Diversity in Ophthalmology

Examining the state of diversity in ophthalmology and how to build a more inclusive field.

THE PANEL

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In regard to diversity, what was the landscape like when you were in training?

Leon Herndon, MD: I trained at the University of North Carolina (UNC) at Chapel Hill. As a medical student, I knew early on that I wanted to be an ophthalmologist. There was an African American ophthalmologist in my area, Dwight D. Perry, MD, who was a mentor. He was the first ophthalmologist of color to complete his residency at UNC. I also reached out to Eydie G. Miller-Ellis, MD, who was a senior resident in ophthalmology at UNC when I was a medical student. She gave me encouragement to pursue ophthalmology as a career choice. I would have likely pursued ophthalmology even without their guidance, but having their trusted advice gave me more confidence that I could one day also become an ophthalmologist.

Constance Okeke, MD, MSCE: When I was in training as a resident, I was fortunate to have a close friend, Camille M. Hylton, MD, who was a year ahead of me at Yale Medical School and also went to Wilmer Eye Institute for ophthalmology residency. It was a blessing to have her as a mentor, to allow me to believe it could be done and then follow in her footsteps. She was the second Black female resident at Wilmer, and I was the third. In the

Figure. Dr. Herndon (center) with his first all-Black OR team in 25 years at Duke University.

history of Wilmer, there have been only nine Black residents to graduate to date.

Gloria P. Fleming, MD: When I was in training, there were few women ophthalmologists and barely any people of color. This intersectionality opened my eyes to the challenges ahead for women of color in this field.

Mildred M.G. Olivier, MD: Harlem Hospital ophthalmology was the only residency offer I received, despite interviewing widely and having excellent board scores. I was grateful that I had the opportunity to have a diverse faculty and patient population to educate me in this field, but as an underrepresented in medicine (UIM) individual, I was not [offered] opportunities that were available to my counterparts. Harlem Hospital's program did allow me not only to be in an underserved community but also to train with colleagues who were diverse in terms of gender, sexual orientation, and race—and with other Haitians.

Rotating to Columbia-Presbyterian allowed me to experience different cohorts of White and Hispanic patients, both low- and high-income. Our faculty was diverse. Interacting with different cultures and the New York melting pot gave me an awareness of cultural competence and the social determinants of health. These terms are widely used now, but the idea was just emerging then. I was living the dream, getting a wider and deeper understanding of how to be a well-rounded individual. The residency also showed me how the disease of glaucoma affected underserved and overserved communities.

If you talk to many UIMs, their story is the same: The only job they were offered was the one they took. Often, that led to being the only UIM person in the department, which caused them to feel isolated and without a safety net within the medical system.

Zaiba Malik, MD: I can only speak of my experience as a first-generation American Muslim Indian Hijabi woman, representing several ethnic and cultural intersectionalities.

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My residency program was in the hub of a culturally diverse city. Although the residency program represented a diversity of ethnic and racial groups, it lacked gender diversity. I was the only female in my residency class of five residents, and with only one part-time female attending involved with resident training, it was extremely lonely having no female camaraderie or mentors.

I had my first child in intern year, and my second during my senior year. There were no separate call rooms for female residents or pumping rooms on the eye clinic floor. I was told more than once that, if women were having children in residency, "they had too much time on their hands." I was also told that, in the past, the program would never have allowed (female) residents to get pregnant. (Presumably, this unspoken rule was for female residents because, when male residents were [becoming fathers], everyone was high-fiving and congratulating them.) Microaggressions create barriers for women at work and take away their mental energy from being more productive.

Eve J. Higginbotham, SM, MD, ML: In the early days of my career, discussions about diversity never really occurred. The topics now discussed as bias, microaggressions, and structural racism existed but were never acknowledged. The situation was reflected in the few ophthalmologists of color I met at the AAO or National Medical Association (NMA) meetings, the existence of primarily Black and African American clinics, and the absence of a robust array of opportunities to advance my career compared to other colleagues. I recall only three other women of color whom I either knew of or knew personally who preceded me in the profession. There may have been more, but at the very least, they were few and far between.

