

Pet owners expect veterinarians to disclose medical errors

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Objective

To document the opinions of owners presenting to veterinary teaching hospitals regarding the disclosure of medical errors.

Methods

This cross-sectional study surveyed pet owners from 7 veterinary teaching hospitals in the US from 2021 to 2022. Data collected included demographics, personality traits, animal ownership, animal death experiences, animal-owner bond, and experiences with medical error. Multivariate regression models were built to assess the relationship between the belief that medical errors are inevitable and respondent characteristics.

Results

A total of 5,026 pet owners completed the survey, and 1,629 people provided descriptive accounts. The belief that medical errors are inevitable was negatively associated with extroversion and positively associated with education level. The majority (72%) indicated that they wanted to know about every medical error, 72% wanted to be notified immediately if an error occurred, and 88% wanted to know if a medical error had the potential to cause harm to their pet. The vast majority of respondents (87%) indicated that when a veterinarian poorly communicated about medical errors, they lost trust in the practitioner. When a veterinarian communicated a medical error well, 58% reported an improvement in trust. Respondents indicated that errors in communication, treatment, and diagnosis resulted in negative patient case outcomes.

Conclusions

Participants in this study wanted to know about all medical errors and wanted to be informed of those errors immediately. Communication, misdiagnosis, and treatment errors leading to poor case outcomes were reasons pet owners believed errors occur.

Clinical Relevance

Veterinarians should be prepared to communicate completely with clients when a medical error occurs.

Keywords: medical error, communication, human-animal bond, survey, patient safety culture

Medical errors occur in veterinary medicine and can cause significant harm to patients.¹ Medical errors are defined as “an act of omission or commission in planning or execution that contributes or could contribute to an unintended outcome with the patient” and “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve

an aim.”^{2,3} Medical errors arise when people work in complex medical systems with numerous interlocking components. All medical systems must work toward promoting safety and reducing preventable harm through open communication, perpetual awareness, and evaluation.^{2,4} Improving veterinary patient safety includes fostering a positive patient safety culture, which promotes open communication within medical teams and with pet owners, including disclosing medical errors to pet owners when they occur.^{4,5}

A recent study¹ evaluating medical errors occurring at 3 veterinary hospitals in the US, self-reported via an online portal, found an incidence rate of 5.3 errors in every 1,000 patient visits, with drug safety

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incidents and communication errors most frequently reported. In that study, 45% of all errors reached patients without causing harm. Of those patients experiencing harm, > 82% experienced temporary harm and up to 8% permanent harm or patient death.¹ Medication errors have been shown to have the potential to cause significant and lasting harm, including death.⁶ Another study⁷ found an incidence rate of 4 patient safety events for every 1,000 patient visits, with medication (34%) and patient care and handling (29%) being the most common. A substantial number of students (85%) have reported being present during a medical error.⁸ Educating students about patient safety culture has been emphasized recently,⁹ and well-executed debriefings after a medical error event improve psychological outcomes in those involved.¹⁰ These data indicate that medical errors are a prominent phenomenon in veterinary medicine.

As relationships with companion animals continue to evolve in meaning and significance, pet owners' perspectives and expectations around their pets' care also change.¹¹ Research indicates that people with stronger pet bonds seek higher levels of veterinary care and are more likely to follow the veterinarian's advice, independent of the cost of care.¹² In a study¹³ of German pet owners being seen at a general practice veterinarian, participants identified a variety of causes of error including communication, treatment, and diagnosis and expressed significant emotional distress. A large dataset providing pet owners' perspectives on medical errors at referral institutions in the US has not been investigated.

The purpose of this survey was to document the perceptions and opinions of owners presenting to veterinary teaching hospitals throughout the US regarding disclosure of medical errors in veterinary medicine. The research questions were the following: what do participants identify as a medical error and, when one occurs, when do they want communication and what do they want communicated; would specific participant characteristics predict whether they believe medical errors are inevitable as well as what an acceptable error rate is; what are the most common medical errors reported by participants; and does the veterinarian's communication during a medical error impact participant trust.

