY
ORGANIZATIONS

+ **CHIEF MEDICAL OFFICER AND
CHIEF EXECUTIVE OFFICER**
HOW DO THEIR PATHS
CROSS?

MEET

**RICHARD
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The Editorial Board is a group of advanced leadership in the ophthalmology industry.

Here to share their knowledge and advice in an array of topics.

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The Birth and Purpose of CEO Ophthalmology

CEO Ophthalmology was created with a clear and deliberate mandate to serve the decision makers shaping the future of ophthalmology. In an era defined by information overload, accelerating economic complexity, and constant disruption, leaders need more than news. They need perspective, synthesis, and judgment. *CEO Ophthalmology* exists to curate and elevate the most relevant insights so leaders can make better decisions.

Who We Serve

CEO Ophthalmology is written for CEOs, founders, managing partners, physician owners, senior executives, and board members across the full ophthalmology ecosystem. Our audience spans industry partners within ophthalmology, leaders of small, medium, and large ophthalmic companies, private equity backed platforms, and surgeon owned practices. We also serve CEOs and senior leaders across professional societies, nonprofit organizations, academic institutions, and universities. While organizational structures may differ, leadership challenges consistently overlap across strategy, capital, governance, innovation, talent, and long-term growth.

What We Deliver

CEO Ophthalmology is a quarterly publication supported by a multi-platform ecosystem. Each issue is produced as a premium print magazine and extended through an online platform, audio programming, video content, and a dedicated podcast. Across these channels, we conduct in-depth interviews with CEOs and senior executives and present thoughtful analysis grounded in real world experience. Our objective is not volume, but clarity. Every piece of content is designed to respect the time and responsibility of senior leaders.

Where and When

Published quarterly, *CEO Ophthalmology* is intentionally designed to be durable rather than transactional. Print issues are meant for the boardroom, executive office, and focused reading. Digital content extends the dialogue between issues, while audio and video formats allow leaders to engage during travel, training, or reflection.



ROB MELENDEZ, MD, MBA

Why We Exist

The business environment confronting ophthalmology leaders has never been more complex. Capital markets, private equity, workforce pressures, reimbursement dynamics, technology adoption, and patient expectations are converging simultaneously. Leaders are inundated with data and opinion. *CEO Ophthalmology* places its primary emphasis on helping decision makers sift through this volume of information, identify what truly matters, and apply it with confidence. Our purpose is simple and unwavering: help leaders make better decisions.

How We Approach Content

CEO Ophthalmology operates across multiple levels of leadership insight. We address governance and board level strategy, financial and operational excellence, organizational culture, leadership development, and innovation through a business- and outcomes-focused lens. Clinical and technological advancements are explored within the broader context of enterprise value and long-term impact.

Core Content Pillars

Leadership and Decision Making

Strategy Growth and Scale

Finance Capital and Private Equity

Governance and Board Dynamics

Operations and Practice Performance

Innovation Technology and the Future of Ophthalmology

Talent Culture and Organizational Design

Editorial Leadership

CEO Ophthalmology is led by Editor-in-Chief **Robert F. Melendez, MD, MBA** with Editor-at-Large **Adam Szaronos, MBA**, and Managing Editor **Steve Lenier**.

Founding Editorial Board

The founding editorial board reflects the breadth and depth of leadership across ophthalmology, industry, and academia: **Adam Szaronos, MBA; Eric Donnenfeld, MD; Richard Lindstrom, MD; Lisa Feulner, MD, PhD; Cynthia Matossian, MD; Tom Ruggia; Erin Schallhorn Powers; Vance Thompson, MD; Sidney Gicheru, MD; Wayne Caulder; Leo Otero; and Adam Shuford.**

Future Plans: *CEO Ophthalmology* Leadership Summit

The goal of creating the *CEO Ophthalmology* Leadership Summit within the next year is to convene the most influential C suite leaders across ophthalmology for focused, high level dialogue and collaboration. The summit will bring together physician CEOs, industry executives, private equity leaders, and society and academic leaders to address the strategic, financial, and organizational challenges shaping the future of eye care. Designed as a leadership forum rather than a traditional meeting, the summit will emphasize decision making, governance, innovation, and long term value creation. Ultimately, the *CEO Ophthalmology* Leadership Summit will serve as a trusted annual platform where leaders learn from one another and help define the direction of the profession.

Get Involved

CEO Ophthalmology is actively seeking authors, contributors, and content creators who are interested in interviewing senior leaders and sharing high level executive-focused insights with our readership. We welcome original perspectives that help elevate decision making across ophthalmology and healthcare.

If you would like to nominate a CEO to be featured on the cover and highlighted in a two page executive profile within *CEO Ophthalmology*, we invite your nomination. Interest has been strong, and a robust list is already in development.

Thank you for your interest,

Rob Melendez, MD, MBA | eic@ceoophthalmology.com

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RICHARD L. LINDSTROM, MD

PRACTICE OF THE FUTURE

The Future of Eye Care in America

CHANGE, CHALLENGE, AND OPPORTUNITY

While conventional wisdom urges us to focus on the present, thoughtful leaders must also look ahead. In this first article for *CEO Ophthalmology*, I will highlight a single megatrend that will significantly shape the future of eye care delivery in the United States. In future issues, I will expand on additional forces influencing our profession.

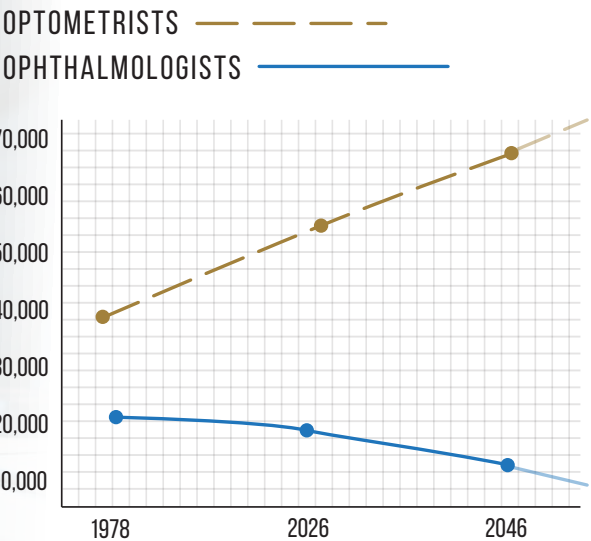


The most important megatrend facing American eye care today is a growing **workforce imbalance**.

Each year, approximately **150 more ophthalmologists retire than are trained**, while **500 more optometrists enter practice than retire**. Ophthalmologists are also older on average, with a mean age near 55, compared with optometrists, whose mean age is closer to 45.

These changes may not be noticeable year to year, but over decades they are profound.

If Current Trends Continue



When I completed my training in 1978, there were approximately **36,000 optometrists and nearly 20,000 ophthalmologists** in the United States, a ratio of **1.8 to 1**. Today, there are roughly 54,000 optometrists and 18,000 ophthalmologists, a ratio of 3 to 1. If current trends continue, in 20 years we will have approximately **64,000 optometrists and only 15,000 ophthalmologists**, a ratio exceeding **4 to 1**. A young ophthalmologist beginning practice today may retire with only **10,000 ophthalmologist colleagues**, but nearly **80,000 doctors of optometry**.

