Annotated Bibliography

Veterinary Communication Project at IHC

Module 11
Breaking the Silence:
Discussing Medical Errors

Institute for Healthcare Communication

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American Veterinary Medical Association (2015, January). Principles of Veterinary Medical Ethics. Retrieved from: https://www.avma.org/KB/Policies/Pages/Principles-of-Veterinary-Medical-Ethics-of-the-AVMA.aspx

Veterinarians are members of a scholarly profession who have earned academic degrees from comprehensive universities or similar educational institutions. Veterinarians practice veterinary medicine in a variety of situations and circumstances. Exemplary professional conduct upholds the dignity of the veterinary profession. All veterinarians are expected to adhere to a progressive code of ethical conduct known as the Principles of Veterinary Medical Ethics (PVME). The PVME comprises the following Principles, the Supporting Annotations, and Useful Terms. The AVMA Judicial Council is charged to advise on all questions relating to veterinary medical ethics and to review the Principles periodically to ensure that they remain current and appropriate.

Beckman, H. B., Markakis, K. M., Suchman. L., Frankel, R. M. (1994). The doctor-patient relationship and malpractice: lessons from plaintiff depositions. *Archives of Internal Medicine, 154*:1365-1370.

OBJECTIVE: To explore plaintiff depositions to gain insight into issues that prompt malpractice claims.
DESIGN: Retrospective content analysis of depositions.
SETTING: Large metropolitan medical center.
SUBJECTS: Convenience sample of 45 patient depositions randomly selected from a sample of 67 made available from settled claims between 1985 and 1987.
INTERVENTIONS: None.
MEASURES: Information extracted included responses to the following questions: "Why are you suing?" and "Did a health professional suggest maloccurrence?"
RESULTS: Relationship problems were identified in 71% of depositions. Four themes emerged: 32% deserting the patient; 29% devaluing patient and/or family views; 26% delivering information poorly; and 13% failing to understand the patient and/or family perspective. Fifty-four percent of plaintiffs responded affirmatively when asked if health professionals suggested maloccurrence. Of these cases, 71% named the post outcome consulting specialist as the one who suggested maloccurrence.

CONCLUSIONS/RECOMMENDATIONS: The decision to litigate is most often associated with perceived lack of caring and/or collaboration in health care delivery. Particular attention needs to be paid to post adverse event consultant-patient interactions.

Blendon, R. J., DesRoches, C. M., Brodie, M., Benson, J. M., et. al. (2002). Views of practicing physicians and the public on medical errors. *New England Journal of Medicine, 347*(24).

BACKGROUND: In response to the report by the Institute of Medicine on medical errors, national groups have recommended actions to reduce the occurrence of preventable medical errors. What is not known is the level of support for these proposed changes among practicing physicians and the public.

METHODS: We conducted parallel national surveys of 831 practicing physicians, who responded to mailed questionnaires, and 1207 members of the public, who were interviewed by telephone after selection with the use of random-digit dialing. Respondents were asked about the causes of and solutions to the problem of preventable medical errors and, on the basis of a clinical vignette, were asked what the consequences of an error should be.

RESULTS: Many physicians (35 percent) and members of the public (42 percent) reported errors in their own or a family member's care, but neither group viewed medical errors as one of the most important problems in health care today. A majority of both groups believed that the number of in-hospital deaths due to preventable errors is lower than that reported by the Institute of Medicine. Physicians and the public disagreed on many of the underlying causes of errors and on effective strategies for reducing errors. Neither group believed that moving patients to high-volume centers would be a very effective strategy. The public and many physicians supported the use of sanctions against individual health professionals perceived as responsible for serious errors.

CONCLUSIONS: Though substantial proportions of the public and practicing physicians report that they have had personal experience with medical errors, neither group has the sense of urgency expressed by many national organizations. To advance their agenda,

national groups need to convince physicians, in particular, that the current proposals for reducing errors will be very effective.

Bonvicini, K. A., & O'Connell, D. (2008, January/February). Disclosing Medical Errors:

Restoring Client Trust. *Compendium: Equine Edition,* 14-22.

Discussing medical errors with affected clients can ultimately benefit your practice. This article provides tips on creating a protocol for resolving medical errors.

