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Research Focus: Are They Thinking Differently? The Perceptions and Differences in Medical Disputes between Veterinarians and Clients

Elly Russell BA VetMB CertAVP(GSAS) MRCVS

Julie Gibson BVetMed MRCVS

Sally Everitt:

Hello, and welcome to this Research Focus podcast from RCVS Knowledge. During these podcasts, we'll be covering all aspects of veterinary clinical research, from getting involved in research in practice, to discussing published papers and evidence, with particular emphasis on how we can integrate them into our clinical practice. The paper we're going to discuss today is called 'Are They Thinking Differently? The Perceptions and Differences in Medical Disputes between Veterinarians and Clients'. This is a subject that's probably of interest to us all, but as the research was carried out in Taiwan, one of the things that we need to consider is whether the results of the study can be generalised to veterinary practice in the UK.

To discuss this paper, I'm delighted to be joined by Elly Russell and Julie Gibson. Elly worked as a GP in a small animal vet for over 15 years before undertaking a PhD at the University of Lincoln exploring the role of communication in veterinary patient safety. She's a keen advocate for the benefits of applying qualitative research to understanding many of the complex social situations relevant to how we work in practice. She now works within the VDS training team, heading up their communication, patient safety, and quality improvement training, and helping vet teams to use the VDS's VetSafe Adverse Event Reporting System.

Julie qualified from the RVC in 2005. After two years in large general practice, she undertook an equine internship at Leahurst and has been in general practice ever since. In addition, Julie is nearing completion of a PhD at the University of Nottingham. Her research explores practitioners and clients' experiences of adverse events and is developing an evidence-based framework that practices can use to support practitioners in relation to adverse event occurrences. Welcome, Elly and Julie.

Perhaps before we discuss the findings of the paper it'd be helpful if I just briefly outline the methodology that was used. This study set out to examine vets and clients' perceptions regarding risk factors and possible solutions to medical disputes in veterinary practice. Data was collected using an online survey and collected completed responses from 125 vets and 120 clients. The questionnaire was divided into three main parts: demographic data, including age, gender, and experience of medical disputes, questions relating to the perceptions of risk factors for medical disputes, and questions regarding reducing the risk and possible solutions in medical disputes.

While questionnaire studies are a good way of collecting data from a large number of people, they do have some inherent limitations. So perhaps now will be a good time to discuss some of the limitations of this type of research and alternative ways of researching the subject matter. Elly, perhaps I can bring you in first with your qualitative research background.

Elly Russell:

I think surveys are a really common way to try to gather, as you say, the perceptions or attitudes or beliefs of a relatively large number of participants. I think one of the reasons that we see them used

quite a lot is because from a quantitative research framework, more responses is better. And so that certainly is one of the potential advantages that we can be looking across a bigger group of people in terms of trying to understand their perceptions, attitudes, or beliefs. But I think what's important to think about as you've alluded to Sally is what might some of the limitations be. One of the things I noticed in this paper is it's not entirely clear where the survey questions have come from. What we have is that we've presented participants with a predetermined set of questions. So what we're looking at is what they think in relation to the particular questions that the researchers have decided to ask, and that therefore necessarily limits the amount of information and evidence that we're gathering in terms of what might some of the other perceptions or ideas or beliefs that participants have.

Sally Everitt:

Yeah, I would agree completely because they've set their parameters, they've said, "What do you think about these factors?" but they haven't really given anyone a chance to say were there other things. The other thing about qualitative/quantitative research, these questions have been asked as what we call Likert scale questions, so people are asked to grade them from a one to five, so they're really trying to turn something fairly qualitative about perceptions into a number. Now, that makes it easier to analyze in some ways, but again, you are forcing people down a particular route in how you do it. Julie, have you got any thoughts on this?

Julie Gibson:

Yeah, I mean, I think that the authors of this paper in particular have tried to explain how they've come to especially the dimensions that they have come to because they've based on a questionnaire that was previously developed, they referenced that, and then focus groups of experts. I think it would really strengthen their study to just explain, like you said, how they've come to that. Because what they're really saying in that, I think, is that this more quantitative approach has actually been borne from some qualitative work. I think that's just a really important thing to bring to this paper and understand that background work that's gone into it.