Work patterns further intensify this imbalance. When I entered practice, the average ophthalmologist worked five days and more than 50 hours per week, with limited vacation. Today, many younger ophthalmologists work four days and closer to 36 hours per week, with substantially more time allocated to vacation and continuing education. This has led to a meaningful decline in **full-time equivalent ophthalmologists**, beyond simple headcount reductions.

At the same time, demand for eye care is rapidly increasing. New treatments and technologies emerge each year, while the U.S. population continues to age. Patients over the age of 65 consume nearly **ten times more eye care** than those under 65. Demand is rising just as the supply of ophthalmologists is shrinking and the optometric workforce continues to grow. In parallel, optometric scope of practice continues to expand on a state-by-state basis.

These trends make it clear that ophthalmologists must become significantly more efficient in both clinical and surgical settings. Advances in diagnostics, surgical platforms, artificial intelligence, and robotics will help improve productivity, but even with these gains, ophthalmologists will not be able to meet the growing demand alone.

As a result, an increasing number of patients—particularly those requiring primary medical and refractive eye care—will be managed by doctors of optometry. I have long advocated for **ophthalmologist-led, integrated eye care delivery**, where ophthalmologists and optometrists work side by side within the same practice. I believe the future will favor models with **two or more optometrists per ophthalmologist**, supported by advanced clinical team members.

These workforce shifts will be disruptive but unavoidable. Leaders who anticipate and adapt to these changes will be best positioned to thrive in the future of American eye care.

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LISA FEULNER, MD, PHD

The Impact of Private Equity on Ophthalmology

Private equity (PE) has become a pervasive reality in ophthalmology, reshaping how practices are financed, managed and scaled. Once dominated by independently owned groups, ophthalmology is now at the center of a broader consolidation trend. Ophthalmology's predictable revenue streams, procedure-driven economics, opportunities for insurance-independent cash options, and a growing aging patient population have made it particularly attractive to financial institutions seeking a consistent growth opportunity.

Private equity investment in ophthalmology is built around the management services organization (MSO) model. In this model, physicians retain ownership of the clinical entity, while the PE-backed MSO provides administrative infrastructure including billing, revenue cycle management, human resources, compliance, IT, marketing, and supply chain optimization. Traditional private equity ownership reflects the classic buyout model in which the PE firm acquires a controlling equity stake in

the company itself, installs centralized management, and drives growth through acquisitions, cost optimization, and operational standardization. Decision-making authority resides with the board and management team appointed by the investor, with a clear mandate to maximize profits with the intent to position the entity for resale over a prescribed period, typically 4-7 years. Ophthalmology, like most physician-based specialties, cannot adopt this traditional approach due to corporate practice of medicine (CPOM) laws in many states. These regulations prohibit non-physicians from owning or controlling medical practices or influencing clinical decision-making. The MSO model is designed to respect CPOM laws while allowing investors to centralize operations across multiple sites.

From the PE perspective, **ophthalmology is a growing innovative, technology-driven specialty** which makes it an attractive investment opportunity. Cataract surgery is the most common procedure in healthcare and retina practices have offset declining

reimbursement for long surgical procedures with recurring injection-based treatments. More recently expanding options for glaucoma treatment have provided general ophthalmologists with the ability to treat glaucoma with procedures instead of medications, expanding the opportunities for practice growth. Refractive surgery was the foundation for cash pay offerings within ophthalmic practices; however, many practices have incorporated aesthetics, premium lenses, and office-based surgery to grow fee-for-service options. These factors create relatively stable cash flows that can support debt-funded expansion and acquisition-driven growth. By centralizing operations and management, PE firms aim to improve margins through economies of scale and enhanced payer contracting, with the intent to sell in the future.

For older physicians, acquisition by **PE can represent a retirement plan**, allowing them to capitalize on years of built equity. Most PE partners require physician owners to reinvest in the company once acquired and often offer non-owner physicians the opportunity to purchase stock in the new company. For younger physicians, this may provide an opportunity for affordable ownership without a large capital investment and the burden of administrative responsibilities. It can also facilitate growth

opportunities without personal capital investment, allowing for innovation without the restraint of long term personal financial burdens.

However, PE ownership is not perfect. Critics are concerned that financial performance is incentivized above—and in some cases at the expense of—clinical judgement, and in many cases the patient experience and satisfaction. The loss of autonomy and sole decision-making power is challenging for many physicians. The ability to quickly pivot in response to changing economic pressures and challenges is exponentially more difficult within a large multi-practice corporation. Changes to practice culture, and pressure to increase volume or reduce costs in ways that could affect staff morale or patient experience cannot be avoided. The long-term impact of private equity on ophthalmology remains an open question. At its best, PE can serve as a catalyst for innovation, supporting investment in technology, data analytics, care coordination, and clinical research that independent practices may struggle to fund. At its worst, rapid consolidation and short-term financial focus risk physician dissatisfaction and burnout, as well as the loss of practice culture, branding, and patient perception of their care.



THE MODERN C-SUITE

DEFINING LEADERSHIP ROLES IN OPTHALMOLOGY ORGANIZATIONS

As ophthalmology practices evolve into multi-site enterprises, surgery center operators, and private equity backed platforms, leadership requirements have fundamentally changed. Clinical excellence remains essential, but sustainable growth now depends on clear executive roles, disciplined governance, and strategic alignment. Leading management and healthcare publications, including Harvard Business Review and Becker's Healthcare Review, consistently emphasize that high-performing organizations are built on role clarity at the executive level. For ophthalmology leaders, understanding the C-suite is no longer optional, it is strategic.

Chief Executive Officer (CEO)

The Chief Executive Officer is the enterprise leader responsible for vision, strategy, and long-term value creation. In ophthalmology, the CEO is often a physician-founder or a professional executive tasked with balancing growth, culture, quality, and financial performance.



Chief Financial Officer (CFO)

The Chief Financial Officer is the steward of financial performance and enterprise value. Beyond accounting, today's CFO plays a central role in strategy, capital allocation, and decision support.

Chief Operating Officer (COO)

The Chief Operating Officer is responsible for execution. As ophthalmology organizations scale across locations and service lines, the COO ensures that strategy translates into consistent, high-quality operations.

Chief Medical Officer (CMO – Medical)

The Chief Medical Officer represents clinical leadership at the executive level. This role is essential in ophthalmology, where outcomes, technology adoption, and physician alignment directly impact reputation and growth.

Chief Marketing Officer (CMO – Marketing)

The Chief Marketing Officer oversees brand, demand generation, and patient acquisition. In ophthalmology, marketing has evolved from advertising into a data-driven growth discipline.

Chief Information Officer (CIO)

The Chief Information Officer enables scale through technology. In ophthalmology, where diagnostics, surgical platforms, and patient engagement are increasingly digital, the CIO plays a strategic role.

CEO Ophthalmology Perspective

The most successful ophthalmology organizations of the next decade will be led by executives who understand both medicine and management, both outcomes and economics. Clear C-suite role definition is not bureaucracy, it is a strategic advantage. *CEO Ophthalmology* is committed to helping decision-makers build leadership structures that support growth, resilience, and long-term enterprise value.



