Communications for this section will be published as space and priorities permit. The comments should not exceed 350 words in length, with a maximum of five references; one figure or table can be printed. Exceptions may occur under particular circumstances. Contributions may include comments on articles published in this periodical, or they may be reports of unique educational character. Please include a cover letter with a complete list of authors (including full first and last names and highest degree), corresponding author’s address, phone number, fax number, and e-mail address (if applicable). Specific permission to publish should be cited in the cover letter or appended as a postscript. CHEST reserves the right to edit letters for length and clarity.

Enhancing Patient Compliance in Asthma Management

To the Editor:

Blessing-Moore’s (CHEST 1996; 109:9-11) editorial and the article by Kolbe and colleagues (CHEST 1996; 109:86-90) in the January issue highlight a major problem with asthma management, i.e., the erroneous assumption that patient education is synonymous with behavior change. Clark and Starr-Schneidkraut\(^1\) state it more forcefully: “Management is behavior, and it is the behavior that must be measured . . . The link between knowing general facts about disease, for example pathophysiology, and behaving differently is not strong. The knowledge a patient needs is that which enables him to reach personal goals. This information varies by individual, is very idiosyncratic, is likely not to be what the health professional sees as important and may not be amenable to standardized tests.” These are sobering, if not depressing facts. They are more troublesome because they fly in the face of the prevailing recommendations. It is axiomatic that education, per se, is good. Empowering patients to self-manage their asthma is good. Knowledge is power. But it is power only if it is translated into action. Successful self-management obviously depends on adequate patient compliance with an effective treatment program. But the literature on patient compliance is also glum:\(^2\) 40 to 50% of patients do not use medicines as prescribed . . . Compliance is not associated with age, sex, educational level, economic status or personality traits, with characteristics of the disease, including diagnosis (except mental illness and alcoholism), or with severity or frequency of symptoms . . . Physicians cannot predict better than chance alone which of their patients will or will not comply.”

If these facts are true, it is clear that there is no easy answer to improving patient self-management. Merely teaching a class will not be enough. To be successful, we need to change our paradigm. We should stop using the phrase “patient education” and start talking about “effective education” or “behavior change.” We need to face the fact that a “cookbook” approach will be successful in only a limited number of patients (CHEST 1996; 109:9-11). We would also do well to study indepth those programs that have effected beneficial behavior change\(^3\) and try to adopt their methods, realizing that different patients under different circumstances may respond to different strategies. Here, in the Sacramento area, we are trying various approaches to enhance patient compliance.

Asthma education is clearly needed. We must allow our patients to reach their full potential. The problem is not so much leading them to the water, as it is getting them to drink. Merely providing the water (education) will not be enough, and we will not be successful until we first face that fact.

Joseph T. Marino, MD, FCCP,
Allergy and Pulmonary Medicine,
Carmichael, California

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1 Clark NM, Starr-Schneidkraut NJ. Management of acute asthma by patients and families. Ann J Respir Crit Care Med (suppl) 1994; 149:S5-S66
3 Mayo PH, Richman J, Harris HW. Results of a program to reduce admissions for adult asthma. Ann Int Med 1990; 112:864-71

What About Brantigan?

To the Editor:

Dr. Gordon L. Snider summarized the reports about reduction pneumoplasty in the current literature in an excellent manner (CHEST 1996; 109:540-48). He succinctly noted that, even after 4 decades, certain parameters relating to the procedure are not well defined. The only distressing part of this special report was, although he alluded to the work of Cooper et al\(^4\) and Cooper,\(^5\) he did not mention the report of Brantigan et al\(^6\) who first called attention to this operation in 1954.

Joseph M. Miller, MD,
Timonium, Maryland

REFERENCES

To the Editor:

I knew Dr. Otto Brantigan quite well through contacts over a period of years at national meetings of the American College of Chest Physicians and the American Trudeau Society (now the American Thoracic Society). Otto was a thoughtful, unassuming, delightful man who regularly advocated the surgery he was doing on his patients with emphysema. However, he accepted with equanimity the skepticism with which his accounts of his patients’ impressive relief of dyspnea after surgery were often greeted.

There were a number of reasons that Brantigan’s work did not catch on. These were difficult patients to operate on successfully in an era 5 to 10 years before blood gas measurements would become...