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June 20, 2007

Ms. Teresa Lazo
State Board of Veterinary Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Ref: 16A-5721

Dear Teresa:

The leaders and members of the Pennsylvania Veterinary Medical Association appreciate the State Board of Veterinary Medicine's effort to update, clarify, and improve the Rules and Regulations of the PA Veterinary Practice Act pertaining to professional conduct. Since our original comments made during the public comment period, a copy of which is attached, 2 active members of our Association have raised some major new concerns that should be seriously considered by the State Board of Veterinary Medicine prior to moving to the next steps in the regulatory process. These concerns have been articulated by a veterinarian and lawyer who is an active member of our Association. They also represent the position that is now being taken by PVMA.

It has always been our understanding that the Rules and Regulations of the Board were intended to interpret the language of the Practice Act. When one compares the PA Rules of Professional Conduct with those from states such as Massachusetts and Texas, it becomes clear that the PA Rules are more closely related to the AVMA Principles of Veterinary Medical Ethics than they are to rules of conduct adopted in other states.

In numerous situations the proposed changes to the existing Rules of Professional Conduct attempt to take ethical principles and transform them into legal mandates. In doing so, these alterations truly complicate matters and muddy the waters. What happens then is that many of the proposed rules are vulnerable to challenges that they are "void for vagueness." As such, instead of clarifying the existing rules and attempting to make them more enforceable by replacing "should" with "shall," our fear is that this effort will make many of the changes unenforceable.

While the MA and TX Veterinary Boards have chosen to adopt Rules of Professional Conduct, other states have chosen to define "Unprofessional Conduct." Examples include sets of rules from Minnesota, Virginia, and New York. A close look at each of these shows Rules with far better clarity and, thus, much higher enforceability than the PA draft. It also shows that none of those sets of Rules attempted to codify the AVMA Principles of Veterinary Medical Ethics, as did the PA Board when the existing rules were first adopted.

We apologize that these comments were not submitted during the open comment period that culminated with the Board's public hearing. However, they are so important that it is our opinion that they must be heard before the current effort to change the Rules of Professional Conduct proceeds.

I will go through each section where the proposed changes exist and comment on them as I go. What you see highlighted in yellow indicates the critical verbiage in each section upon which our comments are focused.

1. **§ 31.21 Rules of Professional Conduct for Veterinarians - Principle § 1 (d)** *Veterinarians shall safeguard the public and the veterinary profession against veterinarians deficient in professional competence or ethical conduct as described in this chapter. When a veterinarian knows or has reason to believe that a professional colleague's actions demonstrate professional incompetence, neglect, or animal abuse, a veterinarian should bring the behavior to the attention of the colleague and, if the matter is not resolved, should bring the matter to the attention of the Board. If the conduct is grossly incompetent, or involves neglect or animal abuse, the veterinarian shall bring the matter to the attention of the Board by filing a complaint with the Bureau of Professional and Occupational Affairs*

   - § 21 (4) of the Veterinary Medicine Practice Act sets forth the following as grounds for disciplinary proceedings: incompetence, gross negligence or other malpractice, or the departure from, or failure to conform to, the standards of acceptable and prevailing veterinary medical practice.
   - Is there a reason the language in the disciplinary section of the Practice Act is so different than the language in this section of the proposed Rules?
   - In other words, is there a reason why the proposed Rules only require that licensees report the suspected incompetence, neglect or animal abuse of a colleague?
   - If, in the future, licenses "shall" report actions that demonstrate professional incompetence, why shouldn't they also be required to report suspected gross negligence of other malpractice?
   - Would it not make more sense if the language of the § 21 (4) of the Practice Act and the Rules paralleled each other?
   - Is this an intentional disparity between these two documents or simply an oversight?
   - What does the word "neglect" mean?
   - Does this word in this context mean neglect of a patient in an animal cruelty context or neglect in a medical care setting?
   - Is there a difference between neglecting a patient and neglecting a client?

   - Proposed change: Completely rethink this Rule and decide how to draft a version that would interpret and/or clarify the responsibility to report suspected misconduct of a colleague so that it interprets, supplements or complements § 21 (4) of the Practice Act.