Bonvicini, K & Cornell K. (2007, March/April). Are clients truly informed? Communication tools

and risk reduction. *Compendium: Equine Edition*, 74-80.

Experience in human medicine has shown that clear doctor-patient communication can improve treatment success and lower malpractice risk. The authors apply the lessons learned from human medicine to veterinary practice and present communication techniques to help veterinarians and clients understand each other.

Brock DM[1], Quella A, Lipira L, Lu DW, Gallagher TH. (2014). Physician assistants and the disclosure of medical error. *Acad Med. 89*(6):858-62.

Evolving state law, professional societies, and national guidelines, including those of the American Medical Association and Joint Commission, recommend that patients receive transparent communication when a medical error occurs. Recommendations for error disclosure typically consist of an explanation that an error has occurred, delivery of an explicit apology, an explanation of the facts around the event, its medical ramifications and how care will be managed, and a description of how similar errors will be prevented in the future. Although error disclosure is widely endorsed in the medical and nursing literature, there is little discussion of the unique role that the physician assistant (PA) might play in these interactions. PAs are trained in the medical model and technically practice under the supervision of a physician. They are also commonly integrated into interprofessional health care teams in surgical and urgent care settings. PA practice is characterized by widely varying degrees of provider autonomy. How PAs should

collaborate with physicians in sensitive error disclosure conversations with patients is unclear. With the number of practicing PAs growing rapidly in nearly all domains of medicine, their role in the error disclosure process warrants exploration. The authors call for educational societies and accrediting agencies to support policy to establish guidelines for PA disclosure of error. They encourage medical and PA researchers to explore and report best-practice disclosure roles for PAs. Finally, they recommend that PA educational programs implement trainings in disclosure skills, and hospitals and supervising physicians provide and support training for practicing PAs.

Colangelo, L. L., & Zambito, T. (2005, May). The vets from hell. New York Daily News, Retrieved from http://www.nydailynews.com

This article highlights a Daily News investigation which cites cases of medical errors among veterinary practices throughout New York City including mistaken euthanasia, spay and neutering, etc. and the experiences of pet owners who have filed formal complaints and investigations through attorneys and state veterinary boards

Cupp, R. L., & Dean, A. E. (2002). Veterinarians in the doghouse: are pet suits economically viable? *The Brief, 31*(3).

Tort lawsuits against veterinarians likely will continue to expand in coming years. Animal rights are much more passionately debated today than in the past, when animals' legal status as mere property went unquestioned. At least some of the attorneys who have chosen to specialize in pet lawsuits may be motivated by a desire to increase respect for and improve treatment of animals. Because they are fighting for a cause, these attorneys may be willing to accept cases with less economic potential than those deemed worthwhile in other areas of law. Of course, they also will continue to press for higher damages in pet lawsuits. We have evolved from an agrarian society in which the animals most of us owned had primarily economic utility to an urban society in which most of us derive emotional value from our animals. Although progress has been slow, the law is certain to evolve in response to this shift in social attitudes.

Gallagher, T.H, Waterman, AD, Ebers, AG, Fraser, VG, & Levinson, W. (2003). Patients' and physician attitudes regarding the disclosure of medical errors. *Journal of the American Medical Association, 289*:1001-1007

CONTEXT: Despite the best efforts of health care practitioners, medical errors are inevitable. Disclosure of errors to patients is desired by patients and recommended by ethicists and professional organizations, but little is known about how patients and physicians think medical errors should be discussed.

OBJECTIVE: To determine patients' and physicians' attitudes about error disclosure.

DESIGN, SETTING, AND PARTICIPANTS: Thirteen focus groups were organized, including 6 groups of adult patients, 4 groups of academic and community physicians, and 3 groups of both physicians and patients. A total of 52 patients and 46 physicians participated.

MAIN OUTCOME MEASURES: Qualitative analysis of focus group transcripts to determine the attitudes of patients and physicians about medical error disclosure; whether physicians disclose the information patients desire; and patients' and physicians' emotional needs when an error occurs and whether these needs are met.

RESULTS: Both patients and physicians had unmet needs following errors. Patients wanted disclosure of all harmful errors and sought information about what happened, why the error happened, how the error's consequences will be mitigated, and how recurrences will be prevented. Physicians agreed that harmful errors should be disclosed but "choose their words carefully" when telling patients about errors. Although physicians disclosed the adverse event, they often avoided stating that an error occurred, why the error happened, or how recurrences would be prevented. Patients also desired emotional support from physicians following errors, including an apology. However, physicians worried that an apology might create legal liability. Physicians were also upset when errors happen but were unsure where to seek emotional support.

