**MEDICATION ERRORS**

**“Magic Words” or “Red Flags?”**

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**PROBLEM:** It is becoming increasingly clear that poor communication dynamics among health care practitioners can hinder the recognition of medication errors. Fortunately, continued persistence in communicating recognized problems, even when one is faced with opposition from experts, often results in the correction of errors before they affect patients.

Such was the case when an attending physician ordered pegaspargase (Onco- spar®, Enzon/Aventis) for a patient with acute lymphoblastic leukemia who had previously developed an allergic reaction to asparaginase (Elspar®, Merck). Pegaspargase is used solely for patients with a hypersensitivity to asparaginase. The preferred route is intramuscular (IM) administration; the intravenous (IV) route increases the incidence of cross-reactivity in asparaginase-sensitive patients and creates the possibility of liver toxicity, coagulopathy, and gastrointestinal and renal disease.

Before the availability of pegaspargase on the market, an asparaginase-desensitization protocol was commonly used to treat patients with hypersensitivity. The drug was rapidly administered intravenously, beginning with 1 unit and with a doubling of the dose every 10 minutes until the total accumulated dose equaled the planned daily dose. In the case discussed here, the physician ordered pegaspargase IV, with a dosing schedule that was similar to that for the asparaginase-desensitization regimen, rather than a single IM dose, as indicated for pegaspargase.

To clarify the order, the pharmacist called the attending physician; however, the attending physician was reluctant to change the order because he had reviewed its contents with the director of the protocol for this drug. The protocol director verified that he had suggested using the asparaginase-desensitization routine with pegaspargase. With further persistence, however, the pharmacist confirmed that the protocol director was unaware of the risks of administering pegaspargase IV and had never prescribed it using a desensitization regimen. He simply thought that it would be the safest thing to do. As a result, all eventually agreed that the drug should be administered as a single IM dose.

**SAFE PRACTICE RECOMMENDATION:** The U.S. Pharmacopoeia–Institute for Safe Medication Practices (USP–ISMP) Medication Errors Reporting Program has received numerous accounts of lethal errors involving orders that were questioned but not changed. This situation often results when practitioners are intimidated into carrying out what might be a dangerous order or when they are easily convinced that an order is safe. In the example here, an experienced pharmacist was able to resolve the issue with patience and persistence but by trusting his own expertise—not by flaunting his skill as being superior to that of others but rather by using the opportunity to enhance the proficiency of others. Still, how many of us, particularly early in our careers, would have challenged seemingly unimpeachable sources such as a protocol director or an oncologist?

Timothy Lesar, of Albany Medical Center, has collected a list of phrases (“magic words”) that have often been erroneously accepted as “evidence” when they have been used to convince practitioners to carry out questionable orders. These and similar comments should be considered “red flags” that warrant more definitive answers or evidence in hand:

- The patient is “on this medication at home.”
- “A specialist prescribed it.”
- The patient has been “titrated up to that dose.”
- This is a “special case.”
- The patient is “on a protocol.”
- The drug/dose was “recently published” or from a “published study.”
- I got the order from the patient’s “prior medical records.”
- “Mom (or the patient) said they take it this way.”
- It was “on a list of medications that the patient gave me.”
- “We always give it that way.”

In conclusion, don’t be afraid to question orders when you have reason to believe that a patient is at risk or even when you just have a sense that something is wrong. Use caution when you are presented with what appears on the surface to be “evidence” that an order is accurate and safe.

As a rule, establish procedures that clearly identify the steps a practitioner should take when there is disagreement about the safety of an order.

Finally, when doubting your own knowledge and expertise, ask yourself: which would be worse—the possibility of being wrong, or the possibility of injuring a patient? Practitioners whose lack of persistence has resulted in patient injury sorely wish that they had risked being wrong and had continued to ask questions until the issue was fully resolved.