2. **Principle 3:** *A veterinarian who engages in unprofessional or immoral conduct is subject to disciplinary action…*

   - Several examples are provided in the Board's background material but there is no definition of words "immoral conduct."
   - Immoral according to whom and using what standard?
   - The example in the Board's Regulatory Analysis Form concerning the fraudulent issuance of a health certificate is clearly immoral, unethical, and illegal conduct. It is also linked to one's practice of veterinary medicine. However, if a veterinarian carried on an extramarital affair with his or her receptionist, would that be immoral conduct that is subject to disciplinary action? As long as it did not affect the licensee's practice of veterinary medicine, there is no harm to any consumer of veterinary services. Should the Board be able to discipline a licensee for this type of immoral conduct?
   - Would it be immoral to sell prescription medications, the dates of which indicated they were expired? It seems that here the morality of the action is not nearly as important as the potential harm to patients. Moreover, are there any statutes, rules or regulations in PA that make the sale of outdated drugs illegal? If it is not illegal, is it immoral – especially when licensees legitimately believe that such drugs will be effective for at least a week, month or even a year after the expiration date?
   - What if a licensee was audited by the IRS and determined to have failed to report $50,000 of practice income? That could be proven to be conduct that is illegal but is it also immoral to have done so, especially if the $50,000 was given to a religious or charitable organization. Is it more likely to be immoral conduct if this money was used to pay off a gambling debt? Should the "immorality of the conduct" vary depending on the action taken with the immoral conduct under scrutiny?

- If this Rule is to include "immoral conduct," should it at least be confined to "immoral conduct related to the practice of veterinary medicine?"

- Proposed change: Define unprofessional conduct more clearly and omit the word "immoral" or redraft the *rules of professional conduct* to reflect the methods used in states such as Virginia or Texas.

3. **Principle 3:** f) *Abusing a client, former client, colleague, associate or employee, including verbal abuse, harassment, or intimidation.*

- Are there differences in the conduct or standards that would be disciplined for abusing a colleague vs. an associate vs. an employee?
- Because the acts "included" here all pertain to mental abuse, is the verbiage in this section intended to exclude physical abuse? Just mental abuse? Either of these? Both physical and mental?
- To what source will the Board look as it tries to determine what type of abuse must exist for a disciplinary action?
- Absent a definition, does one use the Webster definition? Another definition?

- Proposed change: Physically abusing or threatening to abuse clients or repeated incidents of mental abuse of clients, former clients, colleagues, associates or employees including, by example, forms of harassment or intimidation.

4. **Principle 3:** g) *Performing a veterinary medical act incompetently or performing a veterinary medical act that the licensee knows or has reason to know he is not competent to perform.*

- **The first issue** to note here is that this Principle is in conflict with § 21 (4) of the Veterinary Medicine Practice Act which, again, includes *gross negligence or other malpractice, or the departure from, or failure to conform to, the standards of acceptable and prevailing veterinary medical practice.*.
  - Is this conflict intentional?
- Since standards of care are not generally available in veterinary medicine, the assumption here is that the testimony of experts would be required to define incompetence. However, how does the Board differentiate the reporting of collegial incompetence from
  - gross negligence or
  - Other malpractice.
- § 21 (11) of the Practice Act also allows for disciplinary action for "departures from or [the] failure to conform to the standards of acceptable and prevailing veterinary medical practice, in which case actual injury need not be established." This delineation of only one of the elements of the four required to prove professional negligence, has always posed problems. To succeed with liability for professional negligence or malpractice, all of the following must be proven, i.e., that
  1. a duty existed to the client who is challenging the care,
  2. the practice of veterinary medicine by the licensee was below the standard of care,
  3. the substandard medical service was the proximate cause of the injury, and
  4. actual injury or damages can be established.
- To succeed with a cause of action for discipline under the Practice Act, the Board only needs to prove that a licensee's conduct failed to confirm to one of these three elements, i.e., the standards of prevailing medical practice.
- Incompetence is much more difficult to prove than "other malpractice." Thus, if the Practice Act § 21 (11) provides for disciplinary action for conduct that is less stringent than incompetence, why does this Rule only require the reporting of incompetence? If anything, the inclusion of this Rule seems to confuse the issue and does nothing to clarify§ 21 (11).
- **The second issue** with this language is quite different. It surfaces in the portion of this Rule related to "*performing a veterinary medical act that the licensee knows or has reason to know he is not competent to perform*".
- If a licensee offers and/or recommends that a client seek the services of a referral specialist but the client declines because of

- a shortage or the absence of money,
- the unavailability of a vehicle,
- inadequate time to transport the patient to another facility, or
- a bad experience with or lack of confidence in such referral specialist or practice,

should primary care doctors forever be prohibited from proceeding with care simply because *they know or have reason to know they were not competent to perform* the procedure?