CONCLUSIONS: Physicians may not be providing the information or emotional support that patients seek following harmful medical errors. Physicians should strive to meet patients' desires for an apology and for information on the nature, cause, and prevention of errors. Institutions should also address the emotional needs of practitioners who are involved in medical errors.

Halbach, J. L., & Sullivan, L. (2005). *Medical errors and patient safety: a curriculum guide for teaching medical students and family practice residents*. MedEdPortal Publications. Available from https://www.mededportal.org/publication/101

This resource is a curriculum guide designed to teach medical students and family practice residents about medical errors and patient safety. The guide is designed to address a glaring deficit in medical education. Now in its third edition, this guide grew out of our own teaching and medical errors and patient safety to third year medical students and Family Practice residents. Nine chapters provide a thorough review of the literature in this area and include: Background, Epidemiology and History; Ethical, Legal, Professional Issues and the Culture of Medicine; Management of Medical Errors: Overview and Disclosure; Effects of Making an Error on the Physician and the Importance of Personal Awareness; Prevention of Medical Errors: Overview and Medication Errors; Education of Medical Students and Residents about Patient Safety: Curriculum Resources.

House A (2014). Breaking the Silence: Disclosing Medical Errors. *AAEP Proceedings, Vol 60*: 270-272.

In circumstances where a medical error results in an adverse outcome, a thoughtful response on the part of the veterinarian, staff, and practice is required. The insurance carrier should be contacted as soon as possible. The fear of formal complaints and potential malpractice suits can cloud judgment when considering the best course of action. This presentation will review communication techniques for constructively responding to these difficult situations.

Hughes, R. G., & Ortiz, E. (2005). Medication errors: Why they happen and how they can be prevented. *American Journal of Nursing*, *105*(3): 14-24.

Medication error is the most common type of medical error. One of every three adverse drug events (ADEs) precipitated by a medication error occurs when a nurse administers medications to a patient. The number would be greater if nurses did not intercept 86% of all potential errors. Preventable ADEs causing injury or death have significant

economic consequences. The annual cost of drug-related morbidity and mortality in the United States has been estimated to be between $1.56 billion and $5.6 billion; most of the costs are related to hospital admissions caused by the use of inappropriate drug therapy or the absence of appropriate drug therapy. Inappropriate prescribing and patient noncompliance resulting in ADEs contribute to 3% to 28% of all hospitalizations, the rate varying by the age and morbidity of patients. Patients injured by ADEs have their hospital stays extended by an average of two days, at an additional cost of $2,000 to $2,500 per patient. This article is not an exhaustive review of the literature on medication errors. Instead, it provides an overview of what is known about errors in medication administration, barriers to implementing safer practices, and current and potential mechanisms to improve medication administration.

Jack, D.C. (2000). Horns of dilemma: The vetri-legal implications of animal abuse. *Canadian Veterinary Journal 41,* 715-720.

Canada proposed a law in 2000 requiring veterinarians to assume the same role as teachers, peace officers, and whistleblower when pet abuse is suspected. This article concentrates on the issues relating to the changing role of the veterinarian in Canada arising from these proposed amendments.

Kinnison T, Guile D, May SA. (2015). Errors in veterinary practice: preliminary lessons for building better veterinary teams. *Vet Rec. 177*(19):492.

Case studies in two typical UK veterinary practices were undertaken to explore teamwork, including inter-professional working. Each study involved one week of whole team observation based on practice locations (reception, operating theatre), one week of shadowing six focus individuals (veterinary surgeons, veterinary nurses and administrators) and a final week consisting of semi-structured interviews regarding teamwork. Errors emerged as a finding of the study. The definition of errors was inclusive, pertaining to inputs or omitted actions with potential adverse outcomes for patients, clients or the practice. The 40 identified instances could be grouped into clinical errors (dosing/drugs, surgical preparation, lack of follow-up), lost item errors, and most frequently, communication errors (records, procedures, missing face-to-

face communication, mistakes within face-to-face communication). The qualitative nature of the study allowed the underlying cause of the errors to be explored. In addition to some individual mistakes, system faults were identified as a major cause of errors. Observed examples and interviews demonstrated several challenges to inter-professional team-working which may cause errors, including: lack of time, part-time staff leading to frequent handovers, branch differences and individual veterinary surgeon work preferences. Lessons are drawn for building better veterinary teams and implications for Disciplinary Proceedings considered.

