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Justice and Disparity – a Defining Cause
for Diversity, Equity and Inclusion in Optometric Education and Practice

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Abstract

The populations most in need of vision and eye care are the populations least represented in optometry. Efforts to increase racial and ethnic diversity, equity and inclusion (DEI) often are justified from a representational perspective. A more defining justification builds from the historic context of social injustice at the intersection of health inequity and minority under-representation. The issues and factors that inform full acknowledgement and understanding of a contemporary DEI rationalization are complex and founded in history. This paper will focus on the Black American experience with racism and injustice within the frame of diversity, equity and inclusion in optometric education and practice. Strategies are provided to help address continuing challenges and shape optometry's journey toward a more diverse, equitable and inclusive future.

Key Words: *diversity, equity, inclusion, health disparity, social justice*

Introduction

Vision and eye care continue to be among the greatest unmet public health needs in the country, at a high cost to person and society.[1-7] Poor vision and eye health can result in impaired cognitive, social and physical development, low academic performance, employment and economic insecurity, loss of independence, environmental challenges and millions of dollars in unnecessary medical care and lost quality of life years.[8,9] In spite of national health expenditures being at almost 18% of the gross domestic product, barriers to primary vision and eye care persist throughout our nation, most noticeably in underserved populations of color where the risk of eye disease and visual impairment is highest.[5,10] A significant barrier to equitable care is the low representation of optometrists of color, predestined by the low representation of optometry students and faculty of color.[8,11]

It is antithetical that the populations most at risk for disparate vision and eye health and in need of care are the populations least represented among eyecare practitioners and those training in the schools and colleges of optometry. The shifting U.S. demographics and associated health indices impose a continuing urgency for optometry to build a workforce that appropriately reflects the diversity of those it serves. Efforts to increase racial and ethnic diversity are justified mostly from a representational perspective. A more defining justification builds from the scaffolding of social injustice and health disparity at the intersection of inequity and under-representation and is "best understood in the context of the history common to minority health and minority health professionals in America."[12] However, discussions of minority under-representation and disparate health and health care often fail to consider the historic context that helped shape their present state. One must look beneath the surface of casual familiarity with history and confront the historical arc of social injustice to comprehend its legacy on the

complex nexus of issues that inform today's conscience. While cognizant of the negative social experiences and challenges impacting Latinx, Indigenous and other racialized people, this paper focuses on the Black experience of racism and injustice in the United States. Implications for optometric education and practice will be considered within the frame of diversity, equity and inclusion (DEI).

A Year of Vision

The year 2020 was to be "The Year of Vision" with national attention fixed on achieving optimal clarity. The year turned out truly to be a year of vision, but not the one anticipated. Misinformation, distrust, a teetering and racially charged social climate and the invasion of the novel SARS-CoV-2 on a slowly responsive and ill-prepared healthcare system unveiled a pressurized society on the brink of ecologic decay. The syndemic of systemic racism, bigotry, brutality and the disproportionate and devastating health and economic impact of COVID-19 on the lives of Black, Latinx and Indigenous people laid bare the ugly and painful reality of racial injustice and inequity in health and health care in the United States.

The spotlight on the intersectionality of social injustice and the racialization of health exposed a healthcare system that often fails the needs of marginalized communities. This exposed failure also shed light on the compounding effect of overlapping burdens and vulnerabilities arising from converging systems of injustice (e.g., racism, sexism, ageism, ableism, cisgenderism) that synergistically discriminate and oppress along intersecting axes of multiple social inequalities and marginalized social identities.

The confluence of separate but related high-profile events in 2020 galvanized a national awakening of consciousness unparalleled since the 1960s Civil Rights Movement, compelling a public reckoning on systemic racism and social injustice.

The year witnessed global protests, candid exchanges about race and bias, publicized commitments to social justice, renaming buildings and removing imagery that reflect racist and oppressive histories (e.g., the American Medical Association archived the bust of Dr. Nathan Davis – the "father of the AMA" – and removed his name from an annual award for his role in "blocking integration and promoting and embedding racism in the AMA").[13] Dismantling the subtle and not so subtle residuals of racial injustice and discrimination should not be conflated with division, but seen as essential to creating a culture of inclusion and equity in a race-conscious society. The year 2020 made it clear that no longer can society look past the immorality and corrosive effects of racism and injustice across the spectrum of human engagement.

