TITLE 26
LEGISLATIVE RULE
WV BOARD OF VETERINARY MEDICINE
SERIES 4
STANDARDS OF PRACTICE

COMMENTS ONLY RELATING TO SPECIFIC RULE CHANGES
AND RESPONSES FROM THE BOARD

Jim Henderson, DVM March 21, 2016 – 2.3 Dental Operation (New), 7.1.d Dental Services (New), 2.2.a, 2.2.b., 4.7.b (Old)
A concern I and other mobile large animal veterinarians have is the elimination of section 2.2.a, 2.2.b and 4.7.b language regarding dentistry and replaced with that of section 2.3 and 7.1.d.

The inference can be drawn that as long as no sedation or anesthesia is employed, lay people can perform dental operations. This has long been a thorn in our side with "equine specialists" coming in and out of the area and doing not only dental procedures but other diagnostic/therapeutic procedures of doubtful value with no veterinarian on site at either barns or "clinics" set up at various venues. I seem to recall the previous alteration of the standards of practice had no small impetus from the numbers of lay personnel doing small animal dentistry, groomers and the like. This seems to open up the loop hole closed by the previous language.

Kim Smith, MS, DVM March 24, 2016– 2.3 Dental Operation (New), 2.2.a, 2.2.b., 4.7.b (Old)
I am concerned regarding the statement on page 1, new 2.3, which defines dental operation being done under anesthesia. This infers that there are procedures that can be done without anesthesia. I believe this leaves too much room for procedures to be performed by lay people. Dental cleanings cannot, in my opinion, be performed safely, humanely, or properly in an awake animal. The American Veterinary Dental College speaks against anesthesia free dental cleanings. Although I am a small animal veterinarian, I believe this would also impact equine welfare by allowing non-veterinarians to float teeth.

Tracy R. Walker, DVM, March 30, 2016– 2.3 Dental Operation (New), 2.2.a, 2.2.b., 4.7.b (Old)
The proposed revision to the definition of dental procedures is unnecessary and certainly not in the best interest of animal welfare. Standards of practice proposed by both the American Veterinary Medical Association and the American Association of Equine Practitioners advocate sedation and anesthesia as necessary for complete and thorough oral exam, let alone treatment of pathology. Preventative care such as occlusal equilibration ("floating") in equines should be limited to veterinarians only. Scaling and polishing in companion animals should also be limited to qualified technicians under direct supervision of a veterinarian. It is imperative to point out that the preventative care or maintenance procedures are only part of the complete oral exam. Indeed, an equally important or more important portion is conducting an oral exam to search for pathology such as gingival pockets, diastemas, fractures and oral tumors. In human medicine, a "routine dental cleaning" by a licensed hygienist would never be considered complete without and exam by a licensed dentist.

Suggesting that dental procedures could or should be done without sedation, appropriate analgesia or anesthesia is inhumane and below the current standard of care. I routinely perform advanced dentistry on horses. As part of my procedure, horses will first undergo a complete physical exam. Sedation, including opiates, is given to facilitate a complete oral exam and occlusal equilibration. If extraction or other potentially painful procedures are anticipated, additional pain medications are administered and if able, a local anesthetic nerve block is administered. Frequently I will see pathology in the caudal oral cavity that has not been addressed because sedation and full mouth speculum were not employed for a complete oral exam. There is no possible method by which I could safely, humanely and completely examine the oral cavity of the horse without appropriate sedation.
I would propose that the definitions of "dental operation" remain unchanged from the previous rules as described in 2.2a and 2.2b. In addition, I would propose that equine dentistry must be completed only by a licensed veterinarian as this is the only way to ensure that the animal is appropriately sedated and examined completely and thoroughly.

Tracy R. Walker, DVM, March 30, 2016 – 4.7.a. Dental Operations (Old)
Please see Item 1 in this document. As noted in my earlier comments on dental operations, it is imperative that this rule remain in force either here or listed in another section.

Kathleen Anderson, DVM – American Association of Equine Practitioners, April 4, 2016 -2.2.a, 2.2.b., 4.7.b, 4.7.a. and 4.7.b. (Old)
Rustin M. Moore, DVM, PhD, Diplomate ACVS, Dean, College of Veterinary Medicine April 11, 2016 -2.2.a, 2.2.b., 4.7.b, 4.7.a. and 4.7.b. (Old)
We are concerned that the proposed changes would remove dentistry from the practice of veterinary medicine and potentially allow non-veterinarian, non-licensed, and unregulated providers to provide these services.