Sally Everitt:

Absolutely. I suppose the other thing that comes, well, with any research, but particularly with a survey that you've perhaps put out online is who are the people who answer your questionnaire and are they representative of a wider population. Yes, Julie.

Julie Gibson:

Yeah, I think that we have to really look at that. I think when they've talked about where they've recruited people from, there's some information about where they've recruited vets from. They've really tried hard to get a really broad demographic. They've put it out on social media channels, they've done it through various organizations, but there isn't much information about where the clients have come from. I think that's the limitation that we've experienced, probably Elly and I both in our research, of how you go about recruiting clients in a non-biased way. I think that is more difficult than as recruiting vets because it might seem like self-selecting the clients who will come forward and be involved in this type of research. So I think that is an important thing.

Elly Russell:

Yeah, so I agree with those challenges around recruitment, and as you say, Sally, who's going to choose to answer this questionnaire and take the time to do that, and what does that mean in terms of how they might particularly read and interpret those questions? One of the things with this study that I found quite interesting was I think one of the reasons that they wanted to, as you say, convert some quite qualitative concepts into something they could count by using the Likert scales was to compare veterinary and client attitudes. And then going back to those challenges that Julie mentioned about recruiting clients, we've got a really similar number of veterinary and client responses, it's 125 for vets and 120 for clients. But when we've then looked at the numbers of those

two different populations that have experienced medical disputes, almost all of the vets have, 113, but only 33 of the clients say that they've experienced medical disputes.

I think there's a number of reasons why that might have happened. It might be around that difficulty in recruiting clients. Maybe clients are not quite understanding what is meant by a medical dispute as well in the way that vets might be, or they might understand that whole area of complaints, mistakes, negligence, or misconduct differently. So yeah, it is definitely a challenge and we've got quite a significant difference, I think, in terms of the two populations-

Sally Everitt:

It makes sense.

Elly Russell:

... just in terms of what they're saying around what they've experienced in terms of medical disputes.

Sally Everitt:

Perhaps this will be a really good time just to very briefly outline your own research and the populations you were looking at there because that gives a rather different perspective.

Elly Russell:

Julie, do you want to go first?

Julie Gibson:

I can do, yeah. I've done quite a lot of qualitative work, so focus groups and interviews, which are very beneficial for understanding people's perspectives and the emotional aspects of their work, their attitudes. You can get some really in-depth understandings by doing that. I think that they're often grouped together, but you can get different things from those. Focus groups are quite interactive. People can bounce off each other and you really get active discussions going and use that to our advantage and understanding what's going on.

I've been researching people's experiences of been involved in adverse events, and one thing that we were finding through the focus groups was that people were sometimes reluctant to voice certain things within that forum. I actually did quite a number of individual interviews as well, so that removes that limitation. Someone can have a one-to-one conversation about it without that concern about what someone else is thinking. I think there are lots of different ways of doing these things.

I think another aspect of bringing in the kind of work that I've been doing is more what's termed naturalistic methods as well. Just no research or presence at all, and you're looking at data that's already there in documents. And also, I've looked at some social media content as well. That's quite interesting because that is just done without the person that's being researched knowing that there's a researcher. So it is completely unfiltered information. I think Elly has done some similar things with documents as well. That can be qualitative or it can be quantitative. There are really, like I say, advantages of doing that too.

Sally Everitt:

I think the social media bit is quite interesting because probably many people in practice have been on the receiving end of comments on social media that they've found difficult to deal with. We'll perhaps come back to that later, but I think that's a really interesting subset. Elly, you've also looked at adverse events from a slightly different perspective.

