Changing Hearts and Minds: Integrating Social Dynamics into Antibiotic Stewardship Implementation

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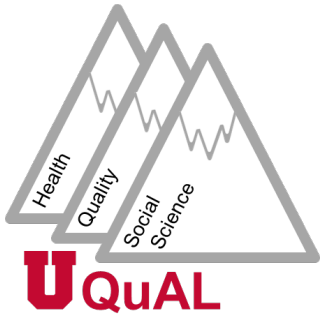
SSHEAR
Social Sciences in Healthcare Epidemiology and Antimicrobial Resistance



HEALTH
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Combating Antimicrobial Resistance with Stewardship
Chicago Department of Public Health

Disclosures

- I have no financial relationships to disclose in relation to this presentation.

Learning Objectives

- Describe the ways in which quality improvement initiatives involve social change
- Identify the social determinants of antibiotic prescribing and determine the value of incorporating them into the design and implementation of antibiotic stewardship interventions
- Incorporate approaches antibiotic stewards and their teams can use to communicate with prescribers to increase engagement while decreasing conflict

Quality improvement involves social change.

Don’t confuse an adaptive problem with a technical one.

Pronovost PJ. *BMJ Qual Saf*. 2011 Jul;20(7):560-3.

Central Lines, Checklists, Context, and Collective Social Action

Bosk et al. *The Lancet*, Volume 374, Issue 9688, 2009, Pages 444-445.

The NEW ENGLAND JOURNAL of MEDICINE

ESTABLISHED IN 1812 DECEMBER 28, 2006 VOL. 355 NO. 26

An Intervention to Decrease Catheter-Related Bloodstream Infections in the ICU

Peter Pronovost, M.D., Ph.D., Dale Needham, M.D., Ph.D., Sean Berenholtz, M.D., David Sinopoli, M.P.H., M.B.A., Haitao Chu, M.D., Ph.D., Sara Cosgrove, M.D., Bryan Sexton, Ph.D., Robert Hyzy, M.D., Robert Welsh, M.D., Gary Roth, M.D., Joseph Bander, M.D., John Kepros, M.D., and Christine Goeschel, R.N., M.P.A.

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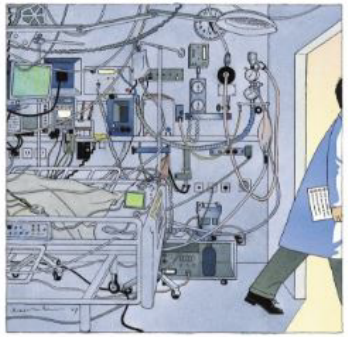
THE CHECKLIST

If something so simple can transform intensive care, what else can it do?

By Atul Gawande

The damage that the human body can survive these days is as awesome as it is horrible: crushing, burning, bombing, a burst blood vessel in the brain, a ruptured colon, a massive heart attack, rampaging infection. These conditions had once been uniformly fatal. Now survival is commonplace, and a large part of the credit goes to the irreplaceable component of medicine known as intensive care.

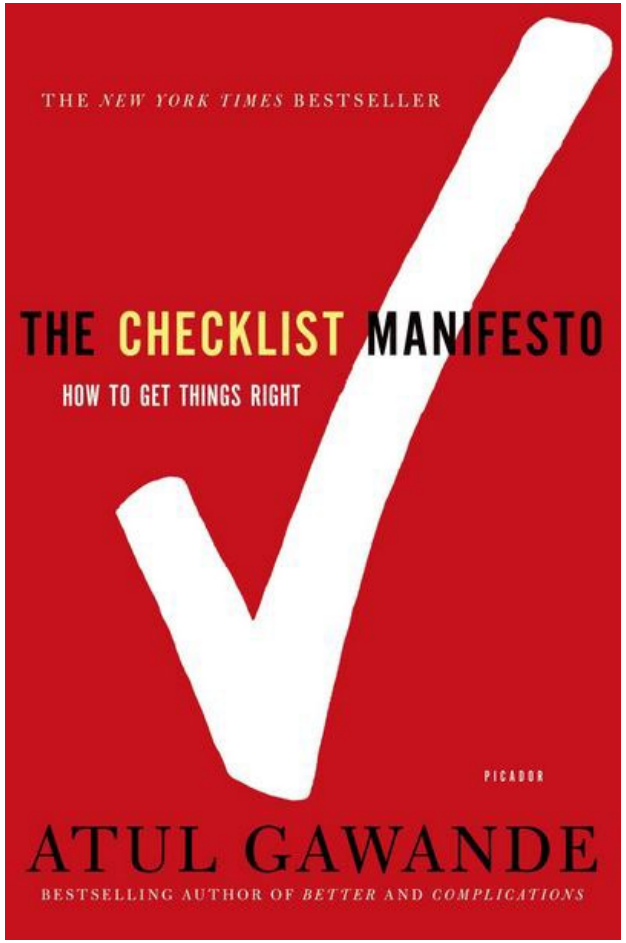
It's an opaque term. Specialists in the field prefer to call what they do "critical care," but



If a new drug were as effective at saving lives as Peter Pronovost's checklist, there would be a nationwide marketing campaign urging doctors to use it.

Illustration by Yan Nascimbene

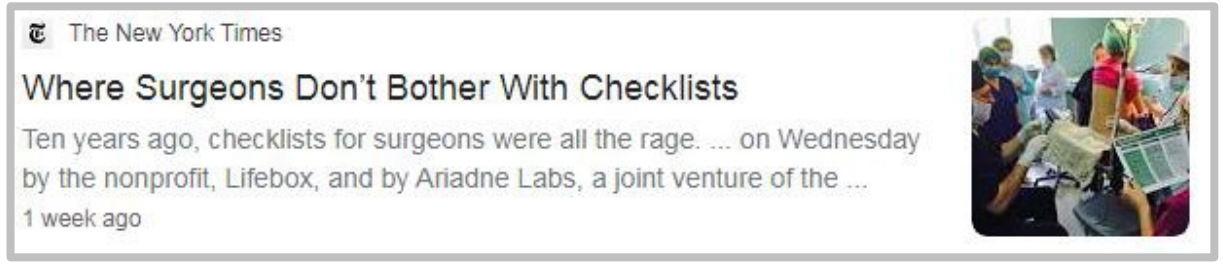
2007



2009

Beware the "Simple Checklist" Story

- This narrative obscures social mechanisms that led to change
  - Engaged leadership
  - Social network of ICUs across the state encouraged institutional isomorphism
  - Leveraging infection data to promote accountability
  - Reframing CLABSI from "cost of doing business" to unacceptable
  - Bolstering climate where nurses felt empowered to speak up when they observed a breach in practice
- Just implementing the checklist without attention to these factors leads to failed replication of effects in other sites



Bion et al. *BMJ Qual Saf*. 2013 Feb;22(2):110-23.

Dixon-Woods et al. *Milbank Q*. 2011 Jun;89(2):167-205.

Reames et al. *JAMA Surg*. 2015 Mar 1;150(3):208-15.