TOM RUGGIA

LEADERSHIP PEARLS

OPTIMIZING CIRCADIAN RHYTHMS TO *Maximize Energy, Focus, and Performance*

Senior leaders in ophthalmology operate in environments that demand sustained cognitive precision, emotional regulation, and long-term resilience. Whether making complex clinical decisions, leading organizations, or navigating rapid innovation, performance is not simply a function of experience or discipline. It is fundamentally constrained and enabled by human physiology.

Yet many physician-leaders and executives behave as if biology were optional. Late nights, fragmented sleep, inconsistent exercise, and reactive mornings are often normalized, even as expectations for clarity, judgment, and endurance increase. This approach is neither optimal nor sustainable. Performance in medicine and leadership demands control of one's biology.

Circadian Rhythms and Executive Function

Circadian rhythms are not just a critical metric in IOP management, they are intrinsic 24-hour biological cycles regulated by the brain's suprachiasmatic nucleus (SCN). These rhythms coordinate hormone secretion, core body temperature, cardiovascular efficiency, metabolic regulation, and cognitive alertness¹. When circadian rhythms are aligned with daily demands, individuals experience improved focus, emotional stability, and physical energy. When disrupted, as is common with irregular sleep schedules, late-night work, alcohol use, and excessive screen exposure, performance declines in subtle but cumulative ways².

Identifying the High-Impact Cognitive Window

Although individual chronotypes vary, research consistently shows that cognitive performance peaks in the late morning and early afternoon for most adults^{3,4}. Executive function, working memory, and decision accuracy are optimized during this period, typically between approximately 9:00 a.m. and 2:00 p.m.

These hours often coincide with the most consequential professional activities: surgical planning, strategic decisions, financial oversight, and personnel leadership. High-performing leaders do not leave this window to chance. They intentionally structure sleep, mornings, and movement to support peak physiological readiness rather than relying on caffeine and willpower.

Structuring Mornings for Physiological Readiness

Early rising, often between 4:00 a.m. and 6:00 a.m., is critical to physiological control. Of course this should be paired with early bedtimes to ensure long term health. Cortisol, a hormone essential for alertness and energy mobilization, follows a predictable circadian pattern with a sharp rise after waking, known as the cortisol awakening response⁵. Earlier wake times allow this response to be mitigated effectively.

Movement, Strength, and Fitness

Morning movement reinforces circadian alignment and enhances cognitive performance through improved cerebral blood flow and neurochemical activation^{6,7}. Resistance training supports musculoskeletal integrity, metabolic health, and healthy aging⁸, while cardiovascular fitness (VO₂ max) is one of the strongest predictors of longevity and functional capacity⁹.

Time-efficient training strategies allow busy leaders to maintain physiological capacity without excessive time commitment. The objective is not athletic performance, but sustained resilience.

Sleep for Peak Performance

No intervention has a greater impact on executive performance than sleep. Chronic sleep restriction impairs attention, emotional regulation, and decision-making, often without conscious awareness². Sleep anchors circadian rhythm and governs hormonal balance, metabolic efficiency, and cognitive readiness. For most adults, seven to eight hours of high-quality sleep is a biological requirement, not a luxury.

Leadership in ophthalmology is a long game. Those who sustain excellence over decades are not those who fight their biology, but those who learn to work with it.

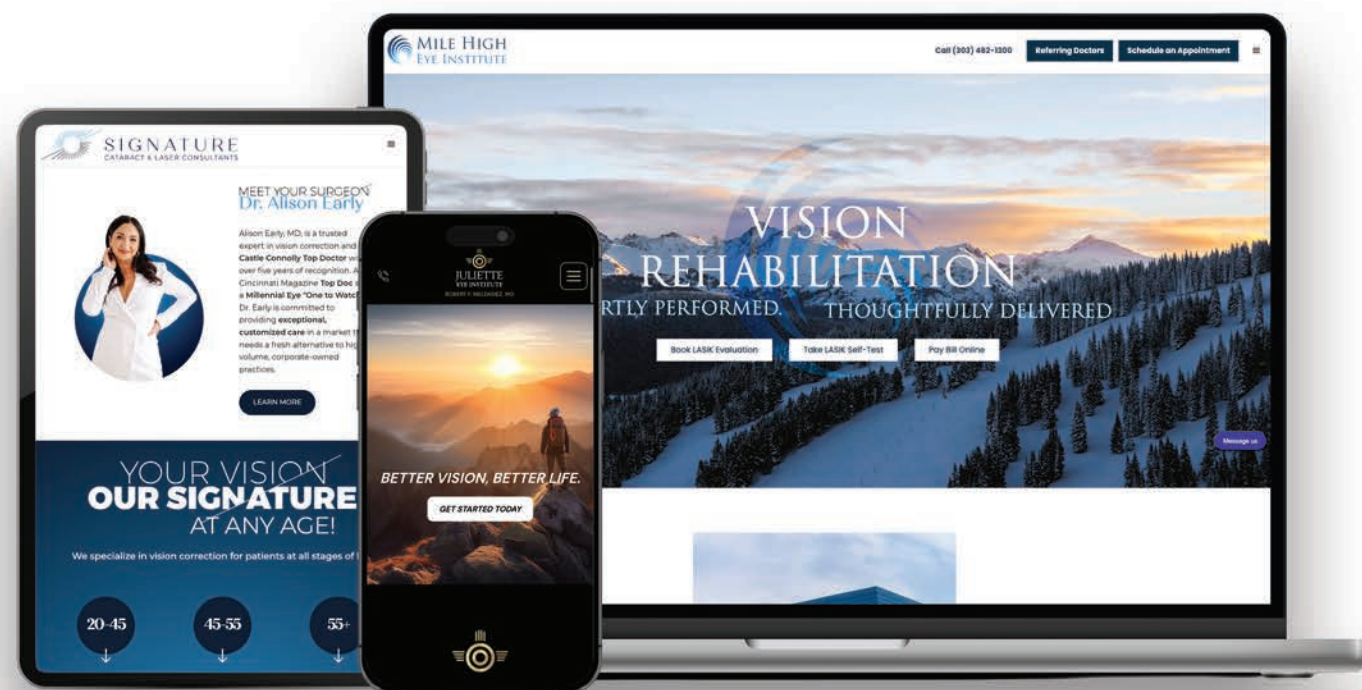
About the Author

Tom Ruggia is the CEO of Samsara Vision, a med tech company restoring vision in Late-Stage Macular Degeneration. He is an editorial board member of *CEO Ophthalmology*. In addition, Tom holds a BS in Kinesiology and is a competitive life-long athlete who often coaches and counsels executives on healthy lifestyles.

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SIDNEY GICHERU, MD

ADVOCACY

Defending the Value of Cataract Surgery in an Era of Decreasing CMS Reimbursement

Cataract surgery remains one of the most common, successful, and life changing procedures in all of medicine. Yet despite its complexity, precision, and the years of training required to perform it safely and effectively, reimbursement from the Centers for Medicare and Medicaid Services (CMS) continues to decline. These reductions have failed to keep pace with inflation, rising practice overhead, workforce shortages, and rapidly increasing patient expectations. The result is a growing disconnect between the value delivered to patients and the financial realities faced by ophthalmologists who provide this care.

