



## Intimidation: Practitioners speak up about this unresolved problem-Part I

All too often, seasoned practitioners feel compelled to warn new staff members about a particularly difficult physician, and perhaps even shield them from that person for as long as possible. It's a telling sign of a culture that tolerates, even fosters, intimidation. More than 2,000 (N=2,095) hospital healthcare providers (1,565 nurses, 354 pharmacists, 176 others) responded to our November 2003 survey on this subject. Sadly, they confirmed that intimidating behaviors continue to be far from isolated events in healthcare. What's more, it's not necessarily limited to a few difficult physicians, or for that matter, to physicians alone. In Part I of our report, learn what respondents had to say about workplace intimidation. Next month, recommendations to address this long-standing problem will be presented in Part II.

About 7% of practitioners reported involvement in a medication error in which intimidation played a role.

Physicians may intimidate, but it's not just physicians. According to respondents, physicians and other prescribers engaged in intimidating behaviors more frequently than other healthcare providers (e.g., pharmacists, nurses, supervisors). For example, respondents reported that physicians/prescribers often used condescending language, were reluctant to answer questions or return phone calls, and were impatient with questions at least twice as often as other healthcare providers.

Sixty-nine percent of respondents told us that physicians/prescribers had often (12%), or at some time during the past year (57%), stated: "Just give what I ordered;" whereas 34% of respondents encountered similar pressure from others. Likewise, physicians/prescribers more frequently employed strong verbal abuse and threatening body language.

**Practitioners feel the sting of intimidation.** Regardless of the source of intimidation (prescribers or others), respondents reported that subtle yet effective forms of intimidation occurred more often than explicit forms. For example, during the past year, 88% of respondents encountered condescending language or tone of voice (21% often); 87% encountered impatience with questions (19% often); and 79% encountered a reluctance/refusal to answer questions or phone calls (14% often). Yet, almost half of respondents also encountered explicit forms of intimidation, such as strong verbal abuse (48%) or threatening body language (43%). Incredibly, 4% even reported physical abuse.

On the other hand, respondents made it abundantly clear that intimidating behaviors were not attributable to physicians/prescribers alone; they encountered a surprising degree of intimidation among other healthcare providers as well. Furthermore, repeated occurrences of intimidating behavior did not arise from a single menacing individual. Thirty-eight percent reported that 3-5 individuals were involved, and 19% reported repeat occurrences with more than 5 individuals during the past year. These disturbing findings suggest that healthcare providers at large, not just 1-2 difficult physicians, have adopted this unsafe practice habit.

continued on page 2

## safetywires

**⚡ Oral to IV hydromorphone.** A physician covering for an oncologist admitted a patient with Hodgkin's lymphoma to a medical unit. At home, the patient had been taking hydromorphone (**DILAUDID**) 2 to 4 mg orally for pain. The covering physician prescribed the same medication, but also wrote an order for hydromorphone 2 to 4 mg IV every 3 hours for pain if the patient was unable to tolerate oral fluids. Like the physician, the nurses did not recognize that the oral dose and the IV dose of this product, as with most opiate analgesics, are quite different. The generally accepted oral to IV conversion of hydromorphone is around 3-5 mg of oral product for every 1 mg IV. A nurse administered 4 mg IV; the patient developed respiratory depression and became unresponsive. Two doses of naloxone IV reversed the effects of the medication. The following morning, a pharmacist investigated the use of naloxone and uncovered the dosing error. To help prevent errors, ask pharmacy to create an oral-to-IV conversion chart for opiates and other narcotics, and post the charts in patient care units where physicians prescribe and nurses prepare medications for administration.