Adaptive vs. Technical Problems

Technical

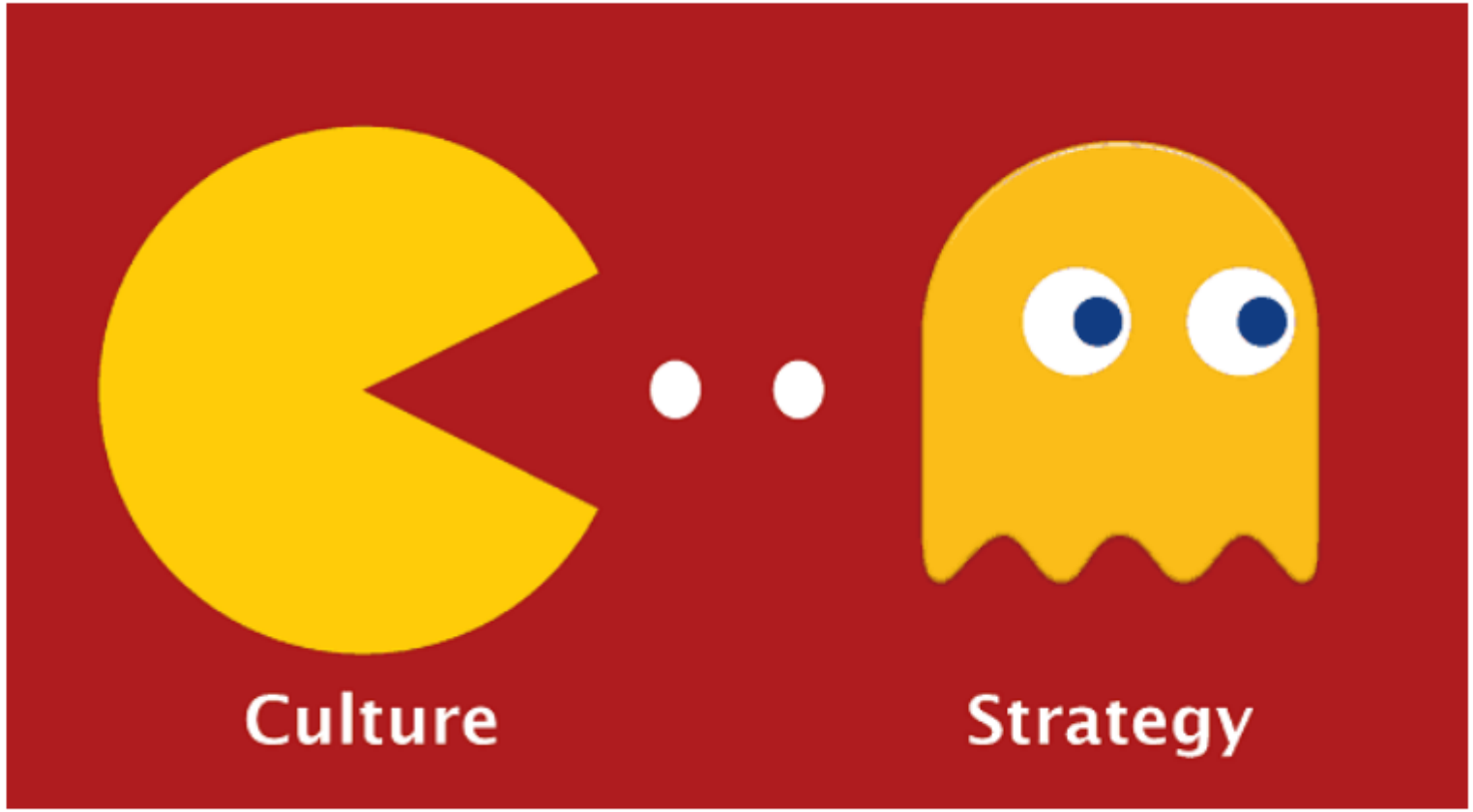
- Equipment, tools, supplies
- Valid measures
- Guidelines and protocols
- Technology

Adaptive

- Local context and culture
- Emotions and psychology
- Social and political dynamics
- History
- People's priorities, beliefs, habits and loyalties

Pronovost PJ. *BMJ Qual Saf*. 2011 Jul;20(7):560-3.

Because “Culture eats strategy for breakfast” (and lunch and dinner….)



Hospital as Small Society

- **Clinical work**
  - People working together *on* sick people
- **Behavior in healthcare organizations shaped by social dynamics of groups**
  - Conflict
  - Status inequality and hierarchy
  - Face-saving and emotion management
  - Identity work
  - Management of uncertainty and risk
- **Medical and healthcare workplaces have distinct cultures that shape decision making to achieve *social* goals (vs. biomedical ones)**

The social determinants of antibiotic prescribing.

If I see a patient a week after surgery, and there's still a little redness, and Mom's nervous I am inclined to just put the kid on the antibiotic**. It just makes everyone comfortable,** and then a week later, the redness is gone. Did I treat an infection or was there just some redness? Some inflammatory post-operative discharge? I don't know.

I'm more careful about how I give antibiotics than I used to be in the past. **You don't want to be part of the societal issue of creating superbugs, but it is surprisingly difficult to look Mom in the face when she is convinced it's infected and you're trying to say 'look, it's not infected,' when you don't even know for sure yourself and a week later it could pus out and Mom's like 'see? Should have put her on antibiotics. I can't believe you did this to my kid!'**

That is what you imagine the scenario being if you don't do something. **It's so much easier to say 'look, we'll put her on a little antibiotic.**

