There are fast becoming no excuses for asthma sufferers to be withdrawn from PE lessons.

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Asthma excuse notes: for the child or the PE teacher?

Any notes or excuses? is a common shout from the PE teacher before most if not all lessons. Invariably, a small line of children forms, looking sick (or attempting to!) and clutching letters that are seen as a passport to sitting at the side of the gym. Sometimes asthma is the reason given, and sometimes it is acceptable, but at other times it is an indication of the lack of understanding by schools of the management of asthma.

A unique ground-breaking initiative in Devon

The Devon Schools Asthma Project (DSAP) has been actively promoting better asthma care in schools by targeting the relevant professionals such as teaching staff and health-care personnel. In the last two years DSAP has run annual conferences to upgrade its messages, educate its practitioners, and imbue them with confidence. It is committed to further this process in the future.

I was fortunate enough to be involved in the last conference, and have been asked to help deliver DSAP's following key messages:

1. To develop a partnership between the education and health services, charities, and the pharmaceutical industry.

2. To work within the national framework of the policies expressed in the HMSO publications *Health of the Young Nation* and *Excellence in Schools*.

3. To support a ground-breaking initiative that is unique to Devon.

4. To create a model for 'best practice'.

5. To monitor evidence indicating that the project is having a positive effect on improving asthma management in Devon schools.

The purpose of this article will be to look at each key message in relation to PE, for the benefit of the PE teacher and other professionals who are concerned with activity or exercise in schools.

1. Developing a partnership

Partnerships between groups such as the education and health services, charities, and the pharmaceutical industry are welcome. However, there is always a danger that the messages needed by PE teachers are either not fully expressed or else fall into the gaps.

The combination of asthma and PE is often perceived as being a potential problem area in the management of asthma in schools, essentially because 'getting out of breath' is a common denominator. However, this misleading conviction does not help either the staff or the children, and it can be overcome by effective information.

Such effective information is provided by all the above partners. Currently, the National Asthma Campaign (NAC, 1995) provides a considerable amount of detailed and 'glossy' information, including information booklets relevant to the PE teacher — these are *Asthma at school: A guide*, *Exercise and asthma*, *Self-management and peak-flow measurement*, and *Take control of asthma*. However, it is not al-

ways easy to find the one that does it all for the PE teacher or the child. Maybe the thinking behind such a plethora of information is that asthma care should be more than just a brief flick through a resource pack; however, even in the researching of this article it became apparent that finding out all one needs to know about asthma and PE from the available resources is far from straightforward. Therefore, a proposal presented here is that the abovementioned partners should provide a more integrated package of information and assistance, directed specifically at the PE teacher.

Asthma care should be more than just a brief flick through a resource pack

2. Working within national policies

There is no doubt that the current national policies for health and education do help to promote improved asthma management, as they offer broad-based support for this particular problem. A massive amount of information is available from the DoH and DfEE, from which the following thought-provoking and challenging points are extracted.

The *Health of the Young Nation* (1995) includes two aspects that should be developed by the DSAP:

- consult the young people themselves;
- take a holistic view of health-related behaviour.

The latter aim is in line with the view of asthma as a medical condition (DfEE, 1996), but there remains the need for:

- a commitment to curricular provision for health-related exercise within the Programmes of Study, and
- an acceptance of the view that medical needs can become special educational needs in a PE context.

All these aims require greater co-operation between PE staff and health-care professionals

To support the DoH viewpoint, the *Excellence in Schools* document includes the following aims:

- to boost opportunities for staff development in SEN;
- to see that good practice is widely disseminated;
- to base local provision on a partnership of all those with a contribution to make.

All these aims require greater co-operation between PE staff and health-care professionals, as well as initiatives such as the DSAP.

3. Ground-breaking in Devon

Devon is the third largest county in England, with 440 primary and middle schools, 56 secondary schools and 21 special schools. The DSAP is, therefore, a substantial advocate for the cause of improved asthma management.

Advocacy is often perceived as something that celebrities or politicians do, but everyone has a role to play. The DSAP has three key advocates (Lady St Cyres, Chris Doak and Wenda Mallard), who between them have made the DSAP a ground-breaking initiative; there is no doubt that these three would deprecate any fuss being made about their role, but this is an appropriate time to do so!

According to Rainbolt & Sherrill (1988), advocacy is 'action aimed at promoting, maintaining, or defending a cause' (p. 218). But what causes should be advocated with respect to asthma management?

In a PE context, Rainbolt & Sherrill indicate the following:

- the right of all children and young people to high-quality physical education, regardless of their condition;
- elimination of attitudinal and aspirational barriers towards the inclusion of children with asthma in the PE programme.

Rainbolt & Sherrill also indicate that the advocate has many varied roles, which include being an initiator, negotiator, counsellor, technical or resource provider, educator, and evaluator. Most of these roles are within the compass of all physical educators, and can be found within the model for best practice, which forms the next section.

4. A secondary-school model for 'best practice'

Reid (1989), looking at programme effectiveness, indicated that there are two elements by which its efficacy must be judged: first, that its potential effectiveness is greater than the alternatives on offer; second, that it can be shown to have achieved its stated objectives.

