

ALL HANDS ON DECK



"Doc, I can't lose my eyesight." "I need to be able to see!" "Oh, my eyes are very important to me."

As retina specialists,

we regularly hear some version of these statements from our patients. Americans across all racial and ethnic backgrounds cite loss of vision and blindness as the most feared health outcome.¹ One of the most gratifying aspects of caring for patients with complex retinal diseases is helping them maintain and, in many cases, improve their vision. One of the most heartbreaking aspects is knowing that some face permanent visual impairment—for example, young patients with bilateral tractional retinal detachments from proliferative diabetic retinopathy. Vision loss brings loss of independence, loss of the ability to provide and care for family and oneself, and diminished quality of life.¹ With our incredible advances in ophthalmology and innovations in retinal care, why are Americans losing vision from treatable conditions like proliferative diabetic retinopathy?

Disparities in vision outcomes across racial and ethnic patient groups are well-known.^{2,3} How can we address these disparities to ensure that patients from all backgrounds are achieving their best vision health? Many clinical trials to date have limited demographic data on race and ethnicity, and retina clinical trial participants have not reflected the genetic and geographic heterogeneity of the US population. (Sexual orientation still isn't collected, for the most part. For more on this topic, see *Further Reading*). Additionally, ophthalmology remains among the least diverse specialties.⁴ Fortunately, the number of women entering medicine and ophthalmology is increasing. Still, we have yet to understand why female academic ophthalmologists are paid less than their male counterparts,⁵ and why there are relatively few female department chairs and women in leadership roles.

In this issue, we will examine some of these topics. We spoke with Julia A. Haller, MD, about her own inspirational *JAMA* editorial, "Cherchez la Femme," from 2015 (see the featured article *Diversity in Retina Leadership: Where are the Women Now?*).⁶ Dr. Haller noted that Neil M. Bressler, MD, editor-in-chief of *JAMA Ophthalmology*, had invited her to write that piece and that much of the increased diversity at *JAMA* is thanks to his overt efforts to increase the number of female editorialists.

Also in this issue, Ron Adelman, MD, MPH, MBA, tackles gender differences in Medicare payment among retina specialists (see the featured article *A New Perspective on the Retina Wage Gap*). His team studied physicians' total annual payment through Medicare in 2020 and found that female retina specialists received 65 cents on the dollar compared with their male counterparts.⁷ When they controlled for the

number of patients seen, the disparity lessened to 89 cents on the dollar. The ensuing panel discussion and audience participation circled around the many potential underlying causes for the disparity, one of which being that women might under-code clinic visits. Jeffrey S. Heier, MD, closed out the session by pointing out that it's perhaps more likely that men over-code their visits. It's such a small distinction, but the room seemed to shift as the implication struck home. Many of us have thought more carefully about how we bill our patient encounters ever since.

Unfortunately, efforts to advance diversity, equity, and inclusion have faced pushback.⁸ Although data show that diversity improves health outcomes and even makes corporations more profitable,^{9,10} some still come to the discussion with a staunch, "Why do we need to focus on this?" *Harvard Business Review* published an excellent article answering that very question and offering pointed rebuttals to explain the resistance.⁸

Diversity, equity, and inclusion is not a zero-sum game. As retina physicians, we are skilled in managing the most complex cases. The more we look for ways to include and retain talented individuals from all backgrounds, nourish this talent, and amplify diverse voices in leadership to help us tackle the complex realm of vitreoretinal disease, the stronger we will be. And our patients deserve nothing less. ■

— Adrienne W. Scott, MD, and Steve Sanislo, MD

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FURTHER READING

LGBTQ+ Pearls for Colleagues

A discussion with Jessica Weinstein, MD; Roberto Diaz-Rohena, MD; Steve Sanislo, MD; and Brandon Johnson, MD; Moderated by Vivienne S. Hau, MD, PhD; and Basil K. Williams Jr, MD



Accepting Transitions in Retina

By Vivienne S. Hau, MD, PhD

