

## Letters to the Editor

### Seeking alternatives to euthanasia

Thank you, Dr. McMillan, for your commentary on euthanasia (*JAVMA*, Nov 1, 2001, pp 1204–1206). It was thoughtful and informative. However, even after reading that death is an unintentional outcome of euthanasia, I must disagree. As it is practiced currently, euthanasia equates with killing. Inserting the “mercy component” does not alter the equation; instead, it only offers justification for the killing. It is, after all, the death that we seek that stops the suffering.

The problems then come: How do we justify killing a pet? How do we help owners justify the decision to kill their pet? When is the appropriate time? Ethically, how do we euthanize and do no harm? Is it possible that euthanasia, when viewed morally and ethically, may compound the grief of the pet owner and the veterinarian?

That we, as a profession, have become the place where pet lovers bring their pets to be killed is not consistent with excellent pet care. For owners, it is not consistent with treating their pet as if it were a member of their family.

Is it the truth that “euthanasia is the last effective tool we have, and use, to stop the discomfort”? Isn't there a way to end discomfort without ending life? Would it be satisfactory and preferable to do the best we can for the pet with pain medication and sedation and then support pet owners while their pet dies? In that way, pet owners do not have to decide to end their pet's life, and the veterinarian does not cause their death.

It is possible to uncouple ending discomfort and ending life if we can be satisfied with doing everything we can, and the best the pet owner will allow, to relieve discomfort short of any procedure we know will cause death. Are we willing to do that?

Lonnie D. Moore, DVM  
Dallas, Tex

### Dr. McMillan responds:

I respect Dr. Moore's opinion; however, I could not disagree more. This view of euthanasia is the reason I wrote the commentary.

Rather than reiterate the arguments I presented, I will address his basic premise that euthanasia is wrong and natural death is preferable.

In my view, the primary objective of all animal care is to protect animals against hurts, discomforts, and pains. Furthermore, animals depend on veterinarians and owners to do this.

Life is widely viewed as sacred, and the concept of the sanctity of life is one of the strongest opposing forces to euthanasia.<sup>1</sup> The deep symbolism of death is intricately connected to the purpose of life.<sup>2</sup> This reverent view of death is a human concept. Children less than five years of age lack an understanding of death.<sup>3</sup> Therefore, it is not surprising that the same appears to be true for animals, suggesting that, to animals, death holds no singular importance, marks no transition, and has no special meaning. Animals' reliance on us to protect them from sufferings is no different at the time around death than it is at any other time.

In some cases, the discomforts of terminal illnesses can be effectively alleviated. However, we cannot effectively relieve the sick feelings and distress of many end-stage diseases, such as hepatic encephalopathy, uremic renal failure, and the pulmonary edema of decompensated heart failure. Even standard physical pain often resists all attempts at alleviation, as is well-known by human oncology patients.<sup>4</sup> In all, the notion that we can stop the hurts of terminal illnesses with pain medication and sedation is wishful thinking.

The special importance of death—along with its corollary tenet, the sanctity of life—provides the basis for the belief that natural death is preferable to euthanasia.<sup>1</sup> This reverent view of life and death underlies the judgment of euthana-

sia as wrong. Is the human concept of death and what it symbolizes sufficient justification for withholding relief from discomfort in a dying animal? If a natural death resulted in even a slightly greater degree of suffering than euthanasia, what would justify this greater suffering?

Waiting for a natural death leaves the animal to battle the hurts of illness without any effective weapons to wage a meaningful fight. The animal and those caring for it have exhausted every tool to lessen the discomforts. In such a case, natural death is not a thing of beauty; rather, it is a welcome end to the misery. Euthanasia delivers on our objective and duty to protect animals from the hurts of life. Is euthanasia “killing”? In a way, yes, but it must remain clear as to what it is that is being killed. When we speak of pain in its collective use as meaning all of the hurtful feelings in life, then we can see euthanasia for what it truly is—the final, and most effective, painkiller. And that is all it is intended to be.

Franklin D. McMillan, DVM  
Los Angeles, Calif

1. Fraser SI, Walters JW. Death—whose decision? Euthanasia and the terminally ill. *J Med Ethics* 2000;26:121–125.

2. Drolet JL. Transcending death during early adulthood: symbolic immortality, death anxiety, and purpose in life. *J Clin Psychol* 1990;46:148–160.