Methods

This mixed-methods study was multi-institutional and cross-sectional. Individuals known to 1 of 2 authors working at colleges of veterinary medicine throughout the US were contacted to be researchers. Teaching hospitals in Alabama, Arizona, California, Colorado, Georgia, Louisiana, and Texas participated. The author at each institution worked through their administration to distribute the survey to the email list of the clients of the institution's veterinary teaching hospital and institutional private practice clinical partners, resulting in a convenience sample. No reminders were sent. The survey was open between January 1, 2021, and October 15, 2021. Each institution's institutional review board reviewed and approved the survey, with the primary investigator's

institutional review board serving as the default approval if the institution did not require separate approval (mutual agreements; No. 20-188 EX 2004).

The survey was designed by the authors after reviewing the literature on medical error communication and anesthesia risk (**Supplementary Material S1**). The survey included demographic questions (eg, education, religious affiliation, household income), the Ten Item Personality Inventory,¹⁴ questions about pet ownership and the relationship with their veterinarian and the veterinary teaching hospital, primary caregiver questions derived from the CENSHARE Pet Attachment Scale,¹⁵ their beliefs about medical error, and an open-response option. The survey had between 1 and 10 questions per page, was 13 to 15 pages in length, and was anonymous. The survey was pilot tested with 8 laypeople known by the authors, and modifications for content and comprehension were made as needed. The survey used adaptive questioning to minimize the number of questions asked (eg, if the participant had not experienced a medical error, they were not presented with questions relating to a medical error).

The survey was built on an electronic survey platform (Qualtrics) and tested for technical function before distribution. The question order was not randomized. Some questions were required, but some could be left blank and there was no summary or completeness check. Duplicates were prevented by assigning unique cookies to each client device. An information letter was provided on the first page, and participants had to confirm their decision to participate by clicking "yes" on the subsequent pages. The information letter included the purpose of the study, eligibility, benefits, estimated time to complete, and risks. There was no incentive provided for participation. The study adhered to the Checklist for Reporting Results of Internet E-Surveys (ie, CHERRIES) guidelines.¹⁶

Statistical analysis

Responses with < 80% of the questions completed were eliminated from the analysis. For education, those with some high school were combined with those who had a high school diploma because of the lower number of individuals with only some high school. Normality was assumed due to the large dataset. For the question, "Medical care is provided by human beings and therefore medical errors are inevitable," *strongly agree* and *somewhat agree* were coded as 1 and all other responses as 0 for a multivariate logistic regression model with backward conditional elimination built with age, gender, race, religion, region of the country (as defined by the Census Bureau), education, personality traits, and pet connection score as independent variables. A multivariate linear regression model with backward elimination was built with the value for "What rate of occurrence (ie, what percentage of the time out of 100%) do you feel is reasonable/acceptable for a veterinarian to commit a medical error?" as the dependent variable and the same independent variables listed herein. Significance was set at $\alpha = .01$.

The final question of the survey was an open-response question in which participants were asked

to describe any medical error experiences with an animal. The data in this question were analyzed as qualitative data with the use of content analysis.¹⁷ For this project, an initial codebook was developed by 3 undergraduate student researchers and a supervising senior researcher (AGW) after reviewing the first 50 responses. The codebook consisted of parent codes for broad themes and subcodes that captured more specific, repeating content within the broad thematic code. The codes were then applied to the remaining qualitative data in an iterative process wherein the student researchers coded 100 responses at a time and changes to the codebook were reviewed by the senior researcher. If a response described more than 1 experience, these were coded as separate experiences. These qualitative responses were coded with MAXQDA analysis software (VERBI GmbH).

Results

Of the 6,191 surveys begun, 5,026 were retained for data analysis. Participant demographics and characteristics are presented in **Tables 1 and 2**.

Table 1—Participant demographics. Data are presented as count (percentage), mean $\pm$ SD (95% CI), or median (IQR [range]).