Pediatric General Surgeon

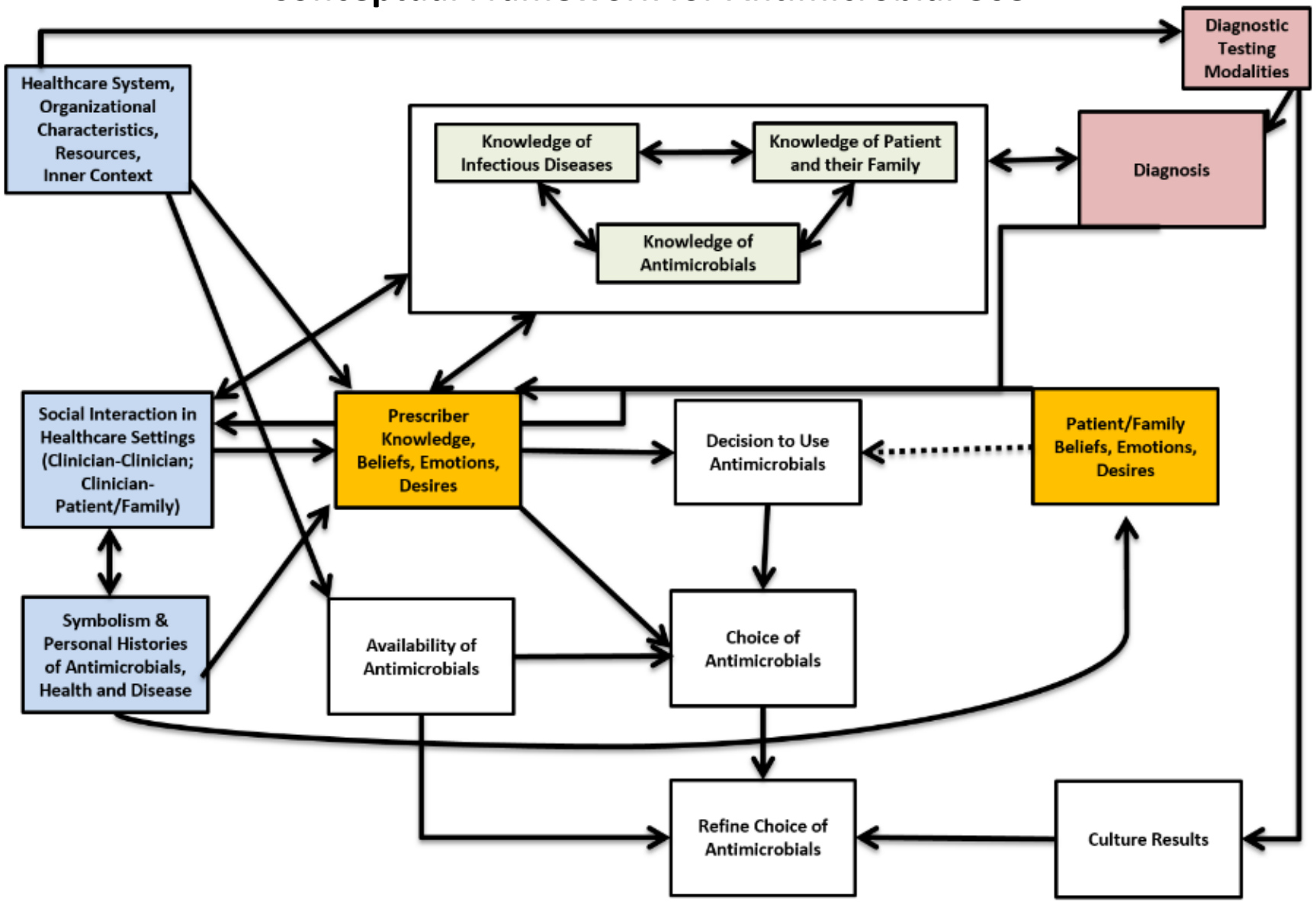
Szymczak (2013) *The Complexity of Simple Things: An Ethnographic Study of the Challenges of Preventing Hospital-Acquired Infections.* University of Pennsylvania.

Prescribing is a Social Act

- Means of communication – demonstrates concern
- Expresses power and facilitates social control
- Produces income
- A prescription is a tool to help clinician navigate practical social challenges of care delivery
  - How to react to patient demands
  - How to project competence
  - How to manage uncertainty about cause/cure of sickness
  - How to end the clinical encounter

van der Geest et al. *Ann Rev Anthropology* 1996 (25): 153-178.

Conceptual Framework for Antimicrobial Use



Szymczak, J.E. and J. Newland (2018). "The social determinants of antimicrobial prescribing: Implications for antimicrobial stewardship" in Barlam, T., Neuhauser, M., Tamma, P., & Trivedi, K. (Eds.). *Practical Implementation of an Antibiotic Stewardship Program*. Cambridge: Cambridge University Press.

The Social Determinants of Antibiotic Prescribing

Relationships between clinicians

Relationships between clinicians and patients

Risk, fear, anxiety and emotion

(Mis)perception of the problem

Contextual and environmental factors

Szymczak, J.E. and J. Newland (2018). "The social determinants of antimicrobial prescribing: Implications for antimicrobial stewardship" in Barlam, T., Neuhauser, M., Tamma, P., & Trivedi, K. (Eds.). *Practical Implementation of an Antibiotic Stewardship Program*. Cambridge: Cambridge University Press.

Relationships Between Clinicians

- "Prescribing etiquette"
  - Strong **norm of noninterference**
  - Avoid altering other prescribers' decisions
  - Ok to intervene on prescribing decisions that are **immediately harmful** but not for those that are **apparently inappropriate**

  - Reluctance to provide critique/feedback/advice
    - Ok sometimes, but only in "appropriate" forum (handoffs)
    - Lack of opportunity to give face-to-face feedback

Charani et al. CID 2013:57
Lewis et al. J R Soc Med 2009:102
Armstrong et al. Soc Health Ill 2006:28, Livorsi et al. ICHE 2015:36

I've noticed something when I've been rounding with the teams. So our ID pharmacists are part of the antimicrobial stewardship team and rotate on and off. One week they'll be doing stewardship, the next week they're on service rounding with the team. **And there will be physicians that see these pharmacists rounding with the team and they'll see them approaching and they're like, 'Oh, no. What did I do wrong?' And the ID pharmacist says immediately, 'Oh, I'm not doing stewardship. I'm on inpatient service.' Or, 'We're not coming after you.'**

ICU Pharmacist, Children's Hospital

Relationships Between Clinicians

- Role of hierarchy
  - Junior physicians defer to senior colleagues

- Opinion of senior colleagues and social networks more influential than guidelines
  - Variation in attitudes by medical specialty

DeSouza et al. J Antimicrob Chemother 2006:58
Charani et al. CID 2013:57
Grant et al. Imp Sci 2013:8
Cortoos et al. J Antimicrob Chemother 2008:62

Szymczak JE. Clin Infect Dis. 2019 Jun 18;69(1):21-23

Clinician-Patient Relationship

- Clinicians identify patient/family expectation and pressure for antibiotics as a key driver of unnecessary prescribing
  - Especially in pediatrics, urgent care, the emergency department, telemedicine, veterinary medicine

