

American Academy of Ophthalmology
Committee for Resident Education
Diversity, Equity, & Inclusion Workgroup

Unconscious Bias & Microaggressions Module
for Ophthalmologists, Ophthalmologists-in-
Training, Staff, and Administrators

Preface

The Accreditation Council for Graduate Medical Education (ACGME) requires that all residency programs educate residents in the areas of diversity, equity, and inclusion (DEI). Additionally, the American Academy of Ophthalmology and the American Board of Ophthalmology have continuing education requirements in DEI, and in the area of accessibility. The educational content herein provides material to fulfill elements of DEIA education via specific scenarios of unconscious bias and microaggressions in ophthalmology.

We believe this education is critical for all ophthalmologists and ophthalmologists-in-training and will help advance equitable patient care, promote inclusive learning and work environments, and improve our means to increase diversity in our field.

Each item in this collection begins with a scenario followed by an explanation, group reflection/discussion questions, and resources. This allows any individual to facilitate a learning session and discussion with their team. Of note, this collection does not review a complete list of DEIA topics; instead, it is a living document with potential to grow over time in scope and content.

We recognize that content in this workbook may be uncomfortable, sensitive, or triggering for some individuals and/or groups, so we strongly emphasize the importance of establishing a safe zone for learning. Methods to do this include:

1. setting “ground rules” at the beginning of the session, with shared expectations for productive discussion and a content warning,
2. informing participants that the session is confidential,
3. reviewing local resources available for support,
4. encouraging open and honest participation,
5. asking all members to practice intentional listening by giving others time and space to share thoughts and experiences,
6. practicing empathy with assumption of other participants’ positive intent, and
7. understanding that disagreement is okay and asking clarifying questions to understand others’ perspectives before coming to conclusions.

In order to better understand unconscious bias in medicine, we suggest also taking the [Stanford Unconscious Bias Course](#) - individually, on learners’ own time and at their own pace.

We suggest utilizing the following scenarios in small group interactive discussions. This can be done during faculty, staff, or resident meetings; team huddles; or grand rounds.

Thank you,

Ambar Faridi, MD

American Academy of Ophthalmology
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ROB SWAN, MD

Scenario

A woman who is a refugee in the US presents to the resident ophthalmology clinic for an annual eye exam. She has a form with her titled “N-648 Medical Certification for Disability Exceptions” that she requests be filled out. This form will exempt her from the requirement to read, write, and speak English, which is normally a part of the naturalization process. Before entering the patient room, the attending physician expresses reservations about filling out this form, characterizing this as a “common tactic” among persons seeking citizenship. Upon entering the room, the doctor learns that the patient has pigmentary retinopathy with nystagmus that corresponds with her stated history of being blind from a young age. She has had no formal schooling. Although she meets legal-blindness criteria, and she has been followed in the eye clinic for years, she has never been declared legally blind or referred for services. Her primary care doctor declined to fill out the form, because her disability is visual, and told the patient that the eye clinic is the more appropriate venue. Upon learning this, the attending and the resident spend the next hour working with the patient and interpreter to fill out the form to indicate that the patient is unable to read or write English due to her poor vision. The patient is also declared legally blind and referred for services.

Explanation

After spending enough time gathering information, the attending was able to get past an anchor bias to appropriately treat and refer the patient. Anchor bias involves relying on the first piece of information to form an opinion rather than looking at the whole picture. Once formed, it can be difficult to modify the initial opinion, even when faced with contradictory evidence. The “common tactic” comment is vague but may imply a deeper stereotype bias toward refugees or those seeking a diagnosis of disability.

Reflection Questions

1. How do you feel when a patient you meet for the first time brings a disability form to be filled out? Has your opinion ever changed by the end of the encounter?
2. Is it reasonable to expect a legally blind patient with no formal education to be able to read and write in a new language? Was it reasonable for the primary care doctor to request that the eye clinic fill out the form?
3. How will you educate yourself on anchor bias? This article discusses cognitive biases for the ophthalmologist: [https://www.surveyophthalmol.com/article/S0039-6257\(17\)30115-7/fulltext](https://www.surveyophthalmol.com/article/S0039-6257(17)30115-7/fulltext)

AMBAR FARIDI, MD

Scenario

You are reviewing ophthalmology residency applications, and you read a letter of recommendation written for a female applicant that contains the following statements “E has physicians in her family, including her mother and her aunt, so she knows what it will take to be an outstanding physician as a woman and still enjoy a balanced life.” and “E is polite, well-groomed, and easy to get along with.”

