



Making Antibiotic Resistance Awareness a Priority— A COVID-Created Opportunity

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It's a conversation I've had endless times. One that I've honed and refined stepwise over time, and one that my patients often tell me they hadn't considered before: the appropriate use and overuse of antibiotics. And right now, with patients hyper-focused on healthy immune systems, medical providers are uniquely positioned to build antibiotic stewardship into our diagnostic process and significantly increase resistance awareness nationwide.

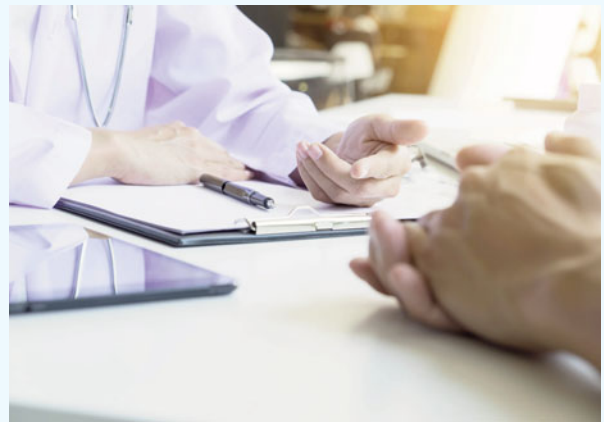
Process and Priorities

A year ago, my approach to sharing a diagnosis and conservative symptom management plan for an upper respiratory infection was offered in a calculated, evidence-based fashion.

First, I'd sit down, as studies have shown this increases patient perception of the time medical providers stay in the room. I want to feel connected to my patients, and not give the impression that I have somewhere more important to be. I want them to ask questions. Those conversations matter.

Next, I'd review the pertinent positive and negative exam findings, explaining how these findings define the diagnosis.

The treatment plan would then be broken into two parts. I would describe a "negative plan," citing common misconceptions of antibiotics or other medications that don't help. More specifically, we would have an important discussion about the difference between viral and bacterial infections,¹ and why the latter are effectively treated with antibiotics while the former are not. And this would naturally lead into the "positive treatment plan"—one that ultimately targeted the reason for the visit—getting my patient feeling better.



Lastly, I would offer a strong follow-up support system, creating expectations on when to return for further care, and offering my card and email address. Both research and personal experience have shown this to be key in gaining patient trust and avoiding arguments about inappropriate antibiotic prescribing.

But today, patients aren't arguing much about antibiotic prescriptions anymore. Everything is viewed through the lens of COVID-19, and when patients find out they do not have it, their fears fall away. Little else matters at that moment. The struggle right now, therefore, is not only educating patients about antibiotic resistance, but cutting through the COVID-19 noise to establish a connection that makes this understanding resonate.

Stories Connect Us

Anecdotes and analogies feel folksy, unscientific, and largely unrelated to realistically weighing risk. This is a problem, as every decision and indecision in medicine carries risk. But being relatable is an underutilized option, and stories connect and persuade us.² They bring clarity to concepts, *including* inherent risk. And we need to dig deep to deploy every tool to communicate the exceptional risk patients face when it comes to antibiotic overprescribing.



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For example, repeated wear and tear on tires results in no tread—no traction on a slippery road. Odds are, you'll encounter inclement weather and lose control of your car. The same is true for the body's defense against infection. Once antibiotics stop working and that tread is gone, there's no new tire shop for our immune system, and bacteria are always in the forecast.³

We can share that we treat the “right bug with the right drug” as strong proponents of evidence-based medicine, but we need to come at the issue from multiple angles. Sharing antibiotic resistance information as part of “healthy immune system maintenance” might be the way to approach it. A straightforward, “Have we talked about antibiotic resistance before?” could be another.

Whichever approach makes sense will depend on the patient and his/her overall medical profile, combined with concerns gathered during the visit. Regardless, the end goal is understanding, and we must find creative ways to arrive there with every patient.

Antibiotic stewardship is happening after all, but wide-scale awareness remains an urgent concern. And with the pandemic raging, we have a window right now to make meaningful strides in educating patients about the inutility of antibiotics for viral infections.

COVID-19 Water Cooler Conversations

In the era of COVID-19, antibiotic stewardship seems nearly effortless most of the time. Our collective exhaustion over demands for Z-Paks, overused to the point of impotence against sinus infections, has been replaced by other forms of exhaustion overnight.

Every moment of available time is dedicated to public health topics: discussions concerning, safety, time frames, and an array of medications patients have heard about on the news now occur “while we wait for the vaccine.” During these “COVID water cooler conversations,” I cover all possible testing outcomes because this is the moment in which I have a captive audience. And I've found it is also time well spent on stewardship.

The most valuable part of an urgent care visit, after all, has never been giving a patient test results, but rather anticipatory guidance on what to do with that knowledge.

The general public is hungry for this knowledge. Overall, the patients we see now have a much better understanding of true red flag signs, such as fever in adults, difficulty breathing, and low oxygen levels. For the first time in decades, the narrative on effective viral respiratory infection treatment, or lack thereof, has permeated the public's collective consciousness.

Despite this, the pervasive patient satisfaction myth among urgent care providers persists.

The Patient Satisfaction Myth

In my clinical experience and teaching on antibiotic stewardship,

“Satisfaction cannot be bought by ‘giving the patient what they want.’ Providers who employ this method are also dodging the underlying problems that create these scores while providing suboptimal care.”

I have found the most commonly cited reason providers give for inappropriately prescribing antibiotics is patient satisfaction and lack of time to dissuade patients about their need for an antibiotic. The reality though, is that antibiotic prescriptions don't actually help to save time or increase patient satisfaction.

Prior studies have shown the amount of “extra” time it takes to educate a patient on the topic instead of sending a prescription is approximately 1 minute. For the average electronic medical record user, it may very well take the same time simply to order an antibiotic.

And isn't an extra minute worth doing the right thing? An educated patient is armed with a more comprehensive expectation of a disease's time course, which in turn saves us from answering unnecessary phone calls when the antibiotic, unsurprisingly, doesn't achieve the patient's goal.

As for patient satisfaction, it cannot be bought so simply as by “giving the patient what they want” (at least not reliably). Medical providers with poor satisfaction scores who employ this method are also dodging the underlying problems that create these scores while providing suboptimal care.

Patients do not want antibiotics anyway. Not if they don't need them. No one looks forward to taking extra pills and risking diarrhea. They just want to feel better.

Intuitively, we know that patient satisfaction actually *increases* when we invest in empathy, practice evidence-based communication techniques, convey clear expectations for the course of illness, and offer guidelines for when to seek additional care. It just makes sense on a variety of levels.

Improving patient satisfaction is a skill set like any other, strengthened by knowledge and practice. Practicing stewardship through the use of the communications strategies outlined above is the true formula for growth and providing care that both the patient and you can feel good about. ■

References

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