3. Speece MW, Brent SB. Children's understanding of death: a review of three components of a death concept. *Child Dev* 1984;55:1671–1686.

4. Jackson K, Ashby M, Martin P, et al. “Burst” ketamine for refractory cancer pain: an open-label audit of 39 patients. *J Pain Symptom Manage* 2001;22:834–842.

### Question diagnostic technique for hip dysplasia

The article by Lust et al in the Nov 1, 2001 *JAVMA* (pp 1242–1246)

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is the most recent in a series of publications comparing the dorsolateral subluxation (DLS) method of hip dysplasia diagnosis to the PennHIP method. Necropsy examinations were performed on the hips of 129 dogs, mostly Labrador Retriever-Greyhound crossbred dogs at median ages of 15 to 18 months, and DLS and distraction index (DI) scores were correlated with evidence of cartilage degeneration.

In calculating diagnostic sensitivity, we question the choice of a DI cutoff of 0.7, because it has no precedent or clinical relevance in the literature. We ask the authors to recalculate the sensitivities of the distraction method, using a cutoff of DI = 0.38. This figure was derived from receiver-operating characteristic curves of radiographic findings from the hips of 6,277 Labrador Retrievers (mean age, 37.7 months), and it represents the cutoff below which there is 100% sensitivity for this breed.<sup>1</sup> Alternatively, the authors could use a DI cutoff of 0.3, a breed-nonspecific figure for which our research has become known. The fact that Lust et al used a DI of 0.3 in their first article<sup>2</sup> on the DLS method and extrapolated a corresponding DLS score of 56% raises our curiosity as to why the 0.7 cutoff was selected.<sup>3</sup> We have demonstrated consistently that dogs may show hip osteoarthritis (OA) above an index of 0.3 but not below.

A second concern is the reliance on necropsy findings from young dogs. A definitive true-negative diagnosis of hip dysplasia cannot be made at 8 months of age, or even at 2 years of age. Recently, the prevalence of hip OA in Labrador Retrievers was shown to increase linearly over a 14-year study.<sup>4</sup> Therefore, a sizable proportion of the 98 dogs euthanized and found free of cartilage damage could be expected to have developed OA if permitted to age. The late expression of hip OA would lower the estimates of diagnostic sensitivity of the DLS method. In fact, in a recent study<sup>5</sup> of a pool of 41 mixed-breed dogs (mean age, 28 months), the DLS method had a sensitivity of 66%, compared with a sensitivity of 100% for the DI method.

The authors did not examine whether hip phenotypes in Labrador Retriever-Greyhound crossbred dogs accurately represent the relationship of passive hip laxity and hip dysplasia in popular

pure breeds of dogs. In fact, a previous study by Lust et al<sup>6</sup> showed that the relationship of DLS score with passive hip laxity was skewed in this particular sample of dogs.

We feel that the authors' proposal that a DLS score < 55% be considered the true-positive diagnosis of hip dysplasia does not address the central requirement of a diagnostic test to direct breeding practices. Because environmental factors have been shown to confound positive diagnoses,<sup>4</sup> it is far more important to be correct on which dogs do not have the disease (true-negative) than to guess which dogs do.

In summary, we believe the evidence presented by Lust et al does not support claims that the DLS method has advantages over the PennHIP method.

Gail K. Smith, VMD, PhD  
Darryl N. Biery, DVM, DACVR  
Amy S. Kapatkin, DVM, DACVS  
Larry L. Laster, PhD  
Michelle Y. Powers, DVM  
Hilary H. Fordyce, VMD  
Philipp D. Mayhew, BVMS  
Philadelphia, Pa

1. Smith GK, Mayhew PD, Kapatkin AS, et al. Evaluation of risk factors for degenerative joint disease associated with canine hip dysplasia in German Shepard Dogs, Golden Retrievers, Labrador Retrievers, and Rottweilers. *J Am Vet Med Assoc* 2001;219:1719-1724.