Race, History and Health Disparity

From early 1900 to today, racial health disparities have been well-documented at an estimated $93 billion in excess medical care costs per year.[14-18] Interlandi hypothesized that they are "as foundational as democracy itself," implying disparities have always existed as part of the tapestry of U.S. history.[19] Differences in how population groups access and experience health care are routinely stratified by race. Race then becomes a convenient social marker for categorizing disease risk, prevalence and outcome based on phenotype. While race may carry "significance as a sociopolitical lens through which to study racism and inequity," its utility as an epidemiologic tool in population health is under challenge, particularly its employment in the flawed assumption that a socially, politically and legally constructed racial category tied to skin color reflects an innately discrete biology (racial essentialism) and is the putative cause of health disparity.[20-24] Complex identities, such as self-identification as being of two or more races, further complicates race as a discrete biology and the causative factor in racial disparities.[24] It has been posited that racial health disparities often are clinical manifestations of enduring social and economic inequities and more likely the result of the experience of historically entrenched racism, not biology, where race exists as a "social construct that precisely captures the impacts of racism" on

health.[21,22,24-27] The American Public Health Association and a growing list of cities and counties in 41 states and the District of Columbia have declared racism a “public health crisis,” and the American Medical Association identified it as a “serious threat to . . . the advancement of health equity and a barrier to appropriate medical care.”[21,28] The Centers for Disease Control and Prevention also affirmed racism to be a “serious public health threat” and launched a “Racism and Health” web portal.[29]

As Black, Latinx, Indigenous and other racialized communities struggle disproportionately and unnecessarily with undiagnosed and/or untreated vision and eye morbidity, projections of increasing disparity illuminate a less than optimistic trajectory toward racial and ethnic vision/eye health equity.[5,30] The incongruity between health inequity and social justice places an unnecessary, avoidable and unjust, but often unexamined, social tax on the most vulnerable populations. It is customary to teach about associations between race, ethnicity and ocular morbidity and the downstream effects on such life events as learning, employment and recreation. Yet, in pondering interventional strategies for racially, ethnically and culturally diverse patients, how often do we acknowledge that health and illness have – in addition to a biomedical context – a social, cultural, behavioral, environmental, political and legal context? That is, how often do we take a population health approach to understanding the non-biomedical drivers (e.g., systems, policies and practices) of health inequity and attack population gaps by looking upstream at the primordial (e.g., environmental, social, cultural) determinants of vision and eye health and their attendant ill effects on quality of life in racialized communities? Do we attempt to understand the root causes of the sociodemographic conditions that predetermine disparate vision/eye health or how cultural beliefs and patient-provider discordance play on the risk ratio of disproportionate morbidity? How often is health equity in the context of the social determinants of disparate health – including racial discrimination and bias – critically analyzed from the perspective of comorbidity, social epidemiology and patient-centered care?

Discussions about racism and the upstream insults that drive health and healthcare inequities in racially minoritized communities are often omitted from the health professions classroom, where educators may pathologize race without acknowledging the effect of racism on minority health.[25,27,31] A 2021 paper in *The New England Journal of Medicine* (NEJM) suggests, “Faculty and students need a more complete view both of U.S. history and of the ways in which medicine and public health have participated and continue to participate in racist practices.”[32] A myopic view of racial history and its effects on the health of minoritized communities contributes to a failed understanding of the upstream roots of morbidity and disregards the social experiences and environmental conditions that affect health outside the conventional model of clinical care.[33] Where a person is born, lives, learns, works and plays influences the receipt and outcomes of health care.[34] Educators and providers cannot afford to continue focusing only on the downstream, micro- (individual) level consequences of disparate health care while disregarding their upstream, meso- (health community) and macro- (policy) level drivers.[31] Responsible training is incomplete without a discussion of the social determinants of health as “historical roots of contemporary health disparities.”[35,36]

Acknowledging the vestiges of racial inequity in the epidemiology of ill health may be new for some in the academy, but not for the descendants of the physical, emotional and social damage inflicted by centuries of discrimination and abuse. One cannot deny without applying revisionist history to the conversation that the Black experience with racialized health inequities in America started 400 years ago with the introduction of chattel slavery during European colonization. An ill-founded belief in a fabricated racial hierarchy of human value based on skin color disenfranchised and discounted enslaved Black people to three-fifths of a person and excluded them from the unalienable right of life, liberty and the pursuit of happiness, including good health. The racist ideology held by much of the dominant group at the time, including the Eurocentric medical community, buttressed the stage for years of non-consensual, exploitive, unethical, immoral and in many cases sadistic medical procedures and non-therapeutic, pseudoscientific experimentation. It was an era replete with such abject indignities as degrading, painful

and unanesthetized surgical experiments and “Mississippi appendectomies” on Black women, exploitation of the harvested cervical cancer (“HeLa”) cells of Henrietta Lacks and the infamous and relatively recent (1932-1972) U.S. Public Health Service-sponsored “Tuskegee Study of Untreated Syphilis in the Negro Male.”[37-43]