Clara Ann Mason, DVM, April 05, 2016– 4.7.a., 4.7.b. and 2.2.b. Dental Operations (Old)
When I call the Board office to complain on a nomad lay dentist, the employees of the Board ingeminate that "the Board is charged with protecting the public and they have no authority to enforce non-veterinary practice". WV Code 30-10-5 : states the Powers and Duties of the Board to investigate violations. Dentistry (small and large animal) is a national veterinary board certification. Therefore, any invasion into an animal's mouth for the purpose or treatment , diagnosis, manipulation, adjustment or prophylactic services should only be performed by a licensed veterinarian or under the direct supervision of a veterinarian. The WV Vet Board should not have the authority to supersede this veterinary provision. Instead, it is the Board's charge to investigate and charge any non-veterinarian for practicing such acts. It is illegal to practice medicine, law, dentistry as well as other professions in this state without appropriate licensure and those offenders can be prosecuted. The same structures should apply to veterinary medicine. You are NOT protecting the public by allowing dentistry to be practiced by non-veterinarians . Not only are these lay dentists not trained in equine dentistry and actually injure some of the horses, these persons are administering sedatives (dangerous by a non-veterinarian), most are out-of- state residents and none have WV business licenses nor are they paying WV taxes. When a veterinarian calls the Board and lodges a complaint against a lay dentist, the Board has the charge to inform the police that a lay-person is impersonating a veterinarian and is practicing without a license.

George R. Seiler, DVM, April 8, 2016 – 2.3. Dental Operations
Frank J. Cary, DVM, April 11, 2016 – 2.3. Dental Operations
Limiting the definition of "Dental Operation" to animals exclusively under sedation or anesthesia may lead lay individuals to practice veterinary dentistry with no sedation or anesthesia when the patient needs sedation or anesthesia to limit pain. Many (most) conditions in veterinary dentistry cannot be properly treated without sedation and anesthesia. The American Animal Hospital Association and the American Veterinary Dental College recommend that all professional small animal dental cleanings be under anesthesia- it would be a disservice to the public if lay individuals advertise that they do "anesthesia free" dental cleanings that fail to properly clean the animal's teeth and gingival recess. Lay individuals may be encouraged to extract teeth without pain relief or with limited local numbing of the gums-which would lead to animal suffering. Lay individuals do not have the proper training in veterinary disease recognition to practice veterinary dentistry.

Suggested wording: "Dental operation" means: <u>the application or use of any instrument or device to any portion of an animals tooth, gum or any related tissue for the treatment of any disease process, cure or relief of any wound, fracture, injury, disease or other condition of an animals tooth, gum or related tissue. Application of a dentifrice, toothbrush, toothpaste, tooth whitening product, dental flossing with a fiber product or any other procedure which does not alter the tooth, gingival, gum or bone structure shall not be considered a "dental operation".</u>

Holly Kossuth, DVM, April 11, 2016 – 7.1.d.1 Dental Procedures (New)
"Dental Operation" is defined, but on 7.1.d.1 the term "dental procedures" is used. Support staff should be limited to scaling, polishing and charting only.

Lynne Sparks, DVM, April 11, 2016 – 2.3 Dental Operation (New), 4.7.a. Dental Operations (Old)
2.23 Dental Operation- the application or use of any instrument or device to any portion of an animal's tooth, gum or any related tissue for the prevention, cure or relief of any wound, fracture, injury, disease or other condition of an animal's tooth, gum or related tissue.
Explanation:
As stated in the proposed rule change the door is left open for layman dentists, farriers, mechanics, etc. to perform any and all dental procedures as long as they are not performed under sedation or anesthesia. This will lead to inhumane treatment of animals as there are ways to restrain any animal enough to perform any extraction or surgery without the use of sedative or anesthesia. This is already a problem within the equine industry in this state and others and this rule change will only make the unnecessary suffering of our animals worse. In my equine dental practice and regular mobile equine practice, I routinely see horses who have recently had an occlusal equilibration done by a layman who have major problems either caused by the floating that the layman has performed or