- Why couldn't or shouldn't a licensee offer a **written disclosure** of the absence of complete competency and obtain a signature from a client requesting that the doctor proceed with care anyway?
- Isn't the key issue here one of disclosure?
- We are all taught that we are engaged in the **"practice of veterinary medicine."** Because of that, it is ingrained in us that we are always supposed to be learning to become more competent. Moreover, since there are so many different ways to practice quality medicine and the procedures that are in vogue are constantly changing, this process is ever ongoing.
- How will young doctors ever learn to become competent if every time they know they haven't done a procedure but proceed anyway, they risk disciplinary action?
- By including this verbiage, isn't the Board moving from the way services have been provided on a historical basis to a new and much more restricted basis?
- Does the Board realize that by imposing this Rule, it remarkably changes the standard of care that exists in the veterinary profession today?
- **The third key problem** with this proposed change is that contrary to question 14 of the Board's Regulatory Analysis Form, it appears that this change **will have a chilling effect on the availability of veterinary care** for animal patients in PA.
- Contrary to the position taken by the Board in its response to question 14 on the Regulatory Analysis Form, it is the PVMA's position that **many patients will receive inferior or no care or have to be euthanized if this Rule is adopted.**
- **The fourth problem,** again not recognized in the Regulatory Analysis Form is the fact that the inclusion of this language is will likely will have **a serious negative financial** impact on the profession. Why? Because licensees will
  - be reluctant to take on cases where, using perfect hindsight, a Board has the power to "second guess" their level of competence and, thus, their decision to proceed with care and
  - fear tackling procedures where they know they lack competency.
- It seems the entire issue related to "*performing a veterinary medical act that the licensee knows or has reason to know he is not competent to perform* should be left to proof of negligence or a failure to meet the prevailing standard of care and not left to an entirely different standard.

- Proposed change:
  - Leave this section to "should" instead of "shall."
  - Allow licensees to proceed with care in situations where competency questions could be raised but only after providing a written disclosure of the option for a referral and obtaining the written consent of the client rejecting such referral and consenting to the attending veterinarian's further care.

5. **Principle 3:** j) *Inhumanely treating or abusing any animal, whether or not the animal is a patient.*

- What is the definition of *inhumane treatment* under the Veterinary Practice Act and its Rules?
- Does inhumane treatment include neglect?
- What is the definition the Board plans to use for *abusing animals*?
- How will the Board differentiate these two? Does abuse require a malicious or intentional act whereas inhumane treatment includes mere passive neglect?
- The interpretation of these words varies among practitioners and the general public. Some people (and veterinarians) consider cropping tails, docking ears, and declawing cats to be inhumane actions? Will this Rule include those procedures as prohibited actions?

- Will the Board look to the animal cruelty criminal statutes of PA to determine what constitutes inhumane treatment or abuse?
- Will the Board require a conviction of the crime of animal cruelty in a criminal court to enforce this as a disciplinary action?
- Should the Board adopt its own definition of these terms before making it a rule?
- If not, should the Rule at least refer to another PA law as the source of its definition for these terms?
- Will the Board conduct its own full hearing of the facts in these cases and make such a determination rather than rely on the criminal justice system to do so?
- Should this Rule be expanded to include that veterinarians are mandated to report suspected animal cruelty, as is the case in approximately ten other states?

- Proposed change: Link this Rule to definitions of inhumane treatment or animal cruelty found in the PA penal code. Mandate the reporting of suspected animal cruelty and provide immunity from civil or criminal actions for doing so, as is currently the trend in the nation.