Non-factual myths about the anatomy and physiology of Black people were articulated to justify slavery, sanction exploitation and oppression and sustain convenient, but false, narratives about their biological inferiority (such as having smaller brains, thicker skin, less sensitive nerve endings, blacker blood, harder bones, weaker lungs, stronger sight and seldom need for spectacles).[37,38,44] Complicity by the medical community in promoting specious ideologies of an inferior racial biology and lower intelligence erroneously “validated” the fallacious and egregious claim that enslaved men and women were ideally suited for servitude in the sunbaked cotton and tobacco fields of slave masters.[38] The May 1851 issue of The New Orleans Medical and Surgical Journal claimed, “The field of vision is not so large in the negro’s eye as in the white man’s. He bears the rays of the sun better, because he is provided with an anatomical peculiarity in the inner canthus, contracting the field of vision, and excluding the sun’s rays.”[44] Harriet Washington peeled away the layers of medical racism to reveal that, “Slavery created a medical partnership between physician and planter that eclipsed the patient-physician dyad” and that medical schools and hospitals were thought of by Black Americans as “places of terror, violence and shame, not of medical care.”[37] A 2020 NEJM editorial opined that slavery’s “legacy of racism, injustice and brutality runs from 1619 to the present and infects medicine as it does all social institutions.”[33]

The toll in lost health and lost trust levied by scientific racism and exploitation continued across generations to weigh on the present-day bodies and minds of Black and Brown Americans and refuel deep-seated skepticism about the interest and integrity of the U.S. healthcare system.[25,37] Commenting on racism in systems of care, Doubeni et al. state, “Even when deemed unintentional, well-documented structural inequities are evident within the healthcare ecosystem that span the entire prevention-to-treatment continuum.”[45] Biased risk assessments, faulty race-norming algorithms and persistent discriminatory beliefs influence healthcare decisions and, as recently as 2020, 20% of Black adults reported experiencing unfair treatment in getting health care in the previous 12 months because of their race.[38,46,47] Former U.S. Surgeon General David Satcher and Daniel Dawes wrote recently that, “medicine still struggles with how to advance health equity, quash racist beliefs and biases in the profession, and reform racist systems and structures that have created, perpetuated, and exacerbated the health inequities that continue and are experienced by many in US society.”[48]

Diversity, Equity and Inclusion

Diversity, equity and inclusion are essential attributes of social justice and represent investments in educational and clinical excellence, thereby commanding a strong presence on both sides of the classroom podium, in clinical practice and research and in the corporate suites and boardrooms of ophthalmic corporations and professional associations. **Figure 1** models the role of DEI in creating social climates that channel health equity and social justice through positive interactions and outcomes to facilitate culturally mindful care and enhanced quality of life.

Diversity

Patients and providers are more likely today, and in the future, than at any time in the past to bring to the clinical encounter a wide cross-cultural array of clinically relevant needs, attitudes, customs, values, beliefs, preferences, assumptions, expectations, practices and fears that decode experiences, shape perspectives, affect decisions and drive behavior. Intercultural encounters in discordant patient-provider dyads can introduce non-traditional variables into the traditional biomedical paradigm of clinical care and create obstacles to productive communication and interaction. A lack of concordance could curb expectations, widen the health disparity gap and generally limit the quality of the patient-provider

relationship. [8,18,49]



Figure 1. Creating diverse social climates that foster health equity and social justice through attributes of diversity, equity and inclusion in vision and eye care. Click to enlarge

In a modern society, healthcare professionals are ethically and professionally obliged to provide the best possible care that supports the health and well-being of all patients, irrespective of personal identities and characteristics. It is important for optometrists and optometry students to understand how diversity influences care and affects outcomes in order to achieve optimum vision and eye health for everyone. The Institute of Medicine acknowledged that "greater diversity among health professionals is associated with improved access to care for racial and ethnic minority patients, greater patient choice and satisfaction, better patient-provider communication, and better educational experiences for all students while in training."[50] Racial and ethnic diversity also promotes culturally mindful care, trust in the healthcare system, participatory decision-making, timely treatment decisions, patient compliance and different ways of contextualizing solutions to enhancing quality of life.[49-52]