Explanation

The letter writer here perceives that they have good intentions and are advocating for this female applicant. The letter writer is displaying unconscious gender bias related to societal expectations and stereotypes of how women should be viewed and what women are capable of in the workplace. Additionally, the letter writer overstates personal attributes of the applicant rather than her accomplishments and abilities that show she is a well-qualified applicant. Personal attributes are important to mention and critical to consider in an applicant. However, studies have shown that recommendation letters written for women and for those who are underrepresented in medicine (URiM) include personal attributes such as being “pleasant” or “well-groomed” or “easy to get along with”—instead of describing candidates’ accomplishments and noteworthy talents—significantly more often than letters recommendation letters written for men and non-URiM candidates.

Reflection Questions

1. Have you thought about the role unconscious gender bias plays in residency applications? Educate yourself with this article: [Gender-based differences in letters of recommendation written for ophthalmology residency applicants | BMC Medical Education | Full Text \(biomedcentral.com\)](#).
2. Have you watched Dr. Tanya Trinh’s TED talk on unconscious gender bias, which contains a segment on letter writing and associated biases? This is worth your time: www.youtube.com/watch?v=A5pf-2SrWRk
3. How might you change the way you approach writing letters of recommendation for women and URiM candidates? Here is a helpful resource: https://csw.arizona.edu/sites/default/files/avoiding_gender_bias_in_letter_of_reference_writing.pdf
4. The following link is a useful resource on testing your own biases, including on gender and career: <https://implicit.harvard.edu/implicit/selectatest.html>

OGUL UNER, MD

Scenario

A resident who was born in China and has lived in the United States since childhood is meeting an attending ophthalmologist, who asks the resident where they are from. After hearing the resident was born in China, the attending congratulates them on their English and asks how they “do not have an accent.” The attending looks at the resident’s badge and mispronounces the resident’s name. The resident corrects them, and the attending pronounces the name correctly that day. However, the attending forgets the correct pronunciation, does not ask the resident again, and continues to mispronounce the resident’s name.

Explanation

The attending ophthalmologist here has good intentions when congratulating the resident on their English-speaking skills but is not aware of having an unconscious bias involving a “perpetual foreigner” stereotype. In this case, the stereotype, expressed by the comment about not having an accent, which implies a linguistic norm, has also resulted in a microaggression. Another facet of this case is the continued mispronunciation of the resident’s name. Though not intentional, this act propagates the same stereotype and gives a message that the resident’s name does not belong.

Reflection Questions

1. How will you educate yourself on perpetual-foreigner stereotypes? This article describes the impact this stereotype has on identity and psychological adjustment:
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3092701/>
2. Do you ask someone how their name is pronounced if you are unsure? How about if you forget the pronunciation?
3. If you were the resident or a witness in this scenario, how would you approach the attending who continued to mispronounce the resident’s name and comment on their English-speaking skills?

CHRIS ALABIAD, MD and AMBAR FARIDI, MD

Scenario

A patient presents to your clinic for evaluation of cataracts. They greet you and the first thing they say is, “I didn’t expect my doctor to be so young.” You chuckle uncomfortably, thank them for the compliment, and begin the visit. At the conclusion of the exam and ancillary testing, you determine that the patient would benefit from cataract surgery. After going through the risks, benefits, and alternatives to the surgery, the first question the patient asks you is, “Are you going to be my surgeon? How many of these surgeries have you done?” You answer honestly and proceed with the discussion.

Explanation

Ageism is bias or discrimination against people based on their age. It often applies to people who are older, but in this case the “young doctor” experiences age bias by the patient. Ageism may negatively affect the younger doctor by making them feel uncomfortable during the visit, nervous about performing the surgery and meeting the patient’s expectations, and, over time, reduce their confidence and contribute to feelings of burnout. Ageism can occur in the workplace both among peers and in the clinical space.

Reflection Questions

1. Do you agree with how the physician responded to the ageist comment (or microaggression) by the patient? How would you have responded?
2. Given the context of the ageist remark and the question about the number of cases performed, should the physician pause in booking this routine surgical procedure? Should they offer consultation with an older physician?

CHRIS ALABIAD, MD and AMBAR FARIDI, MD

Scenario

An 80-year-old patient visits the clinic for evaluation of cataracts and is present with their daughter. The physician enters the room and greets the patient in a loud voice, assuming the patient is hard of hearing. At the conclusion of the exam and ancillary testing, the physician determines that the patient would benefit from cataract surgery. The physician primarily makes eye contact with the daughter, explaining the surgery and associated risks, benefits, and alternatives to the daughter as the patient looks on. The physician concludes the visit by smiling at the patient and waving goodbye.