In your career so far, have you experienced signs of progress toward increasing diversity in ophthalmology?

Dr. Herndon: Absolutely. I have been on the faculty at the Duke Eye Center for 25 years, and during that time, there had been only two African American residents at Duke until 2 years ago, when we had an African American resident in each of the three classes of residents. We have since attracted several African American medical students into ophthalmology (Figure).

Dr. Okeke: Yes, I believe there are signs of increasing diversity, in large part due to the development of mentorship programs for underrepresented minority (URM) individuals, in which many current URM ophthalmologists are providing guidance and support.

One program that has demonstrated success is the NMA Ophthalmology Section Rabb-Venable Excellence in Ophthalmology Research Program, in which I was a participant, which mentors students through research projects and competitive presentation. Another is the Minority Ophthalmology Mentoring (MOM) program, a partnership between the AAO and the Association of University Professors of Ophthalmology (AUPO). The purpose of that program is to increase diversity in ophthalmology by helping UIM students become competitive ophthalmology residency applicants through one-on-one mentorship.

These programs deserve continued financial support, especially from industry, because they work. For example, 88% of the URM individuals who were a part of the Rabb-Venable Research Program matched in the 2021 ophthalmology residency program match. Although strides are being made, there is still much work to be done, especially with funding.

Dr. Fleming: Yes, programs such as those Dr. Okeke mentioned have served to increase awareness among UIMs of the field of ophthalmology. They provide exposure to the discipline and to research, mentoring, and networking opportunities. More women are now entering academic ophthalmology than in the past.

Dr. Higginbotham: I can certainly state there has been progress. Seeing the elevation of the first African American male and female presidents of the AAO has been notable. However, there is still much more that needs to be done. I recently participated in a discussion about structural racism with the AUPO, and it is gratifying to know that there is now,

Practical Steps for Recognizing and Addressing Inequity

GLORIA P. FLEMING, MD

- Make diversity and inclusion pillars within an organization for all aspects of the talent cycle.
- Actively recruit a diverse workforce and make a concerted effort to recruit candidates beyond the "right fit."
- Enhance culture by diversifying all components of an organization.
- Provide resources and support programs that make opportunities available to underrepresented minority students for research and for visiting student rotations.
- Initiate active outreach to underrepresented minority and female students to educate them about the field of ophthalmology and encourage them to consider it at an early stage in their training.
- Support affinity groups (eg, Women in Ophthalmology) and women in all subspecialty groups.
- Actively support the Minorty Ophthalmology Mentoring and Rabb-Venable Excellence in Ophthalmology Research programs.
- Open a dialogue between the AAO, the Student National Medical Association, the Latin Medical Student Association, and their parent institutions on collaborating to address disparities in eye care.
- Make sure conference panels are well balanced and representative with diverse participants.
- Initiate educational programs on implicit and explicit bias, bystander training, the intersectionality of race and gender, gender pay inequity, and holistic review processes. These can help raise awareness of inequities in the profession and encourage mitigation.

MILDRED M.G. OLIVIER, MD

- Increase the underrepresented in medicine individuals in the workforce by identifying the low-hanging fruit of talented individuals and increasing their exposure to ophthalmology.
- Using the tool kit developed by the AAO and visit colleges and high schools to talk about science and vision.
- Mentor individuals of color to consider the field of ophthalmology.
- Add an underrepresented in medicine individual to your National Institutes of Health/National Eye Institute grant as a supplemental.
- Provide scholarship dollars for an individual to travel to an ophthalmology department that can offer the necessary guidance to be successful.
- Have a diversity department or policy within your organization or office that can review and account for your hiring and management practicies. For example, do you need individuals who are bilingual? Do you need magazines and patient handouts that are in concordance with your patient base?
- Reach out to historically Black colleges and medical schools and support their efforts. You do not have to rebuild the system. Instead, support one that has grown up to serve the community.
- Continue dialogue with interest groups to build a long-term plan. Work together to solve the issues that have developed over more than 400 years.

The panelists outline some steps that organizations and individuals can take to better address inequity in ophthalmology.