Equity and inclusion

Diversity is necessary, but insufficient as a climate-changer in the absence of equity and inclusion. Equity implies fundamental fairness, grounded in the ethical principles of distributive justice and is both a means and an end.[53] Racial equity, where outcomes are unaffected by race and all people have the opportunity to achieve their full potential, requires eliminating discriminatory inequalities that negatively affect the life course of racialized groups. Equity is different from equality in that equality assumes same treatment in a meritocracy, without necessarily acknowledging and responding to historical social inequities and structural barriers impacting marginalized groups. Racial equity is central to health equity – the overarching goal of "Healthy People 2030" – and both are foundational to meeting the moral obligation and public health imperative of eliminating avoidable and unfair racial and ethnic disparities in health and health care.[54]

Inclusion is a sense of belonging through welcomed engagement and valued participation. It is an intentional and continuous process to combat racial isolation, "othering" and the feeling of being invisible, overlooked, unacknowledged, undervalued and dismissed in a racially or culturally alienated and otherwise diverse, but White-defaulted, environment. Diversity and inclusion strategist Vern? Myers states, "Diversity is being invited to the party; inclusion is being asked to dance."[55] Inclusion in optometry also encompasses culturally responsive mentorship of students and faculty who may not yet know how to "dance" gracefully in the unfamiliar ballroom of academic optometry. Institutions and individuals that practice cultural humility with an orientation and a lack of superiority toward others are more apt to be open and respectful of diverse cultural backgrounds and experiences.[56] The Vision Council's 2020 Diversity, Equity and Inclusion Survey of the ophthalmic industry found that less than 75% of non-White students (68%) and non-White respondents from academia (72%) reported feeling "comfortable bringing their authentic 'whole self' to their institution/work," while only 58% of non-White student and academic respondents feel they have "the ability to voice concerns about diversity, equity and inclusion without fear of negative consequences."[57] Inclusive excellence requires that everyone has the ability to speak, learn and succeed without fear. Seeing others through their personal lenses and valuing their perspectives are necessary qualities of an inclusive social and professional environment.[58]

Unconscious Bias

Each of us presents as a blend of cultures conditioned by the collective and diverse places and spaces of our age, race, ethnicity, gender identity, sexual orientation, education, religion, socioeconomic status,

geographic residence, national origin and occupation. Mediated through our composite cultures and lived experiences are our conscious (explicit) and unconscious or automatic (implicit) biases. Not all biases are bad, but those based on erroneous premises, fabricated negative beliefs and the baggage of narrow intercultural experiences pose real challenges to equity and inclusion. Eliminating negative biases through constructive interactions with diverse communities and reassessing assumptions and behaviors through objective exposure is fundamental to cultivating inclusivity.

Consciously, one may deplore harboring negative biases, but "implicit attitudes often exist outside of conscious awareness," and implicit measures of bias like the Implicit Association Test may unveil previously unaware dissociations between conscious and unconscious attitudes.[59,60] Greenwald and Krieger advise that implicit biases are "especially problematic because they can produce behavior that diverges from a person's avowed or endorsed beliefs or principles."[60] For example, socially sensitive (e.g., inter-racial) interactions could constrain persons from consciously acting on negative beliefs or stereotypes with overtly discriminatory attitudes or behaviors, while subconsciously veiling beliefs dissonant from their outward expression. Although healthcare providers may be well-intentioned, research has demonstrated that the implicit attitudes and behaviors of healthcare providers are among the factors that affect decisions, interfere with participatory, patient-centered care and contribute to racial health disparities.[59] Because health professions students may demonstrate implicit biases similar to those of practitioners and subsequently carry them forth into clinical practice and patient care, it is essential that faculty and all other actors within the student-to-practitioner pathway self-interrogate their own biases and subtle messaging to ensure equitable and safe learning spaces.[23,59,61] Wilson asserts, "The more we consciously think about the things we normally do without thinking, the more we can become better healthcare providers and medical educators who can effectively shepherd a system toward greater health equity."[62] Providing opportunities for medical students to learn to recognize and address biases, in both themselves and others, is an accreditation standard for U.S. medical education programs.[63]