6. Principle 7: Veterinarian/client/patient relationships

1) *During a veterinarian's regular business hours, a veterinarian shall not refuse to treat an animal which is in a life-threatening condition at the time the animal is physically presented to the veterinarian at the veterinarian's facility. The minimum veterinary medical services that must be provided include triage of the presenting emergency and other patients present at the facility, assessment of the animal's condition, evaluation of the animal's prognosis, and provision of basic life support or euthanasia, as medically appropriate. A veterinarian may provide care for an animal under this paragraph notwithstanding the lack of a veterinarian/client/patient relationship and if the owner is unknown or cannot be reached, without consent of the owner.*

- All of the prior changes in the Rules create problems with clarity and intent. Some have serious economic consequences while others do not. However, all of them pale when compared with the changes that are sought in this Rule.
- **First of all**, what constitutes regular business hours?
- It appears likely that emergency clinics that are open 24/7/365 will be required to see and treat a disproportionate volume of patients where owners have no money. In our experience, the number of such patients presented in life-threatening condition where their owners are unable to pay greatly exceeds the suggested 1-2 cases per year mentioned in the Board's analysis of the economic impact of such a Rule.
- **Secondly,** this section says that veterinarians *shall not refuse to treat animals that are in a life-threatening condition at the time they are physically presented to the veterinarian at the veterinarian's facility.*
    - Does this apply to all animals of all species brought to a veterinary facility by a humane officer?
        - a police officer?
        - a good Samaritan?
    - Does it apply to wildlife?
    - Does it apply to neighbors who are filling in for an owner?
- **Thirdly,** the Rule as drafted says, "*minimum veterinary medical services that must be provided include triage of the presenting emergency and other patients present at the facility, assessment of the animal's condition, evaluation of the animal's prognosis, and provision of basic life support or euthanasia...*"
- With respect to the provision of basic life support, what types of treatments would be required to fulfill this mandate?
- When does basic life support morph into advanced or elective procedures?
- What if basic care is initiated but then clients refuse to allow euthanasia?
    - At what point can licensees refuse to provide ongoing basic life support?
        - A few hours, a day, two days, a week?
    - What if basic life support has been provided but the patient is suffering? At what point can a veterinarian euthanize the patient to end the suffering?

- If no owner can be located, can veterinarians euthanize patients that are stable after they have provided the initial basic life support?
- If an owner shows up, must veterinarians release patients that have received basic life support without any payment by clients? Only after the owners have made arrangements to pay? Even if the patients are likely to suffer and die within a short time period after their release?

- **Fourthly,** the difference between *basic life support* will vary remarkably from one primary care facility to another and from primary care facilities to secondary care centers.
  - Will emergency clinics and critical care centers be held to a higher standard of care than primary care facilities?
- **Fifthly,** and perhaps the biggest problem with this new language is that no system is in place to compensate veterinarians for services provided by this mandate. Thus, the costs for care will come either at the expense of profits for the practice or in the form of higher costs for all the clients who have the financial wherewithal to pay for veterinary services.
- Paragraph 17 of the Board's Regulatory Analysis Form estimates that practices will see 1-2 emergency cases per year where clients lack available funds for care. The experience of PVMA members is quite to the contrary. In some socioeconomic sectors of PA, this is a daily occurrence; in others it is a weekly one; in all practices, it is probably a monthly issue, not a yearly one. Multiply the Board members' experiences of $50 to $500/patient and the profession is looking at a way to finance millions of dollars of basic life support.
- Paragraph 17 goes on to say that many veterinarians are able to work out payment plans for patients in need of emergency care where clients have inadequate funds. It fails to indicate that in many cases they **are <u>unable to work out payment plans, especially if the patient dies!</u>**
- **Sixthly,** there is no system in PA to share responsibility for making decisions about medical care for stray animals. A solution to this dilemma exists in the California Penal Code section 597. It outlines a course of action the requires the provision of emergency care as described below:

> *Any peace officer, humane society officer, or animal control officer shall convey all injured cats and dogs found without their owners in a public place directly to a veterinarian known by the officer to be a veterinarian who ordinarily treats dogs and cats for a determination of whether the animal shall be immediately and humanely destroyed or shall be hospitalized under proper care and given emergency treatment.*

This California statute goes on to provide a mechanism whereby veterinarians can be paid for the costs associated with such treatments:

