Today's Veterinary Business

By Ed Branam, DVM, CIC

The Second Victims

When a mistake harms a patient, the caregivers also pay a heavy price. We can do better.

A dog awaiting a mass removal is inadvertently neutered. A cat receives 6 milliliters of ketamine as an induction agent. After grooming, a dog is left in a cage with the hair dryer on high and the timer disabled. A heating pad severely burns a cat. A diabetic dog is discharged with the wrong insulin and dosage regimen.

Unfortunately, all those real-life cases led to adverse medical outcomes and, sometimes, legal litigation.

Previous articles discussed the external legal exposures (civil lawsuits and license board claims) that can arise from errors in the delivery of veterinary medical services like those above. This time, I'll focus on the internal aspects.

No One's Perfect

As the saying goes, "To err is an inevitable part of being human." We are all fallible regardless of our knowledge or experience. Any veterinary health care team member who devotes enough time to delivering clinical services will err, sometimes adversely affecting one or more patients. In most instances, the conditions and events leading to a medical error are complex, not singular. Workplace conditions, staff shortages, miscommunication, poor handwriting and even fatigue are a few of the predisposing systemic factors that frequently play a key role in adverse events.

The error patterns in health care are no different than those in other high-risk industries. Unfortunately, data from human medicine identify medical errors as the third-leading cause of death in the United States behind cancer and cardiovascular disease. At the same time, the World Health Organization indicates that up to 80% of the harm to human patients during the delivery of medical care is preventable. Those statistics are truly frightening.

As veterinary professionals, we must recognize the significant truth in those statistics. The big question is, what do we do about it?

Get to the Root Causes

Dr. Rochelle Low, a veterinarian and patient-safety expert at Mars Veterinary Health, along with others in the human and veterinary health care fields, are pioneering an area of medical science related to the causation and management of medical errors. Most importantly, they are studying the issue from an internal versus external, legally based viewpoint.

Their efforts focus on:

- Identifying and addressing the root causes of adverse patient events.
- Addressing the importance of individual and collective support of the health care team following an occurrence.

What happens after an adverse event? Historically, everyone looks for someone to blame. Then, they isolate the offender's actions from those of others and the practice's overall operation. That reaction works great for attorneys attempting to identify who to sue on behalf of a pet owner and for licensing boards investigating alleged wrongful acts. But does any of that, which adds to the stress and anxiety prevalent in our profession, change the reality that similar adverse events routinely occur? No.

We know deep down that we are fallible. We also know that someday, if not today, we will make a mistake that harms a patient.

Dual Focus

Of importance is the need to advocate for both patient

safety and the long-term mental health of the medical team. We must focus not on blaming individuals but instead on how and why errors occurred.

Medical errors are rarely as simple as one person doing something wrong. Instead, they typically result from a chain of events. Experts discovered that if we don't go back and identify and fix the preexisting conditions that led to a medical error, the same outcome will happen again. Just ask any veterinary professional liability insurance carrier.

Safety experts predict that up to 95% of medical errors are made by well-trained, well-meaning, conscientious people caught in faulty systems that set them up to make mistakes. Thus, in virtually every circumstance, individual remedial training is not the issue; the problem is the work environment. Such an environment includes poor systems, protocols and workflows, faulty equipment installation and maintenance, distractions, noise, and miscommunication, just to mention a few. Thus, many factors might share responsibility for a single team member's medical error.

Turning the Tide

How do we prevent adverse patient events? First, we must develop a strong internal safety culture. We need environments where practice owners, managers and the entire health care team know they will be supported when they ask for assistance, make recommendations or investigate a medical error.

We must recognize that:

- Every system has weaknesses and needs to be evaluated and modified continually as equipment, staff, office hours and treatment modalities change.
- Few errors are due to the incompetence of a single individual. In contrast, they usually result from a complex series of events.
- If possible, unsafe or outdated conditions and protocols must be identified and corrected before an adverse medical event can occur.
- Any team member who commits a medical error needs immediate and unwavering support. The person's professional confidence and mental health might depend on the assistance of their peers and teammates.

AUTHOR'S NOTE

This article is based on a webinar by Dr. Rochelle Low titled "Have You Ever Made a Mistake?" I thank Dr. Low and Mars Veterinary Health for allowing me to utilize her proprietary material and insights on this important topic.

Harvard Professor Dr. Lucian Leape, often considered the father of patient safety, said, "The single greatest impediment to error prevention in the medical industry is that we punish people for making mistakes." His is a compelling and disconcerting statement.

Typically, when an error occurs, veterinary hospital personnel immediately focus on the patient and pet owner, which is appropriate. As a result, the pet and client are referred to collectively by patient-safety experts as the "first victim." However, Dr. Albert Wu, director of the Johns Hopkins Center for Health Services and Outcomes Research, coined the term "second victim," which he describes as people often marginalized or ignored. He was referring to health care workers negatively affected by their roles in at-fault adverse medical events.

Mental health professionals recognize the psychological trauma on human health care providers associated with an adverse event. The same impact is true for veterinary team members. They might suffer physical or emotional harm, question their professional competence, and feel isolated from their peers and teammates.

Unfortunately, I've spoken with numerous veterinarians who felt so traumatized by their role in an adverse medical event that they thought about leaving clinical practice. Almost always, their feelings were driven by a sense of guilt, failure, professional humiliation and isolation. The feelings are exacerbated when the event leads to a legal malpractice claim.

Johns Hopkins University developed a program for its professional staff called RISE, or Resilience in Stressful Events. It's a volunteer peer support group for doctors and nurses dealing with an adverse patient event. The program is based on recognizing that people, in times of psychological stress, are typically more comfortable reaching out to their peers than leadership or management.

The veterinary community should consider incorporating a similar program into current mental health initiatives. TVB