2. Farese JP, Todhunter RJ, Lust G, et al. Dorsolateral subluxation of hip joints in dogs measured in a weight-bearing position with radiography and computed tomography. *Vet Surg* 1998;27:393-405.

3. Smith GK, Gregor TP, Fordyce H. Letter to editor. *Vet Surg* 1999;28:117-118.

4. Kealy RD, Lawler DF, Mantz S, et al. Influence of body condition on canine osteoarthritis. *Purina Nutr Forum* 2001;9:14.

5. Fordyce HH, Smith GK, Gregor TP. Relative sensitivities of three methods to measure passive hip laxity in the dog, in *Proceedings*. 26th Vet Orthop Surg Conf 1999;11.

6. Farese JP, Lust G, Williams AJ, et al. Comparison of measurements of dorsolateral subluxation of the femoral head and maximal passive laxity for evaluation of the coxofemoral joint in dogs. *Am J Vet Res* 1999;60:1571-1576.

### The authors respond:

We thank Dr. Smith et al for their interest in our article (JAVMA Nov 1, 2001, pp 1242-1246). They have asked us to recalculate the sensitivity for the DI, using a cutoff of 0.38. We have done so, using a DI of 0.4. The sensitivity indeed increases, as one would expect, to a value of 89%; however, the specificity falls dramatically to a value of 32%. In other words, we can be

confident that a puppy with a DI less than 0.4 will be normal, but we can do little more than "guess" the prognosis for the puppy with a DI greater than 0.4. We agree that if the goal is to direct breeding practices, and no trouble or expenses need be spared in culling animals that may develop hip dysplasia and osteoarthritis, use of the DI at a cutoff of 0.4 (or 0.38) should achieve that goal. We suspect, however, that the goals of most veterinarians and their clients will be more varied and complex. With such a low specificity (32%), large numbers of clinically normal dogs would be culled unnecessarily. This may not be feasible. Furthermore, the typical pet owner, perhaps with an already neutered dog, may be much more interested to know how strict to be in controlling diet and exercise and if the likelihood of developing the disease is great enough to warrant the risk and expense of long-term prophylactic treatments.

In brief, our purpose was not to place the DLS score, DI, and extended hip radiographic interpretation in competition but to provide the practicing veterinarian with as many tools as possible to help clients make the wisest decisions based on individual needs. Based on the data in our reports,<sup>1,2</sup> we submit that the DLS score will be useful on 8-month-old dogs, because a single cutoff of 55% provides simultaneously both high sensitivity (83%) and high specificity (84%). The method is easy to use and requires only one radiograph, which is taken without manually holding the dog. Thus, the DLS score may have broad application. This test can be used to rigorously identify dogs with normal hips and to provide an accurate prognosis regarding the potential to manifest hip dysplasia in dogs that have abnormal hip conformation.

George Lust, PhD  
Rory J. Todhunter, BVSc, PhD, DACVS  
Hollis N. Erb, DVM, PhD  
Nathan L. Dykes, DVM, DACVR  
Alma J. Williams, MS  
Nancy I. Burton-Wurster, PhD  
Ithaca, NY  
James P. Farese, DVM, DACVS  
Gainesville, Fla

1. Lust G, Todhunter RJ, Erb HN, et al. Comparison of three radiographic meth-

ods for diagnosis of hip dysplasia in eight-month-old dogs. *J Am Vet Med Assoc* 2001;219:1242-1246.

2. Lust G, Todhunter RJ, Erb HN, et al. Repeatability of dorsolateral subluxation scores in dogs and correlation with macroscopic appearance of hip osteoarthritis. *Am J Vet Res* 2001;62:1711-1715.

### Focus should be on standard of care, not fees

My office manager and I just finished reviewing the National Commission on Veterinary Economic Issues (NCVEI) survey. There is no meaningful way for us to participate, because the information requested is not meaningful to our future.

The survey ignores standard accounting tools, including the balance sheet, income statement, and statement of retained earnings. Accounting is a well-established information gathering system that has been applied to every type of business imaginable. It gives the kind of information that allows us to compare the fiscal health of businesses within and between industries in a meaningful way.