## ⚡ Lantus alone increases risk of diabetes complications.

Physicians may prescribe **LANTUS** (insulin glargine, Aventis) for diabetic patients because it provides a constant basal insulin level over 24 hours with a single injection, most often at bedtime. This long-acting insulin suppresses glucose production between meals and overnight. However, for optimal control, short-acting insulin is still needed for hyperglycemia after meals. Unfortunately, you may see

continued on page 2

Intimidation continued

**Intimidation clearly impacts patient safety.** Almost half (49%) of all respondents told us that their past experiences with intimidation had altered the way they handle order clarifications or questions about medication orders. At least once during the past year, about 40% of respondents who had concerns about a medication order assumed that it was correct, or asked another professional to talk to the prescriber, rather than interact with a particularly intimidating prescriber. Three quarters (75%) had asked colleagues to help them interpret an order or validate its safety so that they did not have to talk to a prescriber. Similarly, 34% reported that they found the prescriber's stellar reputation intimidating and had not questioned an order for which they had concerns. Even when the prescriber had been questioned about the safety of an order, 31% of respondents had suggested or allowed the physician to give the medication himself, and almost half (49%) felt pressured to accept the order, dispense a product, or administer a medication despite their concerns. As a result, 7% of respondents reported that they had been involved in a medication error during the past year in which intimidation clearly played a role.

#### **Gender makes little difference.**

Female respondents (86%) to the survey outnumbered male respondents (14%), but only minor differences were reported in the frequency with which each group encountered intimidating behaviors. In general, male respondents reported a higher degree of effects from intimidation, but again, the differences were not large. For example, more male respondents reported that they had, during the past year, assumed that a medication order was correct safe rather than interact with a particular prescriber (48% male, 37% female); assumed that a medication order was correct

because of the stellar reputation of the prescriber (42% male, 32% female); and felt pressure to carry out a medication order despite concerns about its safety (53% male, 49% female). On the other hand, female respondents had asked another practitioner to talk to a particularly intimidating person more often than male respondents (41% female, 35% male).

#### **The least experienced practitioners may not be the most affected.**

Surprisingly, nurses with less than 2 years experience encountered intimidating behaviors from all sources (prescribers and others) less frequently than more experienced nurses. These nurses also reported fewer individuals involved in repeated encounters, but the number steadily rose as nurses gained more experience. Furthermore, nurses with less than 2 years experience reported less frequent effects from workplace intimidation than nurses with more experience, with one notable exception: newer nurses had asked another professional to talk to a particularly intimidating person more often than experienced nurses. These findings suggest that perhaps less experienced nurses are initially shielded from intimidating staff, or they are not confident enough to speak up about drug safety issues, thus less frequently encountering situations where intimidation may be a factor. It's also possible that less experienced nurses were not as comfortable as more experienced nurses in disclosing intimidation and its effects on their practice. To this point, there was a lower survey response rate from nurses with less than 2 years practice (n= 63, 4% of nurse respondents). Nurses with 2-5 years experience reported a marked increase in the frequency with which they encountered intimidating behaviors, and were more negatively affected by these behaviors when compared

continued on page 3

#### **safetywire** continued

Lantus prescribed without short-acting insulin coverage, or prescribed in combination with other agents that won't cover mealtime peaks in blood sugar (e.g., long-acting oral hypoglycemic agents). Experts claim that these practices can expose patients to an increased risk of developing diabetic vascular complications, resulting in an increased risk of mortality (Reinhart, L et al. Insulin glargine: A new long-acting insulin product. *Am J Health-Syst Pharm* 2002;59:643-649). Be alert for Lantus orders that are not accompanied by a short-acting insulin or short-acting oral hypoglycemic agent, and consult with a pharmacist or physician if encountered. Keep in mind, too, that Lantus should not be diluted or mixed with any other insulin or solution; it may become cloudy, and the onset of action and time to reach peak effect may be altered in an unpredictable manner. A final reminder: this clear insulin should never be given IV. Its intended effect would change if given by this route. Its long-acting properties would be lost, and it would act more like regular insulin.

continued on page 3

#### ► **Special Announcement**

##### **Don't miss our next teleconference.**

Are you a medication safety or patient safety specialist? Is your organization considering this new and exciting position? Whether such a position is under consideration, in development, or well-established in your organization, please join us for an informative teleconference, **A Real-Life View of the Medication/Patient Safety Specialist**. The teleconference will be held on April 14, 2004, from 1:30-3:00 p.m. Eastern time. Varying perspectives will be provided by a nurse and two pharmacists who currently practice in this area in a large multihospital system, midsized hospital, and small community hospital. Continuing education credit will be provided for nurses and pharmacists. For details and to register, please visit [www.ismp.org/psa](http://www.ismp.org/psa).

