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EDITORIAL

Asthma education — where now?

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Nationally agreed guidelines for the treatment of asthma, emphasizing the regular use of inhaled preventative medication, avoidance of triggers and the use of self-management plans have not eliminated burdensome asthma for our hospitals and surgeries (1).

Despite modern, potent and seemingly effective treatments, asthma remains a major public health problem. In the U.K. it afflicts nearly 3.5 million people, with young adults reporting the highest rates of symptoms in Europe. It is no surprise therefore that the costs of asthma are high for patients, their families, the healthcare system and society: the total direct cost to the NHS and the indirect cost due to lost productivity and social payments totals about £2 billion per year.

Why does asthma morbidity remain so high? A possible explanation has been that patients have not been trained to use their treatments correctly. Indeed, support for this follows research indicating that as many as 50% of asthmatics do not take their treatments as prescribed. Such a hypothesis led to the widespread adoption of asthma education programmes, in the main delivered by specialist nurses in primary and secondary care, with the intention of 'educating' patients or 'telling' them what they should do.

This was very rational and therefore should have improved the patient's lot. However, the article by Morice and Wrench in this issue describes education improving patient knowledge but not affecting other outcomes such as hospital admission (2). Other education programmes have reported similarly, demonstrating improvement in knowledge but not important outcomes such as the adoption of appropriate self-management skills, improvement in symptom control or a decrease in attacks or hospital admissions (3–5).

This apparent conundrum has been explained by psychologists, who have demonstrated clearly that improvement in knowledge alone does not translate into a change in patient behaviour to master self-management skills or take control of their illness. We therefore now need to investigate the component parts that make up an education programme and determine which are effective in producing predetermined and measurable outcomes.

That education must involve the giving of information to improve knowledge is not doubted, but the process must be determined by the patient who must be involved as a partner in their care, with other dimensions, often emotional, recognized and addressed (7,8). The healthcare professional needs to improve communication skills to involve the patient in decision making, and should take into account the attitude, beliefs and feelings of the patient, especially if external factors in their social environment, such as lack of family support, affects them. This should make each consultation unique as each patient will have their own beliefs, needs and problems for which they seek a solution. However, many consultations merely involve the passive transfer of knowledge from the healthcare professional to the patient (9). This alone is bad enough, but in reality things may be worse. Recent work carried out in primary care described the different beliefs held by the doctor or nurse and the patient during a consultation. Each turned out to have a completely different agenda (10). The doctor and nurse were concerned about medications used to treat wheeze and night-time wakening; the patient on the other hand focused on an inability to take part in activities that were important to them. An education programme must now not only impart knowledge, but the patient should also be an active partner in the process; they should be allowed to develop the capacity to observe themselves, make sensible judgements and acquire the confidence and skills to take more control. This should be an active process in which the patient is encouraged to make attempts to influence and take decisions (11). This type of education package now requires to be put to the test. Can the quality of education be measured, taking into account patient interaction and satisfaction? Should outcome measures be standardized so that different programmes can be compared?

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