In recent years, proposed and enacted CMS payment cuts threatened to further erode reimbursement for cataract surgery. Fortunately, a coordinated response from the ophthalmology community helped alter this trajectory. National societies including the American Academy of Ophthalmology (AAO) and the American Society of Cataract and Refractive Surgery (ASCRS) worked alongside practicing ophthalmologists to educate policymakers on what cataract surgery truly entails. This advocacy emphasized that cataract surgery is not a commodity procedure. It requires deep medical knowledge, surgical judgment, advanced technology, and accountability for outcomes that profoundly affect patients' quality of life.

At the same time, ophthalmologists are shouldering increasing responsibility. Practices face higher staffing costs, technology investments, compliance burdens, and patient volumes, all while reimbursement per case declines. Patients quite reasonably expect excellent outcomes, premium experiences, and access to the latest innovations. Ophthalmologists accept this responsibility willingly, but sustaining this level of care becomes increasingly challenging when reimbursement does not reflect the time, expertise, and risk involved.



Three themes are critical as the profession moves forward.

1 First, advocacy is no longer optional. Ophthalmologists must actively advocate for their patients and their profession at the legislative level. Policymakers often lack direct understanding of the complexity of modern cataract surgery. Without consistent education and engagement, reimbursement decisions risk being made in a vacuum. Advocacy is fundamentally about protecting patient access to high quality surgical care, not merely protecting physician income.

2 Second, engagement with national and state societies is essential. The recent mitigation and reversal of proposed reimbursement cuts did not happen by accident. It was the result of coordinated efforts by organizations such as the AAO and the ASCRS, supported by data, physician testimony, and unified messaging. It goes without saying State Eye Societies are the backbone of Advocacy. Membership, participation, and leadership within these societies amplify the voice of individual ophthalmologists and translate collective expertise into meaningful policy impact.

3 Third, industry partnership deserves recognition and gratitude. Ophthalmic industry partners, including companies that provide pharmaceuticals, surgical instruments, diagnostic platforms, software, and intraocular lenses, play a vital role in advancing patient care. Their collaboration with physicians supports innovation, training, and outcomes research. These partnerships strengthen the entire ecosystem of eye care and ultimately benefit patients who rely on continual technological progress.

The central lesson is clear. Ophthalmology does not succeed in isolation. Progress occurs when physicians collaborate with one another, engage their professional societies, advocate effectively to legislators, and partner responsibly with industry. Together, these stakeholders ensure that cataract surgery continues to be delivered at the highest standard, even in the face of economic pressure.

Protecting the future of cataract surgery means defending its value. That value lies not only in restored vision, but in the expertise, commitment, and collaboration required to deliver it safely and successfully for millions of patients each year.

Data Analysis



ADAM SZARONOS

AI Without Illusions

A CEO Perspective on Hype, Readiness, and Real Value

WHY MOST AI INITIATIVES STALL AND WHAT LEADERS MUST GET RIGHT FIRST

Let me start with a confession: this may sound contrarian coming from a CEO who believes in the long-term potential of AI. I'm bullish on the technology, on the productivity it can unlock, and on the role it will play in shaping how organizations operate.

What I'm not persuaded by is the current rush to adopt AI as an end in itself. Too many organizations are deploying AI primarily to signal participation rather than to solve a clearly defined problem. As one of my graduate school professors often emphasized, progress begins with good problem formulation. Yet many teams move straight to execution without asking the first question: **what problem are we really trying to solve?**

The data reflects this gap. MIT refers to it as the GenAI Divide—widespread adoption paired with limited transformation¹. In a recent 2025 study, **95% of companies reported no clear, measurable return on investment** from generative AI initiatives. If this were a clinical trial, failure to meet the primary endpoint at this scale would give most leaders pause.

This pattern is not unique to generative AI. Gartner research similarly finds that most enterprise AI initiatives fail to scale beyond pilot phases². The constraint is rarely the technology itself. Instead, the limiting factors are organizational: **data quality, workflow integration, and unclear ownership of AI-informed decisions.**

That distinction helps explain where early economic value is beginning to appear. **The strongest results are coming from comparatively unglamorous applications such as predictive analytics in demand forecasting, pricing optimization, and customer retention.** These use cases rarely headline conferences, but they directly influence margins and working capital. By contrast, highly visible pilots focused on chatbots or automated content often generate attention without durable financial impact.

Meanwhile, The Wall Street Journal has noted that the current AI infrastructure boom would require more than two trillion dollars in additional annual revenue to justify the capital being deployed—more than the combined revenues of the world's largest technology companies today. All current projections fall well short of that threshold. Expected demand has driven extraordinary capacity expansion, but meaningful transformation has lagged.

This is not a failure of AI. Generative and predictive systems represent real advances. The challenge lies in how organizations deploy them. Too many initiatives are launched before foundational issues such as process clarity and decision ownership are addressed. In most cases, the AI is ready; the organization is not.

Decision ownership, in particular, is often overlooked. Many organizations deploy AI tools without asking: **who is accountable for acting on what the system recommends?**

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When insights are generated without clear ownership, AI becomes informational noise rather than an operating advantage.

A more useful way to think about **AI is not as a transformational event, but as a practical efficiency tool.** The purpose of technology is to remove inefficiency from a process. As Peter Drucker observed, there is nothing so useless as doing efficiently that which should not be done.

AI will reshape operating norms over the coming decade. The more relevant question for leaders is not how quickly they adopt it, but whether they use this moment to take inventory of the decisions and processes that truly matter.

AI is not the strategy.

It is the amplifier.

And if you don't like the music being played, turning up the amplifier will not change the tune.

Author Bio

Adam Szaronos is the CEO of Iantrek, a medical technology company advancing bio-interventional solutions for glaucoma care. He is an editor-at-large and founding editorial board member of *CEO Ophthalmology*, and a frequent speaker on innovation, leadership, and healthcare transformation.

AN INTERVIEW WITH
Richard L. Lindstrom, MD

What was your high school job?

I worked in construction for our family business, Lindstrom Restoration, from age 12 through college. Then medical training intervened. Today I own the company, and my son is the President.

What is your leadership philosophy?

Lead by example.

What is your favorite leadership book?

Good to Great, How the Mighty Fall, and Built to Last by Jim Collins, in general, and John Pinto's classic Little Green Book of Ophthalmology for practice management.

What is your personality profile?

Culturally: A fourth generation Minnesota Swede = Nice and Hard Working. There are many classifications, but: I am a Type A, Rational, Ambitious, Motivated, Intellectually Curious, Extroverted, Caring and a Giver...not a Taker.

What is an interest of yours outside of ophthalmology?

Number one is family. I have 2 children, ages 40 and 43, and 5 grandchildren, ages 12-17, who live nearby, a great wife, many in-laws, and a core of friends that are like family to me. I enjoy many outdoor activities. I live on a lake shore in Minnesota: I boat, ride a motorcycle, play golf and tennis, walk the dog, enjoy classic cars, hunt upland birds, fish, and share an interest in sports with my very athletic and active wife of 35 years, Jaci. I also love to read and in addition to ophthalmology I especially like historical fiction. I also enjoy supporting investment, innovation, and education in ophthalmology and serve on 15 Boards and 25 Medical Advisory Boards. I enjoy writing, and create 26 Lindstrom Perspective editorials each year for Ocular Surgery News.