Elly Russell:

My PhD set out to understand the role of communication in veterinary patient safety. And yes, similarly to Julie, used a range of qualitative techniques. I also did some survey-based work, and I did some quantification of textual data as well. So I combined a little bit of quantitative approaches alongside the qualitative research that I was doing. I mean, I think one of the things that we often do is think of qualitative research as just one thing, and it is the opposite of quantitative, if you like. But actually, it's a really, really wide range of approaches and techniques. Similarly to Julie, I've looked at existing textual data. So I analyzed case records associated with litigation cases handled by the VDS, and I also used both focus groups and interviews and often within a study combined focus groups and interviews.

I think going back to your point about the social media, I think what's really important to understand is that when we've got a kind of quantitative research hat on, if you like, and thinking about this survey approach, we're assuming a relatively unproblematic relationship between what people say and some kind of truth out there in the world. Actually, with qualitative research, what we're really recognizing is that what people will say, what people will present as the meaning that they make from the world will be really impacted by the way in which you have those conversations with them. Whether that's looking at textual data, I think Julie's work, looking at what people say within social media conversations is fascinating. As Julie's alluded to, what focus groups do is allow us to actually look at social interaction. We are not just doing a group interview, lots of interviews at once, we're actually looking at how does what one person say impact the way that somebody else might respond. So we're starting to dig into some of those social structures that are really important particularly in the context of things like complaints, how we deliver care in practice. It is a social exercise, so digging into that I think is really, really important.

Sally Everitt:

Perhaps one thing we could unpick a little bit at this point, you've both been talking about adverse events and patient safety, which implies that there may be something that's actually gone wrong. Objectively we can talk about that. I think probably some people will feel in practice that not all complaints are when they perceive something as having gone wrong. So there's this distinction between where we've delivered what we think is the best care but we've still got a complaint, or where we know something has gone wrong and that's led to a complaint or a dispute. I wonder if we can unpick that a little bit. Who'd like to go.

Elly Russell:

I can start off very briefly just with an example from one study from my research, and then I'm sure Julie will pick up on this. But in my first study, I was looking, as I've alluded to already, at the role that communication played in litigation cases. I think one concept which resonated for me as a practitioner and I think most people working in practice would recognize is that we can have a complaint from a client when we've delivered care exactly in the way that we've intended to. So there might be that we haven't met their expectations or they're unhappy with the service that we've delivered, but in terms of what we have planned and set out to do as a practitioner, we have done that. That's quite different from, and there's all kinds of words, something's gone wrong, it's an incident, it's a mistake, it's an error, it's an adverse event, there's so many different words we can use, but essentially care has not been delivered in the way that we intended it to be delivered.

And again, what my research showed was that communication plays a role in both of those things. So communication can increase the likelihood that a client will complain. Communication, particularly within the team, when that's problematic may make it more likely that we don't deliver care in the way that we intended and we have an incident or an error, if you want to use that word. We can do something, care cannot go the way we intended, and a client may not complain about that at all. Similarly, how we communicate around a complaint or an unintended outcome has a really big impact on the client.

Sally Everitt:

Julie, did you want to come in there at all?

Julie Gibson:

Yeah, I mean just really, really briefly on the terminology. I think we can get really hung up on what we call these things, and I certainly have, and I'm sure Elly has as well, just going through a PhD, trying to get your words right. I think adverse event is a great term for it because it just encompasses lots of different things, error, actual mistake that's happened, it can just be something that we deem to be an acceptable complication, but that still comes under that umbrella, so that's the word that I tend to use, adverse event.

My work really was quite focused on how these adverse events impact vets mainly, vets and nurses, veterinary practitioners, people doing clinical work. I would say in terms of complaints, this emotional theme that came through with the qualitative work of this impact of adverse events were huge. And then this other theme of experiencing this client complaint ran alongside that. The conclusion that we really made was that when a complaint is attached to an adverse event, so something that really has gone wrong-

as it were, the emotional impact for the veterinary practitioner is often a lot larger because they're judging themselves already. Whereas, those complaints that are driven by other factors and by what the vet perceives to be different motive from the client are extremely pesky and can really bother the vet or nurse emotionally. But certainly when it is underpinned by a feeling that they have actually done something that's not optimal, then it is a lot worse for the vet definitely.