Kohn, L. T., Corrigan, J. M., & Donaldson, M. (2000). *To err is human: building a safer health system*. Washington, D,C.:National Academy Press

This report lays out a comprehensive strategy for addressing a serious problem in health care to which we are all vulnerable. By laying out a concise list of recommendations, the committee does not underestimate the many barriers that must be overcome to accomplish this agenda. Significant changes are required to improve awareness of the problem by the public and health professionals, to align payment systems and the liability system so they encourage safety improvements, to develop training and education programs that emphasize the importance of safety and for chief executive officers and trustees of health care organizations to create a culture of safety and demonstrate it in their daily decisions. Although no single activity can offer the solution, the combination of activities proposed offers a roadmap toward a safer health system. The proposed program should be evaluated after five years to assess progress in making the health system safer. With adequate leadership, attention and resources, improvements can be made. It may be part of human nature to err, but it is also part of human nature to create solutions, find better alternatives and meet the challenges ahead.

Kraman, S. S., Cranfill, L., Hamm, G., & Woodard, T. (2002). Advocacy: the Lexington Veterans Affairs Medical Center. *Joint Commission on Quality Improvement, 28*(12).

BACKGROUND: After the Veterans Affairs Medical Center (VAMC) in Lexington, Kentucky, lost two major malpractice cases in the mid-1980s, leaders started taking a more proactive approach to identifying and investigating incidents that could result in

litigation. An informal risk management team met regularly to discuss litigation-prone incidents. During one in-depth review, the team learned that a medication error had caused the patient's death. Although the family would probably never have found out, the team decided to honestly inform the family of exactly what had happened and assist in filing for any financial settlement that might be appropriate. This decision evolved into an organization wide full disclosure policy and procedure.

DISCLOSURE POLICY AND PROCEDURE: The Lexington VAMC's policy on full disclosure includes informing patients and/or their families of adverse events known to have caused harm or injury to the patient as a result of medical error or negligence. The disclosure includes discussions of liability and also includes apology and discussion of remedy and compensation.

RESULTS: Full disclosure is the right thing to do and the moral and ethical thing to do. Moreover, doing the right thing actually seems to have mitigated the financial repercussions of inevitable adverse events that result in injury to patients. As reported in 1999, Lexington VAMC was in the top quarter of medical centers for number of tort claims filed but was in the lowest quarter for malpractice payouts resulting from these torts.

Mazor, K. M., Simon, S. R., & Gurwitz, J. H. (2004). Communicating with patients about medical errors: A review of the literature. *Archives of Internal Medicine, 164*:1690-1697.

BACKGROUND: Ethical and professional guidelines recommend disclosure of medical errors to patients. The objective of this study was to review the empirical literature on disclosure of medical errors with respect to (1) the decision to disclose, (2) the process of informing the patient and family, and (3) the consequences of disclosure or nondisclosure.

METHODS: We searched 4 electronic databases (MEDLINE, CINAHL, PsycINFO, and Social Sciences Citations Index) and the reference lists of relevant articles for English-language studies on disclosure of medical errors. From more than 800 titles reviewed, we identified 17 articles reporting original empirical data on disclosure of medical errors to patients and families. We examined methods and results of the articles and

extracted study designs, data collection procedures, populations sampled, response rates, and definitions of error.

RESULTS: Available research findings suggest that patients and the public support disclosure. Physicians also indicate support for disclosure, but often do not disclose. We found insufficient empirical evidence to support conclusions about the disclosure process or its consequences.

CONCLUSIONS: Empirical research on disclosure of medical errors to patients and families has been limited, and studies have focused primarily on the decision stage of disclosure. Fewer have considered the disclosure process, the consequences of disclosure, or the relationship between the two. Additional research is needed to understand how disclosure decisions are made, to provide guidance to physicians on the process, and to help all involved anticipate the consequences of disclosure.