Demographic variable	Value
Gender (n = 5,024)	
Male	1,067 (21%)
Female	3,935 (78%)
Other	22 (0%)
Age (n = 4,591)	56 (44–87 [16–87])
Race (n = 4,990)	
White/Caucasian	4,487 (90%)
Black/African American	68 (1%)
Hispanic/Latino	162 (3%)
Asian American	39 (1%)
Native American	17 (0%)
Indian American	2 (0%)
Other	215 (4%)
Religious affiliation (n = 4,987)	
Christian	3,647 (73%)
Jewish	75 (2%)
Muslim	9 (0%)
Hindu	7 (0%)
Atheist	292 (6%)
Agnostic	465 (9%)
Other	492 (10%)
Religion importance (n = 4,983)	
Extremely important	1,228 (25%)
Very important	1,042 (21%)
Moderately important	956 (19%)
Slightly important	674 (14%)
Not at all important	1,083 (22%)
Geographic area of residence (n = 4,997)	
Northeast	19 (0%)
Midwest	55 (1%)
South	3,802 (76%)
West	1,121 (22%)
Highest education obtained (n = 5,015)	
Some high school	13 (0%)
High school diploma	216 (4%)
Some college but no degree obtained	909 (18%)
Bachelor's or associate degree	2,033 (41%)
Master's degree	1,064 (21%)
Professional or doctoral degree	780 (16%)

Participant feelings about medical error and preferences for communication are presented in **Tables 3 and 4**. Notable results include that 29% reported being a victim of a medical error by a healthcare practitioner for humans, a reasonable rate of error occurrence for veterinarians is 5%, 72% wanted to know about any medical error for their pet regardless of whether harm occurred or not, 72% wanted to be immediately notified in the event an error occurred, and 23% wanted to be informed of a near miss. Drug miscalculations leading to an incorrect dose administration to the patient (81%), administration of a medication intended for patient A to patient B (77%), excessive bleeding during surgery due to accidental cut of a blood vessel (68%), failure to discuss the pet's test results in a timely manner (48%), and deficient interpersonal communication skills (45%) were most commonly identified as medical errors.

For reporting to the state licensing board, 79% indicated that it should happen if the medical error was a result of willful neglect or sabotage, 63% if the medical error caused long-term harm to their pet, and 53% if further care and expense resulted from the medical error. Similarly, 25% to 55% of participants felt that internal committees should review incidents of medical error for further investigation (Table 4). When the veterinarian does a poor job of communicating a medical error, 87% reported a moderate or complete loss of trust and 1% reported an increase in trust. In contrast, when the veterinarian does a good job of communicating a medical error, 6% reported a moderate or complete loss of trust and 60% reported an increase in trust.

Those who strongly agreed or somewhat agreed that medical errors are inevitable had a negative association with extroversion (0.952; 95% CI, 0.928 to 0.977; $P < .001$) and a positive association with education level (1.220; 95% CI, 1.137 to 1.309; $P < .001$) (Nagelkerke $R^2 = 0.024$). The reasonable rate of medical errors was negatively correlated with emotional stability ($P < .001$; unstandardized $\beta = -0.237$; 95% CI, -0.393 to -0.111) and education level ($P < .001$; unstandardized $\beta = -0.545$; 95% CI, -0.885 to -0.298) (adjusted $R^2 = 0.009$).

A total of 4,551 people responded to the final open-response question, and 149 of 4,551 responses (4,402 remaining) were eliminated because of an incomplete response. The researchers considered most complete responses (2,773 of 4,402 [63%]) to be irrelevant to medical error. Examples of these responses included “no” or “N/A,” complaints about the veterinary clinic or staff, and statements of personal experience that did not describe a medical error. A total of 1,629 responses (37%) were analyzed with content analysis, and 4,242 subcodes were applied (**Supplementary Table S1**). The 4 parent codes that were developed included *case outcomes* (n = 1,140), *communication errors* (991), *treatment errors* (814), and *diagnosis errors* (728). The subcodes applied most frequently for case outcomes (**Figure 1**) included *loss of trust in veterinarian* (28% [464 of 1,629]), *pet owner verbalizes a negative emotional response* (22% [359 of 1,629]), and *animal dies from condition/error* (20% [332 of 1,629]). The most common communication

Table 2—Participant characteristics. Data are presented as count (percentage), mean $\pm$ SD (95% CI), or median (IQR [range]).