Explanation

Ageism is bias or discrimination against people based on their age. It typically applies to people who are older and can manifest in ways where physicians and family members treat their loved one in an infantile fashion or discuss prognosis and treatment without inclusion of the patient. Training in the appropriate approach to the care of the older patient is critical to provide competent and inclusive care, because ageism has a negative impact on physical and mental health, morbidity, and mortality. The same can be said of the younger patient who experiences undertreatment due to their age (thought to be too young to have the disease).

Reflection Questions

1. How do you think the physician treated this older patient? What could the physician have done differently?
2. In a 2023 paper titled “Ageism in Society and Its Healthy Impact,” ageism is defined as “an increasingly recognized form of cognitive bias involving stereotypes, prejudice, and discrimination directed toward people based on their age. Age-based bias influences how medicine is practiced and can result in profoundly negative but avoidable health outcomes. Awareness and education regarding ageism and its manifestations can improve the ability to identify and mitigate ageism” (source: <https://pubmed.ncbi.nlm.nih.gov/36722760/>). How will you counter ageism in your practice?

MANI WOODWARD, MS3 and AMBAR FARIDI, MD

Scenario

A 14-year-old patient presents to your clinic for eye strain. You notice the patient is Asian and his parents are white. While chatting with the patient, you ask him, “Where are you from?” The child responds that he is from Portland, Oregon, but you follow up inquisitively with, “But where are you really from? Where were you born?”

The patient informs you that he was adopted from Korea when he was 4 months old. You congratulate the patient and his parents, saying, “Oregon is an incredible place, and you must be grateful to your parents for bringing you here.” As the visit continues, you begin to wonder if the child has a hereditary disorder related to his eye strain. You ask him, “Do your real parents have a history of eye problems?” The patient responds, “Once again, I was adopted at 4 months old. I don’t know anything about my biological parents.”

Explanation

This interaction highlights microaggressions faced not only by adoptees but also by many people of color. Asking the patient where they are from and further eliciting their birth country may imply that they are not truly Oregonians or Americans. This child, specifically, has grown up in the US and may likely have few to no memories of or ties to their birth country.

The next problematic statement is congratulating the child on being adopted and suggesting that they should be grateful to their parents. This is a common sentiment felt by adoptees, as many face interactions with others that imply they should be grateful for being “saved” from a “less desirable” place. For an adoptee, these sorts of interactions may cause them to experience guilt and a feeling that their birth country is inferior to the US.

The last microaggression in this scenario is that the parents in the room are not his “real” parents. This questions whether his parents are as “real” as his biological parents and whether their unit is a family. Adoptees encounter this frequently in the healthcare system: being asked about their family history when the provider knows (or should know) from a history and physical requirements (H&P) form or intake form that they are adopted. A better approach is to convey our understanding that they are an adoptee and may know little to nothing about their family history, but explain that we still need to ask, in case they do have knowledge that aids in their care.

Reflection Questions

1. What steps can you take to be more mindful of the language and behavior you may use when providing care for patients who are in “non-traditional” family units, such as adoptees, foster care children, or those raised by guardians other than their biological parents?
2. In what ways do you acknowledge and appreciate the diversity of your patients, particularly those who are people of color? Do you recognize them as fellow Americans, and do you adapt your communication style accordingly to foster a comfortable and respectful environment?
3. How can you enhance your patient-provider relationship to create a more trusting and empathetic dynamic? Are there phrases or questions that you typically use when interacting with certain patient groups, and have you considered how these may impact their experience and emotional responses?

GABRIELA ESPINOZA, MD

Scenario

You are talking to your ophthalmology residency selection committee and are discussing recruitment and selection of a more diverse group of residents. One faculty member says that it is fine to give more weight to the consideration of a medical student from a group that is underrepresented in medicine (URiM), but also asserts that a URiM student struggles more during residency and may not excel in our specialty.

Explanation

The faculty member is displaying affinity and “fit” or “pedigree” biases in believing that non-URiM residents are more likely to succeed in their residency program than URiM students. They believe that URiM students are not as well prepared to succeed in residency as non-minority students, and that they therefore cannot succeed.

Reflection Questions

1. How does your program provide a learning environment and mentorship conducive to the success of URiM students?
2. Does your institution provide a learning environment conducive to the success of URiM faculty?
3. In what ways does your program support faculty development on the topic of diversity, equity, inclusion, and accessibility? Do you fully support the concept of improved diversity of thought and experience creating better patient care for your community?

