Prescribing Antibiotics: Seeing the Whole Picture

The editorial by Sargent[1] warrants a rebuttal.

First, as a pediatrician, the author's sweeping views do not appear to be fully applicable to adults (which is the population in the study report).[2]

Second, the pejorative use of quotation marks—"unnecessary"—is hardly balanced or evidence-based medicine.

Using the term *paternalistic* to describe "the current approach to restricting antibiotic use" is misleading and incorrect—misleading because the paternalistic approach is being used by the physician who, with the knowledge that 90% to 95% of upper respiratory infections and bronchitis are not bacterial in origin, prescribes an antibiotic; incorrect because, as the author notes, even after education the antibiotic prescription rate for a presumed viral illness remained over 60%. In the published study,[2] the current approach without intervention was an 85% antibiotic prescription rate falling to 64% in the interventional group.

If after years of schooling, training, and experience, the practitioner is unable to make an educated judgment and recommends that this decision devolve to the patient, why is it necessary to see the physician at all? The logical conclusion of this reasoning is to make antibiotics (with a brief description of the pretreatment Bayesian probabilities plus the risks and benefits of this approach as a package insert) an over-the-counter medication.

A more practical approach when in doubt (at least in adults) is to provide symptomatic therapy (e.g., bronchodilators, analgesic-antipyretic cough suppressant-expectorant) plus a prescription for an antibiotic to be filled if the patient's symptoms have not improved or have worsened in 48 to 72 hours.

Finally, a series of nine position papers on this topic were recently published as clinical practice guidelines in *Annals of Internal Medicine* in the 20 March 2001 (134:479-529), and these were endorsed by the Centers for Disease Control, American Academy of Family Physicians, American College of Physicians–American Society of Internal Medicine, and the Infectious Disease Society of America.

While children are different, I'm not sure they are that different nor is it appropriate for a pediatric and adolescent approach (if valid in the first place) to be imposed on a study and approach to this very serious problem in adults.

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References

1. Sargent JD. Reducing "unnecessary" antibiotic use in primary care: hard rules, soft calls [Editorial]. Eff Clin Pract. 2001;4:136-8.
2. Gonzales R, Steiner JF, Maselli J, Lum A, Barrett PH. Impact of reducing antibiotic prescribing for acute bronchitis on patient satisfaction. Eff Clin Pract. 2001;4:105-11.

THE AUTHORS RESPOND

While we appreciate Dr. Matz's rebuttal to our editorial, we believe he has misconstrued its major points. We agree that there is a need to reduce antibiotic use. The goal of our editorial was to consider a larger set of explanations of why antibiotics are given "unnecessarily." (Note: the quotation marks are not intended to be pejorative, instead they are intended to remind all of us that there is a value judgment involved).

Dr. Matz suggests that the editorial applies to pediatric patients, but not adults. We disagree. While the clinical examples are from Dr. Sargent's pediatric practice, the issues raised (that giving antibiotics is expedient, that there is often uncertainty about the cause of the condition, that the benefits might outweigh the risks from the patient's perspective, and that marketing of antibiotics plays a role) are equally applicable to the elderly veterans with bronchitis in Dr. Welch's practice.

Dr. Matz suggests we are advocating that the decision about antibiotics be devolved to the patient. We are not. Instead, we are acknowledging that the decision about whether to take an antibiotic, like all treatments, should be shared. From our perspective, it's up to the physician to make a diagnosis and present information about cause and the risks and benefits of different treatment options. Then the patient and the physician interact to develop a treatment plan. We suspect that simply asking patients about their expectations will help identify which patients simply want reassurance and which want an antibiotic so much that they will go elsewhere (or return the next day to see a different physician) to get them.

Finally, we applaud Dr Matz's suggestion of sending selected patients home with an unfilled prescription. This is the kind of innovative approach as editors we love to learn more about. How do patients like it? How often do they fill it? How quickly? Do patients save the medications for another day? These are all questions we hope we can tell you more about in an article in a future issue of **ecp**.

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