Mazor, K. M., Simon, S. R., Yood, R. A., Martinson, B. C., Gunter, M. J., Reed, G. W., & Gurwitz, J. H. (2004). Health plan members' views about disclosure of medical errors. *Annals of Internal Medicine, 140*(6):409-418.

BACKGROUND: Various authorities and national organizations encourage disclosing medical errors, but there is little information on how patients respond to disclosure.

OBJECTIVE:To examine how the type of error, severity of adverse clinical outcome, and level of disclosure affect patients' responses to error and disclosure.

DESIGN: Mail questionnaire survey (8 versions were developed) varying 3 factors in a completely crossed, randomized, factorial design. Each questionnaire included a vignette describing 1) a medical error (failure to check for penicillin allergy or inadequate monitoring of antiepileptic medication); 2) an associated clinical outcome (life-threatening or less serious); and 3) a physician-patient dialogue, with either full disclosure (acceptance of responsibility and an apology) or nondisclosure (expression of regret without acceptance of responsibility or an apology).

SETTING: New England-based health plan.

PARTICIPANTS: Random sample of 1500 adult members received the questionnaire, with a 66% response rate.

MEASUREMENTS: Likelihood of changing physicians, likelihood of seeking legal advice, ratings of patient satisfaction, trust and emotional reaction in response to a vignette and dialogue, and views on medical error and disclosure.

RESULTS: Full disclosure reduced the reported likelihood of changing physicians and increased patient satisfaction, trust, and positive emotional response. Full disclosure reduced the reported likelihood of seeking legal advice in only 1 error-and-outcome vignette. In the other vignettes, the percentage of patients indicating that they would seek legal advice was relatively high even with full disclosure. Almost all respondents (98.8%) wanted to be told of errors, most (83%) favored financial compensation if harm occurred, and few (12.7%) favored compensation if no harm occurred.

LIMITATIONS: Since the study was done in the context of a managed care plan in one geographic area, it could not assess whether the results are generalizable to other populations. In addition, it could not determine whether responses to the simulated situations used predict responses to real situations.

CONCLUSIONS: Patients will probably respond more favorably to physicians who fully disclose medical errors than to physicians who are less forthright, but the specifics of the case and the severity of the clinical outcome also affect patients' responses. In some circumstances, the desire to seek legal advice may not diminish despite full disclosure.

Mellanby, R. J., & Herrtage, M. E. (2004). Survey of mistakes made by recent veterinary graduates. *The Veterinary Record, 155*, 761-765.

To investigate the incidence and types of mistakes made in veterinary practice, and to assess the impact the mistakes had on the veterinarians involved, a questionnaire was sent in November 2002 to all the veterinary graduates of the Universities of Bristol, Edinburgh, Glasgow, London and Liverpool in 2001. One hundred and eight (27 per cent) of 402 questionnaires were returned completed; 87 of 106 respondents (82 per cent) worked frequently or always unsupervised and only 46 (43 per cent) could always rely on support from other veterinarians in the practice. Since starting work, 82 of 105

respondents (78 per cent) stated that they had made a mistake, defined as an erroneous act or omission resulting in a less than optimal or potentially adverse outcome for a patient and in many cases these mistakes had had a considerable emotional impact on the veterinarians involved. The survey highlights that a large number of recently graduated veterinarians work with little supervision and that many veterinarians beginning their year in practice do not always have access to assistance from other veterinary colleagues.

Nunalee, M. M. M., & Weedon, G. R. (2004). Modern trends in veterinary malpractice: how our evolving attitudes toward non-human animals will change veterinary medicine. Animal Law, 10:125-161. Retrieved on July 28, 2005, from http://www.animallaw.info/journals/jo_pdf/vol10_p125.pdf

O'Connell, D and Reifsteck, SW (2004) Disclosing Unexpected Outcomes and Medical Error. *Journal of Medical Practice Management*. May/June, 2004. Vol 19(6) 317-323.

This article provides an overview of the process of disclosing medical errors with clients and builds on research and experience in veterinary and human medicine, as well as the broader customer service literature to address the dynamics of disappointment in small animal practices. The authors offer strategies to reduce the frequency and intensity of such disappointments and resolve them more satisfactorily when they do occur.

