It is estimated that approximately 85% of all patients with asthma or chronic obstructive pulmonary disease (COPD) in the UK and in the Netherlands are treated by a general practitioner (GP). This underlines the importance of providing good medical respiratory care in general practice. Strangely enough, guidelines for the diagnosis and treatment of asthma and COPD have mainly been written by national or international thoracic societies. Of course, the GP has many diseases to deal with other than asthma and COPD alone, so one could argue that it is the chest physician who is the specialist and should therefore be the one to produce these guidelines. However, the patients seen by chest physicians often differ from those seen by GPs in the severity of their disease and consequently in their treatment. It would therefore seem logical to include primary care experts in asthma and COPD guideline panels in order to improve respiratory practice in primary care.

Research has shown that currently there are deficiencies in respiratory practice related to primary care. For example, delays in diagnosis are common and lead to inappropriate treatment being given while, in other cases, the severity is underestimated with the result that preventive treatment is underused. One study showed that 74% of those admitted to hospital with severe asthma could have had the admission prevented by different primary care. Surveys of deaths from asthma have shown that nearly 90% of cases involve avoidable factors. This does not always mean that the GP is to blame. It might also be related to the patient who does not present his symptoms to the GP. Underdiagnosis has been shown to be mainly due to underpresentation of bronchial symptoms by the patient to the GP, and this seems to be associated with a poor perception of asthma symptoms by the patient.

The improvement of respiratory practice in primary care starts with making clear guidelines for primary care. In the Netherlands the first national guidelines on the diagnosis and treatment of asthma and COPD in general practice were published in 1992 by the Dutch College of General Practitioners. In 1997 these guidelines were updated on the basis of new literature and re-evaluation of the 1992 guidelines. As it is known that publication of guidelines alone will not change the actual care provided by physicians, a large study was undertaken to investigate the best strategy for implementing these guidelines. Two intervention groups and one control group of general practices were formed: a small education group (17 GPs with 210 patients), a monitoring and feedback group (24 GPs with 299 patients), and a control group (17 GPs with 223 patients). The actual health care provided for asthma and COPD by the intervention groups was compared with the health care given by the control group. The outcome was measured in terms of structure and process parameters (knowledge and skills of GPs, presence of equipment, and pharmacological and non-pharmacological treatment) and patient outcomes (symptoms, smoking habit, exacerbation rate, and asthma-specific quality of life). In the education group the intervention consisted of an interactive group education and peer review programme (four sessions of 2 hours), while in the monitoring/feedback group the intervention consisted of monitoring the intake procedure, regular follow up, and feedback on lung function, smoking habits, use of medication, and compliance. In the education group the only significant difference from the control group was in the skills of the GP. In the monitoring/feedback group, however, there were clear improvements in knowledge, skills, presence of peak flow meters, and adequate pharmacological treatment compared with the control group. This led to the conclusion that monitoring and feedback results in a significant change in the care provided for asthma and COPD. Improving care by implementing guidelines appears to be most successful when physicians are directly confronted with the specific health care results of their patients. It therefore seems that feedback of information to health professionals about their care can lead to an alteration in their behaviour. Audits alone in general practice may only give negative feedback when the care provided is compared with the optimal care displayed in guidelines. When the care provided is compared with the care given by peers, and subsequently discussed with these peers, both negative and positive feedback are given and the best (social) learning situation is created for obtaining clear
changes in health care behaviour. This might be especially important for GPs who see patients with many diseases other than asthma and COPD and therefore cannot be expected to know in detail how to treat these patients in accordance with the guidelines.

The World Health Organization, the ERS, and the EAACS have recently started work on the Global Initiative for Asthma (GINA) guidelines to make them more applicable and easier to implement in primary care. Primary care specialists from all over the world have been asked to comment in order to produce a short and practical guideline best suited to the situation in primary care. It is hoped that this initiative will help to improve respiratory practice in primary care.

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8 Schayck CP van, Heijden FMMA van der, Boom G van den, et al. Under-diagnosis of asthma: is the doctor or the patient to blame? The DIMCA project. Thorax 2000;55:562–5.