FAMILY = PET BOND = PROFIT

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HAB = human animal bond = the interaction of people and animals in our society = profit center of the future.

A majority of veterinarians make their living because of the human-animal bond, yet most veterinary practices do not capitalize upon the potentials available. The client calls the veterinarian because they have a concern about the well being of their animal and want an expert to assist them during their stressful decision time; they want *peace of mind*. The basic premise which needs to be taken when the phone rings is that "the phone shopper" wants a quality-based, caring veterinarian at "an affordable value". A phone "emergency case" wants to be told they have done the right thing by calling and should come into the practice. No client who calls wants to be told to stay home.

The contemporary pet programs such as active pet selection assistance (AVMA©), pets by prescription and the Pet Partners© certification program (Delta Society©), Prescribe Pets Not Pills (VPI Skeeter Foundation©), and behavior management (AAHA©) promote the human-animal bond while supporting the healthcare reverence for life and quality of care programs. Many Veterinary Teaching Hospitals are starting telephone "hot lines" for pet owners to allow the students who volunteer to better understand the stress of animal stewardship grief and stress. A multi-faceted, interdisciplinary group, sponsored mainly by Hills, named VetOne©, started publicizing the family-pet-veterinary bond at major veterinary meetings and in our media as we entered the new millennium. The text, *Promoting the Human-Animal Bond in Veterinary Practice*, was released in May 2001, and the second edition was published by the VIN Press in 2009 with a new well care chapter; it has 26 appendices of practical application programs. HAB information abounds, but practice commitments vary.

Definition of BIOETHICS: *applied ethics to real-life, day-to-day problems of ethical decision making in health care delivery.*

In the past, veterinary ethics have been forensic (legal) values we used to describe the professional approach to veterinary practice, but bioethics are the values we use personally in practice. Sometimes the veterinarian is the person who makes the bioethical decision, sometimes it is the person answering the

phone, and on some occasions, it is the person who observes the suffering inpatient in a cage. But more often, the decision is laid at the feet of the lay people we come into contact with -- family, clients, public officials, judges, humane societies, and others. There is seldom any clear bioethical solution. Rather, there needs to be an awareness of its existence within the veterinary practice environment.

CHOOSING A THERAPY WHEN DOCTORS DISAGREE

This situation presents a wide array of ethical issues. Whether or not the client should be informed of the nature and prognosis of the illness is certainly pertinent, but is hardly the most significant question in the bioethics at hand. Attention should be focused upon a cluster of three basic ethical questions raised in this case:

- Who should make the ultimate decision when choices between alternate modes of therapy must be made is an obvious issue that must be faced in a multi-veterinarian practice?
- When we start to evaluate a patient, then continue to make the treatment decisions (often based on economics in lieu of best care), how should the client be involved in selecting the alternatives?
- The third, and perhaps the most fundamental issue, is who makes the decision when each of the alternatives (often conservative medicine versus exploratory surgery) is substantially correct?

The option to be chosen in each of the above three questions is not just a medical decision based on scientific training, but rather, a professional value judgment. When a healthcare team is being developed, these cases deserve a full staff discussion so the professional logic, subjective feelings, and practice core values become established so others can make similar decisions in the future.

ACTIVE EUTHANASIA

The American Medical Association states that active euthanasia is illegal, but they only deal with one species of animal. Exactly what are the fundamental measures of animal value and worth which require the veterinary bioethics to be evaluated?

- A pedigree animal with a genetic defect, or maybe just not meeting the specifications of the American Kennel Club.
- Killing an animal because a family is relocating to a home that cannot allow animals, or maybe the travel requirements are too extensive to continue economic support of the family animal(s).

- The medical ethics of letting an animal die due to a disease syndrome versus accelerating the process and minimizing the family cost or anguish.
- A problematic issue in euthanasia is who should bring up the options first. Is it a client concern or a medical concern?

The alternatives in euthanasia are generally not based in veterinary science. They are based in personal value systems and practice philosophies. In many of the practices we support, we suggest a “pain” versus “suffering” discussion when the patient is entering the golden years, when there is malignant oncology present, or other debilitating or chronic syndromes. Be proud that we can treat pain in many ways now; many clients do not know this. Suffering on the other hand, is often a subjective value observed by the client, including the animal soiling its den (urinating or defecating uncontrollably at home), bumping into walls due to poor eyesight, inability to maneuvering stairs, snapping at the children when startled due to loss of hearing, or similar behavior challenges. We spend the extra client time ensuring they know that we can “treat pain”, so they need to call whenever it seems to be present, while in a case of “suffering”, the client must tell us when the love of the animal outweighs the loss of the companion, and it is time for euthanasia.