Being asked to speak both at national and regional conferences on the role of PE teachers in asthma care has given me an insight into what 'best practice' means, and the reaction of audiences to my attempt at developing the secondary-school asthma programme described below leads me to believe that they were, at least,

intrigued. I apologise in advance to any other others who may have been developing their own models, but I have to say that mine was far more effective than any alternatives available at the time, since there weren't any in this particular school!

The following details of the programme should permit a judgment of how well it achieved its stated objectives.

The need to be met

Too many PE excuse notes with asthma as the principal reason

The programme was initiated because of the large number of PE excuse notes being received in which asthma was given as the principal reason. Although these notes were treated on their merits, it was felt that something had to be done to reduce their number.

The response of the PE department led to the two following innovations.

1. Technical/resource provision

As the special needs liaison teacher I became a provider for the other members of the PE department, providing them with information about recognising attacks, medication and prevention; I also arranged for information sheets about asthma to be displayed on PE notice boards, which added to the supportive atmosphere.

2. An Asthma Club

I developed this school-based club, membership of which was negotiated via an open invitation to all the pupils identified as having asthma problems. There were junior (Years 7–9) and senior (Years 10–11) sections, holding lunchtime sessions that offered 'trigger counselling' and activities on a timetabled rota; these were available on a drop-in basis.

Regular communication with parents could form part of the counselling process

These activities were based on education and technical/resource provision for the pupils. They included:

- self-care techniques (relaxation, diaphragmatic breathing [yoga], warm-ups and downs);
- weight-training;
- games;
- trips to the local swimming pool.

Evaluation

The following results were immediately apparent.

- Swimming was the most popular lunchtime session, and ultimately led to pupils going to the pool at lunchtime independently of the club;
- fewer attacks due to exercise-induced asthma (EIA) were reported;
- there was a noticeable reduction in the number of asthma-related excuse notes!

Eventually the programme was well on the way to achieving its ultimate objective, self-redundancy, since the pupils became so successful in managing their own asthma that they could take a larger part in normal extra-curricular activities. This was helped by the way the school offered a number of different levels at which the pupils could participate in physical activity (unstructured as well as structured; recreational and developmental competition; high-performance sport).

A divisive programme?

Some may see a 'segregated' programme serving a minority as divisive. It is because I am committed to the full involvement of all pupils in physical education programmes that I felt the needs of the asthmatic children outweighed any possible stigma attached to this 'exclusive' club. In fact, on finding out what interesting things were happening, many other pupils conducted impromptu self-diagnoses that proved they were asthmatic and therefore eligible to join!

I was aware of some other aspects that an ideal programme would have covered, although I was not in a position to do so. They would also have to be considered by the PE staff involved.

Communication with parents

There is a need to realise that panic interferes with proper care. Instead of relying on excuse notes at times of crisis, regular communication could form part of the counselling process.

Working with the child: a collective commitment

This includes:

- explaining the teacher's degree of confidence in working with asthmatics in PE environments;
- recapping on the established medical and emergency procedures, increasing liaison between parents, staff, doctor, school nurse and pupil;

- finding out from the pupils their history of asthma episodes and how they have coped with EIA);
- finally, to what extent they recognise biofeedback and use it to monitor their body during exercise (answering such questions as *am I breathing too fast?* or *is my heart beating too quickly?*)

Programme planning

PE staff also need to be aware of:

There must be a willingness to risk failure rather than not try at all

- the potential EIA risks of certain aspects of the programme;
- what efficient breathing entails (skills that all children should be taught);
- warm-up;
- cardiovascular fitness;
- the extent to which PE homework can be developed.

PE homework has a certain novelty value that brings a smile to most people's faces: this is because it generally never has to be set, as the pupils are normally highly motivated!

However, at-risk groups such as asthmatics cannot achieve the desired exercise benefits from timetabled PE lessons alone, and so it is necessary to counsel and provide long-term programmes and activities that asthmatic children can complete after all their other homework has been finished.

Key pointers for 'best practice'

I base these suggestions on my programme's attempts to advocate for asthma management, bearing in mind the fact that there is still room for improvement.

- The programme initiator does not have to assume all the 'Sherrill roles' in order to make it work;
- there must be a willingness to risk failure rather than not try at all;
- the programme should be thought of as being aimed at children that have 'asthma attacks' rather than at 'asthmatic children';
- there is a need for an inclusive ethos during the extra-curricular as well as the curricular programme;
- what has been reported here may not necessarily be the 'best practice' for another school.

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5. Monitoring the evidence

We have yet to prove that the DSAP is having a positive effect in improving asthma management in all Devon schools. The level of asthma management is an area for future research: it is possible to collect descriptive evidence, but it will be more important to recount all the good practice that can be identified and to celebrate its diversity and success.

Improved asthma management in schools, which should include greater participation in PE lessons, will lead to lifelong benefits. Once this is achieved, attention can be focussed on other priorities.

The purpose of this article was to draw attention to the work of the DSAP and to show how PE teachers can promote the health and welfare of asthmatic pupils in a positive way. There are fast becoming no excuses for sufferers to be withdrawn from lessons — or for PE teachers to exclude them.

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