> *If the veterinarian determines that the animal shall be hospitalized under proper care and given emergency treatment, the costs of any services that are provided pending the owner's inquiry to the responsible agency, department, or society shall be paid from the dog license fees, fines, and fees for impounding dogs in the city, county, or city and county in which the animal was licensed or, if the animal in unlicensed, shall be paid by the jurisdiction in which the animal was found, subject to the provision that this cost be repaid by the animal's owner. The cost of caring for and treating any animal seized under this subdivision shall constitute a lien on the animal and the animal shall not be returned to the owner until the charges are paid.*

Lastly, the CA statute provides one of the most important elements needed prior to the change in this Rule by stating that:

> *No veterinarian shall be criminally or civilly liable for any decision that he or she makes or for services that he or she provides pursuant to this subdivision.*

- Because no such law exists in Pennsylvania that allows for licensing fees to pay for emergency care for dogs and cats, the burden for all costs associated with this emergency care falls to the veterinary practice providing it. The potential for these costs is high.

- The California law also requires the involvement of an animal control or humane officer and limits the provision of emergency care to stray and abandoned dogs and cats where no owners are available. This places some of the responsibility for the medical decision making on the officer or humane organization that will be paying for the care from income generated from licensing fees. Moreover, if a *peace officer, humane society officer, or animal control officer* transports the animal to a veterinary practice and authorizes treatment or euthanasia, there is no civil or criminal liability for the attending practice or the practice!
- The proposed change to the Pennsylvania Rules does nothing to provide for the emergency care of stray animals and, instead, allows private owners to present their animals for treatment regardless of their ability to pay. This encourages, rather than discourages, responsible animal ownership.
- Adopting a Rule change like this before at least passing a statute similar to the CA Penal Code 597 would clearly place the cart before the horse and present an economic crisis for many veterinary practices Pennsylvania.
- It is the PVMA's positions that changing this Rule will place an excessive burden of costs for emergency care on the veterinary practices of PA. Moreover, it will place an inordinate, unfair, and disproportionate financial burden on the emergency clinics in the state. After all, they are open 24/7/365 and can easily become the dumping ground for practices that refer all indigent owners to them.

- Proposed change: Leave this as a "should" admonition or go back to the drawing boards and completely rethink and redesign this Rule.

7. **Principle 7 (a) (2)** *If a veterinarian deems it necessary to discontinue the treatment of an animal with which the veterinarian has a veterinarian/client/patient relationship, the veterinarian shall give notice to the client of his intention to withdraw and provide reasonable time to allow the client to obtain necessary veterinary care for the animal.*

- It is completely appropriate that veterinarians should not withdraw services from patients under their care until those patients are stable and their owners have had time to find alternative care.
- As in other situations, the key ingredient required by this Rule is one of notice.
- A solution with a written document exists in consent form exists in Dr. Jim Wilson's *Legal Consents for Veterinary Practices, 4th Ed* on page 110, i.e., "Termination of the Doctor/Client Relationship."

- Proposed change: Leave the verbiage here as drafted and promote the use of model language similar to or the same as that in *Legal Consents* book.

7. **Principle 7 (a) (2)** *Veterinarians shall consider first the welfare of the animal for the purpose of relieving suffering and disability while causing a minimum of pain or fright. Alleviating or ending suffering for the animal shall transcend personal advantage or monetary gain in decisions concerning therapy.*

- This change **requires** the above instead of suggesting it (shall vs. should). Again, this is a monumental shift in its application.
- How does or will the Board determine when the alleviation of suffering transcends operating a profitable veterinary facility?
- Would fees generating profits for the facility higher than 10% constitute a violation of this section? Higher than 15%? Higher than 20%?
- Would fees that generated a 100% profit on a given procedure for the facility, but simply helped produce a 10% at the end of the year, indicate that veterinarians were not "first considering the welfare of their patients" and, instead, were allowing personal advantage or monetary gain to affect decisions for therapy?
- Could a veterinarian fund a pension or profit-sharing plan if alleviating suffering transcended monetary gain?
- On first glance, it appears that the adoption of this Rule basically eliminates the ability for a veterinary practice to make a profit, grow, and invest in its staff, equipment and/or equipment.
- What about owner's ability to pay as it pertains to decisions concerning therapy?