Intimidation continued

to nurses with less than 2 years experience. However, as years of experience increased, nurses reported less satisfaction with the organization's ability to handle intimidation effectively (48% satisfied during the first 2 years, 33% satisfied by years 5-10), with some improvement after 10 years (39% satisfied).

Pharmacists reported a remarkably similar pattern of experiences associated with the number of years in practice, albeit less pronounced.

**Intimidation may affect pharmacists more than nurses.** Overall, pharmacists and nurses encountered about the same frequency of intimidating behaviors by physicians/prescribers. On the other hand, pharmacists reported more frequent intimidating behaviors perpetuated by other healthcare providers, especially strong verbal abuse (encountered by 50% of pharmacists, 38% of nurses), and a reluctance or refusal to answer questions or return calls (encountered by 83% of pharmacists, 69% of nurses).

Pharmacists also reported more frequent effects from intimidation than nurses. For example, 64% of pharmacists and 34% of nurses reported that, during the past year, they had assumed a medication order was correct and safe rather than interact with a particular prescriber. Pharmacists (56%) reported more often than nurses (29%) that they had assumed a medication order was correct because of the stellar reputation of the prescriber. Pharmacists (49%) had also asked another professional to talk to an intimidating prescriber about an order more frequently than nurses (38%). While more nurses (62%) than pharmacists (50%) felt that their organizations had defined an effective process for handling disagreements with the safety of an order, both reported equal dissatisfaction with their organizations' ability to deal effectively with intimidation (61% dissatisfied). Visit [www.ismp.org/Survey0311.asp](http://www.ismp.org/Survey0311.asp) to view selected data from the survey.

Look for Part II of our report covering suggestions to reduce workplace intimidation in our next issue.

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**Two routes.** When a prescribed medication allows for administration by more than one route, it's important for the medication administration record (MAR) to indicate this within the context of the order. In a hospital using computer-generated MARs, a pharmacist was required to make two separate entries for **LASIX** (furosemide) 100 mg daily, one for the oral route and one for the IV route, without mentioning in each entry that the drug could be given by either route. Thus, the orders did not appear sequentially on the MAR since the computer first sorted the orders by route, and then alphabetically. Consequently, the patient received the medication by both routes for several days. A single entry for each medication, despite alternative routes of administration, may reduce the risk of an error. Unfortunately, some pharmacy computer systems require separate entries for each route of administration. Under these circumstances, errors like this might be prevented if the directions on the MAR entries prominently stated "May be given either IV or PO."

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To report medication errors to ISMP, please call 1-800-FAIL-SAF(E).

## Congratulations to the ISMP Medication Safety Contest Winners

In February, we invited subscribers to join us in celebrating National Patient Safety Week (March 7-13, 2004) by participating in a contest. The following health systems submitted winning or honorable mention entries in the categories of *timely delivery of medications* and *failure mode and effects analysis (FMEA)*.



### Winner - Children's Hospital and Regional Medical Center, Seattle, WA.

This hospital measured the turn-around time for medications supplied from the pharmacy and uncovered unacceptable delays. Pharmacy workflow was subsequently redesigned, resulting in a 65% improvement.



### Winner - Thomas Jefferson University Hospital, Philadelphia, PA.

This hospital performed a FMEA on chemotherapy ordering, dispensing, and administration processes. They successfully gained full administrative support for the needed improvements, which have now been implemented.



### Honorable Mention - Lehigh Valley Hospital, Allentown, PA.

This hospital performed a FMEA on the narcotic dispensing process in the OR. The initial concept for narcotic dispensing was abandoned after identifying too many failure points, and another FMEA was performed on an alternative process that has since been implemented.



### Honorable Mention - Advocate Trinity Hospital, Chicago, IL.

This hospital performed a FMEA on the use of the crash cart. The team transformed a poorly coordinated process for using the crash cart into an efficient and safe process by improving the stocking process and providing staff with readily available resources.

Each winner receives \$500 for their organization and the videotape, *Patients Play a Vital Role in Patient Safety*. Honorable mentions receive a \$50 gift certificate to be used toward ISMP products or services. For more information on the winning and honorable mention submissions, please visit [www.ismp.org/ismpwinners.htm](http://www.ismp.org/ismpwinners.htm). Thanks to the many health systems that submitted entries.



Although we solicited entries on preventing intimidation, no winners were chosen in this category.