What words of wisdom would you like to share?

I have 10 that I share in lectures.

1 We are each unique, **be yourself**, everyone else is taken.

2 **Be nice, be kind, love yourself and others.** Follow the Golden Rule.

3 **Work hard, work smart**, there is no elevator to success. You have to take the stairs.

4 The three P's: **Patience, Persistence and Perseverance** are key to success, Never, Never, Never quit.

5 **Be honest, honorable, ethical, truthful, and transparent.**

6 **Choose wisely**, especially spouse, friends, partners, business associates, and advisers.

7 **Plan Ahead.** Make one, three, and five year personal, business, financial, and spiritual plans and update them every year and share with those close to you.

8 **Say YES to opportunity.** Most regrets in later life are things not done...not things done. Be positive. Optimists are the happiest and most successful people.

9 **Never stop learning.** Fortune favors the prepared mind!

10 **Do it with Love.** Love for yourself and others. Remember the Paradox of Giving: The More You Give, the More You Will Receive!



Chief Medical Officer *and* Chief Executive Officer

How Do Their Paths Cross?



ERIC DONNENFELD, MD

Ophthalmology sits at a unique intersection of medicine, technology, and consumer-driven care. With rapid advances in diagnostics, affiliation with industry, surgical innovation, ambulatory surgery centers, and private equity participation, the alignment between the **Chief Medical Officer (CMO)** and **Chief Executive Officer (CEO)** has never been more critical. Each position carries distinct responsibilities—clinical excellence, defining unmet needs and patient outcomes for the CMO, and organizational performance, fiduciary responsibilities, and long-term strategy for the CEO. Their paths increasingly cross as health systems confront complex challenges like digital transformation, declining reimbursement, regulatory pressure, physician burnout, and financial sustainability.

The **CMO** role in ophthalmology was historically rooted in clinical oversight—**ensuring care quality, patient safety, and adherence to standards**. The CMO served as an interface with other physicians in clinical practice as a representative of their satisfaction and defining unmet needs. Over the last two decades, however, that role has expanded significantly. Modern CMOs often participate in shaping **growth strategies, population health initiatives, cost-quality optimization, and integration of new technologies, blending clinical insight with business acumen**. According to Beckers Hospital Review the modern CMO through formal training or on the job experience must have a knowledge of business that was just not needed in the past. Financial reimbursement has decreased for most ophthalmic procedures; costs have increased and clinical practices have consolidated and enlarged. Meanwhile, the **CEO** remains accountable for overall **organizational performance, stakeholder alignment, and strategic vision**. In healthcare, CEOs cannot succeed without the CMO as a partner; neither can the CMO drive meaningful clinical transformation without senior leadership support.

One of the central ways that the CEO and CMO paths intersect is strategic alignment. CEOs increasingly recognize that clinical excellence is no longer just a support function—it's a competitive differentiator that influences reputation, referral networks, growth, and long-term viability. Conversely, CMOs must translate clinical priorities, physician requests, and new technology implementation into language that resonates with financial and operational leaders. This requires a **shared understanding of risk, data literacy, and an appreciation for organizational dynamics**. As Harvard Business Review notes, "leaders who do undertake a voyage of personal understanding and development can transform not only their own capabilities but also those of their companies¹." That insight holds especially true for CMOs and CEOs striving to bridge clinical and business silos.

An important intersection point for CEOs and CMOs is **culture and trust building**. CEOs set the tone for organizational norms, but CMOs influence the clinical culture that drives frontline performance. There is an adage often attributed to Peter Drucker, "Culture eats strategy for breakfast²". Both the CEO, primarily, and the CMO secondarily take responsibility for creating strategy, while the reverse is true for culture. If the people in an organization aren't aligned, engaged, or if the culture is toxic, strategy is rarely optimized. Essentially, a strong, positive culture is crucial for strategy execution, as people drive results; a poor culture leads to failure regardless of brilliant strategy, because employees won't buy in or will work against it. In the past when ophthalmologists ran small

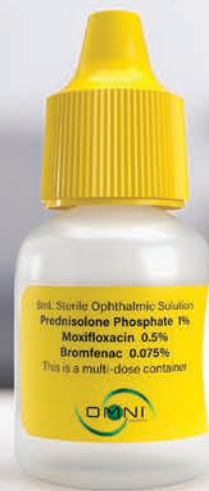
practices a strong business partner was often not necessary. **Perhaps most importantly, the CEO-CMO relationship shapes physician engagement**. Ophthalmologists are highly autonomous, data-driven, and acutely aware of productivity metrics. CMOs often serve as the trusted intermediary—explaining business decisions in clinical terms and conveying physician concerns upward. When the CEO and CMO present a unified message around compensation models, scheduling optimization, or quality initiatives, adoption accelerates and friction declines.

With ophthalmology practice consolidation the CEO has become essential. Unfortunately, in too many cases, once the CEO takes on responsibility for strategy the CMO may abrogate engagement in maintaining culture, physician engagement, and adoption of new technology. Shared leadership models—where CMOs are empowered as strategic partners rather than advisory voices—tend to foster environments where innovation thrives and resistance to change diminishes.

As healthcare continues to face disruption, the CEO-CMO relationship is no longer a transactional reporting line—it's a **strategic alliance**. Their paths cross not just at board meetings or executive retreats, but in how they jointly interpret data, co-create organizational priorities, communicate, and represent a unified leadership voice to the rest of the company. Healthcare organizations that cultivate this partnership will be better positioned to deliver superior clinical outcomes and sustainable business performance.

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*Continuous 20/25 or better
[†]Compared to TECNIS Synergy™ based on bench-testing
[§]Compared to PanOptix® based on bench-testing (white light MTF at 50 c/mm measured for 3mm & 5mm pupil in the ACE model)

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ERIN SCHALLHORN POWERS

Mergers and Acquisitions for Enhanced Value

FROM TRANSACTION TO TRANSFORMATION

Mergers and acquisitions have long been a staple of corporate strategy and more recently, healthcare practices, but their raison d'être has evolved. Where once deals were pursued primarily for cost consolidation and scale, today they are increasingly instruments of transformation: a means to reconfigure portfolios, accelerate capability-building and build knowledge bases, and capture growth that, hypothetically, neither company could achieve alone. The ultimate litmus test remains unchanged, however—the combination must be greater than the two separate entities.

Let's break this down into simpler context of understanding the purpose behind a merger or acquisition. Beyond the obvious of purely increasing revenue, a broader set of value drivers could be multifactorial.

Market share and scale remain important, but they are only the starting point. Faster access to customers, distribution networks, and pricing leverage matter, yet they rarely deliver enduring advantage on their own.

Geographic and footprint expansion lets firms enter new markets quickly, acquiring regulatory licenses, distribution, and local relationships that would take years to build organically.

Adjacent spaces and new therapeutic or product areas provide **diversification and accelerated pipeline growth**; buying platforms or IP can leapfrog internal R&D timelines.