Characteristic	Value
Extroversion (n = 4,947)	8.5 $\pm$ 3.0 (8.4–8.6)
Agreeableness (n = 4,922)	10.7 $\pm$ 2.0 (10.7–10.8)
Conscientiousness (n = 4,940)	11.9 $\pm$ 1.8 (11.8–11.9)
Emotional stability (n = 4,941)	10.2 $\pm$ 2.4 (10.2–10.3)
Open to experiences (n = 4,946)	10.5 $\pm$ 2.0 (10.4–10.5)
Current No. of dogs owned (n = 5,021)	2 (1–2 [0–100])
Lifetime No. of dogs owned (n = 4,968)	6 (4–10 [0–2,588])
Current No. of cats owned (n = 5,023)	0 (0–1 [0–30])
Lifetime No. of cats owned (n = 4,979)	3 (1–6 [0–300])
Length of primary care veterinarian relationship (n = 4,777)	
< 1 y	444 (9%)
1–5 y	1,805 (38%)
6–10 y	991 (21%)
11–15 y	565 (12%)
16–20 y	371 (8%)
> 20 y	455 (10%)
I do not have a primary care veterinarian	146 (3%)
Primary care veterinarian practice type (n = 4,777)	
Solo practitioner	747 (16%)
Small practice	2,517 (53%)
Large practice	1,356 (28%)
I do not have a primary care veterinarian	157 (3%)
Length of specialty hospital relationship (n = 4,777)	
< 1 y	1,314 (28%)
1–5 y	2,074 (43%)
6–10 y	643 (13%)
11–15 y	283 (6%)
16–20 y	220 (5%)
> 20 y	243 (5%)
Pet Attachment Scale (n = 4,753)	12.4 $\pm$ 1.9 (12.4–12.5)

Table 3—Participant feelings about medical error events. Data are presented as count (percentage), mean $\pm$ SD (95% CI), or median (IQR [range]).

Question	Value
Has been a victim of a medical error by a healthcare provider for humans (n = 4,748)	
Yes	1,373 (29%)
No	3,375 (71%)
The medical error they personally experienced was disclosed to the participant (n = 1,372)	
Yes	536 (39%)
No	836 (61%)
Level of satisfaction with handling of the medical error they personally experienced (n = 1,246)	
Extremely satisfied	84 (7%)
Somewhat satisfied	152 (12%)
Neither satisfied nor dissatisfied	210 (17%)
Somewhat dissatisfied	262 (21%)
Extremely dissatisfied	538 (43%)
Possible medical errors (n = 4,597)	
Excessive bleeding during surgery due to unknown blood clotting disease	872 (19%)
Excessive bleeding during surgery due to accidental cut of a blood vessel	3,138 (68%)
Excessive bleeding during surgery due to intentional cut of a blood vessel	1,844 (40%)
Administration of a medication intended for patient A to patient B	3,551 (77%)
Deficient interpersonal communication skills	2,067 (45%)
Drug miscalculations leading to incorrect dose administration to patient	3,726 (81%)
Drug miscalculations that were caught and corrected prior to administration to patient	743 (16%)
Unexpected increased wait time in the client lobby area	682 (15%)
Unexpected adverse reactions to medications administered at correct doses	821 (18%)
Failure to discuss pet's test results in a timely manner	2,212 (48%)
Medical care is provided by human beings, and therefore medical errors are inevitable (n = 4,597)	
Strongly agree	1,707 (37%)
Somewhat agree	1,944 (42%)
Neither agree nor disagree	462 (10%)
Somewhat disagree	341 (7%)
Strongly disagree	143 (3%)
Acceptance/reasonable error rate of occurrence (n = 4,582)	5% (3–10 [0–100])

Table 4—Participants' feelings about medical error communication. Data are presented as count (percentage), mean $\pm$ SD (95% CI), or median (IQR [range]).

