Letters to the Editor

GHLIT medical insurance coverage

I wanted to comment on the recent *JAVMA* News story[1] reporting on the decision by the AVMA Group Health & Life Insurance Trust (GHLIT) to end medical insurance coverage for AVMA members. I know that this change is stressful for and confusing to the many AVMA members who have held this insurance over the years. But, I think it might be important to look more deeply at the causes of this change.

The article suggests that the Patient Protection and Affordable Care Act of 2010 was "to blame" in the GHLIT's decision. I would submit that factors other than the new health-care law also played a part. For example, the article says "Additionally, [New York Life] expects the new regulations will create market conditions and a regulatory environment that would put the company at a competitive disadvantage against government-subsidized medical insurance providers," suggesting that New York Life was concerned that under the new regulations, it would not be able to make as much money providing this insurance to AVMA members as it had previously.

Although the Affordable Care Act may have made New York Life's business relationship with the GHLIT less profitable, the ultimate purpose of the act is to protect patients and make health insurance more affordable for Americans overall through, among other things, preventing insurance companies from denying coverage because of age or preexisting conditions. This is good news for the large number of Americans that were previously shut out from affordable insurance.

I know that the GHLIT's recent decision is disturbing for the many AVMA members who previously had medical coverage through the trust, and I applaud the GHLIT for its commitment to help members with the transition. As the article states, we are "all in this together."

The new health-care legislation is intended to provide Americans more choices at more affordable prices, and as indicated in the article, the new exchanges created under the Affordable Care Act will act "like a market in bringing together insurance providers that offer a range of plans at various rates so individuals can select a plan that best meets their needs." This includes a lot of the good things that GHLIT medical coverage previously provided, such as portability, affordability, and coverage of preventative care. I for one would praise, rather than blame, the Obama administration for working to improve health insurance coverage for significantly more Americans.

Linda Rhodes, VMD, PhD
Holmdel, NJ

1. Nolen RS. AVMA GHLIT medical insurance to end after 2013. *J Am Vet Med Assoc* 2013;242:426–429.

Veterinary college accreditation

I read with interest the two *JAVMA* articles[1,2] on the recent hearing by the US Department of Education's National Advisory Committee on Institutional Quality and Integrity (NACIQI) regarding continued recognition of the AVMA Council on Education (COE) as the accreditor for colleges of veterinary medicine in the United States. I was among those arguing that the US Department of Education should withhold recognition until the AVMA abandons the current process by which COE members are chosen (election by the AVMA House of Delegates) and can show that it conducts its business without any discussion, review, or participation by AVMA officers, Executive Board members, or staff members.

The second article describes a statement read at the meeting that was signed by 50 individuals (including current administrators at 22 of the 28 US veterinary colleges) who said they believe the COE offers a "proven process of educational evaluation." However, it mentions only in passing the 13 letters received by the NACIQI recommending against the COE's continued recognition, whose signatories included a veterinary school dean, several former deans, six members of the Institute of Medicine, a recipient of the National Medal of Science, and a president of a university with a veterinary school. These letter writers suggested creation of an accrediting body similar to the autonomously functioning Liaison Committee on Medical Education (LCME), which accredits schools of medicine in the United States and is cosponsored by the American Medical Association and the Association of American Medical Colleges. I contend that adopting such a model would dispel doubts about the AVMA's influence on accreditation policies, procedures, and decisions and allay concerns about how COE members are chosen. Indeed, the LCME model was endorsed by the Trustees of the Pennsylvania Veterinary Medical Association just prior to the 2012 NACIQI meeting.[3]

Instructions for Writing a Letter to the Editor

Readers are invited to submit letters to the editor. Letters may not exceed 500 words and 6 references. Letters to the Editor must be original and cannot have been published or submitted for publication elsewhere. Not all letters are published; all letters accepted for publication are subject to editing. Those pertaining to anything published in the *JAVMA* should be received within one month of the date of publication. Submission via e-mail (*JournalLetters@avma.org*) or fax (847-925-9329) is encouraged; authors should give their full contact information, including address, daytime telephone number, fax number, and e-mail address.

