The American Ophthalmological Society

Established 1864

Marilyn T. Miller Lecture

2025

Council Introductory & Editorial Comments

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Introductory Comments

AOS Council

In this timely lecture titled “Corporatization of Ophthalmology – Drivers and Implications,” Dr. David Parke provides an insightful analysis of this important topic for our profession. While it is convenient to condemn private equity incursions and erosions of the ophthalmic profession, Dr. Parke points out that similar factors underlie the growth of ophthalmology within Academic Medical Centers and non-profit health care institutions.

Dr. Parke summarizes the reasons for and the rapidity at which ophthalmic practice is becoming consolidated and corporatized, and concludes that this is an inescapable trend. This is occurring as a result of private equity acquisitions, growth of academic health centers, and physician employment by large health care institutions. There are differences in each agent of corporatization, and in the risks each brings to the process of consolidation.

This lecture is a cautionary tale with practical insights as to the importance of professionalism and ethics in preventing the patient-physician relationship from becoming one that is transactional, solely based on typical business considerations.

The AOS Council hopes you will read or listen to this lecture as well as the associated Knapp Symposium to increase your understanding of this timely topic.

2025 MARILYN T. MILLER LECTURE

Corporatization of Ophthalmology - Drivers and Implications

David W. Parke, II, MD

Carol, thank you for those overly generous words. One of my great regrets as a Department Chair was being unable to recruit Carol to Oklahoma City. It was really an honor when she called asking me to give this lecture linked to Marilyn Miller.

As you can see, Marilyn represented the antithesis of corporatization. She devoted herself both to individual patients and to diverse populations of patients all over the globe. She spent her entire career as a true servant-leader. In recognition of her selfless but profound achievements, Marilyn was selected to take important positions representing our profession. And she received some of its highest honors—most notably the Academy's Humanitarian Award, the AOS Howe Medal, and the Academy's Laureate Recognition Award. It was my privilege to be a part of that last presentation.

I'd like to also recognize the four prior Marilyn Miller lecturers—Anthony Fauci, Michael Chiang, Jean Bennett, and George Bartley. Like Marilyn, each has left a deep imprint on our profession.

As my official disclosures, I am currently the Executive Chair of Verana Health, which operates the IRIS Clinical Data Registry, and I previously served the Academy as its CEO. Neither position represents a conflict of interest for this presentation.

In the spirit of this talk, I'm also going to offer a different disclosure. I come from a long line of physicians dating back nearly two hundred years. Pertinent to the corporatization trend, my grandfather was an optometrist in solo practice, my father a general ophthalmologist in a small group practice, I was a subspecialist in academia, and my son is a vitreoretinal subspecialist in a large private practice and actively engaged in our profession, whose practice was purchased by private equity.

This morning, I shall address many facets of a very complex topic—and I commend Drs. Karp and Chew for suggesting a topic so timely and full of nuance. I'll start with a working definition of corporatization and move on to its arc within medicine and ophthalmology, the drivers for its growth, its possible inevitability, the outcomes and implications, and finally some suggestions for our profession.

It is appropriate that we start with Sir William Osler. "You are in this profession as a calling, not as a business; as a calling which extracts from you at every turn self-sacrifice, devotion, love, and tenderness to your fellowmen. Once you get down to a purely business level, your influence is gone, and the true light of your life is dimmed." I doubt that many of us would disagree with this statement. But note that he says "…to a purely business level". He has left a lot of room.

The dilemma was put more bluntly a few years ago by a dermatologist who noted, "You can't serve two masters—patients and investors." I'm going to argue that this admonition applies not just to private equity, but to any entity, for-profit or nonprofit, whose behavior reflects a primary focus on short-term operating profits. As we consider these categories of investors, note the two most significant differentiating factors—their intimacy with clinical decision-making and their time horizons—short-term profits vs organizational sustainability.