Shared services is always an attractive aspect of M&A. Consolidating HR, finance, procurement, and IT creates persistent economies of scale and free capital for strategic reinvestment.

Talent acquisition is often the most strategic rationale in innovation-driven sectors: acquiring teams, culture, and velocity can be the core asset, not just the product lines.

Transformation requires a different vision

Transitioning from transactional M&A to transformational M&A demands a shift in how leaders view the entire process. "M&A's strategic shift from business 'transaction' to 'transformation' presents a paradox: yesterday's transactional approach—which seeks certainty, standardization, and continuity—has more limited success in today's volatile business landscape¹." Successful transformational deals treat the transaction as a hypothesis to be tested and follow this train of thought from inception through execution.

How leaders translate vision to value

Approach: Scenario plan to surface failure early. Treat the merger thesis as provisional and explicitly design for uncertainty.

Agility: Define objectives and key performance indicators, divide integration into sprints, and use iterative feedback loops. Short, measurable cycles reduce risk and enable rapid course correction.

People-Focused Power: Implement pulse surveys, focus groups, and employee retention KPIs. Monitor whether acquired talent stays, knowledge flows occur, and new teams find pathways for advancement.

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Sprint vs. Marathon: Sprint to capture back-office synergies early while methodically sequencing customer-facing and product integrations to preserve relationships, revenue, and morale. Culture is either a KING or a KILLER of deals—protect it!

After Action Planning: Ruthlessly pursue lessons from each deal to create a flexible playbook for future opportunities. Call the baby ugly in every way to chip away opportunities for an improved process going forward.

Conclusion

The goal of all M&A is to create more value together than separate, but in reality, this is not always the case. It can unlock transformative value when it combines strategic ambition with adaptive execution. Deals that simply add scale without integration discipline and hyper customer and cultural centricity may mask underlying decline or pitfalls; deals that pair a clear transformation thesis with a mindset for ambiguity, agile execution, and people-focused pursuits stand the best chance of delivering value that is truly greater than the sum of its parts.

Robert J. Dempsey

Becomes CEO of Okyo Pharma

What makes a great CEO?

I believe great CEOs are leaders who can create the best teams, inspire others, and set a clear vision that aligns with the company mission. Effective CEOs are decisive and able to make decisions with speed and conviction. They surround themselves with exceptional leaders, empower them and hold them accountable because the success of the CEO is a direct reflection of the team they built. A great CEO provides clarity, earns trust through consistency, and ensures that strategy translates into results that drive shareholder value.

High-performing CEOs prioritize building high-trust relationships with their Boards from day one. High trust with the Board signals confidence to investors and stakeholders while enabling effective governance and faster execution. An aligned leadership team facilitates better decision-making under uncertainty and greater stability during setbacks.

Can leadership characteristics be acquired, or are you “born to be a leader”?

I believe leadership is learned over time. While some people may have natural traits that make leadership more intuitive, like confidence or communication, effective leadership is built through experience. You become a leader by observing both good and bad leaders, understanding what motivates people, and learning how your actions impact others. Some of the most important leadership lessons come from failure when things don’t go as planned and you’re forced to reflect, adjust, and grow.

Taking risks, being accountable for outcomes, and learning to lead through uncertainty all shape how someone develops as a leader. Over time, those experiences build judgment, empathy, and resilience, which I think are far more important than any innate trait.

For me, leadership has been an ongoing process of learning, listening, and evolving, not something I was simply born with.

How will you build a team at a new pharma company as a new CEO?

Some of the strongest teams I’ve built came from learning what didn’t work early on and being willing to quickly adjust structure and personnel as the company evolved. Strong teams don’t happen by accident, they’re built intentionally through alignment, mutual respect, and continuous development, and sometimes this takes time. I’ve found that investing more time upfront to find the right talent saves significant time and friction later. Strong teams are built deliberately, not quickly.

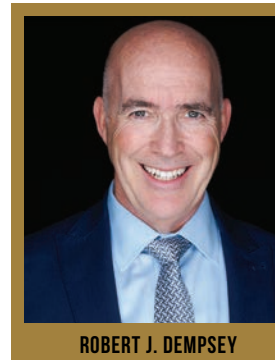
What advice can you give to physicians interested in becoming CEOs? What is the path to becoming a CEO?

I would advise physicians to secure board positions or fractional roles in startups to see first-hand how leadership at the CEO level is about decision-making, alignment, and accountability at scale. Spend time with C-suite leaders and listen and learn how they think because physicians who succeed as CEOs are the ones who deliberately broaden their perspective.

How do you approach bringing a first in class drug to market as a new CEO?

Building a strategy tailored to OKYO to enable swift uptake of urcosimod is an opportunity I find both exciting and meaningful. Neurotrophic corneal pain (NCP) is a severe condition with no FDA-approved treatments, and that level of unmet need demands a thoughtful, disciplined approach to commercialization.

I’m motivated by the challenge of translating strong science into real-world impact, and I believe that with the right strategy grounded in clinical understanding, physician insight, and patient need, we can position urcosimod for successful adoption if approved. I am fortunate to be able to build upon my success launching Xiidra.



ROBERT J. DEMPSEY



CYNTHIA MATOSSIAN, MD



Turning Strategy into Operations

HOW OPHTHALMOLOGY LEADERS TURN VISION INTO REPEATABLE EXECUTION, CONFIDENT DECISION-MAKING, AND MEASURABLE RESULTS.

In ophthalmology, leaders often know what needs to change, but turning strategy into day-to-day operations remains the challenge. Improving clinic flow, upgrading technology, adjusting staffing models, or strengthening revenue cycle processes are familiar priorities. The difficulty rarely is identifying opportunities. It is executing change in a way that supports patient care, staff stability, and financial performance. Harvard Business Review has long described operations as the discipline that turns strategy into consistent execution. In healthcare, that discipline determines whether improvement efforts gain traction or stall.

Operations is the system that turns strategy and improvement into repeatable action. In an ophthalmology practice, strong operations supports patient flow, reduces friction for staff, and enables informed decision-making. When operations is effective, leadership time shifts away from daily problem-solving and toward performance management and growth.

Core Components of Operations

From an operational perspective, performance depends on several interconnected functions. While emphasis may vary by organization, the following areas are central to most ophthalmology practices:

Clinic flow: Patient movement, room utilization, staffing efficiency, and bottleneck management

Scheduling: Access, visit mix, provider utilization, and template design

Billing and revenue cycle: Charge capture accuracy, collections, and financial visibility

Budgeting and forecasting: Cost management, margin awareness, and predictability

Staffing and training: Aligning roles, skill sets, and education with operational systems

Technology and data: EHR optimization, reporting, dashboards, and automation

Emerging tools, including AI: Reducing administrative burden and supporting operational decisions

These components do not function independently. Improvements in one area often affect several others, and sustainable progress requires understanding how the system works as a whole.

Why Operational Challenges Persist

Operational issues are rarely the result of lack of effort or clinical expertise. More often, they stem from reliance on familiar processes that no longer scale effectively. As practices grow, inefficiencies become more visible. Increased volume, staffing pressures, and higher patient expectations expose gaps that were previously manageable.

