Letters to the Editor

Balancing medical advances and the client's budget

In recent years, veterinary medicine has made remarkable advances. There is little that we cannot offer our patients and our clients. However, in the past 25 years, I have also seen a sad trend from wanting to serve our clients and their animals to wanting to squeeze every last dollar out of them. Although I don't ask clients why they left their former veterinarians, I have recently heard stories that disturb me. One client was faced with a difficult decision concerning a cat with urethral blockage. The client could not afford the estimated $400 to $800 to treat the cat and chose euthanasia instead. The veterinarian proceeded to castigate the client for not loving the cat enough, making a difficult time much worse. Another client did not bring a fecal sample when bringing her dog in for an annual examination but was charged for a fecal examination and given a container to bring a sample in later. The client said she did not want to have a fecal test done because the dog was 10 years old, was regularly receiving heartworm medication year-round, and had not had a positive test result in 9 years. Nevertheless, the clinic charged her anyway. A friend of mine who lives in a small city called me and asked if it should cost $400 to castrate a 6-month-old cat that had been regularly examined, tested, and vaccinated to date. Another veterinarian told me recently that because he is morally opposed to doing cat declaws, he will charge twice as much to do them.

These experiences make me concerned that our public image is going down the drain. Should we only offer services to those people with money or insurance? Should we take pet ownership out of the hands of the poor or the lower middle class? I am tired of hearing the excuse that "if they can't afford a pet, they shouldn't have one." I realize that we need to charge for our equipment and expertise, but at some point, can't we offer people economical alternatives? Yes, it is great to practice high-level medicine and surgery, but can't we offer economical options as well? By offering only top-of-the-line service, many go wanting. I think we can do better for our patients and our clients.

Karen Detweiler, VMD
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Thoughts on the changing face of the profession

The February 15, 2010, *JAVMA* News section, which focused on diversity, brought back many fond memories from my 22 years (1973–1995) working on the AVMA staff, primarily with the Council on Education. I'll start with a word about Tuskegee University's legacy.[1] I was privileged to serve as staff on two accreditation site visit teams to the school. Whenever I visited the Tuskegee campus, I was in awe, given the history of the place. Here is where the first students made the bricks that were used to build some of the first buildings there, likely under the watchful eye of Booker T. Washington himself. The second Morrill Act (1890) was pivotal in establishing Tuskegee University as a part of the land-grant system. The connection with Iowa State University was impressive too. Not only were the first two founders of the school from there, but so was George Washington Carver, who helped establish a cooperative extension service for black farmers in the South.[2] The site visit team was impressed with the effectiveness and diligence of the faculty at the veterinary school, which had the fewest members and smallest budget of any veterinary program in the United States and Canada at that time. Dr. Walter Bowie, recently deceased, was the dean in those days and an outstanding leader. The current dean, Dr. Tsegaye Habtetemariam, was an innovator in computer sciences back in the 1980s. Dr. Carolyn Schaefer was Dean Bowie's effective and delightful liaison to our site visit teams.

The "Evolution of a profession"[3] time line, which provided highlights in diversity from 1899 with the first African American veterinarian to 2009, was very informative and enlightening.

The piece on male veterinarians becoming a minority caught my eye.[4] I taught veterinary parasitology at the University of Missouri College of Veterinary Medicine between 1968 and 1973. We only had four to eight women in the five classes I worked with, and they were at or near the top of every class. Women clearly had to be a lot better to be admitted in those days.

After joining the AVMA in 1973, I became the Director of Continuing Education and the

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. 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.

editor of the Continuing Education News. In an editorial in 1974, I predicted that the biggest revolution for our profession for decades to come was going to involve gender, with the coming large increase in the number of women in the profession. Since then, I've known two female presidents of the AVMA, and I expect many more to come!

The story about Dr. David Rickards, "Putting diversity into practice,"[5] reminded me of another colleague I got to know and appreciate. His leadership in promoting diversity in the profession and in his community has been exemplary. Thanks, too, for the story about Drs. Usman and Siddiqi and the Muslim VMA. The points about Islam being, at its center, about compassion and peace are well-taken and timely.

Edward R. Ames, DVM, PhD
Corvallis, Ore

1. Nolen RS. Tuskegee's diversity legacy continues today. *J Am Vet Med Assoc* 2010;236:370–371, 381.
2. Campbell JR. *Reclaiming a lost heritage: land-grant and other higher education initiatives for the twenty-first century*. Ames, Iowa: Iowa State University Press, 1995;37, 137.
3. News. Evolution of a profession. *J Am Vet Med Assoc* 2010;236:370–380.
4. Burns K. At veterinary colleges, male students are in the minority. *J Am Vet Med Assoc* 2010;236:376–377, 384.
5. Kahler SC. Putting diversity into practice. *J Am Vet Med Assoc* 2010;236:372, 382.

The special section of the February 15, 2010, *JAVMA* News on diversity[1] was far and away the most interesting and edifying News piece ever. When this year's national magazine/journal awards are handed out, *JAVMA* deserves one.

One minor point—on page 373, there is a reference to "human physicians." That's a redundancy. A physician who doctors to any species other than *Homo sapiens* would be practicing veterinary medicine without a license and—if I hear about it—is in big trouble.

Bruce Max Feldmann, DVM
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1. News. Special issue: diversity. *J Am Vet Med Assoc* 2010;236:368–384.

Requests clarification on ventricular tachycardia study in Boxers

Congratulations on the excellent article, "Electrical cardioversion of sustained ventricular tachycardia in three Boxers."[1] Could the author please explain the statement, "Left bundle branch block pattern of the QRS complexes indicates a right ventricular origin of the arrhythmia," found in the caption for Figure 1?

Henry E. Childers, DVM, DABVP
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1. Prošek R. Electrical cardioversion of sustained ventricular tachycardia in three Boxers. *J Am Vet Med Assoc* 2010;236:554–557.

The author responds:

Thank you for the kind words and an excellent question. Your question gave me some time to reflect and accept that it is fairly confusing to use one ECG abnormality (bundle branch block) to discuss other ECG abnormalities like ventricular arrhythmias. With that preamble, the focus of a ventricular premature contraction (VPC) can be suggested by QRS morphology; that is, QRS complexes with left bundle branch block patterns suggest right ventricular ectopic contractions, and complexes with right bundle branch block patterns suggest left ventricular ectopic contractions. Perhaps a better description would be that VPCs originating in the right ventricle should have QRS complexes that are positive in lead II (disregard the T wave), and VPCs originating in the left ventricle should have QRS complexes that are negative in lead II. This is based on the fact that left ventricular mass normally exceeds right ventricular mass, with depolarizations of the left ventricle overwhelmingly controlling the magnitude and direction of QRS forces in dogs. Hence, given that lead II's positive pole is towards the left ventricle, an ectopic impulse originating in the right ventricle heading towards the mass of the left ventricle would be positive in lead II as in Figure 1 of the article. As with many clinical medicine problems, there are always exceptions or gray areas, and consideration has to be given to VPCs that originate in the septum (shared by both ventricles) and VPCs originating near the conduction system.

Once again, thank you, Dr. Childers, for a thoughtful and stimulating question.

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