ANIMAL ABUSE OR NEGLECT

This issue is sad but raises no difficult questions of principle at all. If there is a violation of the Animal Welfare Act - Code of Federal Regulations (CFR), Title 9, Chapter 1, Subchapter A, there is neglect; if the act was intentional, it is usually considered abuse. Presumably in these cases, the individual or the family who has support responsibilities for the animal(s) is deemed inappropriate to the animal's welfare. But the veterinary practice which makes the decision to elevate the issue to the authorities must face bioethical issues.

- Is neglect due to a lower than expected family knowledge of basic animal care, or is the situation caused by an overt disregard for the animal's welfare?
- Does the practice have the right to decide between referral and in-house counseling? If referring the case would cause a greater trauma to the family unit than individual counseling by the practice staff, is there a decision to be made?
- Will this counseling or referral (or lack of it) cause a loss in income or trust for the practice within the community?
- If the community laws or rules tend to promote certain action, or an uncertain or undesirable disciplinary behavior, should that affect the bioethical issues of this situation?

When a practice promotes behavior management services, starting with house training, the incidence of neglect decreases in the clientele. Most clients are unaware of proper animal care, since they learned from their parents, who in many cases either came from the farm, or had parents who came from rural America, where farm dogs and barn cats had to fend for themselves. Like parenting, there are very few prerequisites in our family stewardship system, so if we do not do it in the veterinary practice setting, no one will. This is a wonderful area for staff bonding with clients, and the brochures and literature from AAHA make a great starting point, along with the appendices of the above mention text, *Promoting the Human-Animal Bond in Veterinary Practice*.

THE KEY QUESTIONS

It is often said that issues of bioethics fall into two categories: some concern procedures for decisions, others the substance for decisions. The distinction, while intuitive, is not easy to sustain. How do we know which values should be followed unless we know what values should to be sought?

In biomedical ethics, there are usually five basic decision-making agents that require consideration by the veterinary practice:

1. **The hospital** has arrived at a series of policy judgements over the life at the practice, often based on facilities, equipment, and staff limitations or capabilities.
2. **The technician nurses and staff** often prefer certain types of cases or admissions, and certain treatment modalities that allow them a comfort zone of operation.
3. **The client** may wish to be involved in, and not merely informed of, the decisions being made in the case. The values of the client may or may not match the values of the practice.
4. **The patient** has certain needs and the animal's welfare must be considered when extending any morbid state (the arguments concerning an animal's "rights" are certainly bioethical issues).
5. **The veterinarian** not only makes the policies of the hospital, but is also bound to interpret them on a case-by-case basis in light of state-of-the-art veterinary medical knowledge, as well as fiscal management concerns of the practice and client.

There is a traditional adage in medicine, that is, "First, do no harm". In the previous bioethical issues, some would feel that the solutions were clear and definitive, that ethical issues do not exist. The areas discussed are illustrative of veterinary medical situations where there is room for reasonable people to disagree. The reason for this discussion was to make the concept of ethics in

biomedical decisions become a reality, to show that bioethics do apply to veterinary practices, and to offer the opinion that bioethics should be an element of the decision making process in quality health care delivery in the veterinary practice.

THE PSYCHOLOGICAL BOND

The American Veterinary Medical Association developed and has available all the documents and aides needed for active pet selection assistance by veterinary practices, including some very well done color brochures. The AVMA also introduced the Lost Pet Kit over a decade ago, yet many practices have neglected to integrate it into their practice programs; with digital photography, it is easy and takes very little space! The Delta Society has developed the protocols for Pet Partners and pets by prescription within the community and school environment. Either of these programs can develop new pet owners, clients who are already bonded to the practice since they selected their pet with the expert assistance of the veterinary professionals of that facility.