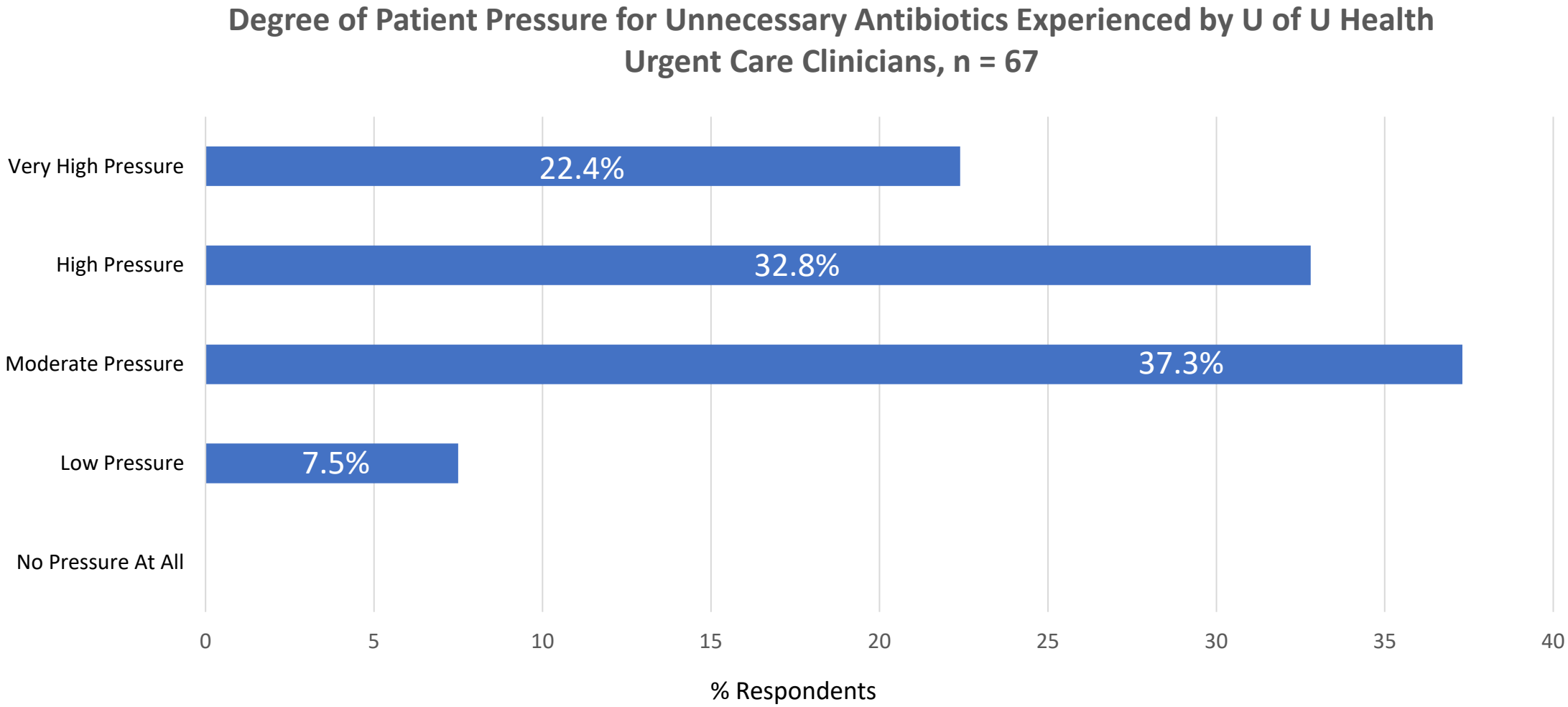
Bauchner et al. Pediatrics 1999:103
Brookes-Howell et al. BMJ Open 2012:2
Vazquez-Lago et al. Fam Pract 2012:29
Szymczak et al. ICHE 2014:35(S3): S69-78
Kohut MR et al. Fam Pract. 2020 Mar 25;37(2):276-282
Zetts RM et al. Open Forum Infect Dis. 2020 Jun 20;7(7):ofaa244.
Szymczak JE et al. Mayo Clin Proc. 2021 Mar;96(3):543-546
Spencer HJJ et al. Antimicrob Steward Healthc Epidemiol. 2022 Jun 29;2(1):e107.

"Sometimes you just don't have time to argue with a parent. You just don't. It can be a war zone. It is in the middle of the winter, and the kid is outside throwing up in the hall, and the mom says 'I need an antibiotic prescription.' Most of the time you can reason with her. You say 'look, we don't need to treat this.' And she says 'but my neighbor says this. I have an uncle who's a doctor and he said yes, I need it.' They come up with a million reasons why they need it. And you just don't have time."

Primary Care Pediatrician

Szymczak et al. ICHE 2014 35(S3):S69-S78

You aren't alone in this experience!



Source: May 2023 IMPART Project Survey

Patient Expectations and Pressure

- Relationship between receipt of antibiotic and patient satisfaction varies across studies
- Patients who expect to receive an antibiotic are more satisfied when they are prescribed one
- When a clinician perceives that a patient expects an antibiotic, they are more likely to prescribe
  - Evidence to suggest that clinicians perceive patient expectation where this is none

Cziner MJ et al. Antimicrob Steward Healthc Epidemiol. 2023 Apr 26;3(1):e83.
Sirota M et al. Heal Psychol 2017;36:402–409.
Ashworth M et al. Br J Gen Pract 2016;66:e40–e46.
Curt AM et al. Clin Pediatr (Phila) 2020;59:618–621.
Foster CB et al. Pediatrics 2019;144:e20190844.
Ong S et al. Ann Emerg Med 2007;50:213–220.
Huang Z et al. J Glob Antimicrob Resist. 2023 Jun;33:89-96.

Clinician-Patient Relationship

- Why capitulate to patient/family pressure?
  - Desire to provide something of value to patients
    - Acknowledge discomfort
    - Navigation of consumerism
  - Conversations are unpleasant and tiring
    - In context of time constraints, clinician burnout, incentives – difficult to counter
  - Reputational and economic risks
    - Loss of practice income, local market competition

Butler et al. BMJ 1998:317
Shapiro Clin Ther 2002:24
May et al. ICHE 2014 35(9): 114-1125
Szymczak JE et al. Mayo Clin Proc. 2021 Mar;96(3):543-546

Risk, Fear, Anxiety and Emotion

- Perception that risk of under-treating > individual patient risk from receiving unnecessary antibiotics
  - Potential adverse effects of antibiotics have limited impact on decision-making

- Risk perceptions re: broad spectrum antibiotics
  - Overly dire consequences for initiating coverage that is too narrow
  - Broad spectrum drugs feel "safe," more "comfortable"
  - Overarching goal is "prevention of disaster in next 24 hrs"

May et al. ICHE 2014:35
Bjorkman et al. Qual Saf Health Care 2010:19
Livorsi et al. ICHE 2015: 36
Szymczak JE et al. ICHE. 2020 Aug;41(8):914-920.

"We overprescribe because we don't want the patient to do badly…As a physician, you feel really bad when you do something and you could have done something differently and the patient does badly. That is what haunts you. I can't remember a time where I clearly did too much and I was bothered by that later. I'm not haunted by those. I'm haunted by the ones I missed and I could have done more."

Critical Care Physician

Risk, Fear, Anxiety and Emotion

- Emotional desire to provide all immediate therapeutic options regardless of wider population consequences
  - Shaped by face-to-face interactions with patients and their families
  - The "pull" of social relationships stronger than the "push" of guidelines or restrictive policies

Broom et al. Soc Sci Med 2014:110
Szymczak et al. SHEA 2018 Abstract #9990

(Mis)Perception of the Problem

- Numerous survey studies find that clinicians perceive antibiotic overuse is a problem generally, but not locally
- Other medical specialties responsible for overuse
- Exceptionalism
  - Guidelines do not apply to my patients
  - My past experience and expertise trump guidelines
  - Guidelines are "academic" and are not always practical in application
  - Disbelief that one overprescribes

Giblin et al. Arch Intern Med 2004:164
Wood et al. J Antimicrob Chemother 2013:68
Abbo et al. ICHE 2011 32(7): 714-718
Stach et al. JPIDS 2012 1(3):190-7
Szymczak et al. ICHE 2014:35
Charani et al. CID 2013:57
Grant et al. Implementation Science 2013 8(72)

