EDITORIAL

Patient-centred asthma education in the emergency department: the case against

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Patient education is based on a delicate balance between a suffering individual and a clinician. This professional is supposed to assume a public service duty falling between institutional requirements and the choices of patients. This task is complicated by one indisputable fact: it is impossible to make people do what one wants them to do. In this situation, the ethic considerations may counterbalance the social values. These principles often try to help people against their own will to make them comply better with the established social order.

No study or comparison has been published in the literature about the best location in which the therapeutic education is going to be provided (emergency departments (ED), outpatient clinics, asthma schools, mobile units). No study has specified the relationship between a patient's specific needs and the proposal for a particular location [1]. The most recent French guidelines on therapeutic education in asthma state that the ideal location remains the patient's choice [2]. Thus, asthmatic patients attending the ED become potential clients of health-education sessions. They are often also "bad clients" and it is commonly said that: "those who are most in need are those who don't usually come". This is probably because we anticipate educational actions (by giving a booklet, making an appointment, showing how to correctly use inhalers) before analysing and understanding the patient's requirements. Although information and education are important in asthma, particularly to make acceptable decisions about health, it is rarely sufficient to change health behaviours or beliefs to modify a life history in a chronic disease. In the ED, education may be associated with the patient's feeling that we already knew what happened and who they are. They can misunderstand that we are judging them (poorly informed, non-compliant, responsible for the occurrence of the present exacerbation). Therefore, we should not be surprised by the low rate of returns in the study by SMITH *et al.* [3], presented in the current issue of the *European Respiratory Journal*, as educational interventions have been reported to give poor results when they are made in the ED [4, 5].

At the ED, the patients are in a weak position. They are distressed and highly dependent on the healthcare providers for multiple reasons. They are not autonomous or capable of making choices or self-determination, as they are physically in the power of others, psychologically fragile and often too confused at a cognitive level to process medical information correctly. The feeling of not being in control is known to be a potentially important barrier to education [6].

Informed consent in such situations is questionable and may be linked to the relationship of authority, embodied in this study by the researcher. This submission leads neither to adherence to the contents of the educational programme nor to presence at subsequent education sessions. Obviously, the first time of contact with the asthmatics for this research programme is crucial and will impact on the future. Initially, if the patients are not correctly invited, they will put up passive resistance; most of them are generally in a hurry to get back home and get on with their lives, their professional and familial responsibilities, and have no real desire to come back and participate in any trial. This clearly applies to most of the patients recruited in the study by SMITH *et al.* [3]. The reattendance rate was low for the second session, which took place in an outpatient setting, although this is not clear from the title of the study [3]. Paradoxically, this rate is even lower when "patient-centred" methods are used.

At present, there is a trend to incorrectly classify under the terms "active methods" or "subject-centred methods", methods that involve a person in real-life situations. This was not the initial meaning given by the major European educationists C. Freinet or J. Dewey, who coined these terms [7]. They introduced a different way of teaching based on transmission: trial and error as a means of access to knowledge. In this context, self determination and personal autonomy were considered to be of paramount importance in a learning situation. In the study by SMITH *et al.* [3], the term patient-centred education is misleading. It was during "programme-centred education" that patients were supposed to be responsible for deciding on the order in which knowledge, predetermined in a standard national programme, namely the Australian Asthma Management Plane, was dispensed. This is a traditional and conventional approach focusing on the contents to be learnt within an educational context. Patients are not really active in the learning process but become objects rather than subjects of the programme. This is one content-centred education *versus* another content-centred education. Therefore, this format

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will not favour a real partnership as advocated by most of the asthma guidelines [8].

In their conclusions, SMITH *et al.* [3] reassured the healthcare providers and national institutions, *i.e.* the National Asthma Council. The results indeed confirmed the validity of health campaigns, as conducted in the past and validated by any society, to decrease the financial burden of asthma. An activity really centred on the patients themselves must consider each patient with his/her own specific objectives. A programme should be proposed after identifying and analysing the beliefs, representations, capacities, skills, resources, needs and desires of each person. Therefore, an educational diagnosis must be the first step of any tailored intervention, as recommended by the World Health Organization [9].

In the words of C. Freinet [10] on his amusing comment about learning to read, luckily, “no therapeutic education method has ever prevented a willing patient from learning how to look after himself!”

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