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ReachMD

www.reachmd.com
info@reachmd.com
(866) 423-7849

Implicit Bias in Uncontrolled Asthma Care: Impacts on Clinical Decision-Making

Announcer:

You're listening to *Deep Breaths: Updates from CHEST* on ReachMD. This series is produced in partnership with the American College of Chest Physicians, and this episode is a non-promotional, non-CME educational program brought to you by CHEST in collaboration with and sponsored by GSK. And now, here's your host, Dr. Isaretta L. Riley.

Dr. Riley:

This is *Deep Breaths: Updates from CHEST* on ReachMD. I'm Dr. Isaretta Riley, Assistant Professor of Medicine at Duke University School of Medicine in Durham, North Carolina. Joining me today to discuss research on unconscious bias in uncontrolled asthma treatment are Drs. Nicola Hanania and Jay Peters. Dr. Hanania is a Professor of Pulmonary Medicine and the Director of Airways Clinical Research Center at Baylor College of Medicine in Houston, Texas. Dr. Hanania, welcome to the program.

Dr. Hanania:

Thank you, Dr. Riley, for having me. It's a pleasure to be here, and I look forward to our fruitful discussion.

Dr. Riley:

Also with us is Dr. Peters. He's a Professor Emeritus of Medicine in the Division of Pulmonary Diseases and Critical Care Medicine at the University of Texas, San Antonio. Dr. Peters, thanks for being here.

Dr. Peters:

No, thank you for inviting me. It's a very interesting discussion, and we look forward to talking about unconscious bias in the treatment of uncontrolled asthma.

Dr. Riley:

First, let's discuss asthma disparity. Disparities in asthma outcomes are most pronounced among racial and ethnic minoritized persons and low-income populations. These groups experience higher rates of asthma morbidity, hospitalizations, and mortality compared to white and higher-income populations.

Causes of these disparities are multi-factorial, including differential exposure to low-socioeconomic factors, poor housing conditions, environmental exposures like air pollution, systemic racism, and limited access to quality healthcare. Implicit bias in healthcare, along with inadequate patient-provided communication and cultural misunderstandings, can also exacerbate these disparities by leading to misdiagnosis, undertreatment, or delayed care.

Healthcare providers play a critical role in addressing these disparities by recognizing and mitigating biases, considering the broader social and environmental contexts of asthma, and ensuring that all patients receive personalized equitable care.

Now, let's start our discussions with you, Dr. Hanania. Could you provide some background on unconscious bias and how it could impact clinical decision-making?

Dr. Hanania:

Sure, Dr. Riley. Thanks for, again, your introduction. I think bias in general, either positive or negative, is a filter through which we evaluate the world. And, obviously, both positive and negative biases, as clinicians, may impact our clinical decision-making. In bias, we can have explicit bias where the person would know that an evaluation is taking place.

However, implicit or unconscious bias includes the subconscious feelings, attitudes, prejudices, and stereotypes that an individual has

that developed from learned experiences and other influences that imprint throughout their lives. Both implicit and explicit bias are problematic and can lead to discriminatory behavior, influence decision-making, impact communication with the patient, and, ultimately, result in suboptimal delivery.

And so, within the healthcare settings, biases may exist regarding age, education, gender, geographic location, body habitus, race, sexual identity, and socioeconomic status. The data on unconscious bias in healthcare, particularly related to asthma, in patients with asthma, are limited, and that is the focus of our research in this area.

Dr. Riley:

Thank you. With that in mind, Dr. Peters, let's turn to you now to discuss the research CHEST conducted on this topic. What was the objective of the study?

Dr. Peters:

When you look at medical literature, it's quite clear that you can find numerous articles and studies looking at unconscious bias and how it impacts the care that physicians provide to their patients. A lot of this data really relates to disparity of cardiac care received by women, especially black women, compared to the care that's received by males.

There's also a lot of data about the disparity of care given in the emergency room, showing that females of any race actually receive less referrals to specialists or procedures than their male counterparts. Unfortunately, when we were trying to find data on whether race, gender, and socioeconomic status impacts the care provided by both primary care physicians as well as pulmonologists and the treatment decisions of patients with uncontrolled asthma, we were really unable to find any data that addressed this particular issue.

So the purpose of this study was to assess the impact of unconscious bias in providing care to patients with uncontrolled asthma. Additionally, we sought to assess physicians' awareness of healthcare equity and adherence to using validated asthma-control questionnaires as well as spirometry in the management with patients.

Dr. Riley:

And Dr. Hanania, what was the methodology for this research?

Dr. Hanania:

So, the study was conducted by CHEST—the American College of Chest Physicians—and it included an online survey with a sample of pulmonologists and primary care practitioners. We had about 150 pulmonologists and 163 PCPs. We were very careful in identifying individuals who care for patients who have historically experienced systemic bias in their medical care.