Letters containing defamatory, libelous, or malicious statements will not be published, nor will letters representing attacks on or attempts to demean veterinary societies or their committees or agencies. Viewpoints expressed in published letters are those of the letter writers and do not necessarily represent the opinions or policies of the AVMA.

The article also mentions that I have criticized the way the COE has applied its standards, particularly in regard to accreditation of the Western University of Health Sciences College of Veterinary Medicine. I want to make it clear that I do not oppose accrediting schools that use off-site facilities for clinical training and, in fact, have expressed admiration for the distributive clinical teaching model adopted by the University of Calgary Faculty of Veterinary Medicine.[4] Rather, given the large number of off-site facilities used by the Western University of Health Sciences College of Veterinary Medicine, I have concerns about the quality of instruction students receive and about the degree to which faculty can control what students are taught. I am even more concerned about the Western University of Health Sciences College of Veterinary Medicine's case-based learning system, by which first- and second-year students, working largely on their own, are expected to acquire a solid grounding in the sciences basic to the practice of clinical medicine (eg, biochemistry, physiology, pharmacology, microbiology, immunology, parasitology, genetics, and molecular biology). I favor curriculums that encourage student initiative, but I believe that, owing to the scope and complexity of these foundational disciplines, dependence on a student-directed case-based learning system is excessive.

Robert R. Marshak, DVM, DACVIM
Newtown Square, PA

1. Larkin M. COE given more time to comply with USDE standards. *J Am Vet Med Assoc* 2013;242:430–432.
2. Larkin M. Philosophical differences of opinion. *J Am Vet Med Assoc* 2013:242:432–435.
3. Wandzilak C, Pennsylvania Veterinary Medical Association, Hummelstown, Pa: Personal communication, 2012.
4. Marshak RR. Use of distributed teaching models (lett). *J Am Vet Med Assoc* 2012;240:1412.

Response from the Chair of the Council on Education:

The AVMA Council on Education (COE) appreciates all of the input received from stakeholders regarding its policies and procedures, including the comments from Dr. Marshak. The goal of the COE is to ensure educational quality by evaluating compliance with the Standards for Accreditation. To ensure relevance, fairness, and consistency for all institutions, the COE is continually reevaluating not only the Standards for Accreditation but also the policies and procedures used to assess compliance with those standards.

The COE membership represents the breadth of the profession, including private practice, academia, industry, and the public. The AVMA officers and Executive Board members do not participate in discussions or decisions of the COE. The AVMA staff members who provide administrative support for the COE do not vote or otherwise participate in the decisions of the COE.

The COE shares the concerns expressed by others about the manner by which its members are appointed. The COE discussed this matter with the leadership of the AVMA and the Association of American Veterinary Medical Colleges in the fall of 2012. In January 2013, the Liaison Committee on Medical Education (LCME) was invited by the Association of American Veterinary Medical Colleges to give a presentation and lead a discussion with the deans of its member institutions on the pros and cons of the policies and procedures of the LCME. This discussion included the method of appointing members, how standards for accreditation are established and reviewed, how site visits are conducted, and how distributive models for clinical education are evaluated for compliance. The deans who are current COE members will lead a discussion about this LCME presentation at the March COE meeting. The Council on Dental Accreditation will give a similar presentation during the same COE meeting. The COE will consider best practices of these and other health profession–accrediting agencies when modifying its policies and procedures.

The COE evaluates all institutions for compliance with the Standards for Accreditation in an evidence-based manner. Importantly, the COE does not prescribe the manner by which students are taught, but assesses the effectiveness of the educational model and the outcome of instruction. Self-directed, case-based learning and distributive models for clinical training have been shown to be effective methods for instruction in multiple professions, including veterinary medicine.

Sheila W. Allen, DVM, MS, DACVS
Dean
College of Veterinary Medicine
University of Georgia
Athens, Ga

Representations of human-animal interactions in advertising

For some time now, I have been concerned by the oft-repeated "Leaving your Legacy" advertisement from the American Veterinary Medical Foundation (AVMF) that appears in the *JAVMA* (*see*, for example, page 261 of the January 15, 2013, issue) and depicts a woman kissing a cat on the forehead. Because the advertisement appears in a veterinary publication and is directed at veterinarians, I assume that the woman portrayed is, or is meant to be, a veterinarian. I fully understand the human-animal bond and the love and respect that veterinarians have for animals, but I worry that this advertisement does not portray veterinary medicine in the best light, either professionally or hygienically.