Question	Value
Medical error notification (n = 4,550)	
I want to know of any medical error that occurs regardless of whether harm was caused to my pet	3,292/4,550 (72%)
I want to know if the medical error has the potential to cause harm to my pet even if my pet is not currently showing any signs of harm	3,948/4,486 (88%)
I want to know even if the medical error caused temporary harm to my pet	3,684/4,486 (82%)
I only want to know if the medical error caused permanent harm to my pet	302/4,486 (7%)
I am comfortable leaving the decision to disclose up to my veterinarian's discretion/opinion	203/4,550 (4%)
Medical error disclosure timing (n = 4,550)	
Immediately upon discovery that a medical error has occurred	3,261 (72%)
After the extent of the medical error is known	1,235 (27%)
After my pet has recovered completely	33 (1%)
I do not want to know that a medical error occurred	21 (0%)
Want to be informed of a near miss (n = 4,550)	
Yes	1,069 (23%)
No	1,132 (25%)
I am comfortable leaving that up to my veterinarian's discretion/opinion	2,349 (51%)
When should a veterinarian be reported to the state licensing board (n = 4,505)	
For all medical errors no matter how trivial	565 (13%)
If the medical error caused temporary harm to my pet	1,125 (25%)
If the medical error caused long-term harm to my pet	2,823 (63%)
If further care and expense resulted from the medical error	2,401 (53%)
If the medical error was a result of willful neglect or sabotage	3,569 (79%)
Never; I do not feel medical errors should be reported to the state governing body	27 (1%)
When should a veterinarian be reported to an internal committee (n = 4,505)	
For all medical errors no matter how trivial	1,296 (29%)
If the medical error caused temporary harm to my pet	1,341 (30%)
If the medical error caused long-term harm to my pet	2,523 (56%)
If further care and expense resulted from the medical error	2,287 (51%)
If the medical error was a result of willful neglect or sabotage	2,831 (63%)
Never; I do not feel medical errors should be reported to an internal committee	23 (1%)
Who is responsible for error disclosure if a trainee commits a medical error (n = 4,505)	
The person responsible for the medical error	123 (3%)
The direct supervising veterinary mentor	1,353 (30%)
Both the person responsible for the medical error AND the direct supervising veterinary mentor	2,843 (63%)
The hospital administrator/business owner	138 (3%)
Other	48 (1%)
How is your trust in your veterinarian impacted when they do a POOR job disclosing a medical error that occurred with your pet? (n = 4,432)	
Complete loss of trust	2,034 (46%)
Moderate loss of trust	1,812 (41%)
Mild loss of trust	446 (10%)
No change in trust	101 (2%)
Mild improvement in trust	12 (0%)
Moderate improvement in trust	12 (0%)
Complete improvement in trust	15 (0%)
How is your trust in your veterinarian impacted when they do a GOOD job disclosing a medical error that occurred with your pet? (n = 4,432)	
Complete loss of trust	34 (1%)
Moderate loss of trust	202 (5%)
Mild loss of trust	542 (12%)
No change in trust	646 (15%)
Mild improvement in trust	459 (10%)
Moderate improvement in trust	1,192 (27%)
Complete improvement in trust	1,357 (31%)

errors (**Figure 2**) reported were miscommunications occurring between the participant and veterinarian (18% [290 of 1,629]), that the pet owner was suspicious of medical error or neglect (11% [173 of 1,629]), and that the veterinarian did not listen to the pet owner (9% [147 of 1,629]). The most common treatment errors reported were giving the wrong treatment or no treatment administered or recommended (16% [256 of 1,629]), surgery or skills technique errors (15% [249 of 1,629]), and medication dosing errors (8% [138 of 1,629]). The

most common diagnostic errors reported were misdiagnosis (22% [353 of 1,629]) and failure to diagnose (16% [260 of 1,629]). A total of 79 people (5%) reported maintaining or increasing their trust in the veterinarian. All of these participants reported that there was clear communication from the veterinary care team about the event, and many participants (n = 38) reported that an apology was provided. Pursuit of litigation was reported by 38 participants (2%), and only one of these participants reported receiving a partial apology from the veterinary care team.