- Proposed change: Keep these as an ethical admonition by retaining the word "should."

8. **Principle 7 (e)** *Veterinarians shall explain the benefits, risks, and side effects of treatment alternatives to the client.*

- We find this to be a most important Rule change that reflects medical trends all over the nation.
- Some states such as Idaho and Missouri already require that veterinarians obtain a written consent before proceeding with anesthetic or surgical procedures. Others, like Massachusetts, require a witnessed verbal or written consent before proceeding with sedation or general anesthesia.
- Clients have a right to know something about the risks, benefits, and side effects of treatment alternatives in a form other than an oral discussion.
- One merely has to look at 72 consent forms in Dr. Jim Wilson's *Legal Consents for Veterinary Practices* book in English and Spanish that focus on client education as to risk, benefits, and side effects to see how easily this can be accomplished. Moreover, the PVMA believes in the value of this Rule sufficiently that it is purchasing 50 copies of this resource to provide to its new members. We are also providing an opportunity for PVMA members to purchase it a discount. We urge the State Board to recommend it as well.

- Proposed changes:

  i. Leave the Rule as is;
  ii. Change the Rule slightly to say, "Veterinarians shall **document** and explain the major benefits, risks, and side effects of treatment alternatives to clients."
  iii. Change the language to require the use of written consent forms similar to the one already set forth in Idaho's Practice Act and Rules IDAPA 46.01.01 Rules of ID Bd of Vet Med .02. An example would be, "Except in emergency situations, educational consent forms signed by the patient's owner or other legal caretaker shall be obtained for each animal and maintained on file with the veterinarian for any anesthetic, surgical, and/or euthanasia procedure."

In addition to the issues illustrated above, further conversations with several large animal veterinarians and the State Veterinarian Dr. Paul Knepley have raised additional concerns with subsection (2)(b) regarding providing emergency care regardless of an owner's ability to pay in the case of large animal veterinarians who must travel to their patients. We briefly outlined our concerns with this section in our last letter but realize that our concerns may need further clarification based on IRRC's comments. Some points to consider are listed below:

- It would be devastating to the ability of a large animal practice to stay in business if every time an owner phoned in an emergency, the veterinarian had to deploy regardless of payment likelihood/history of that client. The stray animal or hit-by-car situations that commonly apply in small animal practice rarely apply to livestock.
- Also, it's an apples-oranges resource comparison between a practice taking in a small animal in an emergency vs. all the considerations needed to commit to an off-site large animal emergency.
- If this professional conduct regulation were to be rigidly enforced on large animal practices, it would effectively end large animal practice services in the Commonwealth.
- These duties cannot fall to state and federally employed veterinarians. Veterinarians employed by the United States (USDA) and Pennsylvania Departments of Agriculture (PDA) do not have the resources, authorities, or (in the case of USDA) the PA license to provide emergency treatment for livestock. The mission of animal health regulatory officials is to prevent, detect, contain, and eradicate reportable diseases—not to provide primary care.
- In emergency situations involving livestock (barn fire, trucking accident, tornado, flooding, etc.), PDA veterinarians would be involved by assisting County Animal Response Teams (CARTS) or other first responders by locating private practitioners who can provide primary care *on a fee basis* for the livestock owner.
- For large scale natural disasters, CART donations would be the resource to cover temporary emergency housing/care for impacted livestock until owners could be located and their animals returned. Under that scenario, medical emergencies of individual livestock would likely result in euthanasia rather than costly intervention.

We greatly appreciate the opportunity to provide these additional comments. We sincerely hope that you will give the consideration that is warranted about these concerns. If you would like to meet with representatives from our Association to discuss these issues further or to assist you in any way, please feel free to contact Charlene Wandzilak, Executive Director, at 1-888-550-7862, or cwandzilak@pavma.org.

