Decision-Making in Veterinary Practice

Barry Kipperman

WILEY Blackwell

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***Barry Kipperman**, DVM, DACVIM, MSc, DACAW*
Instructor, Veterinary Ethics, University of California at Davis, School of Veterinary Medicine, Davis, CA, USA;
Adjunct Associate Professor, University of Missouri College of Veterinary Medicine, Columbia, MO, USA

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Contributors

Jim Clark, DVM, MBA
Instructor, Professional Skills
University of California at Davis
School of Veterinary Medicine
Davis, CA, USA

Kathleen Cooney, DVM, CHPV, DACAW resident
Companion Animal Euthanasia Training Academy
Loveland, CO, USA

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Introduction: Why a Book on Decision-Making in Veterinary Practice?

During my 33 years as a small animal internal medicine specialist and 17 years as a practice owner interacting with patients, clients, associates, technicians, and referring veterinarians, and teaching students and interns, I realized that there is an absence of principles or strategies to guide veterinary practitioners in the process of decision-making. This sometimes results in decisions that, when examined retrospectively, appear to be illogical or difficult to justify based on the information in medical records. McKenzie observes that "There is nothing we do as often or that is ultimately as central to clinical medicine as making decisions. However, veterinarians and veterinary students receive little, if any, formal training in decision-making, and there is little explicit discussion in the veterinary literature about this critical activity" [1].

In my experience, each hospital has a unique culture that profoundly influences the way in which its clinicians make decisions. These influences are known as the "hidden curriculum," where clinicians are implicitly expected to adopt systems and behaviors that align with the philosophy of the practice. For example, a specific practice may customarily send patients home shortly after surgery or advise hospitalization overnight. Some practices encourage their clients to pursue diagnoses in sick patients while others prioritize therapeutic trials. At some practices, clinicians perceive pressure to proceed with euthanasia requests they find ethically problematic, while other practices support declining euthanasia requests on moral grounds.

To mitigate cognitive dissonance and interpersonal conflicts, clinicians may unknowingly modify their behaviors to conform with their practice's expectations. Doing what is expected of you or what your employer has done preceding you is quite understandable. But when scrutinized, this practice may discourage care shaped by sound principles and evidence in lieu of adhering to historical precedents or hospital protocols.

The goal of this book is to examine veterinary decision-making. Many unique considerations that influence clinical outcomes will be addressed, including how to obtain a patient history, why the time of day and the day of the week matter, why patient weight should be an important determinant of course of action, how to render a prognosis, when it is reasonable to perform a therapeutic trial, and interpreting results of diagnostic tests and treatment outcomes.

Other questions relevant to decision-making that often differ between practices and clinicians that will be covered in this book include:

- What standard should be utilized to assess clinician success?
- How should a veterinarian balance client or patient advocacy?
- How should veterinarians balance paternalistic or shared decision-making?
- Should clients be offered all available options, only those the practice can provide, or those that the clinician believes the client can afford?
- Should practitioners be compensated based on their production?

- How should economic concerns influence clinician decisions?
- When should veterinarians refer cases?
- Should clinicians disclose medical errors to clients?
- What factors should influence whether, when, and how a diagnosis should be pursued?
- How should veterinarians balance the desire to make a diagnosis with client requests for therapeutic trials?
- What considerations should dictate whether a patient is admitted to the hospital or managed at home?
- What circumstances should inform when treatment should stop?
- How should veterinarians balance the need to effectively manage postoperative pain versus client desires to have their companion at home?

One of the recurrent themes in this book is that *reflective* thinking by veterinary clinicians is challenged by the standard of modern-day practice in which the short duration of consultations does not accommodate such deliberation. This often results in *reflexive* decisions being made "on the fly," analogous to a myotatic reflex, limiting not only the capacity to make good decisions for patients but also acquisition of informed consent from our clients. In veterinary school, students spend hours writing extensive and impressive patient medical records, then discover after graduation that medical records are characterized by their brevity.

For most of my career in practice, my consultations were 60 minutes in duration. I typically spent about 10 minutes reviewing patient records; 10 minutes creating a list of patient problems, differential diagnoses, and a potential diagnostic plan; and spent the remaining 40 minutes in the exam room with my clients. While I appreciate that applying this time frame for appointments in general practice may be untenable, there is no doubt that the quality of veterinary decision-making would improve dramatically if consultation times and fees for sick patients both doubled. Barring this type of paradigm shift, a clinician who wishes to apply some of the counsel provided in this book will need to spend decision-making time before or after consultations have been completed.