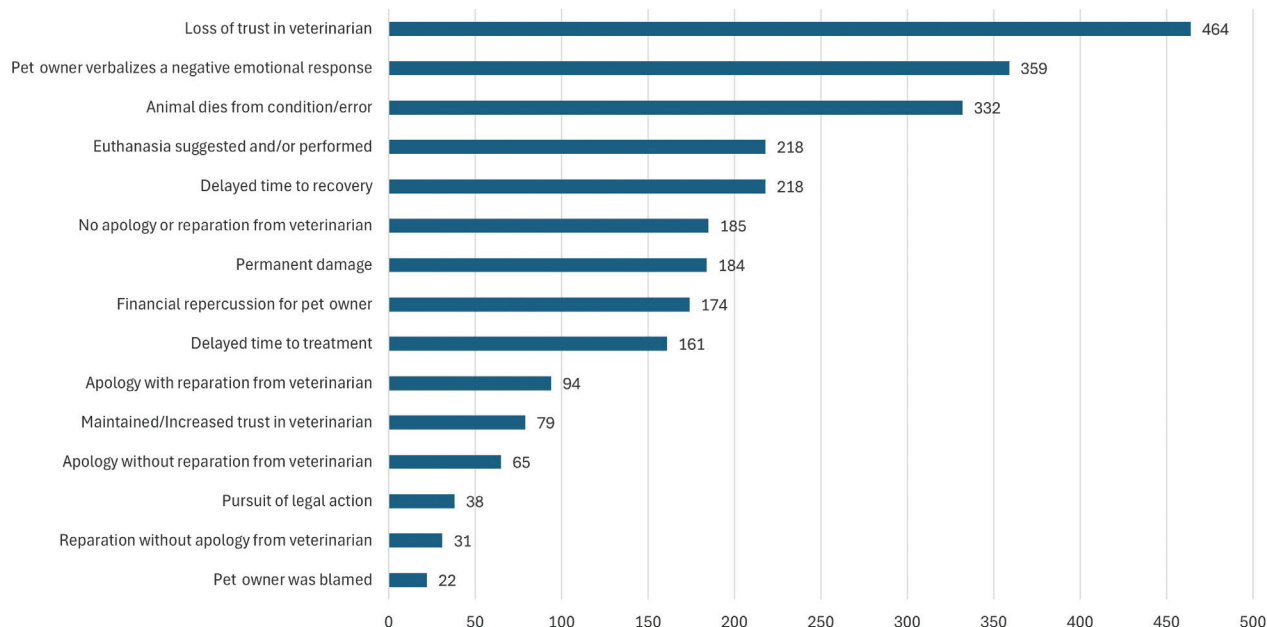


Figure 1—Number of codes for outcome of a medical error reported by 1,629 clients of veterinary teaching hospitals.