Change also introduces perceived risk. Leaders must consider financial investment, staff adoption, and potential disruption. Without clear data or a structured way to evaluate decisions, maintaining the status quo can feel safer than pursuing improvement. Over time, this hesitation limits progress and places unnecessary strain on both teams and patients.

Developing Operational Capability

Operations is a learned discipline. Most leaders develop their operational skill set through experience, mentorship, and continued education. Professional organizations such as the American Society of Ophthalmic Administrators (ASOA) provide valuable resources, benchmarking, and peer insight. Business and healthcare publications, including Harvard Business Review, help frame operations as a measurable and repeatable leadership function rather than an abstract concept.

Equally important is application. Operational confidence grows when leaders evaluate processes, test improvements, and refine systems based on real-world results.

Reducing Risk Through Testing and Data

Strong operations allows leaders to assess change before full implementation. Pro formas, financial modeling, pilot programs, and targeted trials help evaluate the impact of new initiatives on workflow, staffing, revenue, and patient satisfaction.

This disciplined approach reduces uncertainty and supports clearer communication with teams. When decisions are grounded in data, leaders can move forward with confidence and adjust as needed. Over time, testing and measurement replace hesitation with clarity.

Moving Forward

Operations is not an administrative function. It is a core leadership responsibility that directly influences patient experience, staff engagement, and financial performance. In ophthalmology, operational excellence enables growth without compromising care.

As practices navigate increasing complexity, leaders who invest in operations will be better positioned to execute strategy effectively and lead with confidence.

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INDICATIONS

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WARNINGS/PRECAUTIONS

Physicians should weigh the potential risk/benefit ratio before implanting the enVista Envy lens under any of the circumstances or conditions outlined in the Instructions for Use labeling. Some visual disturbances may be expected due to the superposition of focused and unfocused multiple images. These may include some perceptions of halos or radial lines around point sources of light (starbursts) under nighttime conditions, glare, double vision, haziness and blurred vision. It is expected that, in a small percentage of patients, the observation of such phenomena will be annoying and may be perceived as a hindrance, particularly in low illumination conditions such as nighttime driving. As with other trifocal IOLs, there is a possibility that visual disturbances may be significant enough that the patient will request explant of the IOL. A reduction in contrast sensitivity as compared to a monofocal IOL may be experienced by some patients, therefore, patients implanted with trifocal IOLs should exercise caution when driving at night or in low light or poor visibility conditions. Care should be taken to achieve IOL centration as IOL decentration may result in patients experiencing visual disturbances or suboptimal vision under certain lighting conditions. The surgeon must target emmetropia to achieve optimal visual performance. Patients should be advised that unexpected outcomes could lead to continued spectacle dependence or the need for secondary surgical intervention (e.g., intraocular lens replacement or repositioning). Please provide a copy of the Patient Information Brochure, which can be found at www.bausch.com/IFU. Posterior capsule opacification (PCO) may significantly affect the vision of patients with multifocal IOLs earlier in its progression than patients with monofocal IOLs. This may be due to the reduced contrast sensitivity observed with multifocal IOLs. **Additional Precautions for Toric IOLs:** The enVista Envy Toric IOL has not been evaluated in a clinical study. In general, astigmatism that is corrected with a higher cylinder power IOL can result in clinically significant residual astigmatism. The effect of residual astigmatism at distance, intermediate, and near was evaluated in a clinical study of patients who had been implanted with non-toric enVista Envy IOLs and were induced with cylinder power to simulate various levels of residual astigmatism. If a secondary surgical intervention is necessary to reposition the IOL, explantation should be considered as some patients may have recurrent or persistent issues related to rotational instability and misalignment.

CAUTION: Federal law restricts this device to sale by or on the order of a physician.

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ADOPTING THE CEO MINDSET FOR ANY LEADER IN OUR INDUSTRY IS ESSENTIAL FOR SUSTAINED, LONG TERM SUCCESS, BUT WHAT EXACTLY IS THIS CEO MINDSET AND HOW CAN YOU ADOPT IT IN YOUR ROLE IN YOUR ORGANIZATION?



The CEO MINDSET

Leadership requires a seamless integration of vision, decisiveness, and empathy.

You must be adept at articulating a clear and compelling vision for the future, one that motivates the entire organization to work toward shared goals. This vision should be both ambitious and realistic, pushing us to innovate and excel while staying grounded in practical realities. As John Quincy Adams aptly said, *"If your actions inspire others to dream more, learn more, do more, and become more, you are a leader."* For a deeper understanding, I highly recommend *"The Leadership Challenge"* by James M. Kouzes and Barry Z. Posner, which offers valuable insights into visionary leadership.

Decisiveness is another critical trait. In the fast-paced world of business, decisions often need to be made quickly and confidently. The CEO Mindset must be capable of evaluating the available information, weighing potential risks and benefits, and committing to a course of action. This decisiveness is essential for maintaining momentum and ensuring your organization can adapt and flourish in an ever-evolving environment.

Empathy is equally important. The CEO Mindset must recognize and value the perspectives and needs of employees, customers, and other stakeholders. By fostering a culture of inclusivity and respect, you can build strong, trust-based relationships that drive collaboration and innovation. Empathy also helps create a supportive and positive work environment where employees feel valued and motivated to excel. An employee or customer that feels valued and appreciated is the mission.



In summary, the leadership mindset of a CEO should encompass vision, decisiveness, and empathy. By embodying these qualities, you can guide your organization toward new heights of success and ensure a promising future for all.



Collaboration Between the Ophthalmic Industry and Clinical Practices

Collaboration between the ophthalmic industry and clinical practices has never been more critical. As technologies advance at an increasing pace and product life cycle development shortens, and patient expectations rise, the intersection of industry expertise and clinical insight becomes the engine that drives sustainable innovation, successful reimbursement strategies, and higher satisfaction with visual outcomes. When these parts of the ecosystem work in synergy, the benefits extend beyond normal commercial success, they elevate standards of care and accelerate the adoption of breakthrough solutions.

Innovation

In ophthalmology, innovation thrives when industry and clinicians co-create. Industry teams bring R&D capabilities, manufacturing scale, and regulatory expertise; clinical partners contribute real world experience, unmet need identification, and iterative feedback on usability and safety. This collaborative loop shortens development cycles and ensures technologies, from IOL platforms to diagnostic imaging to drug delivery systems, are not only scientifically advanced but also clinically impactful. When innovation is informed by real clinical workflow constraints and patient diversity, adoption becomes more natural and outcomes more predictable.

Reimbursement

Market access is another area where partnership is indispensable. Even the most innovative technology cannot help patients if coverage and payment barriers prevent access. Industry can lead the generation of health economic data, evidence packages, and payer engagement strategies, but clinicians provide the essential clinical efficacy, outcomes reporting, and real-world validation that reinforce these dossiers. Joint data collection initiatives such as registries, post-market studies, or outcomes benchmarking have been shown to help establish the economic and clinical value propositions that payers require. Aligning earlier on reimbursement strategies reduces delay between regulatory approval and broad clinical availability, allowing innovations to reach patients faster by exploring all approval pathways.

