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 this area. The educational content herein provides material to fulfill elements of DEI 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 DEI 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) inform participants that the session is confidential, 3) review local resources available for support, 4) encourage open and honest participation, 5) ask all members to practice intentional listening by giving others time and space to share thoughts and experiences, 6) practice empathy with assumption of other participants’ positive intent, and 7) understand disagreement is okay and ask clarifying questions to understand 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 pace.

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

Thank you,

Ambar Faridi, MD

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ROB SWAN, MD

Scenario

A refugee 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 being required to read/write/speak English that is normally a part of the naturalization requirements. Before entering the patient room, the attending expresses reservation about filling out this form as it is a “common tactic”. Upon entering the room, the doctor learns that the patient has pigmentary retinopathy with nystagmus that corresponds with her stated history of being blind since a young age. She has had no formal schooling. While she meets legal blindness criteria, and has been followed in the eye clinic for years, she has never been declared or referred for services. Her primary doctor declined to fill out the form since her disability is visual – telling the patient that the eye clinic is the more appropriate venue. Upon learning this, the attending and 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 towards refugees or those seeking 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 doctor to request the eye clinic to 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
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 gender unconscious 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 ability that show she is a well-qualified applicant. While personal attributes are important to mention and critical to consider in an applicant, studies have shown that letters written for women and for those who are underrepresented in medicine (URiM) mention personal attributes such as being “pleasant” or “well-groomed” or “easy to get along with” (rather describing candidate accomplishments and noteworthy talents) significantly more than in letters for men and non-URiM candidates.

Reflection Questions

1. Have you thought about the role gender unconscious 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 underrepresented in medicine candidates? A great resource may be found here: https://csw.arizona.edu/sites/default/files/avoiding_gender_bias_in_letter_of_reference_writing.pdf

4. A great resource on testing your own biases, including on gender & career, may be found here: https://implicit.harvard.edu/implicit/selectatest.html
OGUL UNER, MD

Scenario

A resident 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 correct 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 does not realize their unconscious bias involving a “perpetual foreigner” stereotype. In this case, the stereotype has also created a microaggression with the comment of not having an accent, which implies a linguistic norm. 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 name and comment on English-speaking skills?
**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 and 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 may 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 number of cases performed, should the physician have pause in booking this routine surgical procedure? Should they offer consultation with an older physician?
Scenario

An 80 year-old patient presents to the clinic for evaluation of cataracts and are 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 with 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, as 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 entitled “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, while 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 four 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 four 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 little to no memories or ties to their birth country.

The next problematic statement is congratulating the child on being adopted and implying 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) that they are adopted from an H&P or intake form. A better approach is to convey our understanding that they are an adoptee and may know little to nothing about their family history, but 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 a medical student from an underrepresented group, but they have issue with the fact that a URiM 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 and URiM students will not. 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, and inclusion? Do you fully support the concept of improved diversity of thought and experience creating better patient care for your community?


[https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2794197](https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2794197)


[https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9552628/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9552628/)


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 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 resident 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 is unable to be positioned to reach the patient. The resident proceeds to do a pen light exam and measure the eye pressure by a tonopen. Visual field and oct testing are not ordered due to 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 in 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 wheelchair patients. 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 backwards 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 noted in patients’ charts for future visits. When possible, dedicated rooms should be reserved for wheelchair patients at their appointment times so they are not waiting longer than other patients and longer exam times should be allotted when necessary. If patients have difficulty moving their heads or placing their chin at the slit lamp, portable instruments such as portable slit lamps and tonopens should be available.

Accessibility is not only important for providing thorough eye care, but 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 medical services. Private offices are considered places of public accommodation and are also covered by the ADA. Additionally, for programs that receive federal financial assistance, such as Medicare or Medicaid, 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.

Reflection Questions
1. Does your eye clinic have adequate accommodations to provide patients with mobility disabilities access to equal vision care? 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/medcare_mobility_ta/medcare_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 is in the clinic being seen by you and notices your colleague’s rainbow flag pin in support of the LGBTQIA+ community. The patient notices your colleague’s pin and asks them, “You don’t support that kind of lifestyle, do you? I thought I knew this clinic was better than that! What 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/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.

