Intimidation by Superiors Affects the Safety of Medical Orders

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**Problem:** Many harmful prescribing errors that affect patients share a surprisingly common factor: at least one person—a health care practitioner, patient, or family member—felt that there was something wrong with the order before the medication was dispensed and administered. In some cases, health care practitioners or patients did not voice their concern because they were intimidated by the stellar reputation or disruptive behavior of the prescriber. They either assumed that they did not know as much as the prescriber or worried that if they were wrong, they would fall out of favor with the prescriber. In fact, in a 2003 survey conducted by the Institute for Safe Medication Practices (ISMP) on workplace intimidation, 40% of respondents reported they had questions about the safety of an order in the past year but decided to assume that the order was correct rather than interact with a prescriber they perceived as intimidating.1

In other cases, concern about the safety of a medication order was brought to the attention of another nurse, pharmacist, supervisor, or the prescriber. However, the person raising the concern was easily convinced that the medication was safe as prescribed.

Sometimes practitioners or patients proceeded with the order despite a feeling that something was still wrong because they were unable to express their concern more clearly, or the concern was not taken seriously by the prescriber. In the 2003 survey, half of respondents said that when questioning the prescriber, they felt pressured to dispense or administer the drug despite their concerns.

The missing link in preventing these errors is a defined process for handling such concerns—a stipulation that a drug order not be processed until all parties are satisfied that the problem has been resolved. A health care professional’s persistence in communicating a perceived problem, even when he or she faces opposition from experts, can usually prevent an error from reaching patients. Thus, an effective process for handling conflicts involving drug therapy requires more than just a hierarchical structure of referring problems up the chain of command. Staff members need clear guidance and support from the organization’s leaders to follow through when supervisors or those in authority (such as the prescriber) do not agree with their expressed concern. Although the process to meet the unique needs of individual organizations may vary, guidelines may be helpful for developing or revising a process for handling conflicting opinions objectively and professionally.

**Safe Practice Recommendations.** Some guidelines for resolving conflicts are presented as follows:

- **Gathering Information.** If staff members, such as nurses and pharmacists, suspect that an order is potentially harmful, they should pursue the matter until they are satisfied that the therapy is safe for the patient or until the order is changed. The nurse may contact a pharmacist to help research the problem before talking to the prescriber so that the facts supporting the concerns can be clearly communicated. The pharmacist or nurse might need to review the medical record; talk with the patient; consult reputable drug information resources; and discuss the matter with other nurses, pharmacists, or physicians to gather the information needed to communicate the safety concern effectively.

- **Questioning the Order.** Pharmacists and nurses should not be afraid to question an order when they believe that a patient is at risk or even if they simply suspect that something is wrong. Health care practitioners who doubt their expertise should consider which would be worse: to be wrong, or to allow injury to a patient.

Any questionable order should be discussed directly with the prescriber. Use of a standard communication strategy, such as SBAR (see next), can help frame the discussion:

- **(S) Situation:** Staff members should discuss their concerns about the safety of the medication order.

- **(B) Background:** They should provide pertinent information about the drug and the patient to support the reason for their concern.

- **(A) Assessment:** They should offer their assessment of the potential harm that could occur to the patient if the drug is administered as prescribed as well as the likelihood of an error.

- **(R) Recommendation:** They should suggest an action that they believe would make the order safe, or they should request that the order be discontinued.

**Implementing TeamSTEPPS** (Team Strategies and Tools to Enhance Performance and Patient Safety). This evidence-based teamwork system can also be adopted to improve communication among health care professionals.2 If applicable, the pharmacist or nurse should ask the prescriber for documentation (e.g., with protocols or journal articles) supporting the order and should read any materials provided. The prescriber may have misinterpreted published information or may have used references that contain misprints.

Statements such as “the protocol says to do it this way” or “that’s how they do it at University Hospital” should never be accepted as proof. These statements are red flags signaling that the order...
needs to be investigated further. The staff should check with risk-management experts about the best way to document any safety concerns and the prescriber’s response to the concern.

**Taking the concern to a higher level.** If the prescriber does not change the order and the nurse or pharmacist still thinks that the patient might be harmed, the prescriber should not be asked to, and should not be allowed to, personally administer the drug. Transferring responsibility to the prescriber is not likely to absolve the practitioner legally or emotionally if patient harm were to occur. Instead, the prescriber’s chief resident, the chief attending physician, the department chair, or a specialist in drug therapy for the patient’s illness should be contacted. If that person also believes the order might be unsafe, he or she should contact the prescriber.

**Referring the problem to a peer-review group.** If concerns persist despite these efforts, the nurse or pharmacist should consider whether it would be more harmful to administer the drug than to withhold it. Health care practitioners should refuse to dispense a medication if they are reasonably sure that withholding it is the safer action. The problem should then be referred to a timely *ad hoc* group for peer review to determine the order’s safety.

**Calling a rapid-response team.** If a patient’s well-being is likely to be compromised while peer review is being undertaken and the patient’s condition requires immediate attention, a rapid-response team, if available in the hospital, can be called. The team can help recommend and take emergency action as needed until the conflict has been resolved. Upon admission to the facility, patients and family members also should be advised that they can call the rapid-response team if they have time-sensitive concerns about a medication and believe that it might be unsafe.

Unfortunately, the ISMP has heard from health care practitioners who were involved in a fatal error and live with regret because they did not follow through on a suspected problem. The lesson they want to share with all practitioners is to speak up and be persistent, even if there is just a hint of a potential safety concern. All health care professionals involved in the medication-use system have an obligation to protect patients from harm, and following these guidelines when they have a concern about the safety of a medication order can help fulfill that obligation.

REFERENCES


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

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