malocclusions that were not taken care of at the time of the service. I have also seen many horses who have had teeth incompletely extracted or have had them extracted with no sedative or analgesic. In a horse, the only way to accurately determine that the entire tooth and root on a cheek tooth has been completely removed is through postoperative oral radiography. It is also imperative to radiograph the teeth prior to removal to determine which tooth or teeth are affected as this is not always apparent through an oral exam. The AAEP advocates strongly the use of sedative when oral exams and occlusal equilibations (floatings) are performed on horses, much less more invasive procedures. I advocate this as well. It is imperative that the entire oral cavity has a thorough evaluation at every dental. This is nearly impossible, even with a speculum, in most unsedated horses. For those not well versed in equine dentistry, my procedure for occlusal equilibration (floating) will be explained. The horse has a full physical examination and then is sedated. Once sedated the mouth is rinsed with a chlorhexidine based solution. A speculum is placed that holds the mouth open so that the entire oral cavity can be palpated and visually examined. A bright Luxeon LED light is placed on the speculum to allow visualization. A dental mirror and an array of dental probes and picks are used to evaluate the entire tooth crown and all soft tissue structures within the oral cavity. Once lesions are addressed, the treatment plan is discussed with the owner and a Powerfloat system (a modified Dewalt drill with a high speed rotating diamond disc blade) is inserted into the mouth and the enamel points or other anomalies found on the exam are corrected by grinding away the tooth surface. Both the cheek teeth and the incisor arcades are balanced. If any periodontal pockets (severe gingivitis) are noted they will be flushed and treated. Any need for further testing or therapy such as analgesic medication or antibiotics is discussed with the owner and a plan is developed.

4.7 Dental Operations

4.7a All dental operations shall be carried out by a licensed veterinarian, technician or veterinary assistant under the direct supervision of a licensed veterinarian.
Explanation: A veterinarian is essential to the diagnosis and treatment of oral disease. Any procedure performed on the teeth or oral cavity should be classified as a medical or surgical procedure that will impact the health and well-being of the animal. The remainder of the digestive system is under the care of the veterinarian, why should the oral cavity not be? Just because the general public can access a part of an animal does not mean that they should have free rein to treat it in any way. This should be left to those of us who have the training and experience to identify and treatdisease.

Jenna Palmer, DVM, April 11, 2016 - 2.3 Dental Operation (New)
"Dental Operation" By adding "under sedation or anesthesia" leaves an opening for nonprofessionals to do damage to animals mouths. I was always taught never to do an equine dental without sedation because the horse can hurt itself or others when fighting with the mouth speculum. I don't think there is any other way to do an appropriate dental exam and float/treatment without sedation. I have seen the damaging effects that were caused by the hands of untrained nonprofessionals that have worked on horse's feet and decided to "file" the horse's teeth as well with the hoof rasp. If you have ever seen a hoof rasp then you know that there isn't a smooth surface on any edge. One can image the damage that was done to the horse's mouth. Once the amateurs have done their damage, myself as well as other licensed doctors are then tasked with the burden of trying to "fix" the sometimes irreversible damage done by the untrained nonprofessional.

Dr. Shawn D. Sette, April 11, 2016 - 2.3 Dental Operation (New)
I feel that the last few words ("under sedation or anesthesia") need to be removed. Their presence seems to indicate that there are procedures that can be done without anesthesia. I believe this leaves too much room for procedures to be performed by non-licensed, non-professionals. Dental cleanings cannot be performed safely, humanely, or properly in a non-anesthetized patient. The American Veterinary Dental College is against anesthesia-free dental cleanings.

Justine Saville, DVM, April 11, 2016 - 2.3 Dental Operation (New)
Rule 2.23 states that dental operation will incorporate most to all dental procedures but only under sedation or anesthesia. So my confusion is, does this mean its ok for laymen to provide dental care to animals as longas they are not utilizing sedation/anesthesia? Ifso, this is unacceptable. I have experienced first-hand the devastating damage an undereducated individual can create by providing "dental care". As a result, once the damage is done they have no means to correct the problem or provide follow up care because they aren't qualified. Therefore, animals suffer. I'm not ok with this.