Sally Everitt:

I think that takes us quite nicely back to the paper and the findings of this paper, which they looked at under two broad categories. The first of those was, what were the perceptions of risks for medical disputes? What were the standout findings for you in this area? Who'd like to take that one first?

Elly Russell:

I'm happy to start with that. I mean, I think what the authors really tried to pull out here was a significant difference between vets and clients, where what they were suggesting was that clients viewed medical skills, so I guess this does link to what Julie's just been saying, a kind of problem around actually how the vet has delivered that care and, maybe if you like, a gap or deficit in their medical knowledge that clients were scoring that as a risk factor for medical disputes. Whereas, what they're trying to pull out from vets particularly, and I wasn't sure that they had big enough numbers to do this, but I think they were trying to draw a bit of a distinction between more experienced vets and less experienced vets and highlighting that more experienced vets put more emphasis on the role of what their client's perspective was, the communication and empathy with the client.

Sally Everitt:

I must admit, when reading this paper, I wasn't entirely sure or whether they were conflating the idea of experience in terms of medical experience with just being in practice longer and therefore more likely to have experienced medical disputes and complaints in that time. Obviously, the two go alongside each other to some extent, but I think they are actually quite different things, you don't have to have one to have the other, but I think that was a little bit conflated in their reporting.

The other thing I suppose that also brings to bear is whether clients are just latching onto medical issues rather than communication because it's perhaps more socially acceptable, there's no criticism of them involved in that. It puts the responsibility firmly in the veterinary practice.

Whether it may or may not be, that's not a judgment, but from their point of view, there's a slight social desirability emphasis coming out in their responses.

Julie Gibson:

Absolutely, and I think that that is, again, a limitation of this study because of the way that questions have been asked and what questions have been asked because they've concluded that vets placed more emphasis on the attitudes of the clients during the interactions. Well, it's very unlikely that a client is going to say that it's their attitude that has driven it, so that's a real limitation of that question, I think.

I think in terms of them making conclusions about the perceptions of the risk factors here, I agree with you, Sally, that some of the claims that they're making conflated. Actually, when you do look at it, both complaint management and medical expenses were actually within the top three overall for vets and clients. So although they're saying that there are marked differences between them, actually the top three things, two of them are the same, and it comes down to the way it's managed and expenses to some degree.

Sally Everitt:

I think the other point to note is they converted all these into numerical scores, but actually all of their points scored very highly, sort of four or above. There wasn't, as you say, a great deal of difference. It might've been statistically significant, but everyone was saying these were important points. It was just slightly different there. What do you think would be similarities or differences in the UK situation? Do you think we'd get very different results if we did a similar study here?

Elly Russell:

Yeah, I'm happy to pick up on that. I mean, I suspect probably not. Again, going back to Julie's point on social desirability and responses for clients, I agree that I think it'd be unlikely that clients in the UK would be any more inclined to say that the root cause of a medical dispute is their attitude. So I think that would be similar. And certainly from my experience, as you're saying in terms of that, what's floating up to the top is around is how these complaints are resolved. I think that we definitely know that that has a really big impact here in the UK, that if we manage those complaints effectively, particularly in terms of the way that we communicate as a team early on in the process, then it's much less likely that that's going to escalate into a medical dispute. So I think that the complaints management and financial resolution scoring in the top three, I think that would be similar. Julie, I don't know whether you disagree or would think that's the case.

Julie Gibson:

No, I completely agree. I think you probably would get very similar responses to this, for sure. I think the difficulty is that we could collect the data on this, we don’t have that... I know we’re going to talk about this a bit later on, but we don’t have a huge amount of research in this area. That’s certainly developing at the moment. But even if we did have this evidence, one of the most difficult things, of course, is coming up with the solutions too, because there’s no easy fix to it. But I know we are going to come back to that.

Sally Everitt:

Just before we move on to the solutions, do you think there were any important risk factors that they didn't ask about in this study that perhaps was an omission in their questions? Yes, Elly.