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<https://pubmed.ncbi.nlm.nih.gov/33923280/>

ELEANORE KIM, MD

Scenario

A resident calls in the next patient from the waiting area of the busy clinic. The patient is in a wheelchair. The resident brings the wheelchair into the small exam room and positions it sideways to fit. The patient reports that he cannot transfer to the exam chair without his aide, who is not present. The resident does not see anyone in the hallway to help transfer the patient. The patient reports he is there for a glaucoma exam due to a family history of glaucoma. The resident tries to use the slit lamp, but it cannot be positioned to reach the patient. The resident proceeds to do a penlight exam and measure the eye pressure with a Tonopen. Visual field and optical computed tomography (OCT) testing are not ordered, due to the difficulty with patient positioning. The patient is dilated and found to have healthy-appearing optic nerves and is recommended to return for an annual exam.

Explanation

This scenario highlights the difficulties faced by patients with mobility disabilities when visiting the eye clinic. This patient may not have received access to a standard-of-care glaucoma evaluation, due to a lack of appropriate accommodations. Accessibility in the eye clinic is essential to providing equal access to vision care for people with mobility disabilities. All eye clinics should have rooms and equipment that are appropriate for patients who use wheelchairs. Dedicated rooms should have adequate space for transfers (from either left or right side), maneuvers, and turning, in addition to exam chairs that can be easily moved backward to accommodate a wheelchair. Testing rooms should also have adequate space and tables that can be height adjusted. A patient with a mobility disability may come to an appointment alone, and the provider must provide reasonable assistance for the patient to be properly examined, including recruiting clinical staff to transfer patients. Patients ideally should be screened for disabilities before their visits and accessibility needs should be noted in patients' charts for future visits. Rooms that accommodate wheelchairs should be reserved when needed for appointments of patients who use wheelchairs, so they are not waiting longer than other patients. Longer exam times should be allotted when necessary. Portable instruments such as portable slit lamps and Tonopens should be available for patients who have difficulty moving their heads or placing their chin at the slit lamp.

Accessibility is important for providing thorough eye care, and it is also legally required. The Americans with Disabilities Act of 1990 (ADA) is a federal civil rights law that prohibits discrimination against individuals with disabilities, including in the provision of medical services. Private offices are considered places of public accommodation and are also covered by the ADA. Additionally, section 504 of the Rehabilitation Act of 1973 (Section 504) is a civil rights law that prohibits discrimination against individuals with disabilities on the basis of their disability; it applies to programs that receive federal financial assistance, such as Medicare or Medicaid.

Reflection Questions

1. Does your eye clinic have adequate accommodations to provide access to equal vision care for patients with mobility disabilities? What steps can you take to improve this access? Is your eye clinic accessible to patients with other disabilities, such as visual impairment and deafness?
2. How can you be mindful of your behavior or language when providing care to patients with disabilities? What can you do or say to make these patients feel comfortable and cared for in your eye clinic?

Resources

Department of Justice & Department of Health and Human Services, Access To Medical Care For Individuals With Mobility Disabilities: http://www.ada.gov/medicare_mobility_ta/medicare_ta.htm

AMBAR FARIDI, MD

Scenario

Your new colleague, who is gay, is shadowing you in clinic during a standard orientation/on-boarding process. A long-time patient of yours whom you are examining in the clinic notices your colleague's rainbow flag pin in support of the LGBTQIA+ community and asks them, "You don't support that kind of lifestyle, do you? I thought I knew this clinic was better than that! How does that pin have anything to do with my eyes?" Your colleague is frozen and does not know how to respond.

Explanation

The patient is displaying bias and discrimination against the physician who is gay. LGBTQIA+ physicians play an integral role in our healthcare system and in ophthalmology. In addition to caring for patients, LGBTQIA+ healthcare workers provide critical representation that is necessary for optimal care of LGBTQIA+ patients. However, their own experiences as individuals working within the medical profession are often overlooked. This can perpetuate discriminatory behavior against LGBTQ+ staff, students, and physicians and contribute to negative psychological and physical manifestations. Further, this can worsen disparities in healthcare experienced by LGBTQIA+ individuals.

Reflection Questions

1. How does LGBTQIA+ status play a role in the educational and working experience of our colleagues who identify as LGBTQIA+?
2. How could you respond in this scenario in support of your colleague?
3. While some progress has been made in incorporating LGBTQIA+ education into medical school and other training programs, what are ways your team could work to create a safe, affirming space for your LGBTQIA+ colleagues? What are ways your department, program, and clinic can support current staff, physicians, and learners who identify as LGBTQIA+?

Resources

Yom, SS. Gay men and lesbians in medicine: has discrimination left the room? *Medical Student JAMA*. 1999(182)13.

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