Bob Morris, April 11, 2016 - 2.3 Dental Operation (New) and 7.1.d.1 Dental Procedures (New)
My comments regarding changes to The WVBVM Standards of Practice focus on opening up non-sedated equine dental procedures to non-veterinarians. While exact numbers are difficult to find, a 2004 West Virginia Equine Economic Impact Study estimated

56,800 horses in the state. When this estimate is combined with the small percentage of Veterinarians that focus on equine / large animals it would seem that liberalizing the restrictions on non-vets would provide more (non-sedated) dental care for the state's equine population. An example involving my brother-in-law illustrates the shortage of equine / large animal Veterinarians in our area. My brother-in-law lives in Albright, WV and needed a vet for a black angus bull. The vet that visited his farm came from Somerset, PA, nearly an hour and a half drive.

Opening up the opportunity for non-vets would follow the lead of The West Virginia State Legislature during the most recent legislative session. Our State Legislature, identifying a shortage Doctors in our state recently passed House Bill 4334 which provides Advanced Practice Registered Nurses (APRNs) with full practice authority including prescription authority of Schedule III pharmaceuticals after completion of forty-five contact hours of education in pharmacology and clinical management of drug therapy. A Medical Doctor is not required to be on staff, a collaborative relationship is the requirement. A 'Collaborative Relationship' means a working relationship, structured through a written agreement, in which an advanced practice nurse may prescribe drugs in collaboration with a qualified physician.

Under the WVBVM new Standards of Practice, the new definition of "Dental Operation" means the application or use of any instrument or device to any portion of an animal's tooth, gum or any related tissue for the prevention, cure or relief of any wound, fracture, injury, disease or other condition of an animal's tooth, gum or related tissue under sedation or anesthesia. This definition makes me think that as long as sedation or anesthesia is not used, a non-Veterinarian may perform equine dental procedures. If this is the case, additional clarity is needed in section 7.1.d.1; 'all dental procedures shall be carried out by a veterinarian, technician or veterinary assistant under the general supervision of a veterinarian.' What is the definition of "under the general supervision of a veterinarian?' Following the lead of the State Legislature, it seems this requirement could be achieved with an active working relationship between the Veterinarian and Equine Dental Technician, not on site Veterinarian support.

Opening up non-sedated dental care will improve the health of the state's equine population.

Dr. Audra Melton, April 11, 2016 – 2.3. Dental Operations (New)
My understanding is that the WV board of Veterinary Medicine's main purpose is to provide the public with safe and professional veterinary care. These proposed changes on the face of it, do not achieve those goals. If there is no quality of care issue with my practice, the board is overstepping their authority by telling me I must align with some outside corporate entity. The same could be said for the proposed changes that non-veterinarians can practice equine dentistry. I would note that both these areas of proposed changes are diametrically opposed to every other state I have been able to inquire with, in that those states allow independent mobile practices both small and large. and the general trend of restricting equine dentistry to licensed veterinarians. It is my hope that the board will discern that these changes are of a business/economic nature as opposed to a quality of care issue and substantially modify them so that the number of people desiring veterinary services in rural West Virginia have that option. I also believe that if the board modifies these proposed changes, it will greatly reduce the board from becoming embroiled in legal entanglements that will distract them from providing a quality veterinary environment for West Virginians

We changed "operation" to "procedure" and we changed the definition wording:

Clara Ann Mason, DVM, April 05, 2016 – 2.5 Full Service Practice and 2.10 Limited Veterinary Practice (New) 2.10 (Old)
My mobile veterinary unit (Bowie unit) has hot/cold water, refrigeration, adequate lighting both on and off of the truck, my instruments and surgical gowns/gloves are sterilized, my records are completely computerized and can be accessed from any mobile device {phone, pads, laptops), and my x-ray/ultrasound units are digital and portable. My "office" is the truck cab. If the Board is uninformed and unfamiliar with a mobile veterinary insert, then I invite the Board to inspect my practice/truck at your convenience.

We removed 2.5. “Full-service practice” and 2.10. “Limited Veterinary Practice” definition. We added “ambulatory practice”, “emergency clinic”, “mobile”, “stationary facility” and “veterinary practice” definitions.