(Mis)Perception of the Problem

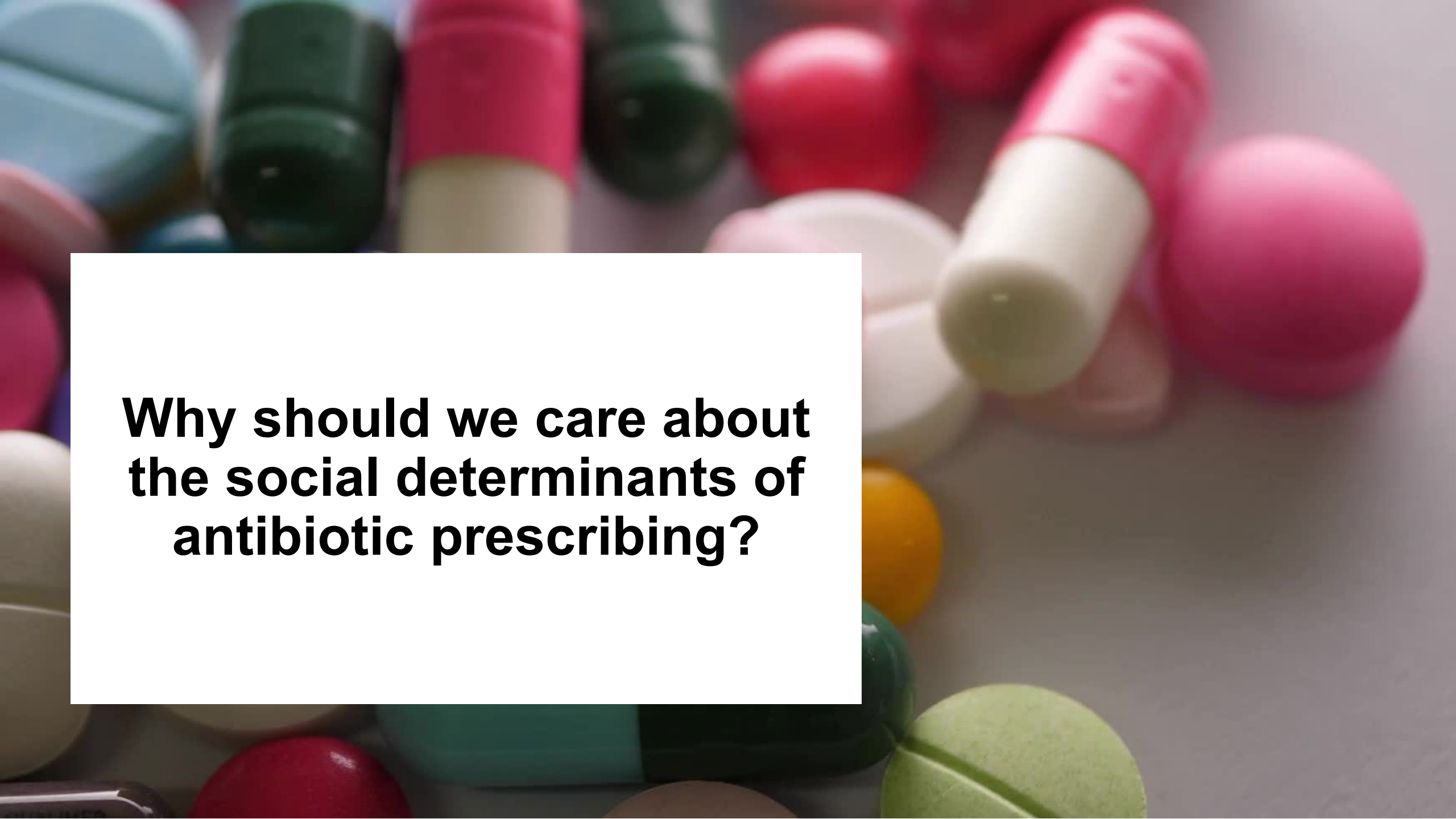
- Antibiotic resistance a macro problem but of limited concern at the bedside
  - Resistance is a "theoretical" or "intellectual" concern, not a practical one
  - Emergent problems take precedence

Bjorkman et al. Qual Saf Health Care 2010:19
Broom et al. Soc Sci Med 2014:110

Contextual and Environmental Factors

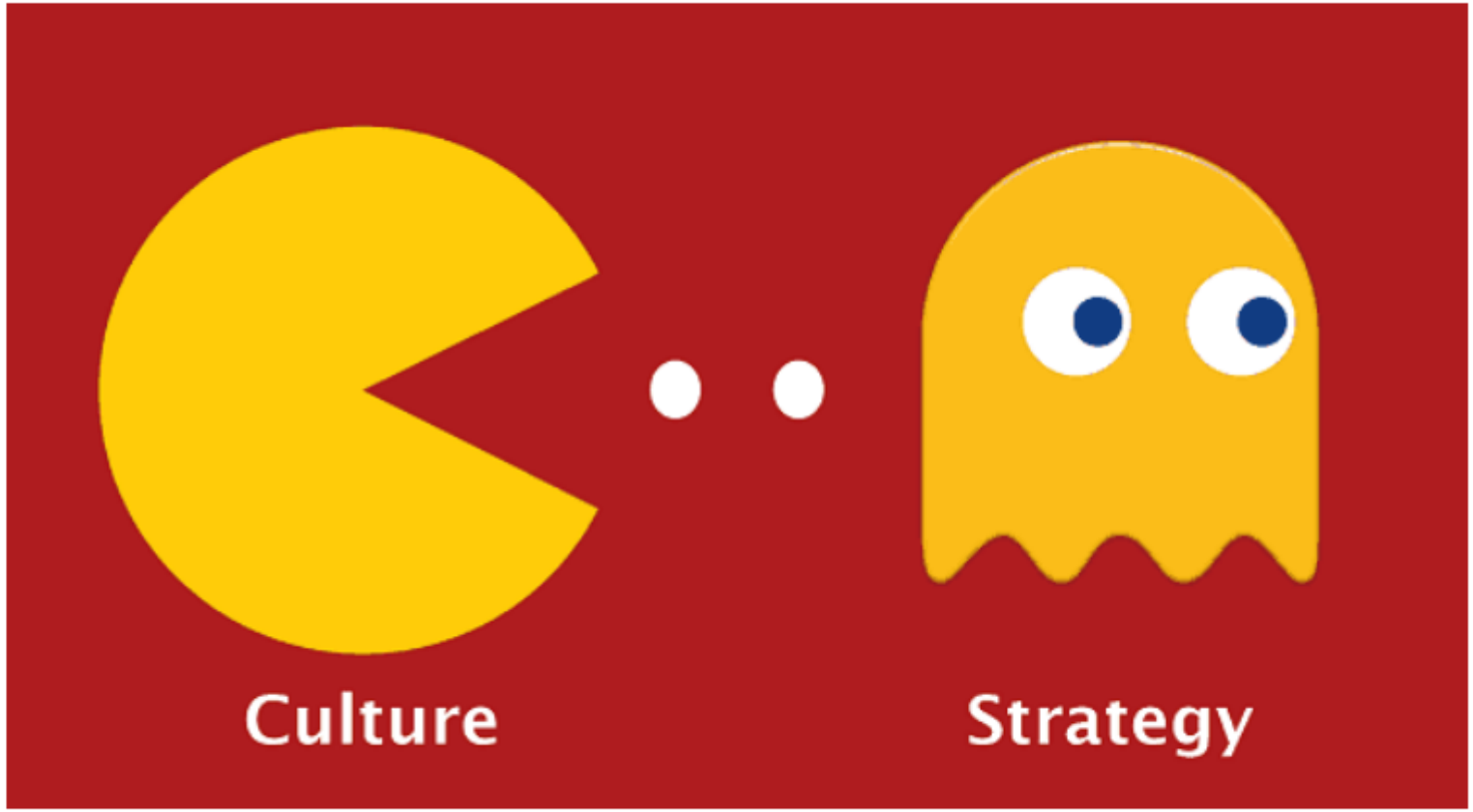
- Time pressures
  - Pressure to discharge quickly discourages a "watch and wait" approach
  - Practice volume and throughput pressures discourage communication with patients
- Ease of accessing diagnostic testing systems and ability to act on the results
- Time of day
  - Decision fatigue – erosion of self control over time (tired, hungry, etc.) – GPs make more inappropriate antibiotic decisions later in the day