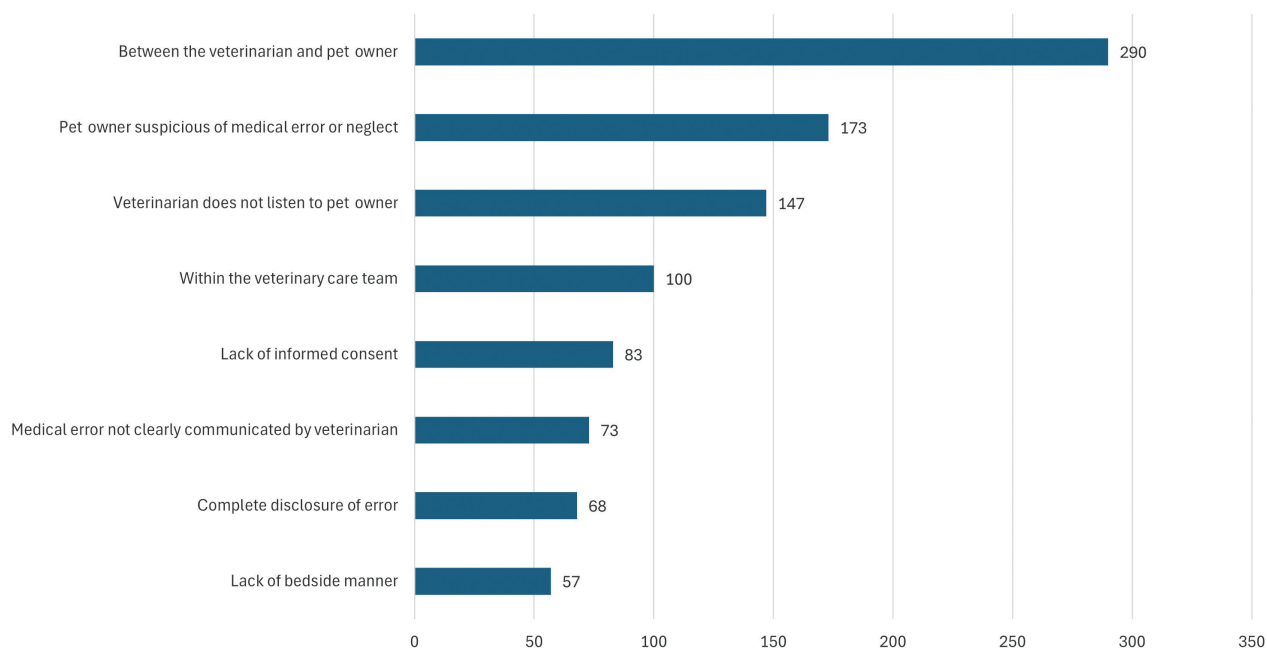


Figure 2—Number of codes for communication errors reported by 1,629 clients of veterinary teaching hospitals.

Discussion

Participant preferences about medical error disclosure for their pets found that most participants wanted to know as soon as possible after a medical error occurred and they wanted to know about all medical errors regardless of patient outcomes. The qualitative analysis of the open-response question indicated that miscommunication and not listening to the client were common communication errors. These findings are consistent with a study¹³ that used interviews to collect data about pet owners' experiences

with medical errors. This corroboration indicates that veterinarians should have clear, open communication with the client, disclose medical errors as soon as they occur, and be prepared to provide the client with extensive information about what occurred.

There was inconsistency in what pet owners believed constituted a medical error: about 15% of reported complications from unknown diagnoses or increased wait times were classified as medical errors by pet owners, while over 70% of pet owners classified drug administration to the wrong patient as a medical

error. This finding suggests that participant expectations about what constitutes a medical error differ from the medical community, further supported by the qualitative responses in which many participants opened their response with “I don’t know if this counts as a medical error, but....” Frequent and clear communication around patient care facilitates clear and consistent expectation between the veterinary care team and pet owner and promotes shared decision-making and improved acceptance of patient outcomes.^{18–20}

Participants with higher education tended to agree more often that medical error is inevitable. It is possible that individuals with higher education attainment are those in advanced and complex disciplines and therefore have seen and experienced the inevitability of errors in their own professions. Conversely, those with higher education indicated a lower rate of acceptable occurrence of medical error. This finding may reflect the fact that, while educated individuals understand it is inevitable because of human error, it should be a low occurrence owing to professional expertise and/or systems to reduce error occurrence.