Elly Russell:

They did have an open response question around this. I can't 100% remember hand on heart at the moment whether that was focused more on the risk factors or the solutions. It was quite a low number of respondents that answered. So I don't want to overly emphasize this, but one of the things that came through in that was actually around more, I would say, the social context around

what's happening in practice. Some of the vets said, "Well, look, we don't have time to have conversations where we are more likely to have informed consent or shared decision-making." And looking at that wider, what I would say, the practice system, so how are things set up in terms of consult length and organization, those are the things that are quite hard or I think have been potentially missed in these domains. Even just in that really small bit of free text response, we're starting to hear those vet participants talk about the real world that they're working in of, "Yes, of course we can talk about whether or not I've understood my client's perspective, but am I being given long enough to do that in the practice system that I'm working in?" So I would say those wider systems issues are potentially missing from some of these risk factors.

Sally Everitt:

I can imagine that most people working in practice at the moment would be able to empathize with that approach. I'm sure it's an issue for many people.

Elly Russell:

Yeah.

Sally Everitt:

Julie, was there anything you wanted to add before we look at the responses?

Julie Gibson:

No, completely agree with Elly. That free text response section that Elly just mentioned in the paper, you're right, there were only three vets and three clients or six vets and six clients or something that answered it, so it was very small numbers, but this idea of the shared decision making was really big. But also an area that I'm really quite interested in, which really is incorporated in that time element, is from the client's point of view having that space to actually voice their concerns in a constructive way as well and creating those channels for that to happen and them knowing how to do that in a constructive way, because I think a lot of dissatisfaction comes from them just not saying anything and then it escalating and snowballing. If it could just be discussed early on, we'd maybe prevent that.

Sally Everitt:

Well, that leads us quite onto the second part of the results section which looked at the ways of reducing risks and possible solutions. We've already touched on that a little bit in terms of communication and shared decision-making. What, again, were the standout findings in this section of the paper for you? Elly.

Elly Russell:

One of the things that stood out for me was that they had four dimensions of possible solutions. One was attitudes of stakeholders during the interaction, medical expenses, so that financial compensation bit, complaints management, so helping people to manage the complaints better. And then they had this quite broad category of education and training. They split that into three sections where they were actually talking quite a bit about the format of that training as much as the content of that training. Looking at the responses in terms of which of those dimensions got scored and appeared, really none of that kind of education and training dimension appeared at all. So it was all those other three. But then again, touching back to those open text responses, one of the things that came up there was, again, communication skills training and support around that. So yeah, I found that interesting that it didn't come up at all in terms of the Likert responses and survey, but again, popped up when you had that more open response way of gathering thoughts.

Sally Everitt:

I did wonder if that might've been partly because the people responding to the questions didn't understand the question in the same way that the people asking the question had intended it.

Because yes, I suppose, do you think your vet needs more training, perhaps if it had been phrased slightly differently about improving communication or, "Would you want to be more involved in shared decision-making? Does everyone need more training in this?" you might've got slightly different responses to the questions.

Elly Russell:

Yeah, I would agree with that. I think there's quite a lot of overlap for me in terms of those questions in those different domains, so would you like more support on handling customer complaints in the complaint management bit one, and would you like courses on customer complaints in the education and training.

Sally Everitt:

Julie, what were your standout bits on possible solutions?

Julie Gibson:

Yeah, I always feel like I'm a little bit on the reactive end when these happen just by the very nature of my research. But I think this point of urging clients to articulate their concerns at an early stage, like I said a few minutes ago, I think that that is just so important and could reduce a lot of the unnecessary escalation of concern, the unnecessary emotional impacts that it can have on the vets, on the nurses, also on the clients. No one wants to be in that situation, and it turning into something quite adversarial is not nice for anybody.