One of the most interesting public exchanges on this topic was a series of letters in 1986 between Arnold Relman, editor of the *New England Journal of Medicine*, and Uwe Reinhardt, one of the leading healthcare economists of his day. Dr. Relman stressed that medicine should be held to a unique and higher standard. Professor Reinhardt posed the tongue-in-cheek question, "If medical ethics erode so easily, what then does set physicians apart?"

So what is the "corporatization of medicine"? For many of us, the term "corporatization" carries connotations of inflexibility, organizational greed, and general cultural undesirability. It implies a shift to corporate management tools and structure designed to ensure the primacy of business success and financial success. It is generally associated with consolidation. Most importantly, however, it implies a leadership behavioral shift to a central focus on short-term profit.

It is important, however, not to conflate consolidation and corporatization. Although consolidation can occur without change in corporatization and corporatization can occur without consolidation, the two generally occur simultaneously. The integration of consolidated entities is best accomplished by metrics and outcome-driven leadership. Corporatization generally involves achieving the economies of scale that consolidation brings. In a sense, this is the antithesis of the traditional intensely personal dyadic relationship between physician and patient.

I would argue that corporatization is, in fact, a historical inevitability in healthcare—an economic segment that is fragmented, very heterogeneous, complex, and large. And because it focuses upon the most inefficient segments of the industry with the greatest potential for success, corporatization will gain momentum. But not all deals are good deals, and when the low-hanging fruit has been picked, some models will fail.

Unsustainable macroeconomics, growth of academic medical centers (AMCs) into financial juggernauts, demographic trends, increasingly complex payer systems, and private capital seeking returns on investment have all combined to accelerate the process of corporatization. It was inevitable that this highly fragmented 20% of our national economy would start to consider economies of scale, new management technology, and new business models. The issue before us is not so much the mere fact of corporatization as it is all the behavioral shifts that can, but need not, accompany it.

Consider private equity (PE), the *bête noire* of many physicians, those in health policy and economics, and even *The New Yorker*.

There are a number of wrinkles in the basic model for private equity acquisition of physician practices. In a typical deal, physicians retain some ownership in the Management Services Corporation created to avoid breaching state corporate practice of medicine laws and to give physicians some authority in operational matters. The PE firm retains key decision-making powers. The PE firms make their money through fees, ongoing financial performance, sale of component assets, and ultimately from selling the practice—most commonly to another PE firm.

PE involvement in healthcare has exploded—going from five billion dollars in 2000 to over 100 billion in 2018. One estimate is an aggregate investment of nearly one trillion dollars over the past decade. In a recent ten-year period, there were over 1,000 acquisition deals for physician practices. Some will turn out to be positive for virtually all involved—including communities. Others not so much.

This is all part of a tectonic shift away from physician-owned practices. Now, less than 50% of physicians practice in a physician-owned organization. 40% practice in a hospital, academic medical center, or health system-owned practice. Only 5% are in private equity-owned practices, but the percentage of practice acquisitions that were PE-funded grew from 34% to 77% in a recent three-year period. Finally, consider that ninety thousand physicians—nearly 10% of the U.S. physician workforce—work for United Healthcare Inc. This poses the question— "Is there any such thing as a 'typical' physician practice anymore?"

Some of these investor-owned megapractices are dominating physician specialty-specific markets. In 28% of Metropolitan Standard Areas (MSAs), a single PE firm has more than a 30% market share. In 13% of the MSAs, a single PE firm has more than a 50% share. And in those MSAs where a single firm constitutes over 30% of the market, price elevation is the highest.

If you break down the PE acquisition deals over a ten-year period by specialty, two stand out—dermatology and ophthalmology, but at least ten different specialties are affected.

The acquisition trend has drawn attention from the profession in all those specialties.

It is also not a specifically American phenomenon, despite the unique aspects of the American healthcare system. Ophthalmology and eye care services have been particular acquisition targets in Canada and Germany.