This survey also focuses on fee schedules. According to the Baldrige National Quality Program's Health Care Criteria for Performance Excellence, "The measures or indicators you select should best represent the factors that lead to improved health care outcomes; improved customer, operational, and financial performance; and healthier communities."<sup>1</sup> Fee schedules have no linkage to financial outcomes. I believe our profession has been fee-focused for the past 25 years. If the secret to success was in our fee schedules, surely we would have discovered it by now.

I propose fee-fixation lies in a misconception about basic economic theory. Price only changes demand in perfectly competitive markets. Buying on the basis of price alone is a rational decision, because in perfectly competitive markets all products and services differ by price alone. This is not the case in veterinary medicine.

Veterinary clinics actually operate in imperfectly competitive markets. The products and services offered in imperfectly competitive markets are similar but are differentiated in ways that are not obvious to the buyers. Therefore, they have no rational basis for making buying decisions, but they do know that

price is not the only meaningful difference among clinics.

I propose that our profession's economic future lies not in raising everyone's fees but in raising everyone's standard of practice. Fees will follow. I think our licensing agencies share this belief, which is why they require continuing education.

We must distance ourselves from legalistic definitions of standard of practice. Just because everyone does it poorly doesn't make it an appropriate standard. Such a paradigm shift implies that quality care must be defined at the leading edge, not by the lowest legally accepted standard.

There is already a health care quality improvement model that does just that. The National Institute of Standards and Technology provides information online.<sup>1</sup> It is how health care providers compete for the Baldrige National Quality Award, which is given to the best of the best.

The Baldrige National Quality Program's Health Care Criteria for Performance Excellence scores excellence in seven areas of operation: leadership, planning, focus on patients, information and analysis, staffing, process management, and organizational performance results. Currently, veterinarians are not eligible to apply for this award. But to adapt this existing program to veterinary medicine would require only minor changes.

I would encourage the NCVEI to review this existing system. Actually, I would encourage everyone to take a look, because looking at what we charge is not nearly as telling as looking at what we do.

Kevin P. Hines, DVM  
Longview, Wash

1. Health Care Criteria for Performance Excellence, Baldrige National Quality Program 2001. National Institute of Standards and Technology Web site. Available at: [http://www.quality.nist.gov/healthcare\\_criteria.htm](http://www.quality.nist.gov/healthcare_criteria.htm). Accessed Jan 28, 2001.

### Mr. Rubin responds:

The National Commission on Veterinary Economic Issues (NCVEI) has a mission to improve the economic base of the veterinary profession, ensuring that the delivery of veterinary care and service meets the needs of society. On its face this is a noble goal, but what does it really mean in tangible

terms? More important, how does it deliver on the objective?

The NCVEI board of directors has concluded that among the best ways to deliver on its objective is to distribute tools to veterinarians that will inspire them, in a pragmatic way, to operate their facilities more efficiently and price their services using analytical value propositions. Taking the lead from the successes achieved in other industries, the NCVEI is bringing benchmarking to veterinary medicine. Benchmarking will teach veterinarians how to reach new levels of performance by driving change through a structured search for superior practices.

Information on the NCVEI's Web site will include 12 tools to help veterinarians get better. Any user simply inputs data about their hospital (eg, prices, costs, clients, staff, and operations—either anecdotal or actual information). The models will provide immediate feedback by producing graphs and tables showing which quartile their hospital data are in for each tool. In addition, there will be illustrations on how to produce the results achieved by those at the highest performance levels. The tools range from creating value-oriented prices to understanding the implications of financial, marketing, client satisfaction, and staffing behaviors.

The purpose of the survey sent to Dr. Hines and several thousand others was to collect seed data for our tools to test some assumptions and provide early users with meaningful comparisons. Because the questions for all 12 tools were intended to gather hundreds of data points, we decided not to send any veterinarian a complete questionnaire, rather only a small section of all the items we are measuring and subsequently reporting. We apologize for not making that clear in our correspondence. We hope Dr. Hines will reconsider his decision and fill out the seed survey.

At the NCVEI, we hear an unrelenting drumbeat that quality patient care requires a sound economic foundation. Our tools will empower veterinarians by providing them with virtually instant access to data, insight on what is possible, and how to get there.

Howard E. Rubin  
Schaumburg, Ill