EVE J. HIGGINBOTHAM SM, MD, ML

- Know your own biases and work toward mitigating them by using your executive functions rather than acting on reflex. Pause before making important decisions and before making biased assumptions about others. Take the implicit association test to understand your own biases (implicit.harvard.edu/implicit).
- Understand your organization's culture and determine its level of inclusivity. Understanding this factor will help an organization to target its efforts in improving diversity and inclusion.[1,2]
- Create a plan to improve the culture so that your efforts to create diversity may be sustained over time.

1. Person SD, Jordan CG, Allison JJ, et al. Measuring diversity and inclusion in academic medicine: the diversity engagement survey. *Acad Med*. 2015; 90:1675–1683.
2. Aysola J, Harris D, Huo H, Wright CS, Higginbotham E. Measuring Organizational Cultural Competence to Promote Diversity in Academic Healthcare Organizations. *Health Equity*. 2018;2(1):316-320.

finally, a critical mass of academic leaders engaged in the discussion and actively involved in planning actions to drive change.

I see these actions as incremental in nature, but what is needed are a dramatic cultural shift in thinking and shared discipline-wide strategic plans to address structural barriers. All stakeholder groups—practicing ophthalmologists, professional organizations, academia, pharmaceutical and device companies, funding agencies, and foundations—have roles to play in advancing inclusion, diversity, and equity in ophthalmology and the visual sciences.

Dr. Olivier: The needle is moving but very slowly. It is not a sprint but a long-distance race. Programs like the Rabb-Venable platform have helped change the ophthalmology workforce. That program has operated since 2000 with a few individuals each year. Recently, efforts were made to involve more medical students. This past year, there were more than 25 individuals involved, who matched with a UIM match rate of 88% and overall program match rate of 87%.

In 2020, the entire Rabb-Venable program was virtual. That platform, I believe, did help level the playing field more than in previous years. A candidate interested in different programs in different places did not have to go into additional debt to travel to possible residency sites or make the hard decision that they just could not go visit for interviews.

Certainly, the Black Lives Matter movement has prompted greater understanding of issues that I feel I have been talking about for years. The AAO and AUPO were proactive before the Black Lives Matter movement. In launching the MOM program that Dr. Okeke mentioned, they have a goal of moving the 5.7% needle of UIM by targeting exposure to ophthalmology for first- and second-year medical students, giving them board prep, interview skills, and exposure to ophthalmology and its subspecialities.

The MOM program learned from the Rabb-Venable Program that we need to engage UIM students even earlier in their training. The difference now, in contrast to when Rabb-Venable was started 20 years ago, is that the majority is on board to help us be successful. The point is to enhance the skills, professionalism, and qualities that we should look for in a physician we would like to see take care of our own family members.

Ophthalmology programs are now offering additional experiences to UIM individuals to help them learn about their programs. The Fireside Chats from the NMA's Rabb-Venable program allowed students of color to learn more about their potential match and allowed programs to be exposed to individuals they might have missed.

Dr. Malik: Although there are more women and minorities entering the field of ophthalmology, top leadership positions remain elusive for these populations. There are few women and even fewer minority chairs. Serving on the local medical school admissions committee, I see more pipeline and mentorship programs in place for URMs. I find that the programs that start early in undergraduate and medical schools provide students with the best opportunities to explore ophthalmology and allow programs to retain strong candidates.

What do you see as the greatest hurdle to increasing diversity in medicine currently?

Dr. Herndon: A lack of role models of color.

Dr. Okeke: In a presentation at the AUPO 2021 meeting, O'Rese J. Knight, MD, highlighted how overreliance on US Medical Licensing Examination scores inhibits diversification in

ophthalmology residency programs. Also, discouragement during the application process led 14% of URM ophthalmology applicants who started the process to not apply. Everyone with any influence in choosing residency candidates should watch Dr. Knight's presentation, which can be viewed at bit.ly/AUPOKnight.

I still have the generic rejection letter that was mailed to me after I just missed the US Medical Licensing Examination score cutoff. By God's grace I was able to convince the Wilmer committee to look at my application, which contained a strong academic record, stellar letters of recommendation, and 5 years of published ophthalmology research from college through medical school. I got an interview and later acceptance. Others who are quite qualified and could significantly contribute to the field of ophthalmology may not be so lucky. One solution is to redefine whom we consider competitive applicants and expand our notion of fit.