Why is ophthalmology so attractive to investor-owned entities? First, the demographics are very favorable in that ophthalmologists generate much of their revenue from age-related diseases in America's fastest-expanding decades of life. Second, ophthalmology generates a comparatively large cash flow per physician, with a component of noninsurance business. Third, ophthalmologists tend to practice in smaller practices with opportunities for consolidation and driving down operating costs. Finally, ophthalmology offers the opportunity for nonprofessional revenue from ASCs, Part B drugs, and various retail programs.

With regard to consolidation opportunities, although the average practice size in ophthalmology has doubled over the past 20 years, it remains smaller than in many other specialties. The percentage of ophthalmologists practicing in academic institutions has increased by about 50% in the past two decades, with 14% directly employed by academic institutions. An additional unknown but material percentage of those in private practice groups and in multispecialty groups are also closely affiliated with or directly employed by academic health systems. In the 2021 Academy survey, 8% worked in private equity-owned groups.

With that in mind, let's turn to corporatization beyond investor-owned models. Of the hundreds of nonprofit health systems in the U.S., a number of them—both large and small—have been publicly questioned for business behavior involving everything from contracting to restricting access based on payer status, to billing and collection policies that have the attention of state attorneys general for violation of nonprofit community obligations. And this includes some AMCs.

As these systems have consolidated and corporatized, they have done so in part because of the promise of better care coordination and greater efficiency. This is certainly possible, can be achieved, and has been achieved…but it is really difficult—taking time and resources. Several studies have demonstrated the difficulty in showing positive improvements in clinical outcomes or safety, but these same studies have greater ease in demonstrating higher readmission rates and higher Medicare beneficiary spending.

Another important study demonstrated that of the 580 US health systems, comprising 84% of hospital beds and 40% of physicians, 80% were AMCs and large non-profit systems. While clinical quality measures and patient experience scores were marginally better than those from non-system facilities, their physician payments were up to 26% higher, and their hospital payments were 31% higher. While some of this is no doubt related to acuity of care and demography, it does add fuel to the question, "Do larger systems usually provide greater value?" "Is there a point where economies of scale break down as corporatization advances?"

Unfortunately, many AMCs increasingly depend upon their clinical practice revenue operating margin to fund the academic mission. Transfers from general institutional endowment, state funds, or other sources of operating revenue are under increasing pressure. Institutions feel they must grow the clinical revenue base to support the innovation engine and the training of tomorrow's health professionals.

Specific to private equity, Bhatla et al in *JAMA* recently showed that hospital rating and likelihood to recommend decreased relative to matched controls after private equity acquisition—and that the differential increased with time. The authors suggested that the impacts are not transient and may be staffing-related.

As for ophthalmology, there are no good data on outcomes of care associated with acquisition by corporate entities. This is in part due to a lack of transparency. But what about the outcomes on cost in ophthalmology? We do have some data here. Two separate studies using different methodologies demonstrated an increased use of higher cost drugs, but not in physician service costs or imaging.

Consider a different sort of outcome of the acquisition transaction. What about the impact or outcomes on the ophthalmologist whose practice is acquired by an entity pursuing a process of corporatization? By definition, the physician has surrendered some degree of individual decision-making authority. And, commonly, corporate financial imperatives impact clinical operations and decisions, be it from changes in staffing, drug selection incentivization, limitation of care based on payer, or other factors. All this constrains professional independence, puts the outcomes of care at risk, and places the physician at risk of what is referred to as "moral injury".

Such acquisition also fosters the emergence of new models of professional life—potentially both positive and negative. Certainly, many physicians pursue acquisition to spend less time in practice management and more in direct patient care or on non-professional activities. And the short-term financial impact of a practice sale may have a notable positive impact. Others have found the loss of control, demands for increasing productivity, and uncertainty surrounding the downstream change of control to have a negative aggregate outcome.