Given the current increased emphasis on the one health concept, the fact that well over 100 zoonotic diseases are known to exist, and the declaration by the One Health Commission that 75% of all human infectious diseases that emerged worldwide in the past three decades originated in animals, it behooves the veterinary profession to pay closer attention to disease transmission across species. Fortunately, disease transmission from animals to people is not a common occurrence in the United States, but veterinarians must still be vigilant to decrease the risk of zoonotic infections. This is especially true in light of the increased numbers of immunocompromised individuals in the general population and the ever present threat of bioterrorism. Our profession must set a good example of proper

professional conduct, particularly as we increase our association with other health science professionals. An important aspect of this would be to follow proper personal hygiene and sanitation practices. Certainly, kissing our animal patients is not a recommended or exemplary practice.

Valuable information and advice on zoonoses can be obtained from the Compendium of Veterinary Standard Precautions for Zoonotic Disease Prevention in Veterinary Personnel,[1] which was developed by the National Association of State Public Health Veterinarians, and from various articles published in *JAVMA*, including a review of reported cases of zoonotic infection in veterinarians.[2]

My comments are certainly not directed at the AVMF's mission or accomplishments. The organization was created in 1963 and is celebrating its golden anniversary this year.[3] To further the objectives of the AVMF, I have made a recent contribution and I urge my veterinary colleagues to do the same.

John E. Willson, DVM
Essex, Conn

1. Scheftel JM, Elchos BL, Cherry B, et al. Compendium of veterinary standard precautions for zoonotic disease prevention in veterinary personnel. *J Am Vet Med Assoc* 2010;237:1403–1422.
2. Baker WS, Gray GC. A review of published reports regarding zoonotic pathogen infection in veterinarians. *J Am Vet Med Assoc* 2009;234:1271–1278.
3. Larkin M. Times change, mission remains the same. *J Am Vet Med Assoc* 2013;242:14–15.

Menace response in muzzled dogs

Testing for a menace response is an important part of the neurologic examination in animals and often facilitates neuroanatomic localization of lesions. An intact menace response indicates integrity of numerous distinct anatomic structures within the rostral, middle, and caudal intracranial fossae.

Techniques to test for a menace response vary,[1,2] and if a robust response is not obvious with one technique, I typically use one or two other methods to elicit a response. Fortunately, the test is benign and painless and can nearly always be performed without first putting a muzzle on the animal. Over the years, however, I have begun to notice that menace responses were often either absent or markedly less robust in dogs that were wearing a muzzle when tested. This observation led me to assess the menace response in 32 consecutive dogs evaluated at a referral neurology practice. The menace response was tested with and without a muzzle on the dog, in a randomized manner. If a dog failed to demonstrate a menace response when muzzled, the test was repeated after the muzzle had been removed.

Twenty-nine of the 32 dogs had bilateral menace responses when tested without a muzzle. However, after a muzzle was applied, 20 of these 29 dogs either failed to demonstrate a menace response or had a response that was muted to such a degree that it was questionable whether the response was present.

Two dogs had a unilateral menace response when tested without a muzzle. For both of these dogs, the menace response was absent bilaterally when a muzzle was applied and the test was repeated.

In the remaining dog, menace responses were absent bilaterally, regardless of whether the dog was or was not wearing a muzzle while tested.

These findings suggest that it may be prudent to interpret menace deficits carefully in dogs wearing a muzzle when tested. The menace test is simple and benign, so practitioners may be better prepared to interpret menace responses in aggressive dogs that can only be tested with a muzzle in place by first comparing menace responses obtained in nonaggressive dogs with and without a muzzle.

John Speciale, DVM, DACVIM, DABVP
Fairport, NY

1. DeLahunta A, Glass E. Visual system. In: *Veterinary neuroanatomy and neurology*. 3rd ed. St Louis: Saunders Elsevier, 2008;399–400.
2. Thomas WB, Dewey CW. Performing the neurological exam. In: Dewey CW, ed. *A practical guide to canine and feline neurology*. 2nd ed. Ames, Iowa: Wiley-Blackwell, 2008;53–74.