On TRACK: The Search for the Holy Grail

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SEARCH FOR THE HOLY GRAIL

The studies of antibiotic use in upper respiratory infection in the last issue stimulated a highly interactive discussion among clinicians and researchers clearly in touch with the realities of practice and patient concerns.[1-3] Young[1] labeled the search for signs, symptoms, or a new test to differentiate respiratory infections that benefit from antibiotics from those that don't as "Hickner's Holy Grail," after the editorialist who framed the question.[4,5] Young also notifies to look for a new meta-analysis that may help to overcome some of the limited power of prior studies to identify clinically useful differentiators of bacterial vs viral respiratory illness.

We learn from the medical director of an Indian Health Center "that clinicians changed their [antibiotic prescribing] behavior when given the latest information."[6] North describes how clinicians in this practice searched their electronic medical records to identify differing rates of antibiotic prescribing for respiratory infections, educated each other, and had individual conversations with those with high prescribing rates. They found huge intrapractice variability, and by using this approach they were able to dramatically reduce their antibiotic prescribing. A follow-up audit 3 years later showed that this reduction was sustained. This shared experience shows that the level of the solution may be in the social context of peer discussions among clinicians working closely together. I wonder whether the solution could be made even more robust by involving patients in the education and interactions, as Westfall, Macaulay, and colleagues showed us in a recent issue of the *Annals*[7-9] The *Annals* Journal Club in the last issue[10] provides a mechanism for starting self-educating conversations and practice-changing evaluation and follow-up.

A wonderful interaction between a recent residency graduate and van Driel, author of one of the antibiotic studies, shows how research findings can be applied in practice. The recent graduate concludes that "although I am still quite fresh out of the residency and this was the way we were taught to practice, I am giving up now and giving the patients what they want. It takes more effort to explain to them the opposite."[11] Despite the possibility of intercountry cultural differences, the study author replies[1]:

> Your patients sound very familiar. We found that our patients who hope for antibiotics were significantly more concerned about pain. They might think that antibiotics are the best way to deal with their pain and not prescribing antibiotics could be interpreted as "the doctor wants me to suffer." Of course, that makes them unhappy. If you want your patients to leave your office satisfied, you could consider using another approach. Instead of (wasting your time) explaining why they don't need antibiotics, you could explore what they worry about and address these specific concerns. Then you would really have something to offer.

The editorialist further responds with the idea of using "delayed prescription"—giving the patient a prescription combined with a message that they probably will get better without it.[13] Only 30% to 50% of patients fill such prescriptions. van Driel challenges even this intermediate strategy, summarizing "the main message is that we need to be convinced that it's OK not to prescribe antibiotics and need to educate our patients. It'll take a while, but we must try if we don't want antibiotic resistance to catch up with us."[14]

SENSEMAKING & CLINICIAN SATISFACTION

Findings from the study "What General Practitioners Find Satisfying in Their Work"[15] resonated with a physician "up to my neck in alligators."[16]

This study also stimulated concern about the loss of time for reflection and the increasing distance that third parties are putting between clinician and patient: "This opportunity for reflection is a gift to the GP and the patient, because it is the 'reflective practitioner' who takes the next step to ponder what he or she should have done differently and better, to improve the interplay and the dance the next time."[17,18]

Finally, Thomas notes:

> I also find it very satisfying to help a patient make sense of multiple symptoms, and consider this to be at the heart of quality general practice. But this recognition does not help me face a critic who says 'how indulgent, that you expect to enjoy your work—what matters is the health of

the patient!"[19] In truth the authors do offer a reply to such a critic, but I want to elaborate. The health of a patient has as much to do with their ability to make sense of the complex interplay of various aspects of their life as with effective treatment of their discrete diseases…. When a patient is able to reframe complaints in more connected way, they avoid the dangers of worsening one thing while they improve another.

He goes on to reflect:

So modern-day general practice needs both—whole person care and good disease management…. The general practitioner role [i]s helping people to make sense of the complexities in their life, as well as treating their diseases…. We must argue at every level that relationships matter—doctor-patient relationships, personal relationships of all kinds, and also the relationships between the different aspects of a patient's health—people really are more than the sum of their medical diagnoses.

OTHER THREADS

I also commend to readers' attention other interesting threads of online discussion that relate to patterns of family illness[20,21]; physician and patient response to breast lumps after a negative screening mammogram[22]; healing, meaning, and depression[23,24]; and understanding and measuring continuity of care.[25-27]

Other online comments discussed race-based drug prescribing,[28-31] the role of academic health centers,[32,33] the epistemology of health care,[34] humble cross-cultural understanding of the meaning of patients' words,[35,36] and this challenging question: "How can laypeople parents [of a multiply developmentally disabled child] without any professional training and oftentimes in the throes (especially early on) of the grief process possibly be expected to do so much without significant assistance in coordination by the doctor?"[37]

Please join in at http://www.AnnFamMed.org.

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