Tracy R. Walker, DVM, March 30, 2016 – 2.7. Humane Disposal (New)
Remove: “Alternatively, an animal may be placed in a suitable home or animal shelter, which shall not include any home or shelter which engages in animal experimentation or, by sale or otherwise, makes animals available for the purposes of animal experimentation.” This sentence irrelevant to the definition of “humane disposal.” There is no need to make an alternative suggestion.

We removed “Alternatively, an animal may be placed in a suitable home or animal shelter, which shall not include any home or shelter which engages in animal experimentation or, by sale or otherwise, makes animals available for the purpose of animal experimentation” from the “humane disposal” definition and moved it to 9.3.

George R. Seiler, DVM, April 8, 2016 – 2.7. Healthcare Provider (Add)
Frank J. Cary, DVM, April 11, 2016 – 2.7. Healthcare Provider (Add)
Add definition “Healthcare Provider”
26-4-2.7 “Healthcare Provider” For the purposes of this Series “Healthcare Provider” shall mean any person or entity providing or enabling the provision of the healthcare needs of animals. It includes, but is not limited to: veterinarians, registered veterinary technicians, veterinary assistants, veterinary staff, prescription providers, and any individual or entity involved in providing healthcare needs or transportation to healthcare facilities for animals.

We removed “healthcare provider” from the Rule; so we do not need a definition.

Tracy R. Walker, DVM, March 30, 2016 – 2.9 Legend Drugs (New)
Remove: “……or other licensed provider.” Who besides a veterinarian is considered a “licensed provider?”

Jenna Palmer, DVM, April 11, 2016– 2.9 Legend Drugs (New)
2.89 “Legend drugs” Strike “or other licensed provider” A licensed Veterinarian should be the only person able to script medication for an animal.

We changed the definition of “legend drugs”.

Tracy R. Walker, DVM, March 30, 2016 – 2.10 Limited Veterinary Practice (New), 4.8.1. Limited Practice Standards (New), 2.11. Secondary Outpatient Facilities (Old)
"Limited Veterinary Practice" -Section 2.10 & Omitted Section 2.11-New Section 26-4-8.1
Your definitions and requirements of "Limited Veterinary Practice" do not take into consideration the special circumstances of large animal ambulatory practice. These definitions must be revisited in their entirety. Forcing impractical standards as defined by rule 26-4-7 on large animal ambulatory practitioners will only result in cessation of these services altogether.

George R. Seiler, DVM, April 8, 2016 – 2.10.c. House Call or Farm Call (New)
Frank J. Cary, DVM, April 11, 2016 – 2.10.c. House Call or Farm Call (New)
Add- 2.10.c. "Immunization clinic" means a veterinary clinic set up in a temporary location for the administration of vaccinations and limited veterinary services.

Jenna Palmer, DVM, April 11, 2016 – 2.10 Limited Veterinary Practice (New)
"Limited veterinary practice" This section is way too vague. For many of the mobile practitioners in rural WV the only way to deliver treatments is to preform them on the farm because many farmers don't have trailers to haul them to a veterinary clinic for treatment. Many animals also are too sick or it is too dangerous to haul them in trailers. The elimination of many of these statements leaves too many openings for untrained unprofessionals to continue "practicing" on animals. It is now unclear what I can and cannot do as a mobile veterinarian.

Justine Saville, DVM, April 11, 2016 – 2.10 Limited Veterinary Practice (New)
Rule 2.10 I'm not sure how to interrupt this one all the way around. Where do we qualify as large animal mobile practices? Are we no longer going to be considered general service? If so, again, this is unacceptable. I practice, as well as many of my colleges, in very rural areas. We have to be able to provide any and all care to animals on the farm because often my clients have no way to transport animals. A lot of them are so far removed from haul in facilities the animal would expire during transportation. Many times the animal's condition will not sustain being transported. Providing the best care possible is my obligation as a veterinarian. Whether it be on the farm or in a clinic I need to be able to care for my patients to the best of my abilities without restrictions. My 8 years of school and DVM focusing on food animal has prepared me to do just that.

I am truly concerned about what these proposed rule changes will mean for my career. I don't feel like it's clear what I can and can't do as a veterinarian. I feel like specific rules have been eliminated and what remains is vague and indistinct. This, again, is a dangerous recipe for laymen to publicly provide veterinary services and animals to suffer.