How we picked out pulmonologists is we sampled them from the CHEST analytic database. The sampling targeted pulmonologists with practice location by zip code, located within two miles of zip codes with low- or lower-middle income-based patient population based on the U.S. census data. The pulmonologists we picked were screened at the start of the survey to meet the qualifying characteristics that we mentioned. The primary care practitioners were accessed via commercial research panels and qualified for the study based on the responses to some screening questionnaires.

Now onto the actual survey. We designed two cases of asthma: one type 2 asthma, and the other one was non-type 2 asthma. And to assess the unconscious bias in the treatment decision, responders were exposed to two pairs of patients: one pair with non-type 2 asthma and one pair with type 2 high asthma. and we had scenarios that were changed from one scenario versus the other based on demographics, social history, medical records, medication records, and patient reports.

And then we asked questions to these physicians. Responders were asked an identical set of follow-up questions regarding factors that they would consider in managing the patients' perceptions they had about the patient approach, the assessment, and testing, including lung function, and next three steps they would take in managing the patient's asthma. We looked at any differences on how providers approached evaluation and management of these patients.

Dr. Riley:

For those just tuning in, you're listening to *Deep Breaths: Updates from CHEST* on ReachMD. I'm Dr. Isaretta Riley, and I'm speaking with doctors Nicola Hanania and Jay Peters about unconscious bias in uncontrolled asthma care.

So now that we have some background on this research, let's move on to the results. Dr. Peters, what were the key findings?

Dr. Peters:

Basically, one of the striking features was that over 20 percent of physicians stated that they had never heard or were unable to define health equity. Also, over a third of physicians said that they failed to use validated asthma assessment tools, and 20 percent felt they were unreliable. Additionally, less than 50 percent utilized yearly or serial spirometry to assess patients with uncontrolled asthma, and

they felt this was mostly secondary to patient non-compliance or the lack of insurance that the patient had.

The main finding of the study was that both Th2-high and Th2-low uncontrolled asthma was affected by socioeconomic factors and, to a less degree, by race. And these features actually impacted the decision-making and the therapies offered to patients with refractory asthma. Overall, considerations of using biologics in uncontrolled asthma was relatively low: 23 to 36 percent, with pulmonologists being much more likely to consider the use of biologics.

The study suggested that physicians had a tendency to attribute poor asthma control of patients in a lower socioeconomic status to a patient's lack of understanding their disease, the treatment plan, and the proper use of inhalers.

Dr. Riley:

And Dr. Hanania, how can we use these findings to inform our day-to-day clinical practice?

Dr. Hanania:

Well, as you heard, Dr. Riley, the results of the study suggest that we, as physicians, often make assumptions about factors that play a role in asthma control. They are actually not explicitly always supported by patients' data. We may not take our time to listen to the patient and make assumptions. Both knowledge and practice gaps exist with respect to awareness of health equity concepts and implementation of health equity practices.

And for pulmonologists and PCP groups, I believe they both can benefit from guidance or dissemination of effective models illustrating how the physicians can integrate in their practices some interventions that support health equity in their patients. It's very critical that assumptions made about a patient are based on discussion, exploration, and other evidence—taking the time with the patient, asking the right questions, and not assuming things based on their patient's background.

Unfortunately, we often bypass aspects of this exploration because we don't have enough time or resources, or reimbursement issues. We can perceive patient compliance using questionnaires or ordering even tests as simple as spirometry, a very important tool in not only diagnosis but follow-up of these patients.

Dr. Riley:

Thank you. And again, I would like to highlight what Dr. Hanania mentioned: that it's important that you make your clinical decisions based off discussion with the patients and not just assuming a racial-ethnic group or income group has particular barriers or particular environmental exposures. But it's really doing that detailed history and a physical, a detailed environmental exposure history that's going to help inform adequate clinical decision-making.

As we approach the end of our program, Dr. Peters, are there any final takeaways you would like to share with our audience?

Dr. Peters:

Yeah. Thank you, Dr. Riley. The most important finding of this study was that physicians appear to draw conclusions based on the perceived social, educational, and economic status of patients with uncontrolled asthma and that these perceptions actually impact their treatment plan. Across the board, the physicians felt that the lack of patients' understanding of controller medications or inhaler technique and lack of affordability of medications were the major causes of uncontrolled asthma.

While most physicians—both primary care physicians and the pulmonologists—tended to follow the stepwise approach to asthma as outlined in the guidelines, primary care physicians underutilized referral to a specialist and were less likely to consider high-dose inhaled corticosteroids combined with long-acting beta-agonists, the use of long-acting muscarinic antagonists, and biologic therapy in their treatment of uncontrolled asthma.

Finally, there continues to be a gap in the knowledge and principles of healthcare equity and the role of implicit bias that impacts patient care.

Dr. Riley:

With those insights in mind, I want to thank my guests, doctors Nicola Hanania and Jay Peters, for joining me to discuss unconscious bias in the treatment of uncontrolled asthma. Dr. Hanania, Dr. Peters, it was great speaking with you both today.

Dr. Hanania:

Thank you so much for having me.

Dr. Peters:

Thank you so much.

Announcer:

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