We should also consider the outcomes on a different group of our colleagues—those who either choose not to be acquired or those whose practice is not a target of corporatization. What does it mean for those whose practices remain physician-owned in communities where they must compete with corporatized entities? Certainly, many practices with strong reputations for quality that operate effectively and maintain market share through organic growth are well-positioned to thrive. However, referral subspecialty practices in particular may find themselves hard-pressed to compete against larger, corporatized ones that are scaling up and internalizing referrals.

As we've seen, corporatization is not unique to private equity but applies as well to academic health systems, to for-profit entities such as United Healthcare, and to large non-profit systems. Is PE unique? All practice acquirers seek to maximize income, and risk is involved. But PE's imperative demands a high-risk tolerance to generate short-term returns to fuel a successful investor exit. The reliance on debt and the insulation from professional and ethical norms make private equity investors more receptive to risky revenue opportunities than are institutional repeat players.

What is the future of corporatization in ophthalmic practice?

Very often, physicians, economists, and policymakers ask, "Why can't we find legislative or legal remedies to the issue?" Brown and Hall, in a recent piece in the Stanford Law Review, argue that for a host of reasons, public policy is likely to be an inappropriate and ineffective tool, and that public policy should target market failures and payment loopholes and only secondarily curb private equity investment per se. They recommend pursuing antitrust oversight, fraud and abuse enforcement, and corporate practice of medicine laws.

However, we have seen so far that regulators and policymakers are reluctant to act so long as they believe that current corporatization initiatives have the net potential to lower total societal health care costs and provide more uniform and better outcomes of care. And to date, we don't have the data to draw definitive conclusions. Professionalism and ethics, balancing mission and margin, remain our primary line of defense.

Speaking of 'no margin, no mission', Sister Irene Kraus, CEO of the largest nonprofit health system in the United States, popularized the term in the 1980s. It is frequently used as the rationale for the corporatization of health care. But I pose the following question: "Even if 'margin' is the defender, the

enabler, the lubricant for the 'mission', isn't that different from elevating 'margin' to the highest of all organizational virtues and objectives?"

I asked a handful of our colleagues who have been leaders in the growth and success of ophthalmic organizations to comment on this issue of corporatization.

Joan Miller acknowledged that medicine is a business and that corporatization, per se, isn't necessarily bad. The AMC model of corporatization can be a force for good—so long as it continues to support and value the academic mission. And she notes the importance of keeping guiding principles.

Paul Sternberg, a former AMC Chief Medical Officer, emphasizes the distinction between AMC corporatization and consolidation. "AMC corporatization is much more than consolidation: it includes closer attention to expenses, RVU generation, patient throughput, patient satisfaction, etc." He echoes Joan's concerns about the potential for disincentivizing critical elements of the traditional academic mission.

And Paul concludes on a highly pragmatic note. "The success of an AMC ophthalmology department requires corporatization – the good, bad, and the ugly. My opinion about the corporatization of medicine overall is about the same: essential for survival but fraught with risking the tripartite mission. However, as they say, "No margin, no mission". Finally, the current headwinds in Washington are only going to increase the need to corporatize how we practice at AMCs."

So, what should we do about corporatization? First, accept that it will occur and that it is occurring. Second, recognize as physician leaders that a cardinal goal is to support a system that both provides the best quality care to the greatest number of people at a reasonable cost and that preserves the importance of individual care relationships in the system. Understand that corporatization is not bad per se and perhaps necessary to achieve these sometimes-conflicting objectives. Help embed the operational principles and ethics that will balance the needs of patients, caregivers, and the health systems to meet the ultimate goals of quality, access, cost, sustainability, and innovation.

Looking forward, a combination of macroeconomic forces and politics is likely to intensify downward pressure on healthcare costs, including those of physicians and facilities. Of the three largest cost components (hospitals, physicians, and retail pharmacy), physicians generally have the least impactful political clout. And specifically, AMCs are likely to find major components of funding (research grants, 340B program, facility fees, government educational support) under increasing pressure.