It is not unusual for clinicians to apply "cognitively beneficial" associations based on race (e.g., glaucoma risk) – albeit potentially reinforcing race as a biological factor – as shortcut hypotheses about patients and their conditions.[23,64] But a preconceived judgment about the success potential of an aspiring student based on phenotype and acting on that judgment is like making an across-the-room, race-centered diagnosis about the health posture of a minority-presenting patient without further clinical assessment. Such practices, whether in the admissions process or during didactic and clinical training, disadvantage minoritized students at two levels: 1) differential assumptions about the abilities of "others" based on their race (personally mediated racism); and 2) assent to the negative stereotypes and assumptions about one's abilities (internalized racism).[25,26,65,66] Internalized racism can cause minoritized students to become discouraged and lose faith in their own capabilities (imposter syndrome). Additionally, the internal response to chronic racism, the hyper-vigilance of a racially marginalized identity and the emotionally burdensome struggle to cope, be accepted and belong can lead to cumulative toxic stress (allostatic load) and the psycho-social strain of "racial battle fatigue."[25,67,68] The need to justify one's qualifications and presence against stereotype threats arising from an insidious undercurrent of unchecked biases and assumptions, unfair generalizations, lowered expectations, macro- and microaggressions, invalidation, tokenism, coded messages and perceived discrimination can contribute to feelings of alienation, anxiety, depression and low self-concept that undermine the educational experience for minoritized students and faculty.[25,66-68]

"Social Indifference or Blatant Ignorance" Revisited

Ever since William H. Lawson graduated from the Toronto School of Optometry in 1912 and became the first Black optometrist licensed to practice in the United States, Black Americans have been under-represented in optometry. In an unpublished 1960 paper, Charles Comer – the first Black graduate of the Indiana University School of Optometry – estimated Black representation at 0.6% with a ratio of 0.7

Black optometrists per 100,000 Black population.[69] Almost 50 years ago and 12 years after Comer's paper, Marshall estimated a minority (including Asian) presence at 1.3% of practicing optometrists and a ratio of 1.1 minority optometrists per 100,000 minority population – and an even lower Black presence (0.5% of optometrists and 0.5 Black optometrists/100,000 Black population) than what was estimated by Comer.[70] Marshall's 1970-71 academic year survey of the then 12 schools and colleges of optometry indicated that the enrollment of Black students also was at 0.5%.

Citing "social indifference or blatant ignorance," Marshall challenged those in the profession who were insensitive to the under-representation of Black and Hispanic optometrists and/or refuted the need for special efforts to increase diversity, hiding behind claims that minority recruitment programs necessitate remedial courses, extended time in school, reduced admissions standards and extensive tutorial programs.[70] Fortunately, such views were not in the majority. Marshall's survey revealed that two-thirds of U.S. optometric institutions had programs to recruit minority students. From 1972 to 1980, the National Optometric Association (NOA) "Project to Increase Minority Optometric Manpower," with support from the federal Health Careers Opportunity Program (HCOP), worked closely with the schools and colleges of optometry to increase under-represented minority (URM) student enrollment. In the 1970s and 1980s, HCOP supported a number of pre-health professions summer enrichment programs, including the Indiana University School of Optometry Summer Institute in the Health-Related Professions. The Institute, which ran from 1973 to 1990, was strategic in attracting large numbers of URM students for whom optometry was relatively unknown and not part of their original career horizon, but who discovered it during the 6-week program. Through its "Developing a Diverse Applicant Pool in Optometric Education Mini-Grant Program," the Association of Schools and Colleges of Optometry (ASCO) provided seed money from 2006-2015 to assist schools and colleges with programs to recruit and retain URM, financially disadvantaged and first-generation college students. A number of optometric institutions continue to host, either separately or in collaboration with other health professions schools, pre-optometry summer camps directed at URM and first-generation students. ASCO's 2004 "Road Map for Diversity in Optometric Education and the Profession" and its "2005-2006 ASCO Diversity Action Plan" called on member institutions to foster climates that welcome and embrace diversity by making it a core value in their missions, goals and objectives. Despite these efforts, there has been little change in Black student diversity in the 60 years since the Comer estimates.

