



**EDITOR-IN-CHIEF**

**JOHN HICKNER, MD, MSc**  
University of Illinois at Chicago

**ASSOCIATE EDITOR**

**RICHARD P. USATINE, MD**  
University of Texas Health Science Center  
at San Antonio (Photo Rounds)

**ASSISTANT EDITORS**

**DOUG CAMPOS-OUTCALT, MD, MPA**  
Mercy Care Plan, Phoenix

**RICK GUTHMANN, MD, MPH**  
Advocate Illinois Masonic Family Medicine  
Residency, Chicago

**ROBERT B. KELLY, MD, MS**  
Fairview Hospital, a Cleveland Clinic hospital

**GARY KELSBERG, MD, FAAFP**  
University of Washington, Renton

**COREY LYON, DO**  
University of Colorado, Denver

**KATE ROWLAND, MD, MS**  
Rush-Copley Medical Center, Chicago

**E. CHRIS VINCENT, MD**  
University of Washington, Seattle

**EDITORIAL BOARD**

**FREDERICK CHEN, MD, MPH**  
University of Washington, Seattle

**JEFFREY T. KIRCHNER, DO, FAAFP, AAHIVS**  
Lancaster General Hospital, Lancaster, Pa

**TRACY MAHVAN, PHARM D**  
University of Wyoming, Laramie

**MICHAEL MENDOZA, MD, MPH, MS, FAAFP**  
University of Rochester, New York

**FRED MISER, MD, MA**  
The Ohio State University, Columbus

**KEVIN PETERSON, MD, MPH**  
University of Minnesota, St. Paul

**MICHAEL RADDOCK, MD**  
The MetroHealth System, Cleveland, Ohio

**KATE ROWLAND, MD, MS**  
Rush-Copley Medical Center, Chicago

**LINDA SPEER, MD**  
University of Toledo, Ohio

**JEFFREY R. UNGER, MD, ABFP, FACE**  
Unger Primary Care Concierge Medical Group,  
Rancho Cucamonga, Calif

**DIRECT INQUIRIES TO:**

Frontline Medical Communications  
7 Century Drive, Suite 302  
Parsippany, NJ 07054  
Telephone: (973) 206-3434  
Fax: (973) 206-9378

# 6 steps to take when a patient insists on that antibiotic

**I**n this issue of *JFP*, Wiskirchen and colleagues discuss the appropriate use of antibiotics in outpatient settings, providing stewardship advice for several conditions we frequently see in primary care practice.

One of the symptoms for which we most frequently battle requests for antibiotics is acute cough. Despite the fact that more than 90% of cases of acute cough illness (aka acute bronchitis) are caused by viruses, the prescribing rate for it in the United States remains about 70%.<sup>1</sup>

Over the years, I've honed a "spiel" that I use with patients with acute cough illness to help keep my antibiotic prescribing to a minimum. It must be working; my prescribing rate is less than 20%. What follows are some of my catch phrases and techniques.

**Patients may be less likely to ask for an antibiotic if you refer to acute bronchitis as a "chest cold."**

**1. Acknowledge the patient's misery.** "Sounds like you have a really bad bug."

**2. Tell the patient what he or she *doesn't* have.** "Your lungs sound good, and your throat does not look too bad, so that means you don't have strep throat or pneumonia. That's good news."

**3. Explain what viruses are "making the rounds."** If you have surveillance data, that's even better. "I have seen several other patients with symptoms just like yours this week." Over 25 years ago, Jon Temte, an FP from Wisconsin, drove down prescribing rates for acute bronchitis below 20% in family medicine residencies by providing feedback to physicians and patients about the viruses circulating in their communities.<sup>2</sup>

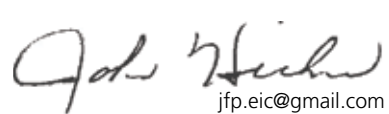
**4. Set realistic expectations.** Tell patients how long their cough is likely to last. The duration of the typical cough is (unfortunately) about 17 days.<sup>3</sup> Most patients (and even some doctors) think a bad cold should be gone in 7 days.<sup>3</sup>

**5. Choose your terms carefully.** Don't use the term "acute bronchitis." It sounds bad and worthy of an antibiotic. "Chest cold" sounds much more benign; patients are less likely to think they need an antibiotic for a chest cold.<sup>4</sup>

**6. When all else fails, consider a delayed prescription.** I reserve this strategy for patients who are insistent on getting an antibiotic even though their illness is clearly viral. Randomized trials of the delayed strategy show that fewer than 50% of patients actually fill the prescription.<sup>5</sup>

Develop your own spiel to reduce unnecessary antibiotic prescribing. You'll find that it works a good deal of the time.

1. Barnett ML, Linder JA. Antibiotic prescribing for adults with acute bronchitis in the United States, 1996-2010. *JAMA*. 2014;311:2020-2022.
2. Temte JL, Shult PA, Kirk CJ, et al. Effects of viral respiratory disease education and surveillance on antibiotic prescribing. *Fam Med*. 1999;31:101-106.
3. Ebell MH, Lundgren J, Youngpairaj S. How long does a cough last? Comparing patients' expectations with data from a systematic review of the literature. *Ann Fam Med*. 2013;11:5-13.
4. Phillips TG, Hickner J. Calling acute bronchitis a chest cold may improve patient satisfaction with appropriate antibiotic use. *J Am Board Fam Pract*. 2005;18:459-463.
5. Spurling GK, Del Mar CB, Dooley L, et al. Delayed antibiotics for respiratory infections. *Cochrane Database Syst Rev*. 2013:CD004417.

  
jfp.eic@gmail.com