Sincerely yours,

Mary A Bryant, VMD

Mary A. Bryant, VMD
President

cc: Dr. Tom McGrath, Chair, State Board of Veterinary Medicine
Mr. Arthur Coccodrilli, Chairman, Independent Regulatory Review Commission
Mr. John Jewett, Independent Regulatory Review Commission
The Honorable Michael P. Sturla, Majority Chair, House Professional Licensure Committee
The Honorable William F. Adolf, Jr., Minority Chair, House Professional Licensure Committee
The Honorable Robert L. Tomlinson, Majority Chair, Senate Consumer Protection and Professional Licensure Committee
The Honorable Lisa M. Boscola, Minority Chair, Senate Consumer Protection and Professional Licensure Committee

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March 30, 3007

Mr. Robert Kline
State Board of Veterinary Medicine
P.O. Box 2649
Harrisburg, PA 17105-2649

Ref: 16A-5721

Dear Bob:

On behalf of the Pennsylvania Veterinary Medical Association which represents over 1,700 veterinarians in the Commonwealth, thank you for the opportunity to provide the following comments on the proposed amendments to the Rules of Professional Conduct for Veterinarians.

Proposed Amendment to Principle 3. Unprofessional Conduct.
In this proposed amendment, the language states that "a veterinarian who engages in unprofessional or immoral conduct is subject to disciplinary action under section 21(1) of the act (63 P.S. §485.21 (1)) and may also be subject to discipline under section 21(11) or 21 (20) of the act." However, there are no specific criteria for unprofessional or immoral conduct that are defined, just examples of possible behaviors or actions that could be construed as "unprofessional or immoral". In addition, what is the definition of immoral and according to whom? This could lead to a disparity in what individuals view as "immoral" unless more clearly defined. Another suggestion we offer is to consider changing "immoral" to "unethical." This could easily be defined by the accepted veterinary code of ethics and therefore, non-compliance would be easier to identify.

PVMA is supportive of a clause being added to Principle 3 that would state that the Board shall refer all initial cases of unprofessional conduct involving a PVMA member in good standing to the PVMA Ethics and Grievance Committee for investigation and recommendation for resolution. The outcomes of the action would then be presented to the Board for review and approval. This process would lessen the workload for the Board; and hence decrease the need for additional resources.

Subsection (6) – "Abusing a client, former client, colleague, associate, or employee, including verbal abuse, harassment, or intimidation." Overall, we commend you on the inclusion of this subsection. However, parameters should be established for what constitutes verbal abuse and harassment. This could be very subjective unless parameters are developed. In cases where there is a dispute between a veterinarian and the client or the veterinarian "fires" the client, a client could misconstrue what would otherwise be a benign statement if the circumstances were different.

Subsection (7) – "Performing a veterinary medical act incompetently or performing a veterinary medical act that the licensee knows or has reason to know he is not competent to perform." How is competence to perform determined? There should be a list of standards of acceptable and prevailing medical practice developed or referred to. For example, if a practitioner takes a wet lab on basic ultrasonography, is he or she considered a competent ultrasonographer and permitted to charge for interpretation?

Subsection (8) – "Making any false, misleading, or deceptive statement or claim as defined in Principle 5 (a) relating to advertising)." There is concern about how this would be proven. We suggest that the veterinarian have the responsibility to discuss both the risks and benefits of treatments, preventatives, etc. and document

such discussions in their client's medical records. As an added, concrete way to prove the discussion took place, it could be required that once the statement is entered into the medical record that the client sign the statement to further prove that the veterinarian fulfilled his or her responsibility.

Subsection (9) – "Delegating a veterinary medical service to a certified veterinary technician or unlicensed person who the licensee knows or should know is not qualified by education, training, experience, license, or certification, to perform. The licensee shall perform a reasonable investigation of the delegatee's skills before delegating a veterinary medical service and provide supervision of the service consistent with the acceptable and prevailing standards of veterinary medical practice." – How would this impact shelters, rescue groups, and breeding kennels who often utilize non-licensed persons to provide veterinary medical care?

Subsection (10) – "Inhumanely treating or abusing any animal, whether or not the animal is a patient." - In the Preamble, this subsection is outlined with the statement that this provision is consistent with the acceptable and prevailing ethical standards of the profession and with many states' practice acts and regulations. We are concerned that without parameters set defining what is "acceptable and prevailing" that this has the potential to open Pandora's box with animal rights groups.

Principle 7. Veterinarian/Client/Patient Relationship.