Discussing medical errors with affected clients can ultimately benefit your practice. This article provides tips on creating a protocol for resolving medical errors.

Robbennolt JK (2009). Apologies and Medical Error. *Clin Orthop Relat Res, 467*(2): 376–382.

One way in which physicians can respond to a medical error is to apologize. Apologies—statements that acknowledge an error and its consequences, take responsibility, and communicate regret for having caused harm—can decrease blame, decrease anger, increase trust, and improve relationships. Importantly, apologies also have the potential to decrease the risk of a medical malpractice lawsuit and can help settle claims by patients. Patients indicate they want and expect explanations and apologies after medical

errors and physicians indicate they want to apologize. However, in practice, physicians tend to provide minimal information to patients after medical errors and infrequently offer complete apologies. Although fears about potential litigation are the most commonly cited barrier to apologizing after medical error, the link between litigation risk and the practice of disclosure and apology is tenuous. Other barriers might include the culture of medicine and the inherent psychological difficulties in facing one's mistakes and apologizing for them. Despite these barriers, incorporating apology into conversations between physicians and patients can address the needs of both parties and can play a role in the effective resolution of disputes related to medical error.

Stangierski A, Warmuz-Stangierska I, Ruchała M, Zdanowska J, Głowacka MD, Jerzy Sowiński J, & Ruchała P (2012). Medical errors – not only patients' problem. *Arch Med Sci. 8*(3): 569–574.

Introduction: Medical error is often a traumatic experience not only for patients but also for doctors. However, patients as victims get much more publicity than those responsible for actual errors. The authors of the study conducted research to learn about Polish doctors' opinions on and reactions to medical errors and how they affect their further professional activity and psychological status. The aim of this study was to evaluate the impact of involvement in medical errors of doctors of different specialties and different age.

Material and methods: The research was conducted in a group of 100 doctors of different specialties. Respondents anonymously completed an experimental survey comprising 6 groups of multiple choice questions concerning such issues as awareness of the nature of medical error, legal liability of the perpetrator, consequences of medical error for further professional activity, the function of the Patients' Rights Representative and consequences of publishing the problem.

Results: The results indicate many negative effects of medical errors on physicians, such as common fear of making an error (82%), increased caution (52%), disadvantageous security measures while performing one's duties (57%), worsening of doctor-patient relations (67%), loss of social trust (62%) and increased treatment costs (40%). Forty five

percent of the surveyed doctors declared that patients need the Patients' Rights Representative and 39% claimed it does not affect their work.

Conclusions: Given the significant burden on physicians' health, well-being and performance associated with medical errors, health care institutions should take this into account and provide physicians with formal systems of support.

Wisch, R. F. (2003). Overview of Veterinary Malpractice. Animal Legal and Historical Center, Retrieved from http://www.animallaw.info/articles/qvusvetmal.htm

This article provides an overview of the elements of a veterinary malpractice case, possible defenses to such an action, and issues related to professional licensing of veterinarians.

Witman, A. B., Park, D. M., & Hardin, S. B. (1996). How do patients want physicians to handle mistakes? A Survey of internal medicine patients in an academic setting. *Archives of Internal Medicine, 156*:2565-2569.

BACKGROUND: Mistakes are an inevitable part of the practice of medicine. While the frequency and severity of medical errors are documented, little is known about patients' attitudes toward physician mistakes.

OBJECTIVE: To examine patient attitudes about physician errors.

DESIGN: A survey instrument assessed attitudes to 3 levels of physician mistakes (minor, moderate, and severe) and 2 fundamental physician responses: disclosure or nondisclosure. One hundred forty-nine study subjects were randomly selected from an academic general internal medicine outpatient clinic.

RESULTS: Virtually all patients (98%) desired some acknowledgment of even minor errors. Patient's desire for referral to another physician ranged from 14% following a minor mistake to 65% following a severe mistake. For both moderate and severe mistakes, patients were significantly more likely to consider litigation if the physician did not disclose the error. In the moderate mistake scenario, 12% of patients

would sue if informed by the physician vs 20% if the physician failed to disclose the error and they discovered it by some other means ($P < .001$).

CONCLUSIONS: Patients desire an acknowledgment from their physicians of even minor errors, and doing so may actually reduce the risk of punitive actions. These findings reinforce the importance of open communication between patients and physicians.