Table 1. Click to enlarge

Table 2. Click to enlarge

Table 3. Click to enlarge

Table 4. Click to enlarge

A statistician could argue that by 2015, the percentage of Black optometrists had increased three-fold and the ratio of Black optometrists to the Black population had increased two and a half-fold (three and a half-fold from the Marshall estimates). However, at 1.8% of the profession and 1.7 Black ODs per 100,000 Black population (compared to 15.2 White ODs per 100,000 White population), Black optometrists remain woefully under-represented and least available to Black patients **(Table 1)**. The ratio of the percent of Black optometrists to the percent of the Black population yields a Black diversity ratio of 0.1 (1.0 = parity), a further expression of severe under-representation. Similarly, Hispanic optometrists were under-represented at 3.9%, with a Hispanic optometrist to Hispanic population ratio of 2.6 per 100,000 and a Hispanic diversity ratio of 0.2. Reliable data were not reported for Indigenous optometrists; however, it is reasonable to expect comparable levels of under-representation. Despite being 30.7% of the population, under-represented minorities comprised only 5.7% of optometrists and 6.0% of ophthalmologists **(Table 2)**. Black and Hispanic practitioners fall at the low end of representation across the range of health professions, with ophthalmology showing a slightly greater Black practitioner representation than optometry. Black and Hispanic faculty in the schools and colleges of optometry increased modestly from 2.9% and 5.3%, respectively, in 2015 to 3.6% and 5.7% in 2020 **(Table 3)**. The continuing low presence of URM faculty can present a structural barrier to attracting and recruiting URM

students and assuring inclusive excellence in optometric education.



Figure 2. Numerator derived from Association of Schools and Colleges of Optometry. Annual Student Data Reports [cited 2021 June 1]. Available from: https://optometriceducation.org/data-reports/data-surveys/; denominator derived from U.S. Census Bureau. ACS Demographic and Housing Estimates [cited 2021 May 29]. Available from: https://data.census.gov/cedsci/table?d=ACS%201-Year%20Estimates%20Data%20Profiles&tid=ACSDP1Y2015.DP05. Click to enlarge

Hispanic optometry student enrollment increased from 4.5% to 7.2% during the past 10 years, but Black enrollment stayed relatively flat – increasing by only seven-tenths of a percentage point from 2.7% to 3.4% **(Table 4)**. There were 89 more Black students and 258 more Hispanic students enrolled in 2020-21 than in 2010-11, while Asian and White student enrollment jumped to 444 and 336 more students, respectively.[11] The 2020-21 first-year matriculant/applicant ratio was 0.5 for Black students and 0.4 for Hispanic students, compared to 0.7 and 0.8, respectively, for Asian and White students, but only 6.0% of the year's applicants were Black with 12.6% being Hispanic. At 0.3 and 0.4, the 2020 Black and Hispanic OD graduate diversity ratios appear insufficient to effect meaningful positive change in the diversity of the optometry workforce **(Figure 2)**. Based on the total number of OD graduates in 2020, 174 more Black optometrists and 193 more Hispanic optometrists would have had to have graduated in 2020 to begin to approach representational parity in the profession. In 2016, the National Academies of Sciences, Engineering, and Medicine reported that "diversity in the eye and vision care workforce is important to address some of the inequities in eye and vision outcomes," but "the lack of diversity in schools and colleges of optometry is a substantial problem."[8] The ASCO "Optometry Gives Me Life" campaign, which showcases optometrists from diverse backgrounds, has begun to show promising results. The number of Black and Hispanic applicants using the Optometry Centralized Application Service (OptomCAS) increased by 14.3% and 19.4%, respectively, between the application cycles of 2019-20 and 2020-21.[71,72] The increase in applications in 2020-21 resulted in Black and Hispanic enrollment increasing by 17.6% and 8.3%, respectively, to 4.0% and 7.8% in 2021-22.[73]

The Response to 2020

The year of vision exposed unanswered questions, tremendous challenges and troubling uncertainty, while at the same time provided clarity about the need to accelerate efforts for achieving a social atmosphere framed in justice, diversity, equity and inclusion. Olayiwola et al. acknowledged that a shift in culture is needed and it "must begin in health professions education, where we bear the responsibility of training the very clinicians who will treat maladies that are caused by and reinforce racial injustice."[31] Concerned about systemic racism and its impact on Black representation in the profession, students from the SUNY College of Optometry class of 2020 and signatories from across the country in a letter to ASCO called upon optometry educators and leaders to make Black representation a priority with a more diverse and welcoming academic community. Organized optometry, its ophthalmic cousins and the schools and colleges of optometry reacted to the year 2020 with a resolve to imbue racial equity throughout the vision and eyecare space.