Dr. Fleming: Lack of accountability and institutional support is a significant problem. Are there any consequences for institutions that do not make deliberate and concerted efforts toward getting this right? Are there rewards for those that do? What is the infrastructure that supports retention and promotion of diverse individuals so that they can serve as magnets for those coming behind them? Lack of sponsorship and opportunities for intentional career development can curtail the talent pool.

Dr. Olivier: Some people just do not get it. They fail to see their own biases reflected in the admissions processes. Self-awareness takes a deep dive into how the issues of race, culture, and economics affect who goes to medical school. We as a community are starting to reflect on our ignorance of these themes. AUPO had a session in February looking into ignorance around the many issues that face UIMs. Now we are formulating resources and guidelines to help our community.

One specific issue is that, as Dr. Okeke mentioned, too many applicants are judged not by their overall ability but by their board scores. There is no evidence that board scores indicate that a candidate can become the kind of physician you want your relatives to go to or become a great surgeon. Selection of candidates should be a holistic process, with race being one of the factors that might be considered in creating a diverse training environment.

Dr. Malik: It's hard to be what you can't see. If you don't see doctors of different races or ethnicities, you may think you're not capable of becoming that. It's not in your vocabulary of possibilities. Entering medicine is a long and expensive endeavor. Many times, students, especially minorities, can't fathom the enormous debt they will incur. It seems beyond their economic reach.

No one wants to be the poster child for diversity in their group. My role at the table has to be more than being the token diverse female voice. There must be more allyship and sponsorship to help increase access to higher opportunities, whether in leadership or academic roles.

Dr. Higginbotham: The culture of ophthalmology must change, at both the local and organizational levels. Shifting to a discussion of equity is critically important to address structural changes that are needed to accelerate progress in inclusion, diversity, and equity efforts. In schools of medicine, we need departments that actively engage students of color and invite them to consider a career in ophthalmology instead of passively waiting for students to knock on our doors. Within departments, we must excite residents and graduate students to be part of the world of academic ophthalmology and visual sciences. As leaders of organizations, we must keep asking ourselves, What is the perspective that we are missing? Do we reflect the diversity of our nation? Are we the stewards we need to be to effect change? We must demand diversity at the board level of the companies from which we purchase equipment, because their advances in medical therapeutics benefit our patients. We can never be satisfied, and we must continue to innovate to make change.

How have others' biases, implicit or otherwise, affected your work as an ophthalmologist?

Dr. Herndon: I have had patients' family members mistake me for a surgical attendant, and I have had patients trust the word of a trainee over my own.

Dr. Okeke: As a Black doctor, it is very common to come across a patient, or even a health care worker like another doctor or nurse, who may size you up based on your outward appearance or second-guess your capabilities. Although this is unfortunate and can weigh one down, I see the challenge as an opportunity. Every time I walk into a room and see a patient with arms crossed, showing concern that I am the doctor they are there to see, I realize that I have an opportunity to make a great first impression and put their mind at ease. I love it when, by the end of the exam, those crossed arms have opened up and the patient is offering a sincere thank you for my care. My hope is that the type of impression that I make can have a positive impact on that patient's future outlook. Maybe he or she will be less judgmental of someone else who looks like me because of their experience with me.

Dr. Fleming: Patients' perceptions can easily become biases when not grounded in facts or realities. Patients'

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biases can delay progress and affect outcomes until they become comfortable and understand that what you are saying is true and in their best interest.

Dr. Higginbotham: The four common types of bias—anchoring bias, confirmation bias, outcomes bias, and the affect heuristic—are highly prevalent in ophthalmology and, in fact, all of medicine. These are important biases that affect all of us. Outcomes bias is one area that I believe we should pay attention to as a community within ophthalmology. Instead of seeking underlying causes, there is a tendency to assume, falsely, that race is the reason, rather than to dive deeply into a comprehensive understanding of the social determinants of health, as one example.