Most importantly, collaboration enhances patient satisfaction with outcomes, a core metric in modern ophthalmology. Patient expectations continue to rise especially as healthcare costs increase or in elective pay procedures, especially in refractive cataract, premium IOLs, or refractive vision correction. By working together, industry and clinical teams can improve both objective outcomes (visual acuity stability, reduced complications) and subjective ones (satisfaction with independence from glasses, comfort, recovery time). Codeveloped education materials, patient education tools, and expectation setting frameworks further contribute to a consistent, quality patient journey. When clinical practice insights shape patient expectations and provide training, digital tools, or workflow support, patient experiences become more predictable.

Three Key Pillars for Leaders Across Ophthalmic Companies

Evidence Driven Co-Creation

Prioritize integrated development models where clinicians are embedded early and throughout the innovation process. Structured clinician or staff advisory boards, rapid feedback cycles, and real-world testing ensure that products solve practical challenges and drive meaningful impact.

Reimbursement Integration from Day One

Build reimbursement and health economic strategy into the product development timeline, not after regulatory approval. Cogenerate quality clinical and economic evidence with leading practices and publish jointly to strengthen payer credibility.

Patient-Centered Ecosystem Support

Go beyond the product by offering training, workflow optimization, digital solutions, and patient education assets developed with clinical partners. Supporting the full patient journey increases satisfaction, enhances outcomes, and accelerates adoption.



ADAM SHUFORD

Trust the Playbook.

LESSONS FROM THE COLLEGE FOOTBALL PLAYOFF NATIONAL CHAMPIONSHIP

The College Football Playoff (CFP) National Championship drew the entire country in this year in a way it never has. I had the privilege of watching the game live with two fanatics - Dr. Jennifer Loh, an Indiana graduate, and Dr. Bill Trattler, a lifelong Miami supporter. But even without a local watch party or a rooting interest, the storyline for this game was nothing short of cinematic and carried lessons for life beyond college football.

Fernando Mendoza Jr., the Indiana Hoosiers' Heisman-winning QB, grew up a Miami Hurricanes fan. He dreamed of playing there, but when he couldn't walk on, he ended up at the losingest program in college football history, Indiana. Indiana had very little tradition or expectation, no five-star recruits, and a new head coach, known for process and discipline. And despite it all, Mendoza ended up back in his hometown, with a fresh Heisman Trophy in hand, leading his team to a Championship game against the team he'd cheered for all his life; the Miami Hurricanes.

On the opposite sideline was Mario Cristobal, the Head Coach at THE U. A historic brand in the sport. To add to the drama, Cristobal was a former teammate of Mendoza's father.

But the story that really caught my attention was the coaches. Both finalist coaches were a part of Nick Saban's coaching tree. Nick Saban is arguably the greatest college football coach of all time, with 7 National Championships to his name. His philosophy is simple, focus on the process, not the scoreboard. Be the best at every play and the scoreboard will follow. They succeed by refusing to abandon the playbook when things get messy. The evidence speaks for itself. Five of the 12 CFP Head Coaches this year spent part of their careers under Nick Saban's tutelage.

This philosophy rings true in business, as it does in football. In commercialization, adversity is inevitable. Markets shift. Reimbursement tightens. Conversion stalls. Individual accounts, practices, and industry miss expectations. Early data looks noisy. Pressure builds fast. And when that happens, the instinct is almost always the same: change the strategy. But most of the time, what's broken isn't the strategy; it's executional harmony within it. Elite coaches don't tear up the playbook after a failed drive, they review film. They adjust routes. They coach fundamentals. They adapt to the defense without losing their identity.

That distinction matters.

Being dynamic doesn't mean changing direction. It means understanding the market well enough to evolve tactics while protecting the core strategy. Commercial teams fail not because they lack intelligence or effort, but because they confuse adaptation with abandonment. The Saban coaching tree produced 5/12 of the best teams in football this year. They didn't produce success by avoiding mistakes. This group's core principle is to stay anchored while adjusting in motion. That's the real lesson.

You didn't have to be an Indiana or Miami fan to appreciate this championship. It was a reminder that progress, whether on the field or in ophthalmology, is rarely linear. But when the strategy is sound, the discipline to stay the course eventually becomes the competitive advantage.

And more often than not, the practice, company or team holding that trophy at the end are the ones who trusted the playbook long enough for it to work.



VANCE THOMPSON, MD

Building the Practice *We Hope* to Work In

Being a physician in modern medicine, especially in ophthalmology, brings extraordinary joy. We have the privilege of restoring sight, improving quality of life, and walking with patients through moments that matter deeply. Yet in today's world, that calling now sits inside something larger: the business of medicine. Whether you practice in a private group, a private-equity backed platform, or an academic environment, the reality is the same. If we want to continue delivering great care, we must also understand how healthy organizations are built, led, and sustained.

That is why this issue of *CEO Ophthalmology* matters so much. It is also why I am so honored to share what I have learned and continue to learn along my journey.

The voices in these pages reflect something powerful: medicine and business are no longer separate conversations. Leadership, financial stewardship, strategic thinking, culture, technology, and growth are now inseparable from patient care. Understanding the roles of a Chair, President, Chairman, CFO, or CEO is not about hierarchy, it is about clarity that comes from structure in a business. When everyone understands how decisions are made, how resources are allocated, and how strategy turns into action, organizations become healthier and more resilient.

Leadership, however, is not just about titles or spreadsheets. It is about people. I have long believed, and will repeatedly say until my journey is over, *the team who loves and cares for each other will create an environment where the patient feels loved and cared for.* That is not a slogan, it is my commitment and core to the business strategy of our practice. Culture drives engagement. Engagement drives execution. Execution drives outcomes. And outcomes, both clinical and financial, are what ultimately determine whether a practice thrives or struggles.

Several contributors in this issue highlight something every physician-leader eventually learns: numbers tell stories. A great CFO doesn't just track expenses and revenue, they translate data into insight, and insight into strategy. When physicians understand what the numbers are saying, they become better partners in shaping the future of their organizations. They ask better questions. They make better decisions. And they help align short-term actions with long-term vision.

We are also entering a time of unprecedented change. Artificial intelligence, consolidation, new care models, shifting patient expectations, and workforce pressures, locally and nationally, are all reshaping our profession. The practice of the future will not simply be a bigger version of the practice of today, it will be fundamentally different. That is both exciting and daunting. But uncertainty becomes far less intimidating when we are proactive learners rather than reactive observers.

As you read this issue, and future ones, I encourage you to look beyond your own four walls. Study what makes other practices and businesses healthy in every environment: private, private-equity backed, and academic. Pay attention to what business leaders look for in organizations that grow, merge, or attract investment. Even if you never plan to sell, those same qualities – *clarity, alignment, accountability, and culture* – are what create enduring success.

You do not have to be the CEO to think like one. When physicians engage thoughtfully in strategy, prioritization, and long-term planning, they elevate the entire organization. They become better leaders, better partners, and better stewards of the teams and patients they serve.

In the end, this work is about more than balance sheets and growth curves. It is about creating organizations that are financially strong, culturally healthy, and emotionally meaningful places to work, so that we can continue to deliver the exceptional care our patients deserve.

Thank you for being part of this conversation. I look forward to learning, growing, and building the future of ophthalmology together.

The team who loves and cares for each other will create an environment where the patient feels loved and cared for

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