Avorn et al. Ann Intern Med 2000:133
May et al. ICHE 2014:35
Linder et al. JAMA Internal Medicine 2014 174(12):2029-31

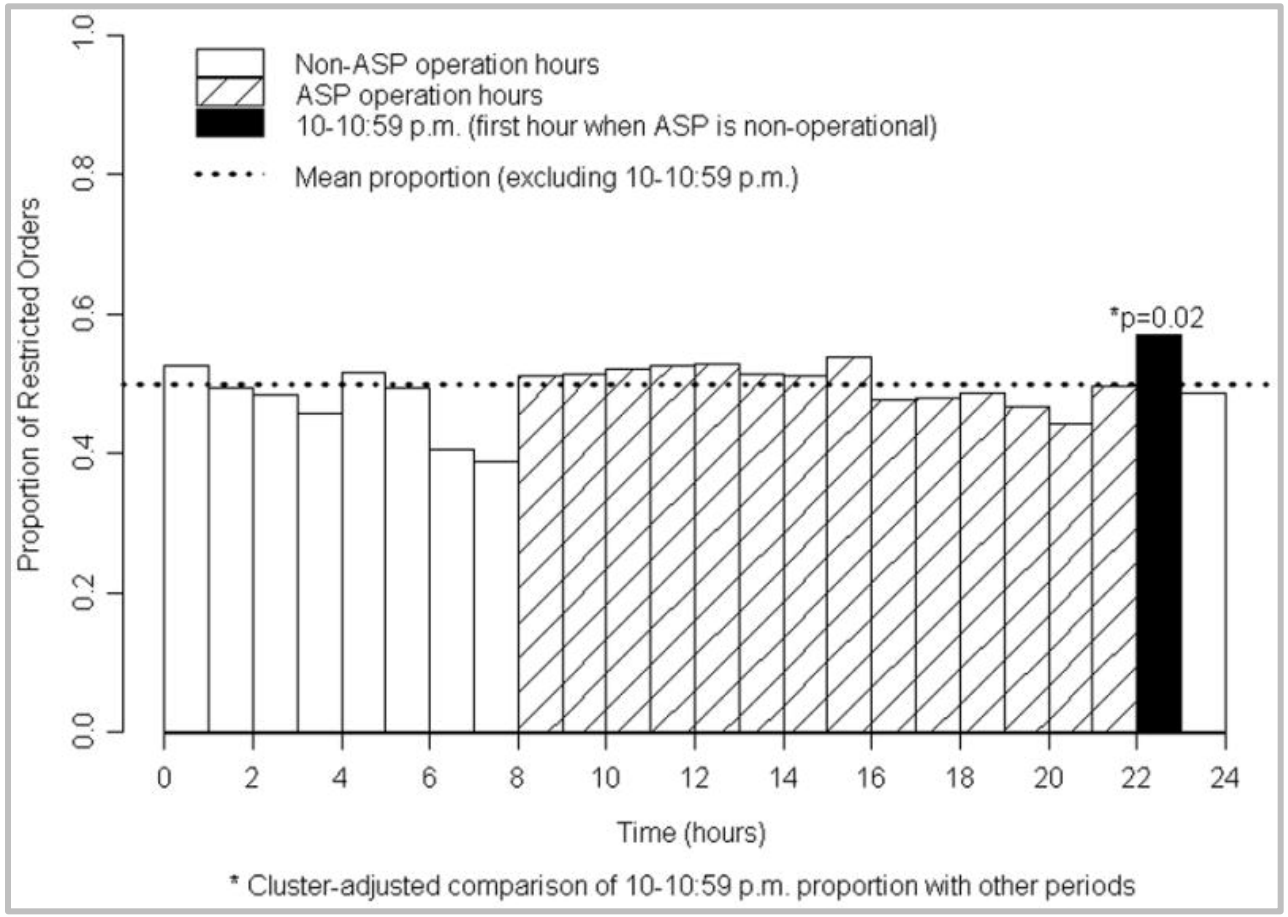


Why should we care about the social determinants of antibiotic prescribing?

Because “Culture eats strategy for breakfast” (and lunch and dinner….)



- Although interventions to improve antibiotic use have been successful to a degree, we can do better
  - Direct educational approaches generally do not result in sustained improvement
  - Restrictive policies can be circumvented
    - "Stealth dosing"
    - Misrepresenting clinical information
  - Audits can be "gamed"



Linkin et al. ICHE 2007:28

Arnold et al. Cochrane Database of Systematic Reviews 2005:4
LaRosa et al. ICHE 2007:28
Calfee et al. Jour Hosp Infec 2003:55
Linkin et al. ICHE 2007:28
Seemungal et al. ICHE 2012 33(4): 429-431
Szymczak et al. ICHE 2014:35

Stewardship from the ground up instead of top-down?

Implications for Antibiotic Stewardship

- Stewardship interventions have to consider the social and organizational context in which care is provided, the psychology of individuals (clinicians, patients) and the nature of their interactions
  - Addressing the social determinants
  - Tailor interventions to PEOPLE
  - Adjunctive implementation strategies

- The problem is multi-faceted, so a singular approach to solving it is not going to have the desired effect
  - Multi-part interventions are more effective that those with only one component

Van der Velden et al. *Br J Gen Pract* 2012:62:e801-7.
Livorsi DJ et al. Infect Control Hosp Epidemiol. 2022 Feb;43(2):139-146.

Research on (and with) Antimicrobial Stewards

Communication for engagement to improve antibiotic prescribing in hospitals.

