At Odds: Do Clinical Practice Metrics Incentivize Bad Medicine?

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We live in a world that revolves around data. If you have been in the medical field for a decade or longer, you have observed the trend toward increasingly data-driven medical practice. If you have been practicing more recently, you have lived it. Metrics continually shape our practice patterns and influence our care, and their utilization will only increase. Currently, analytics and artificial intelligence tools cannot directly process human cognition and emotion. Therefore, data is required.

The Conflict

Although most data-driven solutions are promised to make our lives easier, at times it feels like various clinical metrics are pulling us in different directions. Some data-backed incentives may even seem to directly oppose our moral or ethical obligations to the patient. Recently, a prime example of apparently conflicting clinical incentives has been on my mind. As urgent care clinicians, we are generally tasked with achieving high patient satisfaction scores while simultaneously implementing good antibiotic stewardship practices. We try to key in on patient wishes, and good antibiotic stewardship sometimes seems to run in opposition. I occasionally struggle with this tension and reflect on how challenging it is to consistently achieve both goals.

We all know how crucial it is that we continue to keep patients satisfied with their care and keep them returning to our clinics. However, let us remember the ever-increasing dangers around antibiotic resistance. Deaths attributable to antimicrobial resistance are estimated to reach 1.91 million globally by the year 2050.[1] Although there is potential these projections may change for the better, these numbers are cause for alarm.

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The apparent clash between patient satisfaction and responsible antibiotic prescribing really came to the forefront for me over the past year when our urgent care group began openly publishing provider antibiotic prescribing data. Patient satisfaction scores have been broadcast in our group for years. But now seeing the antibiotic prescribing data, distributed to all, truly brought this conflict to light for me. The expectation to deliver on sound antibiotic stewardship practices while simultaneously pleasing our antibiotic-seeking viral patients was now plain as day. Can we have our cake and eat it too?

The Game-Changer

Education and reframing really helped to change my perspective on this. W. Kevin Broyles, MD, a veteran in our urgent care group, served as lead physician in the ambulatory antibiotic stewardship committee of our healthcare organization for many years. He was responsible for publishing and distributing our antibiotic stewardship data report. Along with that, he provided some pearls for our group that I believe every urgent care clinician should hear at least once. He promised to teach us how to frame the conversation around viral respiratory infections with patients in a positive way, somehow explaining the lack of necessity of antibiotics while still achieving high patient satisfaction. I was intrigued.

Dr. Broyles' teachings drew from the publication Dialogue Around Respiratory Illness Treatment (DART)[2] out of the University of Washington Department of Pediatrics. The core tenet of this framework includes a 4-part formula to assist in supporting both antibiotic stewardship and patient satisfaction. Step 1 is to review physical exam findings with the patient or parent out loud. The second step is to deliver a clear diagnosis, such as "viral pharyngitis." The third step is to provide a 2-part negative then positive treatment recommendation. As an example, "I have bad news and good news. The bad news

is that you have a virus, and antibiotics will not help. The good news is that there are some things that we can do to get you feeling better." The order of the delivery matters, as studies show a decrease in patient satisfaction when the recommendations end with bad news. The last step in the DART process is to include a contingency plan for follow-up.

The Evidence

Dr. Broyles shared his antibiotic prescribing rates and patient experience scores before and after he implemented this technique, and the numbers speak for themselves. He analyzed his own antibiotic prescribing patterns during a 4-month period in respiratory illness season before using the DART approach, and then he compared it to the same 4-month period the following year, in which he implemented the DART approach.[3] In the pre-intervention period, he saw 1,937 patients and noted a 41% antibiotic prescribing rate. In the intervention period, he saw 1,570 patients and noted a 25% antibiotic prescribing rate. Remarkably, his patient satisfaction scores were exactly the same during both periods. All this was accomplished by tactfully educating his patients.

Positive results have also been replicated in the literature. In a clinical trial by Kronman et al.[4], clinicians in a network of pediatric outpatient practices received training on the DART method. Overall antibiotic prescribing rates for acute respiratory tract infections were then compared to a baseline control period. The authors found a significant reduction in the antibiotic prescribing rate during the post-intervention period, and they call for broader dissemination of the DART training to clinicians based on their findings.

After learning about the DART approach, I have followed this formula on nearly every patient that I have seen with viral upper respiratory symptoms over the past year. While I don't have any objective data from my own practice, my experience is that this approach has been overwhelmingly well-received by my patients. Since implementing this method, I have begun to enjoy a sense of fulfillment that comes from providing evidence-based care while simultaneously maintaining high patient satisfaction.

The Big Picture

What is it that patients really want when they come in to see us in clinic? Patients are seeking safe, timely, and effective treatment, human connection and caring from staff, and a healing and comfortable care environment.[5] Our care should focus on consistently delivering across these three pillars. We all intend to do no harm, and focusing on these priority values can guide our efforts towards that aim, even in an increasingly complex, data-driven care environment with competing incentives.

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Conclusion

Through the process of implementing intentional patient-centered antibiotic stewardship, I have experienced greater harmony among aspects of clinical practice, including quality metrics, that I used to consider incongruent. You really can have the best of both worlds. ■

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