Normative ethics is a branch of philosophy where one seeks to determine principles of good and bad, or right and wrong behaviors and attitudes, i.e. what one *ought* to do. We should be able to ask *why* one made a clinical decision and examine the process in hindsight, much as we are trained to perform a patient autopsy to determine what disease we may have missed. The absence of discrete principles for clinical decision-making often has far greater consequences for our patients than our knowledge of medicine or surgery.

My intention in this book is to improve the quality of veterinary clinical reasoning and thoughtfulness. Tables and figures will be utilized to offer guidance, and case studies will be provided for context and to encourage reflection. At my hospital I established a tradition in which in exchange for my efforts in passing on my advice and teaching, the interns would present me with a top-10 list of what they learned during their internship. These lists taught me lessons as well.

Veterinary clinicians should provide their clients and their animals with the benefit of not only our compassion, but also our wisdom, manifested by judicious decisions. It's my hope that passing on what I have learned and considered, including my mistakes, will help you make better decisions resulting in improved patient outcomes. Let's begin examining some of the most important topics relevant to veterinary decision-making.

Reference

1 McKenzie, B.A. (2014). Veterinary clinical decision-making: cognitive biases, external constraints, and strategies for improvement. *Journal of the American Veterinary Medical Association* 244 (3): 271–276.

Section 1

Fundamental Concepts in Making Clinical Decisions

1

How to Define Your Success as a Clinician

Barry Kipperman

Abstract

This chapter considers finding a suitable criterion by which to assess success in clinical veterinary practice and why this is important. It discusses the limitations of satisfying varied practitioner interests including those of referring veterinarians, performing advanced treatments or procedures, financial compensation, conforming to employer expectations, pleasing animal owners, and achieving desired patient outcomes as benchmarks for success. Case studies are used to illustrate these examples. The Principle of Patient Advocacy is defined and introduced as the ideal means by which to determine clinician success.

Keywords: *success, moral stress, referring veterinarian, compensation, employer, advanced care, clients, owners, patient advocacy*

As this book is devoted to veterinary decision-making, perhaps one of the most meaningful decisions is how to define one's success as a clinician. During my career, numerous interns and students have asked me, "How do you know whether you are a good veterinarian or had a successful day?" I had no answer to this profound question when it was first posed, but significant introspection since then has allowed me to gain clarity, which I hope to provide in this chapter.

Why is the answer to this question so vital? Because whatever criterion one uses to measure success will inevitably guide one's practice philosophy and behaviors that may endure over the course of an over 30-year career in the profession. Another reason grappling with this question is so important relates to the mental health of veterinarians. There has been increasing research interest in examining the occurrence of stress within the veterinary profession. Many factors have been cited to cause stress, including ethical dilemmas, client financial limitations affecting patient care, work overload, client complaints, and dealing with death and errors [1].

Two recent investigations discovered that 50% [2] and 31% [3] of veterinarians had high burnout scores. A study of small animal veterinarians found that 49% reported a moderate to substantial level of burnout [4]. In another report, when North American veterinarians were asked "How often have you felt distressed or anxious about your work?", 52% responded "often" or "always" [5]. It's apparent that work-related stress is a significant challenge for the veterinary profession. The effects of work-related stress on mental health are well documented and include

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emotional exhaustion, anxiety, and depression [6, 7]. Numerous studies have documented higher rates of suicidal ideation and suicide in the veterinary profession compared with those in the general population and other healthcare professionals [8–11].

If one applies a standard of success that becomes unfulfilling, too difficult, or impossible to attain, it's likely that moral (dis)stress may be experienced. Moral distress has been defined as "The experience of psychological distress that results from engaging in, or failing to prevent, decisions or behaviors that transgress ... personally held moral or ethical beliefs" [12]. Moral stress is therefore recognized as a consequence of experienced conflicts involving work-related obligations or expectations that do not coincide with one's values [13, 14]. Studies in veterinary medicine have suggested or documented that moral distress is inversely associated with wellbeing and correlates with career dissatisfaction and attrition [15, 16].

To consider the question of how to assess your success, let's systematically examine the numerous interests veterinary clinicians are expected to serve and the viability and limitations of satisfying each of these as a benchmark to evaluate clinical success.

Referring Veterinarian

To meet the demand that medical care for animals rival that of humans, the number of referral and emergency veterinary practices in the United States has increased dramatically in the last three decades [17]. Of the estimated 119 000 US veterinarians [18], 11% are board-certified specialists [19]. These veterinarians have the same diverse obligations as those of the referring veterinarian (RDVM), but in addition must satisfy the perceived or real demands of the RDVM.

Just as general practitioners (GPs) are economically dependent on the animal owner for their livelihood, the veterinary specialist is dependent on present and future referrals from their colleagues. As most pet owners are not aware of the existence of specialists [20], the GP is considered the gatekeeper to the referral process. While GPs are careful not to offend pet owners, specialists feel the same way toward RDVMs due to concern over losing referrals and their associated income.