Communication and Stewardship

- Core hospital-based antimicrobial stewardship interventions influence prescribing via communication
  - Prospective audit and feedback
  - Preauthorization
  - Handshake stewardship

- Stewards need more than proficiency in ID, microbiology, data analytics, informatics
  - Social and communicative skills to implement change in complex organizations

Hurst AL et al. *Pediatr Infect Dis J*. 2016 Oct;35(10):1104-10.

Cosgrove SE *Infection control and hospital epidemiology*. 2014;35(12):1444-1451.

Communication and Stewardship

- Stewards must navigate complex social and cultural dynamics in daily work
  - Delivering advice to people who have not requested it
  - Restricting access and gate keeping role
    - May be perceived as introducing inefficiencies to workflow
  - Contending with "prescribing etiquette"
    - "Antibiotic police"

Charani E, *Clin Infect Dis.* 2013;57(2):188-196.

Szymczak JE, Infect Control Hosp Epidemiol. 2019 May;40(5):522-527.

Communication and Stewardship

- Stewards must navigate complex social and cultural dynamics in daily work
  - Interprofessional stewardship communication can cause conflict (MD-PharmD)
    - Asymmetry in authority, accountability
    - Hierarchy
    - Professional identity and subcultures
  - Engagement of other professions (e.g. nursing), while recommended, made more difficult by lack of interprofessional cooperation
  - Gender identity

Broom A, *Qual Health Res*. 2017 Nov;27(13):1924-1935.

Szymczak JE. *Clin Infect Dis*. 2019 Jun 18;69(1):21-23.

Broom A, *BMC health services research*. 2016;16:43.

Vaughn VM et al. Infect Control Hosp Epidemiol. 2022 Jun 7:1-8.

Kirby E, *BMJ Open*. 2020 Oct

What do stewards say about communication for influence?

We asked them!

- 2 year qualitative study

- Data gathered at 10 hospitals across the US between 2018-2019
  - Mix of community hospitals, academic medical centers, pediatric hospitals

- Interviews conducted with
  - **58 antimicrobial stewards**
  - **146 prescribers**

Szymczak J, et al. *Antimicrobial Stewardship & Healthcare Epidemiology*. 2021;1(S1):s14-s14.

Stewards - Communication Strategies

Language

- Purposeful moderation of language to reduce defensive reaction
- Language is way to adapt intervention to prescribing etiquette

Framing

- Communicates that ultimate goal of stewardship is to improve patient care
- Avoids discussion of finances, regulatory pressures or assessments of medical knowledge
- Acknowledge prescriber expertise and level of responsibility
- Purposefully avoids adopting a conflict orientation in their interactions

Strategy

- Thinks about communication over time, "invests" in future interactions
- Knows which battles to fight, leaves some things on the table
- Meets prescribers where they are at physically and emotionally
- Talks about things other than antibiotics

My approach has changed a little bit in that I try to be more of a, ‘Here's what I see is going on,’ not, ‘I see you're doing this. You need to stop it.’ I tend to use softer language, just because I'm not always right in what I see**…I was somewhat dogmatic when I started this. My approach has shifted. It doesn't mean I have changed what I recommend. My approach has changed to be a little more collaborative.** ‘Here's what I see. Help me to understand. Explain to me why you're doing this. It appears you could do this. This would be more efficient. This would be more effective. This would be better for the patient.’ And my sense is people respond better to that than me saying, ‘What you're doing is not right. You need to stop doing this.’ **People just stop listening when you are very dogmatic. Especially surgical or ICU teams. When you’re dogmatic with those clinicians, they tend to dig in and become dogmatic right back.**

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It’s important to acknowledge the prescriber’s expertise. If you come in as a super-expert, that torpedoes the whole thing, because those people are practicing a craft, just the same as we are. And if you come at it from a standpoint of, ‘Well, let me show you how it's done,’ then you're gonna be miserable, and they're not gonna like you. **Having the emotional intelligence to say, you know, you're preparing to exert the Hawthorne effect on them, and nobody likes that.** Nobody likes when Mom comes over and checks to see how you're folding the underwear, you know? She's probably not gonna be like, ‘Oh, it's so great; great job. Have you thought about folding it this way?’ **You’re not there to second-guess. You're there to understand, and help them think through a problem, because you both have the same goal in mind, which is taking as good a care of that individual as possible.**

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“

And so sometimes – often – I may not get everything I wanted them to do. But if I can get them to do some of what I wanted them to do now, they may do all of what I wanted them to do in a couple of days when they reach an adequate comfort level with it. **And so even if they don't make the change right now, planting the seed of where we're gonna go, I think, is also important.**

”

What do prescribers say about communication in stewardship?

Sentiment of Prescriber Perceptions

What Underpins Negative Perceptions?

- Stewardship symbolizes unpalatable trends in medicine more broadly
  - Encroachment of bureaucracy that puts profits over patients
  - "Cookbook" medicine
- Stewardship a threat to a prescriber's professional identity or sense of self
  - Discomfort with being wrong
  - Feeling as if expertise is not acknowledged
- Goals of stewardship and goals of prescriber appear to be at odds
  - Inefficiency of systems
  - Different motivations by clinical area (surgery, oncology, neonatology)

I mean we tend to be control freaks, and we tend to be very – like we're trained to be the captain of the ship. We're trained to make decisions and make our plan. That is part of our identity. **And frankly, it feels awful when someone says 'Actually your plan is terrible.' And so you need stewards who can say that without actually saying 'your plan is terrible.'**

General Surgeon

What Underpins Positive Perceptions?

- Stewards communicate things of value
  - Education
  - Updated evidence
  - Catches errors
- Stewardship attempts to understand where prescriber is coming from
  - Non aggressive approach
  - Acknowledges prescriber's experience clinically and with the specific patient in question
  - Thinks critically about where and when to interject
- Shared sense of mission and motivation between steward and prescriber

The stewardship pharmacist here has good emotional intelligence. Our unit has a lot of high acuity and high stress. **They're really good about fitting into a team, adding value.** They come on rounds. But they also know when to pick the battle and when to have the discussion. And they're mature in their approach. **So they know who the decision-makers are, who pulls the levers and how to educate.** So they're really good about being total team players and making everybody learn something and feel good about rounds. **They don't make people feel bad about what they don't know, so people really are not afraid to ask them anything. I mean, even the intensivists, who've done this forever, are pretty smart people, but they will constantly ask him questions.**

Hospitalist

What we learned.