And also, if we have those channels in place, then it's much less likely that we get on those social media channels and use that as an outlet. I thought that was a really important thing that they brought forward, but that relies on us not being defensive in our actions and being open to that, which is a tricky one. In the free text response, I was really intrigued, and again, it was small numbers, that they'd had this suggestion of installing surveillance systems into clinics. I don't really have a strong opinion on that either way, but they've suggested that and it's not really been brought forward, so maybe we could just touch on that a little bit.

Sally Everitt:

Yes, I suppose this is a record of what was being discussed so that they felt that they'd got an objective record of what had been said, which I suppose it can be useful, but I do wonder if sometimes the objective record of what has been said is not always the heart of what is the complaint. Because it's the emotions and the feelings and the feeling heard, and that might not come over on a video recording. Yes, Elly.

Elly Russell:

Yeah, I mean, I would totally agree with that. One of the things that I did in my research, I mean Julie talked about this importance of defining what we mean in terms of the terms that we use, and I looked quite a lot at what do we actually mean by communication and what theory of communication are we often implicitly using when we do research around communication? And just as you said, Sally, very often we might be thinking about communication as information transfer, so I told them this thing. In that context, as you say, a surveillance video where you can objectively say, "I gave them that information." And similarly, if we think about informed consent forms, which came up a little bit in this paper, "Look, they've signed and said that they've understood this." That kind of information exchange understanding of what communication is very different from communication as a social activity that creates shared understanding and shared meaning between two participants.

I totally agree with you that unless you put that lens on it, you can very easily think that something like a completed consent form or a video of an interaction tells you everything that you need to

know about the communication. But when you switch to thinking, "Actually, how has this created, or very often not created, shared understanding between those two participants," it's not potentially going to get you very far.

Sally Everitt:

No. So we've talked about what the risk factors are and talked a bit about reducing the risks, but even with all of those things in place, there will be adverse events, potential disputes. What are clients looking for if we get to that stage? I think that's an important thing to unpick a bit, both from this research and from more general understanding. Julie?

Julie Gibson:

Yeah, I mean, I think first of all, to point out that we haven't actually got research on this at the moment. There is some in the pipeline, so hopefully we will have some research soon to put some meat on the bones around this. But there is some good evidence in human healthcare that a lot of the time people just actually want acknowledgement that something has gone wrong. They want acknowledgement that they are affected by it as well. And then there are obviously the other things that they want as compensation of some kind.

But one of the main things that really comes through from practitioners and from people on the receiving end of care that hasn't been optimal, let's say an adverse event, is that they just don't want it to happen again to anyone. So they want evidence that they've been heard and something is being done about it to prevent it.

Julie Gibson:

I think those are the main things that are happening for people. But yeah, we don't have that. I think it's quite an interesting thing to explore in the vet profession as well because we can learn so much from human healthcare. But we do have a different model in terms of the legal status of animals and how that rolls out in practice and our commercial interests are different, although it is quite an uncomfortable thing to talk about, not just from our point of view, but how clients view an animal in their possession or the ownership of their animal. It's really, really complex is all that. So it will be really fascinating to find out if there are similarities and differences between us and human healthcare.

Sally Everitt:

My experience would be that clients can be very variable in this. You can't tell by looking at them. I was talking to a vet student the other day about sometimes some quite burly tattooed men coming in with their pet reptile and being absolutely devoted to it. You might not immediately just make that connection. But yeah, you can't know what an animal means to somebody just by looking. You have got to have that communication and try and work things out. Elly, anything else on what people are looking for?

Elly Russell:

I mean, I was going to add that, and this is not research that I've published but data that I looked at, the way that clients talked about the impact of an adverse event was really emotive. And Sally, as you say, I think that that is one of the challenges is that we've all got very different, potentially, values that we attach to animals, and they mean different things to us in our lives. But certainly for a lot of clients in the data I was looking at, they talked very strongly about the emotional impact of these adverse events on themselves. Julie's work really beautifully also uncovers that emotional impact on vets and veterinary teams, which is also super important.