Subsection (1) – "During a veterinarian's regular business hours, a veterinarian may not refuse to treat an animal which is in a life-threatening condition at the time the animal is physically presented to the veterinarian at the his or her facility. The minimum veterinary medical services that shall be provided include triage of the presenting emergency and other patients present at the facility, assessment of the animal's condition, evaluation of the animal's prognosis and provision of basic life support or euthanasia, as medically appropriate. A veterinarian may provide care for an animal under this paragraph notwithstanding the lack of a veterinarian/client/patient relationship and if the owner is unknown or cannot be reached, without consent of the owner." – In human hospitals, patients are often triaged by nurses and/or nurse practitioners. It would be beneficial to expand this amendment to state that if a veterinarian was involved in the care of a patient, that a certified veterinary technician licensed in Pennsylvania, could assess the incoming emergency and make a determination as to the appropriate action to be taken. There should also be a reference to referral to a nearby animal emergency hospital. In this case, the duty of the initial facility seeing the patient, could in the patient's best interest, refer the animal to improved care at the nearby emergency facility. For instance, a small practice that does not have the appropriate critical care equipment might do more harm to the patient trying to administer fluids than if they called the local emergency facility and advised that the case was on its way and/or assist in getting the patient there.

Subsection (2) (a) – "If a veterinarian deems it necessary to discontinue the treatment of an animal with which the veterinarian has a veterinarian/client/patient relationship, the veterinarian shall give notice to the client of the intention to withdraw and provide reasonable time to allow the client to obtain necessary veterinary care for the animal." – We would strongly encourage the Board to consider providing parameters for what is considered "a reasonable amount of time" otherwise the veterinarian may be placed in a tenuous situation with the client who may state there is no suitable alternative to the present hospital and doctor.

Subsection (2) (b) – "Veterinarians shall consider first the welfare of the animal for the purpose of relieving suffering and disability while causing a minimum of pain and fright Alleviating or ending suffering for an the animal shall transcend personal advantage or monetary gain in decisions concerning therapy." - Our Association and the profession at large agree with this in concept and practice this in veterinary hospitals and clinics every day. However, by mandating this by regulation, it places an undue burden on the veterinarian, who as a small business owner, must then pass on the costs to other clients. In addition, there are concerns about how this applies to a large animal veterinarian who must travel to a location to provide a service and also what the role of the Pennsylvania Department of Agriculture's regional veterinary medical field officers is in these situations.

Subsection (2) (d) – "Veterinarians shall familiarize themselves with advancements in veterinary medicine, including new techniques, drugs and scientific research that may affect treatment decisions. Veterinarians

shall be familiar with the pharmacologic properties and contraindications of drugs and biologics used in their practice.

Subsection (2) (e) – "Veterinarians shall explain the benefits, risks, and side effects of treatment alternatives to clients."

Our suggestion would be to state that veterinarians should discuss the risks and benefits of treatments, preventatives, and products dispensed to their clients. Further, as part of the continuing education requirement for PA licensed veterinarians, we would suggest that a certain number of continuing education hours every two years be specifically focused on shared decision making between veterinarians and their clients which includes appropriate discussion of risks and benefits. Further risks and benefits discussions should be documented in all patient records. This requirement would be similar to that required in the state of Florida for veterinarians who maintain a veterinary license, except theirs is a requirement of the pharmacy law. Communication workshops are already in place at major meeting such as Western Veterinary Conference and the North American Veterinary Conference but our Association would also gladly offer this training in Pennsylvania as part of our annual convention. However, as it relates to Principle 4. Fees, it should clearly state that the veterinarian has the right to charge for his or her time spent discussing the risks and benefits and that the client can request that these discussions not take place, thereby releasing the veterinarian from this discussion with this particular client.

Thank you again for the opportunity to provide our comments and concerns for your consideration. We continue to appreciate the State Board's willingness to work with PVMA on issues related to the veterinary profession and the public that both our members and the State Board serve. We wholeheartedly support elevating the profession to the highest standard of veterinary care within their practices and believe that by elevating the profession we are also helping to protect the public.

If you have any questions, please feel free to contact Charlene Wandzilak, Executive Director, at 1-888-550-7862 or cwandzilak@pavma.org.

Sincerely yours,

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