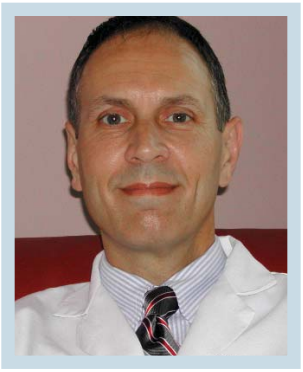
MICHAEL GUERRA, PA-C, MS

Say "No" to unnecessary antibiotics

Picture this: you are a primary care clinician in a busy outpatient office. So far, the morning has been pleasant and uneventful. But, lurking behind the door of exam room 1 is your next patient, a 33-year-old man whose chief complaint is that he's had "a bad cold for 3 days." You know from experience that this patient is likely to be correct. He probably has just that, a cold. However, your intuition tells you that this patient is seeking more than simple reassurance of the diagnosis. He is here for that perceived magic bullet—a prescription for antibiotics!



You open the exam room door tentatively. As expected, the patient is a well-appearing adult male with normal vital signs. He cheerfully announces, "I just need some antibiotics for my infection." As expected. The very sound of that word *antibiotics* painfully reverberates in your purist head and stings your evidenced-based clinical sensibilities. You now realize that this encounter will require so much more than an astute acumen of medical knowledge. You are going into battle. You are armed with pragmatic recommendations derived from countless evidence-based clinical research. Your patient is armed with the anecdotal evidence of historically "only feeling better after taking antibiotics," which have, apparently, been offered for similar symptoms in the past. Make no mistake, you are now engaged in head-to-head combat. There will be damaged egos and fractured presumptions. The encounter will not be pretty.

Sadly, this is a common outpatient scenario. I only wish the details were exaggerated. This type of patient-provider encounter is awkward and uncomfortable for both parties involved. The encounter may spiral into what feels like a clinician-patient standoff. Clinicians cannot easily say no to a patient's pleas for antibiotics. After all, the patient only wants to get better, and you only want to help. The goals seem mutual. Why the controversy?

Estimates are that more than 100 million prescriptions for antibiotics are written annually in the United States.[1] Many of these prescriptions are given to patients with acute, uncomplicated bronchitis, sinusitis, pharyngitis, and other nonspecific upper respiratory infections (URIs). These conditions are largely self-limited in nature. The media has rightfully acknowledged public health concerns in regard to the increase in bacterial drug resistance perpetuated by frequent, often unnecessary, antibiotic administration.[2] So, why do clinicians give in to their patients' requests for antibiotics? There are probably as many answers to this vexing question as there are antibiotics from which to choose.

I believe clinicians and patients share the responsibility for the inappropriate use of antibiotics. Patients may adhere firmly to the belief that their cold or nonspecific URI will only resolve with the administration of antibiotics. Why do patients think like this? Perhaps, no one wearing a white lab coat has ever told them otherwise.

Yes, educating patients about unnecessary antibiotic use is time consuming. Yes, patients may retaliate in numerous ways that can make you feel uncomfortable. Yes, you may be perceived as inflexible, uncaring, or incompetent. You may even become a bit unpopular within your practice. But the bottom line is this: If we, as clinicians, know full well that no sound medical indication exists to prescribe an antibiotic for a patient's medical condition, then we shouldn't prescribe one. You would never consider treating chicken pox with amoxicillin. How is treating an obvious viral URI with an antibiotic any different?

In fact, a line from the classic version of the physicians' Hippocratic Oath states, "I will neither give a deadly drug to anybody who asked for it, nor will I make a suggestion to this effect." Amoxicillin or a similar antibiotic is not likely to be deadly. But, if the antibiotic is unnecessary, why impose such a risk on the patient? Think about the many adverse outcomes associated with allergic reactions, untoward side effects, and drug-to-drug interactions. Imagine one of your patients requiring a colectomy because of pseudomembranous colitis secondary to antibiotic administration—unnecessary antibiotic administration! The scenario may be a bit dramatic; but the concern is real.

In the movie *Spiderman*, the young superhero is told, "with great power, comes great responsibility." Granted, our white lab coats are not capes and our power may be nothing more than the knowledge behind writing a prescription or making a recommendation. But it doesn't take a superhero or great power to do the right thing. More importantly, our duty as clinicians is to act responsibly. JAAPA

Michael Guerra practices family medicine at Family Care Associates in Plymouth, Michigan. He has indicated no relationships to disclose relating to the content of this article.

REFERENCES

1. McCaig LF, Besser RE, Hughes JM. Antimicrobial drug prescription in ambulatory care settings, United States, 1992-2000. *Emerg Infect Dis.* 2003;9(4):432-437.
2. Gill JM, Fleischut P, Haas S, et al. Use of antibiotics for adult upper respiratory tract infections in outpatient settings: a national ambulatory network study. *Fam Med.* 2006;38(5):349-354.