Stewards

- Communication in stewardship is purposeful and multi-modal
  - Consider language, framing, strategy
  - A way to navigate "prescribing etiquette"

- Work to establish credibility and legitimacy is paramount

- Relationship building – thinking about relationships as "chains" of interactions to set the stage for acceptance down the line (and perhaps prescribers stewarding themselves)

Prescribers

- Prescribers in our study generally felt favorably towards stewardship

- Communication viewed positively was:
  - Not dogmatic or aggressive or agenda-driven
  - Conveyed a shared sense of mission: the patient
  - Conveyed a desire to understand
  - Efficient and value-added

The 3Ps/3Ds/3Cs Framework

Table 1. The 3Ps/3Ds/3Cs Framework for Antimicrobial Stewardship

*P*lace	• What is/are the infection(s) or potential infection(s)? • From what possible places is/are infection(s) coming (eg, skin, gastrointestinal tract, oropharynx, health care environment)? • Are there tests that need to be performed to determine location?
*P*athogen	• What organism(s) could be or is/are causing the infection? • If the organism(s) is/are not known yet, which organisms tend to live in the potential locations (eg, skin = *Streptococcus* and *Staphylococcus*) • Are there tests that should be performed to identify the organism(s)?
*P*atient	• Is the patient sick or not sick? • Are there risks for resistance (eg, health care exposure, recent antibiotics)? • Does the patient have characteristics that affect antibiotic choice (eg, renal insufficiency, prolonged QTc interval, antibiotic allergies)?
*D*rug	• What antibiotic(s) is/are patient on? What do you want them to be on? • What sort of monitoring is needed for antibiotics (eg, drug levels, labs, electrocardiograms)? • Are there drug characteristics that affect antibiotic choice (eg, cost, efficacy data, drug–drug interactions, spectrum of activity)?
*D*ose	• What is the dosing frequency of the antibiotic(s)? • Does the dose need to be adjusted for renal function/liver function? • Does the antibiotic need to be dosed by weight? Which weight (ideal body weight, adjusted body weight, actual body weight)?
*D*uration	• Is there an evidence-based duration for the indication(s) being treated? • Is there an evidence-based duration for the antibiotic(s) being used? • If the duration cannot yet be determined, is there additional testing or follow-up that needs to be done to determine duration?
*C*ontext	• What professional or cultural factors may be motivating the provider or team in making antibiotic decisions? • What questions need to be asked to better determine the motivations and context of the provider or team?
*C*ommunication	• How should the recommendations be framed to the provider or team considering the context of antibiotic prescribing? • What team member should be contacted to have effective discussion (eg, intern, resident, advanced practice provider, attending, consultant)?
*C*ollaboration	• How can you work together with the provider or team to increase trust and decrease future conflict? • Is follow-up with the team needed? • Should an infectious disease or other consultation be suggested?

Wang R, et al. Open Forum Infect Dis. 2021 May 8;8(6):ofab231.

The 3 Cs of Stewardship Communication

Communication

In what format will you communicate your antibiotic stewardship recommendation to prescribers?

What team member should be contacted to have an effective discussion? (e.g., intern, resident, advanced practice provider, attending, consultant)

How will you frame the motivation around your stewardship recommendation?

Context

What are the circumstances (physical, workload, emotional) surrounding the person you will be communicating with?

How will you take into account their challenges, perspectives and professional culture when you convey your stewardship message?

What questions need to be asked to better determine the motivation and context of the prescriber?

Collaboration

How will you approach the stewardship interaction with relationship-building in mind?

How can your communication in this moment facilitate trust-building in the future?

If conflict might occur, how might you manage it?

Is follow up with the team needed? Should other resources be suggested?

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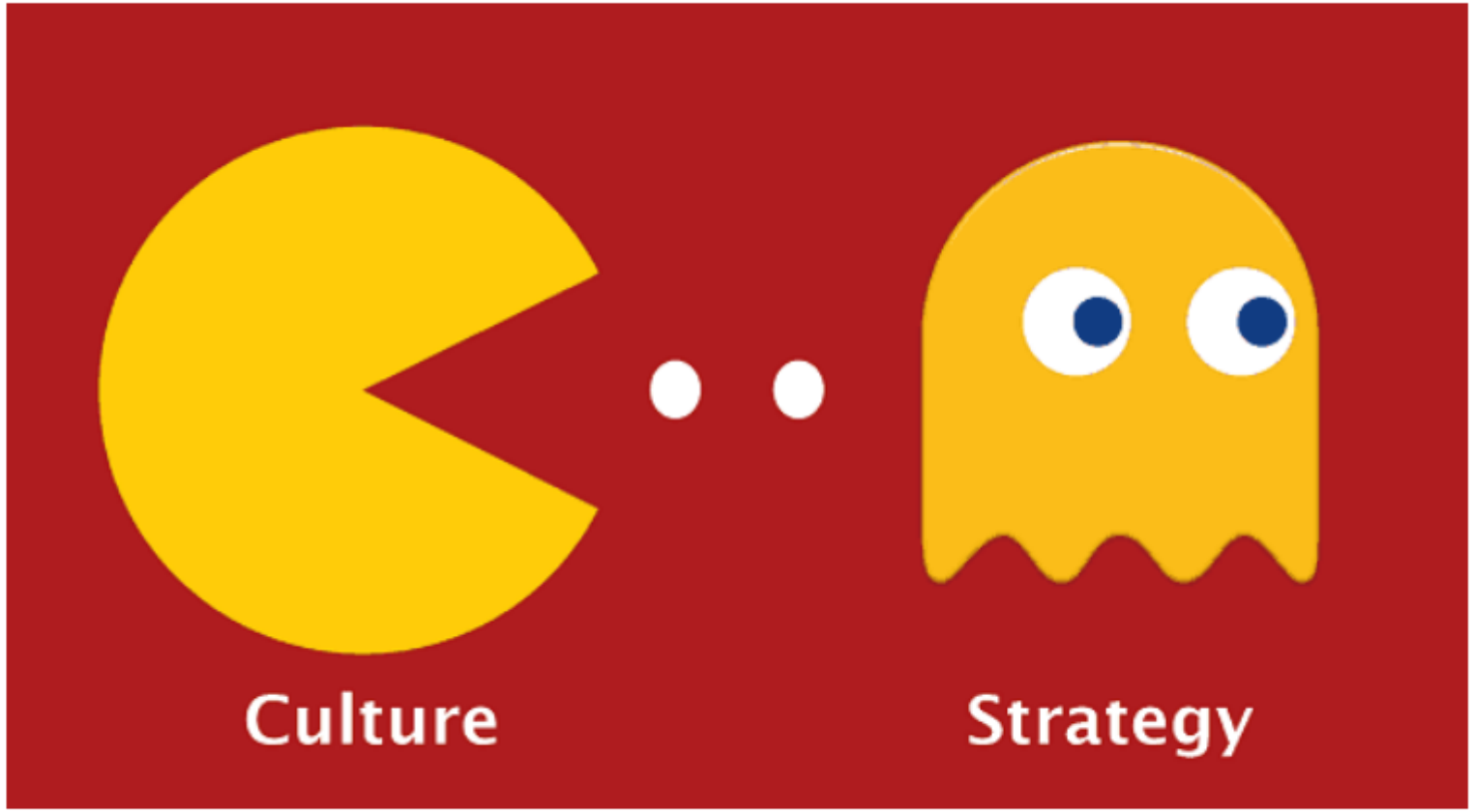
Because “Culture eats strategy for breakfast” (and lunch and dinner….)



Addressing Adaptive Challenges

- Listening
- Taking the view of the other
- Understanding what is at stake
- Finding common ground
- Bolstering credibility
- Delivering things of value
- Returning to shared sense of mission

Health Quality Social Science

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Social Sciences in Healthcare Epidemiology and Antimicrobial Resistance

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