I think that legal status of animals, I think clients are often expecting some financial recompense for that emotional trauma, and that's not what's going to happen. And similarly, the emotional

impact on practitioners, I'm not sure that we deal with that fantastically well. I'm quite interested in an area of work in healthcare where they're looking at or they talk about restorative approaches to adverse events. I would completely agree that what we know matters for families after adverse events, and what I think we want to achieve after adverse events, is learning and looking at preventing them. But there is also this side of things where we have to accept that sometimes things will go wrong and harm will happen. And so then actually what are the restorative responses that both clients and practitioners need?

That isn't to say, "No, no, no, we don't learn from events and we don't try and prevent them," but I do worry sometimes that if our focus is solely on prevention, we actually may not give enough attention to responding effectively when it has happened. A lot of that is around, I think, restoring relationships and managing the emotional impact for everybody involved, clients and teams and practitioners.

Julie Gibson:

Yeah, I agree. I think in this paper they do tease that out a little bit in there. I think it's in the discussion when they talk about third party involvement as well. I think that would be a really interesting area of future work as well. I think with the growth of our veterinary organizations in terms of size and complexity, what is the role of that third party when these adverse events happen? So I'm talking about things like mediation. How necessary is that, and will it become more necessary due to this growth and this change in structure that we have? I'm not sure what the answer to that is, but it's an interesting question, isn't it?

Sally Everitt:

Perhaps I can finish by asking you what else you think we need in terms of research in this area. I'm sure there's a lot, but perhaps you could pick out just one or two.

Elly Russell:

For me, one of the things that would be a really lovely compliment to this paper is a qualitative exploration of clients' experiences and vets' experiences. I think it'd be really fantastic going back to those points that we've made about social interaction and focus groups. I don't know how practical or possible it would be, but it would be really nice to look at actually a focus group with clients and practitioners together. I think the understanding that you would generate by looking at how they interact in discussing the impact would be really, really interesting.

I mean, that actually slightly touches a little bit on what we've been talking about in terms of response to incidents. I'm quite interested in action research approaches and not seeing researchers simply... Sorry, I shouldn't say simply... but not just seeing researchers gathering evidence and information about the world, about our veterinary practices, but also as an intervention to produce change.

I think that practice teams are really under pressure and time always comes up as a thing that we don't have, so I also think there's a moral obligation to some extent to make sure that the time that participants are investing in research, actually, if that's got the potential to produce change for those participants too, I think that's really great. I think my two things would be to think about this through a action research lens and definitely to look at a qualitative exploration of client and vet experiences, which Julie, I think probably sits very nicely in terms of what you have been doing.

Julie Gibson:

No, I completely agree with everything you've said and probably don't have a huge amount to add. Just to back that I think that we're often a little bit perhaps afraid of involving clients in our research of our profession, but I think it's very necessary. We definitely need that lens on it to better understand what we need and how to improve things for ourselves from within as well. So completely agree there, Elly, with the action research approach and involving people in research

not just for change, but as an educational activity as well. I think these podcasts are great because hopefully people will listen and think, "That is something that I could get involved with."

I know before doing a PhD I was in practice for a long time and I didn't think that research was something for me, but I think that if you just dip your toe in the water and get involved in something, you would see that it's actually interesting. You can learn a lot. The more you do of it, the more you recognize its value. Don't be afraid to get involved with these projects if you want to.

Sally Everitt:

Brilliant. Thank you. That was a really interesting discussion, and I'm sure it's given our listeners not only a much greater understanding of the subject but also how we need to consider research using a number of different approaches, especially when considering complex issues. If anyone would like further details of the study, we'll provide links to the published paper on the website along with links to Elly and Julie's papers.

If you have enjoyed this podcast and would like to find out more about veterinary clinical research and evidence in practice, please have a look at the evidence and library sections on our website. For more podcasts from RCVS Knowledge, you can find us on your favorite podcast platform.

Reference for paper

Chen, Z.F. et al (2023) Are They Thinking Differently? The Perceptions and Differences in Medical Disputes between Veterinarians and Clients. *Veterinary Sciences*, 10 (5), p.367. https://doi.org/10.3390/vetsci10050367