Intimidation Presents Serious Safety Problems

Matthew Grissinger, RPh, FASCP

It should come as no surprise that physicians who use intimidation to dissuade individuals who question the safety of their orders create serious problems in the health care community. Unfortunately, it happens more frequently than most people are willing to admit, in both subtle ways and in clearly abusive forms of communication. Here is just one example, which may sound painfully similar to others that probably happen every day in health care organizations.

An oncologist wrote an order for fluorouracil 4,100 mg to be administered over 12 hours for eight doses for a total of four days. The pharmacist who received the order was new to the profession, but she immediately recognized a potential dosing error and contacted the prescriber.

The physician was unhappy about the telephone call, but he cited the review article he had used as a reference to substantiate the dose.¹ The pharmacist investigated further and found that the dose in the review article indeed stated “4 g/m² of body surface area every 24 hours for 4 days.”² But when she calculated the patient’s dose (based on a body surface area of 2.05 square meters), she still considered this amount to be unsafe.

The pharmacist contacted the oncologist again. Incredibly, the oncologist believed the dose written in the review article and that the dose was stated clearly in the references, or even a misprint in otherwise reliable references. Yet the intimidation factor is a real barrier to patient safety because it adversely affects the ability of others to detect potential mistakes, point them out, and have them corrected before they reach the patient.

Hostile and abusive behavior should never be tolerated in the health care professions. This intolerance of offensive behavior should not be misconstrued as an endorsement of punishment for those who make errors. The issue is not whether such abusive behavior results in an error but whether that error is egregious and unacceptable under any circumstances.

Abusive reactions promote stress, job dissatisfaction, employee turnover, resentment, and miscommunication, all of which can only result in poor outcomes for patients. As such, the topic should be fully covered in policies and bylaws, and it should be discussed during all staff orientations, including those for physicians. Abuse should be addressed immediately if it occurs.

In other complex industries with better safety records than those in health care, all uncertainty about safety is presumed to be a serious problem and employees who express their concerns are not put on the defensive to prove that they are right.³ Simply put, if someone thinks that a situation might be unsafe, it is considered unsafe. Equally important, these highly reliable industries follow a “two-challenge rule.” With this rule, a person who is concerned about safety communicates the problem and its rationale two times. If the matter remains unresolved, it is automatically referred to others for resolution. This review process does not imply that the person concerned about safety “wins;” it means that at least one other person must review the situation quickly before a final decision is made. It would be wise to follow this example to help counteract intimidation by health care professionals.

REFERENCES

2. Ibid., p. 325 (at top right corner).

The reports described in this column were received through the USP–ISMP Medication Errors Reporting Program (MERP). Errors, close calls, or hazardous conditions may be reported on the ISMP (www.ismp.org) or the USP (www.usp.org) Web site or communicated directly to ISMP by calling 1-800-FAIL SAFE or via e-mail at ismpinfo@ismp.org.