As a result of these forces, the veterinary specialist may feel conflicted in satisfying their varied duties (Case Studies 1.1 and 1.2).

Case Study 1.1 A Dog with Chronic Vomiting Referred for Endoscopy

You are an internist in a referral practice. Bella, a nine-month-old dog, is referred for endoscopy for evaluation of chronic vomiting. Novel diet trials have not been performed and appetite is normal. Lab work and radiographs are within normal limits. Physical examination reveals Bella to be in good body condition with no abnormalities. Based on Bella's young age and the evaluation, you advise a novel diet trial for food allergy/intolerance, with endoscopy and biopsies to follow if vomiting does not improve within a few weeks.

The client seems confused and explains that endoscopy was advised by her veterinarian. You inform the client that approximately 50% of cases like Bella's will respond to diet change, supporting the recommendation to delay the cost and anesthetic risk of endoscopy and the need for medications that may have undesirable side effects. The RDVM calls you later in the day to express his displeasure with the agreed course of action, stating, "You showed me up to the

client because I wanted an endoscopy. Now I'll refer her to someone else who will do the endoscopy."

In this case, there is conflict between what the specialist perceives to be in the best interest of the patient and the expressed desire of the GP. Ideally, this problem can be sufficiently resolved via a professional conversation. If not, should the specialist comply with the request for the endoscopy? This procedure is benign, commonly performed, and will enhance the income of the specialist, but may be unnecessary for the patient.

Case Study 1.2 A Dog with Abdominal Distension

Sydney, an 11-year-old male German shepherd, is seen by a local GP on Wednesday for lethargy and poor appetite of 1–2 days' duration. The medical record confirms abdominal distention. Sydney is sent home while a mobile ultrasound is scheduled. On Friday, ultrasound reveals a splenic mass. Sydney is sent home for the weekend and arrives at your referral practice Monday morning in a moribund, life-threatening condition, with a packed cell volume (PCV) of 17%. Sydney undergoes emergency splenectomy for abdominal bleeding and dies postoperatively from oliguria and coagulopathy. Should you inform the client or the GP of your concern that surgery should have been advised before 5 days had passed after initial presentation? Should you report this colleague to the state board?

While in many cases the interests of the GP, specialist, client, and patient are aligned, conflicts can occur. Unfortunately, attempts by the specialist to constructively discuss with the RDVM what could have been done better sometimes result in a punitive loss of future referrals. If satisfying the RDVM is viewed as a measure of success, then the specialist may either modify their standards of practice to conform with GP expectations, or may not attempt to provide constructive feedback to GPs to improve their standards of practice. Both choices are detrimental to promoting animal welfare. Conversely, a GP should also feel they can discuss concerns about shared patient care with the specialist. While striving to satisfy RDVMs may seem appropriate as an indicator of success, these examples suggest that in some cases doing so can be self-serving and disregard obligations to the client, the patient, and the profession.

Veterinarian

Veterinary clinicians have an interest in career satisfaction. Professional self-esteem may be linked to learning and performing novel or advanced procedures or treatments [21]. The increased demand of animal owners for advanced care and the rise in availability of emerging technologies and advanced imaging create a recipe for futile or non-beneficial interventions. As noted by Durnberger and Grimm [22]: "Undoubtedly, veterinarians have a positive duty to help animals – but at what point do they run the risk of violating the negative duty not to harm animals?" In considering this issue of when well-intended interventions cause unwarranted harm, studies show that veterinarians are sometimes requested to provide treatment that they consider futile [5, 23].

Emotionally driven factors are often associated with decisions to pursue advanced care (Case Study 1.3). Taylor [24] has noted that "a question being increasingly asked is whether there are many clinicians who currently view euthanasia as a failure rather than a considered, considerate

Case Study 1.3 My Pug with Collapsing Bronchi

Winston was a 13-year-old pug with progressive exercise intolerance and episodes of cyanosis and syncope associated with wheezing. My perception was that his quality of life was worsening. Imaging evaluations confirmed collapsing bronchi as the cause, likely secondary to chronic inspiratory dyspnea from brachycephalic obstructive airway syndrome. While the surgeons at my practice were adept at inserting tracheal stents as a salvage procedure for dogs with collapsing trachea with good short-term outcomes, bronchial stenting at that time was considered experimental. My love for Winston, fear of losing him, and the hope of finding some means of resolution clouded my medical judgment. I called the closest university teaching hospital and was informed no one there performed bronchial stenting. I called the company that produces tracheal stents and discovered it had recently began producing bronchial stents, but very few colleagues were trained in placing them. Out of desperation, I purchased several different-sized stents and requested my other internist and surgeon assist me in trying this for Winston. I arranged real-time remote access to an expert in this procedure, and with his guidance we worked for hours to properly implant the stents via bronchoscopy.

