



Promoting Evidence-Based Nursing Practice:

Putting the 'Self' into Asthma Self-Management (Part 2)

In this newsletter we share the findings of a recent research project in which we explored self management with older people who were diagnosed with asthma.

What is Self-Management?

Close analysis of the self management literature revealed that a medical prescriptive approach to self management is widespread, emphasising adherence to directions provided by health care professionals. The 'self' in self management has been ignored and the person has been objectified as the 'patient'.

Asthma self management literature is no exception with an authoritarian approach. Patients are expected to be compliant to medical management principles. Compliance has been defined as the adherence by the patient to directions given by the prescribing physician, and good compliance has been considered as 80% adherence or greater (Wilkinson et al 2003). Fishwick et al (1997) provided three basic principles for asthma self management. Objective self assessment of asthma severity with educated interpretation of symptoms and peak flow readings; use of and monitoring of inhaled and oral medications for long term prevention and treatment of exacerbations; and the integration of these self assessment and management issues into written guidelines for patients to follow. These are clearly medical management criteria.

Little research has been reported about the way in which older people 'self' manage asthma outside the narrow terrain of medical management, compliance and generic type education. It has been argued that education 'of people with asthma has been reported as an intervention to ensure compliance' (Bone 1996, Brown 2001). Education has been advocated as being important to ensuring 'compliance' with self management and has most often been described in terms of educating 'to patients a prescribed package of information either in groups or individually' (Wilson 1997). Increasingly it has been acknowledged that targeting individual needs may result in positive outcomes rather than relying solely on indiscriminate generic education (Ward & Reynolds 2000).

How did we do the research?

We aimed to understand from the perspective of older men and women living with asthma how the illness has impacted on their lives and to identify the contexts, barriers and issues that were significant for older people living with asthma. Ethics approval was obtained and the participants' names are pseudonyms.

We sought people over the age of 60, who had been medically diagnosed with asthma and were using, or had been prescribed, preventative medications to use on a daily basis. Eight men and sixteen women with asthma volunteered to participate in this project. The average age of participants was 76 years; the youngest person was 60 years and the oldest 92 years old. Based on an assessment carried out by Clinical Educators specialising in asthma, seventeen people had severe asthma, three had moderate asthma, three had mild asthma and one person was asymptomatic.

The study was undertaken over nine months and we interviewed 24 older participants, circulated an open ended questionnaire and held two participatory action research (PAR) mixed gender research groups (equalling eight contact hours).

We found...not one, but three models of self-management!

We merged analysed data from the interviews, questionnaires and PAR groups to discuss three self management models and found that three management models are in operation.

1. Medical model of asthma management

The epitome of management of asthma for older people appeared to be taking medications. Closely tied to taking medications, was following orders from the doctor. Mostly, people took responsibility for management of their medications. In addition to taking medications, prevention of asthma attacks was linked to identification and avoidance of triggers. When people were first diagnosed with asthma, they often found themselves in the medical management model. Jane commented:

I feel I've only had it a short while but I have the right doctor and follow through with my medication. I've learnt a lot. We really must do what the doctors and specialists tell you.

The doctor managed the disease process, not the patient; instead the patient learnt to trust medical knowledge and management. Learning to trust was part of slotting into a medical management program, precisely because the patient was not invited to take part in his or her own management. Medical management is something done to patients and as patients, people are expected to comply with medical orders. On the other hand, older people may have expectations that doctors tell them what they should do.

Jim raised another aspect of medical management:

Some doctors do become complacent with you if you see them for too long. If I have arthritis on my record it doesn't matter what problem I have, it's to do with the arthritis. I couldn't move my foot off the floor and I went to the doctor and he looked at the card and said it's to do with the arthritis.

Medical expertise was questioned in Jim's example. Having another chronic illness label meant that asthma did not gain the medical attention it may have deserved.

Medical management sometimes provided a narrow focus, whereas effective management of asthma demanded the person's life be viewed in context, not only as a disease specific response. Being in a medical management model meant that the doctor's orders were followed and medications were taken as prescribed, otherwise the patient may be labelled as non compliant.