For all these reasons, net financial results for both systems and for physician practices will be stressed, increasing the attractiveness of outside sources of capital and economies of scale, including seeking private equity investment. On the flip side, investors seeking optimal return on capital and a shorter, predictable exit from their investment may increasingly look at other sectors—making health care relatively less attractive and capital less available at acceptable terms.

Zhu and Polsky, in a thoughtful piece in the *New England Journal of Medicine*, remind us that corporatization cannot be considered as an isolated phenomenon. "…physicians should be aware that private equity's growth *is emblematic of broader disruptions in the physician-practice ecosystem* and is a *symptom* of medicine's transformation into a corporate enterprise." "How physicians respond—and the extent to which they retain core values in the service of patients—will ultimately determine the ecosystem's resilience in the face of stressors."

I'd put it another way. We need to consciously remember that the patient-physician relationship is not a transactional one for the patient, and it should not be considered to be primarily one by the physician. For the patient, it is always at least informational; if not transformational.

Thank you for the opportunity to present these ruminations on a complex and timely subject.

References

Ballou B. Plunder: Private Equity's Plan to Pillage America. 2023 Hachette PublicAffairs, New York

Beaulieu ND, Chernew ME, McWilliams JM et al. Organization and performance of US health systems. JAMA. 2023; 329: 325-335

Bhatla A, Bartlett VL, Liu M et al. Changes in patient care experience after private equity acquisition of US hospitals. JAMA 2025; 333: 490-497

Braun RT, Lelli GJ, Pandey A et al. Association of private equity firm acquisition of ophthalmology practices with Medicare spending and use of ophthalmology services. Ophthalmology 2024; 131: 360-369

Brown ECF, Hall MA. Private equity and the corporatization of health care. Stanford Law Review. 2024; Vol 76 (3) 527-596

Gaynor M. Examining the impact of health care consolidation. Statement before the Committee on Energy and Commerce Oversight and Investigations Subcommittee, U.S. House of Representatives. Washington, DC Feb 14, 2018. https://docs.house.gov/meetings/IF/IF02/20180214/106855/HHRG-115-IF02-Wstate-GaynorM-20180214.pdf

Hover AR, Observations on corporatization of healthcare systems in America. Missouri Medicine. 2022; 119: 93-97

Kane CK, Recent changes in physician practice arrangements: shifts away from private practice and towards larger practice size continue through 2022. Chicago, IL): American Medical Association; 2023 Policy Research Perspective 2023 https://www.ama-assn.org/system/files/2022-prp-practice-arrangement.pdf

Kannan S, Bruch JD, Song Z. Changes in hospital adverse events and patient outcomes associated with private equity acquisition. JAMA. 2023;330(24):2365-2375.

Kessler D. Hospital ownership of physician practices. 1% Steps For Health Care Reform. 2021 https://onepercentsteps.com/policy-briefs/hospital-ownership-of-physician-practices/

Khullar D, The gilded age of medicine is here. Dec 12, 2024, The New Yorker. https://www.newyorker.com/culture/2024-in-review/the-gilded-age-of-medicine-is-here

McWilliams JM, Chernew ME, Zaslavasky AM et al. Delivery system integration and health care spending and quality for medicare beneficiaries. JAMA Intern Med. 2013; 173: 1447-1456

MedPAC Report to Congress: Medicare Payment Policy. March 2020. https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/mar20_entirereport_sec.pdf

Parke DWII. Corporatization in ophthalmology. Ophthalmology 2020; 127: 456-457

Singh Y, Aderman CM, Song Z et al. Increases in Medicare spending and use after private equity acquisition of retina practices. Ophthalmology 2024; 131: 150-158

Zhu JM, Polsky D. Private equity and physician medical practices—navigating a changing ecosystem. N Engl J Med 2021; 384: 981-983