Dr. Olivier: We must recognize that we *all* have biases. We need to better understand the process of differential diagnosis and appreciate the social issues at play—such as an individual's inability to access their medications or difficulty dealing with an increasingly computerized system—before we can try to fix it.

Putting race in front of scientific evidence may yield a delayed or inadequate differential diagnosis. For instance, a Black patient may not receive a diagnosis of age-related macular degeneration because it is thought to be a condition of White patients, thereby delaying the proper diagnois and treatment outcome. A physician may see a Black patient and assume they have loss of vision from glaucoma, not taking into account the increased risk factors that might come into play such as thin central corneal thickness, family history of glaucoma, and myopia. If we fail to recognize these historic biases, we will not explore other possible diagnoses for our patients.

It's important to engage in conversation about biases and try to understand them. Then we can come together with our diverse perspectives and create a better clinical experience. At the beginning of many discussions with colleagues, they have told me that they were "color blind" and treated everyone the same. How can that be if there are health inequities in ophthalmology?

Dr. Malik: Even if we didn't start out privileged, our profession puts us in a respected and privileged position. In the hospital, my white coat grants me privilege and often protects me from others' biases. That said, I've received comments such as, "Your English is so good," to which I reply, "I hope so; I was born and raised in the United States." I've also heard, "We're waiting for the attending to come," when I'm in an OR with newer staff members.

The surgical fields are historically male-dominated, and I've felt that some colleagues, especially early on, looked down on me for choosing to work part-time and to prioritize my family. Often, I felt they thought I wasn't dedicated enough or driven enough. However, with maturity and wisdom, I've given up conforming to others' expectations.

Has the expanding conversation on race and racism in America had an effect on your experiences as a physician?

Dr. Herndon: Yes, I have found that I have several colleagues who are interested in taking up the plight of social injustice. I am heartened to feel supported on many levels.

Dr. Okeke: The expanding conversation and openness to truths that have previously been overlooked have really motivated me to do more on my part in mentorship. I'm motivated even more now to help those who are coming into the field after me because I understand the real disadvantages that are present and the difference that I can make in helping them through.

Dr. Fleming: No, I do not believe it has yet. I would like to see the current conversation on race and racism really stimulate cultural competency among our peers. I would like to see more providers demonstrate an appreciation that marginalized groups have lived experiences that are very different from their own as well as an understanding of social determinants of health, which need to be incorporated into their patients' care. Caring for the underserved is a privilege and not something that should be stigmatized.

Dr. Olivier: I mentioned earlier that the AUPO is taking a bold step by having the deep-dive conversations, and the AAO is putting together task forces. We also have had our first Black female and male presidents in

professional societies—people who are awesome in their fields but happen to be Black. They represent the whole and show their cultural diversity. As an African American woman, I cannot be expected to be the voice of all Black and brown individuals.

Tamara R. Fountain, MD, the 2021 AAO President, is focusing on health equity. It is engagement like hers that is expanding the conversation on racism for me and many of my colleagues.

Every practice should assess whether they are diverse in the way they treat their staff, physicians, etc., but I doubt most people have gotten that granular. For now, we should expect it from the universities and organizations while we work to make our own commitments to inclusion.

Dr. Malik: At work we are the boss, but would our patients or other physicians in our practice speak to us if they met us at the mall? I believe community engagement is needed to build bridges and increase dialogue. Physicians need to be more engaged in their communities: sit on school boards, volunteer in shelters, and collaborate with other community organizations.

Dr. Higginbotham: At my home institution at the University of Pennsylvania, I am co-leading an initiative that cuts across the entire health system and school of medicine. The Action for Cultural Transformation (ACT) is a strategic initiative aimed at creating a united, antiracist culture in our Penn Medicine community. ACT is addressing all key areas, including education, research, clinical care, community, people, and culture, and engaging more than 5,000 staff members, faculty members, students, trainees, and administrators in the process. We have conducted more than 170 focus groups to engage diverse perspectives across six hospitals and the school of medicine. ACT is addressing the role of race in the medical curriculum, training of physicians, and clinical protocols. In addition, we have educated more than 40,000 staff, faculty, students, trainees, and administrators about unconscious bias and strategies to mitigate bias in our daily lives, and we are planning to continue training the remaining 10,000 Penn Medicine community members.