2. Collaborative model of asthma management

Participants used a combination of bio-medical and experiential terms to describe asthma. Some participants merged their biomedical understanding of asthma with the impact this condition had on their lives. In this section we will show joint effort between participants and health care professionals had occurred and that this type of management was most likely to be a result of principles of asthma management facilitated by designated Asthma Clinics. Jane commented:

Going to the GP, having access to an asthma management specialist put me on the right medication. I saw the GP twice a week for so many weeks and have only just stopped seeing her. They did try Pulmicort on me. I had a few different things till they got the right combination. I had the lung function test. I used to be bad under the shower ... no energy to wash my hair. At

the clinic it was suggested that I buy a towel and dressing gown [and] put that on instead of drying yourself. Same with slippers. When I did as she told me it was good. I wouldn't have known about the dressing gowns. I've been going on very well.

It was clear from this example that Jane was offered much more than medical advice. We do not deny that medication information is vitally important for good management, but we stress that management of asthma should be more than drug management. Jane was involved in her care and was in a position to make informed decisions about her management as a result.

When clients were involved in care, Isabel suggests that 'we bring intelligence to that relationship (with the doctor)'. When input from the client was acknowledged as valuable, this act may be conducive toward self agency in management. Naomi, when talking about her relationship with her health care providers said:

I would say that I have got a very good GP who put me onto a program that I carry out strictly. I get into bed some nights and think oh I haven't done my blowing so have got up again. I'm on four medications. I ring my GP if I've had a couple of days/nights being short of breath and go down and see her and she writes out the change in medications so I know exactly what to do. I report back in a week/fortnight. And I have her private number if for some reason... I'm so controlled it doesn't ever happen. The GP writes everything down and you can read all her writing.

Asthma clinics have only recently been a health service choice for people in Australia and those people attending tend to be newly diagnosed. Collaborative management seems most likely to be a result of involvement with an Asthma Clinic. It seemed that an Asthma clinic offered much more than straight medical management advice and collaboration between GP and client was central. When input from the client was acknowledged and valued, facilitation of the client toward self agency in asthma management may be possible.

3. Self agency model of asthma management

The way older people learn to incorporate illness into daily life and self manage will be further explored here. Most people had identified their own responses to illness and some were constantly planning as a means of creating order. Developing alternative life style habits appeared to be important for those who had embraced self management of asthma. Taking control of their own lives was crucial for those that claim to manage the self. The person became self determining.

Taking control was evident in the stories from people who were experts in management of the self. Finlay had made decisions about which medications he would take, he prided himself on managing the 'self' and he was constantly working out ways to improve the ways he lived with asthma. He made decisions about what to share with the doctor. In taking control he had governed his illness.

People who had had asthma since childhood were seen as experts of their own condition. Their life experiences had informed them about self management. Remaining alert to changes in medical management was monitored with vigilance. Nevertheless, management of the 'self' was a full time job. Finlay asked the group to reflect on their self management:

Are we taking management of asthma for granted just because we have this thing? We have found out for

ourselves what is happening, we see articles on asthma, and we ask our doctor who may be more prominent in thinking and diagnosis. I wonder whether we encourage people enough to find out things for themselves. Or do people go to the doctor and believe that he cares for me, he will do my thinking and he tells me how to manage my medications. I just wonder!

Finlay had obviously made decisions for himself and would like to entice others in the group to take responsibility for themselves.

What can community nurses learn from this study?

Much of the literature assumes that self-management means the same to all people, both professionals and those living with a chronic condition and yet clearly this is not the case.

This research provides a foundation for nurses to understand how older people living with asthma are able to achieve a level of self agency that does not rely on health professionals taking the lead role in management. It also highlights that chronic disease does not just exist in a clinical framework of expiratory peak flow measurement and medication management. Nor does it necessarily require us to provide off the shelf self - management education about how we perceive people ought to cope.

When nurses cross therapeutic paths with people that have achieved self agency in asthma management, we accept that they are the experts and have chosen to utilise our knowledge and skills to augment their own.

For older people who are not yet self agents in their care, providing the clinical and social environments for them to grow and learn is essential. The way to do this is not to assume we know what they want to learn, but rather to offer a participative partnership that facilitates their control of 'what' and how it is offered. Adhering to the principles of primary care is fundamentally important to our practice ... or working with people.

References

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The full report of this research project will be available on the RDNS website in August 2003. www.rdns.net.au (see *Research and Publications*).

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