Human-animal bond resources are available at almost no cost to the veterinary healthcare facility. There are multiple human/companion animal bond (H/CAB) programs available from associations and other non-profit organizations, and 26 are listed in the appendices of *Promoting the Human-Animal Bond in Veterinary Practice*. The international clearing house for interdisciplinary HAB groups and programs is the Delta Society (800-869-6898). The American Veterinary Medical Association (708/925-8070) has the pet placement handouts and information as well as hosting the American Association of Human Animal Bond Veterinarians (AAHABV – which has a very small membership fee).

The best companion animal practices realize they "sell" only one thing: *peace of mind* for the client. They concurrently are a patient advocate and tell the client what is needed for the best of the pet, either of wellness or professional diagnostic concerns. The client is allowed to select from the list, they are allowed to "buy" what they think they can afford. Lesser cost alternatives are not offered UNTIL the client asks for lesser cost alternatives, but the "options" must be kept in perspective of lesser diagnostics, lesser response rates, or lesser probability of desired healthcare effects. Clients prefer to "buy" and hate being "sold" in most every occurrence, and a smart practice leader trains and rehearses the practice team to "sell" ONLY peace of mind, freedom from fears, or psychological comfort while allowing the client to "buy" products and services to their heart's content.

Dentistry is a common human-animal bond practice program . . . lack of oral hygiene is a cause of breaking the human-animal bond, as in so bad a breath

that it would choke a horse. Restoring “puppy kisses” is the ultimate benefit of a dental prophy, but is seldom mentioned. When a practice starts to “grade” teeth, magic happens, especially with differential pricing. Dentistry is becoming a quotable commodity, so pricing is a community positioning action as well as client bonding action. The Holstrom, Frost Eisner dental text makes a clear differentiation between Tartar and Calculus, which I use here:

> **Grade 1+** - tartar, with biofilm bacteria causing bad breath, brown molars, white incisors, slight red gums, no gingival detachment, door to door it costs $174, total! *It is actually a 20 minute procedure for skilled technician nurses, so three 1+ dentals an hour will cause significant cash flow with minimal overhead . . . and if they are in the USA and have the veterinary pet insurance wellness program, most have dental reimbursements, so* the cost is actually less!
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> **Grade 2+** - tartar plaque and biofilm bacteria causing brown molars, brown incisors, red gums, less than 25% gingival detachment, door to door it costs about $284, total! Smart practices require dental X-rays at this point, at a reasonable price (e.g., $65), since about 40% will convert to oral surgery. *It is actually a 30-40 minute procedure for skilled technician nurses, so two 2+ dentals an hour will cause significant cash flow with minimal overhead . . . and if they are in the USA and have the veterinary pet insurance wellness program, most have dental reimbursements, so* the cost is actually less!
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> **Grade 3+** - oral disease causing tartar AND calculus on the teeth, very red gums, 25% to 50% gingival detachment, oral surgery and radiographs of the roots are required - cost of oral surgery is usually $800-plus! X-rays are ESSENTIAL, and surgery and anesthesia are timed to determine the fees. *It is actually an hour procedure for a skilled veterinary nurse/technician setting up for the veterinarian’s surgery, so one 3+ dental an hour can usually be done, but a doctor must be available in the treatment room for extraction and surgical demands . . . and if they are in the USA and have the veterinary pet insurance wellness program, most have dental reimbursements, so* the cost is actually less! *Many also reimburse separately for the oral surgery too!*
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> **Grade 4+** - oral disease all the way down to the bone, over 50% gingival detachment, oral surgery and radiographs of the roots are required - cost of oral surgery is $950-plus! *It is actually an hour-plus procedure for skilled technicians, so one 4+ dental an hour can be done, a doctor must be available in the treatment room for extraction and surgical demands, and it is systemic condition requiring follow-up visits . . . and if they are in the USA and have the veterinary pet insurance wellness program, most have dental reimbursements, so* the cost is actually less! *Many insurance programs also reimburse separately for the oral surgery too!*

DISCLAIMER - in some areas of the USA, the above example prices are only 50% of the going rates. We usually recommend to phone or e-mail clients, where we have not assessed the community, that veterinary practices with a single dental rate peg their prices by using their current fee as the 2+ prophy rate, decrease by 25-33% for the grade 1+ prophy, increase by 50-75% for the 3+ oral surgery fee, and at least double for the 4+ oral surgery.

Behavior management is one form of HAB practice service; it is one of the hottest topics on the continuing education seminar circuit in recent years. A survey of Internet searches shows behavior management is the #2 reason for new clients selecting a practice (location was #1).