Table 5. Click to enlarge

The Black Eyecare Perspective (BEP) Open Your Eyes video and the SUNY College of Optometry

webinar series on Race in Optometry increased awareness of the discrimination and anxiety experienced by Black optometrists in the U.S.[74,75] The personal stories and honest, open and sometimes uncomfortable conversations provided unfortunate but informed testaments to the realism of ongoing racism and the continuous threat of a "racial hierarchy that, although officially abolished, remains deeply embedded in our social fabric and unconscious attitudes."[52] A number of the schools and colleges of optometry and optometric organizations hosted profession-wide webinars and virtual town halls to further discussions about race and the importance of DEI. Many also created DEI task forces, committees and/or staff positions to advance diversity and inclusion strategies and facilitate a culture of understanding and inclusiveness. The American Optometric Association (AOA) resolved to build a diverse profession with "a renewed effort to address gaps in access to professional education in optometry for members of under-represented minority groups due to the ongoing impact of past discrimination."[76] The year of vision also prompted growth in new scholarship commitments for increasing Black student enrollment in the schools and colleges of optometry. **Table 5** provides an overview of some of the recent actions implemented to promote a more diverse, equitable and inclusive optometric profession.

Recommendations for the Ophthalmic Community

Optometry's schools and colleges, with support from the professional community at-large, must lead the way with intentional, collaborative and sustained action through vested commitment, delineated plans, accountable infrastructures, sufficient resources, institutional will and a "woke" social posture. The following recommendations are suggested to help shift the profession toward being more responsive, representative, equitable and inclusive.

Schools and colleges/ASCO

Climate initiatives

- Provide a welcoming and reassuring public face through webpages populated with mission statements, images and resources that communicate an institution that embraces and lives diversity, equity and inclusion
- Display an ambience of inclusive excellence with visible celebrations of distinguished alumni and faculty of color (e.g., wall of recognition)
- Explore and assess (e.g., via climate surveys) the intent vs. impact of behaviors and perceptions, the presence of biases in policies and practices that impede an equitable and inclusive learning/working environment and formulate culturally responsive mitigation strategies with clear and accountable metrics and dashboards
- Decolonize the curriculum by critically addressing the manner in which race and ethnicity are used in didactic and clinical teaching with intentional inclusion of population-representative narratives and references, culturally responsive case studies and simulations and objective challenges to race-based assumptions, biases and norming while explicitly characterizing race as a sociopolitical construct
- Create opportunities to educate on the social determinants of health, health disparities and cultural beliefs and practices in the context of delivering quality health care
- Foster health as a building block of social justice through cultural humility, patient-centered care and community education and service
- Structure faculty performance evaluations to value: 1) scholarly activity on racial and ethnic vision/eye health disparities; 2) the effects of racism on quality care and vision/eye health; and/or 3) research on evidence-based interventions for improved minority vision/eye health
- Sponsor annual faculty lectures or interdisciplinary summits on vision/eye health equity
- Establish an administrative position with institution-wide authority, leadership and expertise for DEI advocacy, programming, goal attainment and assessment

- Conduct dean/president-led annual intra-institutional town halls for faculty, staff and students to share, listen, assess and respond to DEI concerns, issues and plans
- Form alumni diversity affinity groups and employ advancement offices to advocate endowments for minority student scholarships and minority faculty professorships

Student recruitment and support initiatives

- Partner with federal programs, foundations, academic centers and the corporate community to support summer enrichment and bridge programs for undergraduate STEM and health professions career-seeking students of color
- Establish relationships with academic/career advisors and STEM faculty at minority-serving institutions and invite them to “Introduction to Optometry” virtual meetings
- Sign on to the BEP “13% Promise” with the goal of attaining a Black student enrollment of 13%
- Partner with the NOA “Visioning the Future” historically black college and university (HBCU) mentorship program and the BEP “Impact HBCU: If You See It, You Can Be It” initiative to provide HBCU students with career planning, resource guidance and social, academic and financial support to become optometrists
- Facilitate optometry student and alumni support of the BEP Pre-Optometry Club and expand connections with student organizations, pre-health professions clubs and advisors to build URM pre-optometry cohorts
- Support the National Optometric Student Association/American Optometric Student Association (NOSA/AOSA) Diversity Optometry Program in its efforts to expose optometry to Black and other minority undergraduate students by encouraging alumni to volunteer as undergraduate student mentors
- Appoint URM members to the admissions committee and apply transparent, holistic reviews in a socially accountable admissions process that balances objective metrics (e.g., grades, test scores) with personal attributes (e.g., persistence, leadership skills) and diverse lived experiences that reflect institutional goals for enrollment diversity
- Host a reception/dinner with the local NOSA chapter and minority alumni at the start of the academic year to welcome new incoming URM optometry students
- Develop and support a web-based, interactive, virtual network among the national cohort of optometry students of color (i.e., NOSA members across ASCO institutions) and alumni of color to create a platform of culturally responsive mentor/peer support, belonging and engagement
- Publicize to URM pre-health professions students the institution’s curricular and research attention to health disparities, the social determinants of health and vision/eye health equity