Winston spent the next few days in the hospital receiving sedatives and antitussives to mitigate risks such as stent migration or fracture. When I brought Winston home, it was clear that his condition was worse, and he could barely move without having to honk and wheeze. I let him go the day after Christmas. In hindsight, the risk–benefit ratio for this procedure was quite poor, and in addition to my own sense of guilt and moral stress for putting him through this, I likely also contributed to the same negative emotions for my staff involved in this procedure.

option for a struggling animal." Moral stress is one of the potential consequences of participating in procedures or treatments that one feels are prolonging a poor quality of life or are worsening welfare [21].

Defining one's success by the number or nature of advanced treatments or procedures performed is clearly not a desirable standard.

Financial Compensation

In human medicine, the idea that fee-for-service payment models incentivize recommending highly compensated procedures has been considered [25]. A systematic review of 18 studies concluded that 83% discovered an association between oncologists' care and compensation consistent with influence by financial incentives [26]. A recent review of financial performance incentives in US health systems found that while most primary care and specialist compensation methods included incentives based on performance, they averaged less than 10% of compensation [27].

Veterinarians in practice are commonly compensated based on a proportion of their revenues [28]. Although such systems are purportedly intended to reward those seeing many patients and to discourage discounting and pro bono work, these also create an incentive for the veterinarian to advise costly testing, procedures, hospitalization, and surgery. Consequently, an implicit conflict of interest exists that may influence veterinary recommendations (Case Studies 1.4 and 1.5), contributing to unnecessary, inappropriate, or delayed interventions [29]. After my practice purchased a computed tomography (CT) scanner, I would be dishonest not to recognize the influence of the potential economic benefits to me and my practice for advising this procedure.

Case Study 1.4 Request to Postpone Emergency Surgery

Herbie, a 10-year-old large-breed dog, is referred to you at a 24-hour referral practice at 7 p.m. for evaluation of weakness and anemia. An ultrasound study reveals a splenic mass and hemoabdomen. Herbie's PCV is 20%. You call the RDVM to provide an update and to inform them that emergency splenectomy will be advised. The RDVM requests that surgery not be offered, and that Herbie be medically stabilized on intravenous (IV) fluids overnight and transferred back, so that the surgery can be performed at their practice the following morning. You are concerned that delaying surgery may result in death or the need to provide a blood transfusion to facilitate Herbie's survival for the next 14 hours.

What should you do? Acquiesce to the request? Ignore the request? Decline the request? Inform the client of the conflict? Is there a valid medical rationale for this request, or is financial remuneration influencing it?

Case Study 1.5 Workup for Young Cat with an Abscess

A two-year-old cat presents for lethargy. Physical examination confirms fever and a fluctuant swelling on the lateral thorax. The attending veterinarian advises a complete database of testing to include a complete blood count (CBC), chemistry, urinalysis, feline leukemia virus/feline immunodeficiency virus (FeLV/FIV) test, and radiographs prior to surgery to lance the presumed abscess. You are the practice owner reviewing this medical record as part of your usual evaluation of associate performance. Is this diagnostic recommendation excessive and unnecessary or in keeping with quality medicine? The tests enhance practice revenues and are not risky or painful. Should you confront the attending doctor about this or let it go?

This conflict of interest is perceived by clients, as 30% of pet owners agreed that veterinarians advise additional services to make money [30]. This issue has also been raised regarding veterinary clinicians profiting from dispensing medications, in contrast to the medical profession, which abrogates this concern by relegating the prescribing and selling of medications to outside pharmacies [31, 32].

When I owned my practice, each month I provided associate doctors with a spreadsheet that included numbers of patients seen, average transaction fees, and revenue generated for all staff doctors. At the time, I would have asserted that my motivations included transparency and to inspire good medical care. In retrospect, I believe that this data promoted competition among doctors to raise their revenues, resulting in unnecessary medical procedures and a race to be the "highest performer." I suspect this also caused poor self-esteem for "lower-producing" staff. This approach also appears to be common within corporate veterinary practices to encourage competition [33].

For a portion of my career, I based my success on practice revenue and my gross income. In fact, I recall my accountant writing a personal note of congratulations when my income reached a certain milestone. As many practice owners frequently evaluate such metrics, it's easy to fall prey to this criterion as a benchmark for success. During my career, I have been told by numerous colleagues that the justifications for their medical recommendations included "I've got a house to pay for" and "I've got kids to send to college." It should be apparent that utilizing income as an arbiter of success is tempting, but also can become self-serving and can quickly empty one's soul in the process, leading you away from what inspired you to become a veterinarian and a caregiver.