The primary problem is proactive behavior management services are a staff function as much as a professional service, and the staff members seldom get to attend the seminars. Obedience training is not behavior management, it is most often handler and location specific. HAB behavior management is teaching and rewarding the pet an appropriate family behavior by positive reinforcement. Allowing the client to "buy" these services is a client privilege most practices do not yet offer. Behavior management programs are easily initiated for dogs using the Gentle Leader head collar (usually provides “power steering” in less than 8 minutes when you understand that “release of pressure” is the animal’s reward of that device). The 65-page head collar booklet provides the techniques needed for behavior management, but the "caring" practice offers their nursing staff as “head collar fitters” at sale, and as trainers to help the client if they get stuck ($20 per appointment). This veterinary practice behavior management effort often leads to Puppy Clubs, Kitten Carrier Classes, Senior Clubs, and other client "social" programs (e.g., Guinea Pig Pig Out) which add to the practice bonding (and concurrently increases the client return rates -- and practice liquidity). In some cases, the practice supports a Pet Partner Program (Delta Society), and gains from the community good will and human interest media stories.

Behavior management is a potential practice area for staff to excel. Most are client education programs best done by trained staff members (e.g., house training, feeding, new owner orientation classes, etc.). In America, over 6 million animals a year lose their home and often their lives because of behavior problems. It is worse in many other countries. The veterinary practice team which helps prevent this "disposable pet" syndrome not only keeps clients, but gains positive recognition in the community. Recognition for helping animals is a marketing benefit to the practice without having to advertise or market routine services or products.

Nutrition is the ultimate human-animal bond for most clients. Clients like to feed their pet, because it makes the pet seem happy. We know that premium diets and quality nutrition will extend the active life of most companion animals, but we often forget to tell clients about "smaller stools" or "better smelling cat boxes" when feeding the highly digestible premium foods. Prescription diets should be treated like any other prescription, and be actively monitored by the paraprofessional staff at 2 to 4 week intervals; these can be "no cost" courtesy visits with the "nursing staff", since purchase of goods usually accompanies a visit to the practice.

Changing "boarding" to a Pet Resort, or Canine and Kitty Camp, and changing "kennel kid" to animal caretaker, can change the atmosphere of the separation encounter. Using a Kong Toy for "yappie hour" (if they purchase a Kong Toy at guest check-in, a special feeding using the inside of the Kong Toy will be done at 5 p.m. daily, like a happy hour). When the pet goes home with the Kong Toy and "yappie hour" habit, when the client comes home from work and is greeted by a leaping bundle of fur, they can provide the Kong filled with food, and get changed into their doggy play clothes while the pet is occupied (P.S., Kong Toys are dishwasher safe, and almost indestructible, while not looking like anything in the home, except maybe the Michelin Man).

THE BOTTOM LINE

As a full time consultant, what I miss most about practice is "puppy breath". Like most all veterinarians, our staff joins veterinary medicine because it is a "calling"; we know they do not join for the meager salary and benefits alone. When we can promote hospital staff as patient advocates, human-animal bond specialists, and "nursing" staff (a term the clients understand very well), we can reinforce the "warm fuzzy" aspects of this rewarding profession in their hearts and minds.

In a recessionary economy, clients stay home more, see their pet more, and will strive to fulfill "needs" while they postpone "wants". Since 9-11-01, followed by the GFC (global financial crisis), practices which had been using the word "need" for healthcare have had greater client access; after 9-11, most had the best October and November in their history. Practices that clung to the nondescript "recommend", or those that offer multiple options and expect client expertise to make rational decisions, had slower months than ever before; clients do not want to make choices when stressed, they want to be told what is needed by someone they trust.

Explore every client contact for those moments when the family-pet bond can be promoted. Listen to the Dr. Marty Becker "fear free" initiative being copied at many levels; brainstorm the concept with your staff to get real excitement

going. Use every opportunity to acknowledge the important role the companion animal plays by providing their non-judgmental love in these times of stress and worry. Allow the practice staff members to select HAB areas of interest, help them develop a working knowledge of the subject material and healthcare delivery options, get them practice business cards with their new title (e.g., pain management advisor, veterinary dental hygienist, behavior counselor, nutritional advisor, etc.), and start to promote their interest and new knowledge as a client benefit. Celebrate the bond every day in every way!