As a first step, we eliminated the race "correction" used in calculating estimated glomerular filtration rate, a factor that artificially kept patients of African descent off the waiting list for kidney transplants. If there is ever an example to highlight as a structural discriminatory practice, this so-called correction is one.

In November 2020, the American Medical Association declared racism a threat to public health. What did that declaration mean to you?

Dr. Herndon: This was not surprising to me, living as an African American man. Many of the social determinants of health are adversely affected by racism.

Dr. Okeke: The American Medical Association's (AMA) declaration is a good first step. You cannot fix a problem unless you identify it. It is important for large organizations like the AMA to acknowledge that racism is a problem that directly affects health in a negative way and to begin to implement strategies and steps to overcome it. Time and further action, however, will reveal the true intentions of the declaration.

Dr. Higginbotham: Structural racism affects our entire society. Recognition is a key step in the process of restorative justice. Our research has underscored how the link between discriminatory practices and racist cultures affects the physical and mental well-being of members of our organizations.[1]

Dr. Fleming: This was a public acknowledgement that racism is an underpinning of health care disparities that cannot be denied or ignored. Studies have shown that, even after controlling for social determinants of health, disparities still exist, illustrating the ramifications of structural racism.[2]

Dr. Olivier: Steps like these are appreciated, but they are only part of recognizing racism in medical associations.

I have been a delegate to the AMA for the AAO. I served on the AMA's Commission to End Health Care Disparities and chaired two of their committees. I was there when John C. Nelson, MD, MPH, President of the AMA, apologized to Nelson L. Adams III, MD, the NMA representative. The African American physician, a past President of the NMA, had built a wonderful relationship with Dr. Nelson, and they agreed about the injustices shown toward physicians of color, such as not allowing them to join the AMA.

Similarly, in 1997, President Bill Clinton apologized to Blacks for the Tuskegee Study of Untreated Syphilis in the Negro Male, often referred to as the Tuskegee Study, an episode of mistreatment that solidified the community's mistrust of the medical research field.

In 2019, the AMA finally had a woman of color as president, Patrice A. Harris, MD, MA, almost a quarter of a century after the first man of color, Lonnie R. Bristow, MD, became president of that organization.

COVID-19 has highlighted the inequities in medicine, with increased death rates among people of color—due to structural racism built into our field of medicine.

The AMA's declaration allows us to finally address these issues and to bring everyone to the table. Within the AMA, Aletha Maybank, MD, the chief health equity officer for the organization, has focused policy on bringing these issues to the forefront of medicine. When we can make policy changes and create budget line items, we can then begin to move the needle on inclusivity.

> "IF THE SAME PEOPLE, WITH THE SAME IDEAS, TRAINED BY THE SAME INDIVIDUALS ARE ALWAYS DECIDING THE BEST FIT, THE LANDSCAPE WILL NEVER CHANGE."

Dr. Malik: As a past board member of American Muslim Health Professionals, our work on public health and advocacy efforts has included collaborating with other groups to support the AMA declaration. We know that racism underpins health inequities. This first step in naming racism as a determinant of health must be followed by allocation of resources and strategic action. It's important for us as a society to have these conversations, but talk must be followed by tangible action. We need to call out injustices, even if as witnesses against ourselves.

How would greater diversity, equity, and inclusion benefit the eye care field at large?

Dr. Herndon: Many studies suggest that people of color achieve better health outcomes when they have health care providers who look like them. Engendering a more diverse eye care workforce will have a positive impact on health outcomes in medicine in general and ophthalmology in particular.

Dr. Okeke: There is a lot of distrust in the health care system. Although doctors are trained to treat everyone equally, the harsh reality is that this does not always take place. Comfort and trust can come from being treated by people you are familiar with. Many patients, if they have the option, will want to be seen by health care providers who look like them.