Extroversion was inversely correlated with agreement that medical errors are inevitable. Considering the findings that extroverts value communication, teamwork, and proactive behavior, which may influence their belief that errors can be prevented,^{21–23} this inverse correlation could suggest that participants with a more external orientation may feel that they have more control over events and that errors can be avoided. Those with a high degree of emotional stability indicated a lower rate of acceptable occurrence of medical error. It is possible these individuals are projecting their own stability onto what they expect should happen in medical care, which they may expect would lead to a lower rate of medical errors.

There was no relationship between the pet attachment score and the 2 dependent variables analyzed in this study, suggesting that either the score is not effective at identifying attachment or attachment is not related to people’s perception about medical errors in their pets. In the authors’ experience, clients who have a close connection to their pet tend to be less understanding of medical errors when they happen, but this was not supported by the data presented here. Overall, it seems that complete and prompt disclosure of medical errors is desired independent of the strength of the human-animal bond.

In the current study, 93% of respondents indicated that the veterinarian should be responsible for communicating the medical error if it was committed by a trainee, with 63% indicating that the person responsible for committing the error, even when not the veterinarian, should also be involved in the discussion. Interestingly, research in human medicine indicates that 36% of parents report they are less likely to take legal action if a medical error involving their child is disclosed by the physician.²⁴ While this specific question was not asked in this survey, it is likely that the attending veterinarian taking responsibility for an error through direct, compassionate communication maintains or rebuilds trust and reduces this risk of litigation.

Many respondents cited that a sincere apology improved trust in their veterinary care team, and that a lack of apology contributed to their level of distrust and decision not to return to the same veterinarian. This finding is similar to those about medical error disclosure in human medicine indicating that the risk of litigation decreases when open, honest, and compassionate communication occurs.^{24–28} In a recent study²⁹ evaluating pet owners’ complaint behavior, the pet owners expressed that a lack of a sincere apology significantly contributed to their decision to file a formal complaint. Owners reported that they were more satisfied when patient outcomes were communicated with transparency and honesty, even if they were disappointed with the cause and outcome of the error.²⁹ Veterinarians who reacted with defensiveness by not admitting errors resulted in emotional distress in clients and tarnished pet owners’ loyalty to the veterinarian.¹³ In the current study, how well the veterinarian disclosed a medical error was directly related to the level of trust remaining following disclosure.

Most participants reported that medical errors in veterinary medicine should result in a professional consequence. In the aforementioned study of pet owners’ complaint behavior, primary conclusions included that pet owners are more motivated to pursue a complaint when a perceived injustice exists, and the risk of complaint may be reduced when a collaborative, owner-centered approach is taken, including honest communication, apology, financial reparation, and efforts to prevent future occurrences.²⁹ Taken together, these 2 studies support the concept that the way medical errors are communicated directly impacts formal complaint outcomes.

The limitations of this study included the voluntary nature of the survey, the fact that reminder emails were not sent, an unknown number of clients who received the email, and the inability to follow up on the qualitative data with different methods, such as focus groups or interviews, to confirm the validity of perceived medical errors in their pets. Owing to the convenience sampling of institutions and clients, very little data were obtained from clients living in the Northeastern or Midwestern US; it is possible that this population has different feelings about medical error disclosure. The demographics of respondents (largely white, female, educated, and Christian) probably reflects the demographics of people taking their pets to teaching hospitals or those that think they should respond to surveys and may not be representative of most pet owners. Although significant results were produced by the statistical models, the correlation coefficients were very low (1% to 2%), indicating that other uncaptured variables largely explain participants’ feelings about medical error inevitability and acceptable rates. Future research employing focus groups for qualitative analysis, such as an exploratory mixed-methods design alongside case-based scenario methodologies, may more precisely elucidate the specific informational needs and disclosure preferences of pet owners in the context of veterinary medical errors.

In conclusion, participants in this study wanted to know about all medical errors in their pets, wanted to be informed of those errors immediately, and indicated that communication, misdiagnosis, and treatment errors leading to poor case outcomes were consistent reasons they believed errors occur. This study was the first to evaluate pet owners' preferences in medical error disclosure and provides valuable information for veterinarians as they face these challenging conversations.

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Supplementary Materials

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