Faculty development initiatives

- Encourage, sponsor and mentor optometry students of color to undertake a residency after graduation with the goal of pursuing a career in academic optometry
- Implement processes to attract optometry students of color to graduate study in vision science, basic science or public health (via combined degree or postgraduate programs) through one-on-one mentorship and shadowing opportunities, laboratory experiences, financial assistance and directed guidance toward an academic career
- Establish a loan forgiveness path for URM optometrists who enter the optometry professoriate
- Recruit faculty of color in the basic sciences through collaborative research bridges with graduate programs at minority serving institutions
- Provide mentoring and leadership opportunities to support the career development and advancement of faculty of color to administrative positions (department chair, dean, president)

Optometric associations and regulatory bodies

- Implement an aggressive and collaborative multimedia and in-person recruitment program targeting elementary (starting in the third grade), high school (health science magnet schools) and undergraduate (HBCUs and other minority-serving institutions) students of color and involving optometrists of color from the American Academy of Optometry, AOA, ASCO, NOA and the optical industry to increase exposure to the optometric profession and generate awareness of vision/eye health disparities and the need for a racially and ethnically diverse workforce
- Showcase the profession with recruitment narratives that speak to diversity via “Stories from the Community” about the merits and joys of culturally-centered optometric practice
- Identify a geographically broad cadre of practitioners of color to serve as local mentors and role models to optometry and health professions career-seeking students of color
- Engage optometric associations in a “Bridge to Optometry” program where URM undergraduate students (e.g., “Visioning the Future” and “Impact HBCU” participants) are invited and sponsored to attend lectures and visit exhibit halls at national, regional and state optometric conferences to connect with mentors and cultivate insight into optometry
- Seek ophthalmic industry allies for increasing the visibility of optometrists of color in industry-sponsored product ads, sponsoring health fairs in communities of color and providing paid pre-optometry summer internships and endowed optometry scholarships for students of color
- Expand use of optometric practitioners and faculty of color as key opinion and thought leaders and decision-makers in industry, on governing, advisory and editorial boards and as presenters at professional meetings
- Encourage national, regional and state credentialing and accrediting bodies to incorporate DEI-conscious practices (e.g., cultural competency/humility training) as quality of care measures in their assessment standards
- Embed social justice into organizational policies and practices, make health equity a strategy to quality care and introduce it as a repetitive theme at professional conferences and work collaboratively with other health and non-health sectors to explore interprofessional approaches to eliminating social and structural barriers that contribute to the persistence of racial/ethnic health disparities

Conclusion

As we continue to live in challenging times, in many respects the issues and opportunities of today are not new. It was in 1972 when Marshall wrote, “It is appalling to think it took over 300 years for the souls of the masses of this great nation to be touched by the social concern that is so prevalent today.”[70] What may appear like new conversations are essentially extensions of more than 5 decades of dialogue along the justice, diversity, equity and inclusion journey. “Marathon” often is cited as a metaphor for the DEI process that lies before us, but let us not lose sight of the fact that the optometry diversity marathon started decades ago and continues today as a slow race to progress.

The year 2020 left us with what Martin Luther King Jr. referred to as “the fierce urgency of now,” placing us at a critical inflection point for positive change toward reconciling our history and advancing racial justice and health equity. Status quo is not an option. The only choice before us is to catalyze and enhance the energy and momentum from “The Year of Vision” to effect meaningful, sustainable change with audacious goals and industry-wide clarity based on a common platform of accountability. The 2020 wake-up call re-established the social justice agenda under a renewed consciousness of overdue urgency. It is beyond time to push forward in solidarity with enhanced mindfulness and humility, socially conscious and just values, clearly focused and purposeful intention and transformative action to achieve a profession with a racial, ethnic and cultural complexion that mirrors the U.S. population and one that is prepared to advance equitable care and remedy the vision and eye health disparities so prevalent among racialized communities.

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