Greater diversity and inclusion in the eye care field could help increase access to care. For example, a large proportion of patients with glaucoma are minorities. Many Black patients of mine resist seeing other doctors, even with my blessing and even though resistance could be to their detriment, because they lack comfort with and trust in those doctors.

Dr. Fleming: It is known that glaucoma disproportionately affects URM groups—Blacks and Hispanics—at rates much higher than their counterparts. Despite their being in high-risk groups, there is evidence that these individuals receive a disparate level of care in diagnosis and surgical intervention, and thus there is a higher burden of blindness in these communities.

Research has shown that patient satisfaction, adherence, and compliance increase when there is a concordant racial or ethnic physician-patient relationship. Diversifying the physician workforce is key to addressing health care disparities. Therefore, increasing diversity, equity, and inclusion in the eye care field would play an important role in reducing eye care disparities in these populations.

Dr. Higginbotham: Greater inclusion, diversity, and equity will improve our discipline; enhance our capacity to deliver high-quality, equitable care; and improve eye health for all populations. This is the expectation, as outlined in the National Academies of Sciences, Engineering, and Medicine report, Making Eye Health a Population Health Priority, a consensus study published almost 5 years ago, in which I was a member of the committee.[3] This report called for a more inclusive approach to care to deliver on the promise of improved eye health. By reflecting the diversity of the nation, we can better deliver care and increase innovation at the corporate level and in research.

Dr. Olivier: We must challenge ourselves. It is all about building a better product. We can try to eliminate the disparities in ophthalmology that cause blindness. Treatments we use or devices we place in our patients should be studied for disparate impacts, and recommendations should be made based on differences among racial or ethnic groups.

Individuals must access the health care system earlier, and more individuals must be educated about the inequities of the system or the disease affecting them. Telehealth may give us an opportunity to reach individuals at different times of the day to achieve health equity.

Dr. Malik: It's important for patients to see themselves in their providers. As others have mentioned here, studies show that patients are more likely to trust health care physicians with whom they share similar ethnic or cultural backgrounds. Better compliance and patient outcomes result when patients trust and relate to their physicians.

Our physician population must better represent the larger community population. Innovation, technology, and progress require a diverse group of thought leaders bringing their

perspectives to solve global problems. This can only be done when more voices are at the table.

What practical steps can those in ophthalmology take to better recognize and address issues of inequity in the profession?

Dr. Herndon: First and foremost, we must continue to have discussions around addressing health care inequities. Once our colleagues are properly educated about the negative consequences of social inequalities, we can work toward finding solutions to these problems.

Dr. Okeke: I mentioned some practical steps earlier. We must have more URM and especially Black doctors in the workforce. I believe that the talent is out there, but there must be encouragement, along with financial support of programs that foster and mentor diversity. There must also be more intentional diversity among applicant decision-makers, such as program directors and application interviewers.

Dr. Fleming: I believe that people must be open to having courageous conversations about a topic that may not be easy or comfortable to discuss. This means stepping out of one's comfort zone, being vulnerable to accepting critical evaluation and open to self-reflection and admission that maybe we can do better. If the same people, with the same ideas, trained by the same individuals are always deciding the best fit, the landscape will never change.

Dr. Higginbotham: We have experienced an increase in the proportion of women in ophthalmology, but there has not been a similarly significant increase in the proportion of marginalized Black people, Indigenous people, and people of color represented. In addition to exposing more medical students to ophthalmology in the preclinical years, before the full schedule of clinical rotations in other fields, we must seek to expose students to the research opportunities that abound in ophthalmology.

When I started Student Sight Savers years ago, the intention was to introduce students in their preclinical years to ophthalmology and engage these students in glaucoma screening activities in communities. We must actively recruit residents of color into our faculty ranks and, once in those ranks, ensure their success by actively mentoring and sponsoring faculty. And we must encourage interest in health services research to advance our understanding of disparities in care and inform strategies to strive for health equity.

Dr. Malik: Platforms like this panel allow us to discuss inequity and offer spaces for us to recognize our biases, including implicit ones. It's impossible for those at the receiving end of gender and racial inequity to come up with all the solutions. They need the support and allyship of those in power in order to move the needle and use their power to push forward the conversation. ■

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