We removed 2.5. "Full-service practice" and 2.10. "Limited Veterinary Practice" definition. We added "ambulatory practice", "emergency clinic", "mobile", "stationary facility" and "veterinary practice" definition.

We changed the classification of Veterinary Practices.

Kourtney Morrissette, DVM – 2.11 Minor Surgery, 2.14 Surgery (New)
Could you please explain what a "minor" surgery is if it does NOT include "the use of operative measures for treating diseases, deformities, injuries, and for reproductive sterilization or elective surgical procedures?" I cannot. Therefore the language is very ambiguous.

Does the term "minor surgery" fall within the term "surgery?" If so, do we need this term "minor surgery at all?"

Is the board trying to create a special category of surgery that will not need to adhere to a basic standard of care that we require for "Major" surgeries? If so, why? Is it so we can have low cost clinics with subpar standards of care? Is it so that hospitals that do not wish to purchase equipment, stock medications, and bother to educate themselves and their staff can still perform what they see as "minor surgeries" without following a very basic standard of care that our state board has always followed? I do not see any benefit to these ideas – hospitals that wish to perform ANY surgery (whether it is to suture a laceration closed or to perform the most complicated abdominal surgery) need to have the same anesthetic equipment for safety reasons, the same standards of cleanliness for the health of our patients, the same standards of lighting/medical gear for our safety, and the availability of medicines and equipment for adverse anesthetic events so that our pets survive these procedures! These items are inexpensive, easily obtainable, require no training to use by a veterinarian, are made for even the smallest mobile clinics/farm units, and are portable – they should not be "optional."

Or rather is the board actually trying to set up a standard for procedures under sedation v/s procedures under anesthesia? If so, the language needs to be changed accordingly. If so, what procedures are allowed under "sedation" v/s "anesthesia?"

Dr. Shawn D. Sette April 11, 2016 - 2.14 Surgery (New)
Under the definition of Surgery, you make a short list of things that surgery can be used for. This list is too limited. For example, an exploratory abdominal surgery does not treat. It is used to diagnose. I suggest that you remove "for treating diseases, deformities, injuries, and for reproductive sterilization or elective surgical procedures."

We removed "Minor Surgery" definition and changed "Surgery" definition.

Tracy R. Walker, DVM, March 30, 2016 – 2.12. Sedation (New)
By definition the act of sedation is "administration of a drug to induce a state of calm or sleep". This definition should be modified to indicate the sedation can occur only with administration of a drug.

We removed "especially" from "sedation" definition.

Dr. Shawn D. Sette April 11, 2016 – 2.16 Veterinarian in Charge
I need clarification of what the definition of "veterinarian in charge" is trying to say. As I read it, it sounds like it is referring to the owner of the practice, but it also states that this person is a veterinarian. Currently there are lay people and corporations in WV that own veterinary practices and those individuals are in charge of maintaining the practice within the standards. Or is it only referencing a single veterinarian that is working on a single patient and that veterinarian is in charge of the practice at that moment? It seems like this definition was created to suit specific needs in other portions of the practice act, but it leads to misunderstanding when used in other contexts or sections.

We will not be making any suggested changes. There needs to be at least one veterinarian in charge to be responsible for violations of the Rule.

Ann F. Hubbs DVM, PhD, March 25, 2016 - 3.7. Accreditation (Old)
Section 3.7 is unclear in the context of current accreditation laws (I believe these are at https://www.gpo.gov/fdsys/pkg/CFR-2010-title9-vol1/pdf/CFR-2010-title9-vol1-sec161-4.pdf). In the 1980s, those of us who were accredited were told we were accredited for life unless that accreditation was revoked or suspended However, that has change – to maintain accreditation, a veterinarian now renew their accreditation every 3 years. From the CFR:

> "(a) Accredited veterinarians who wish to continue participating in the National Veterinary Accreditation Program must renew their accreditation every 3 years by completing an application for accreditation renewal and submitting it to APHIS."

My point is that veterinarians who have no need to perform services of an accredited veterinarian may not maintain their accreditation but that no longer means their accreditation has been revoked. For example, I am a board-certified veterinary pathologist and currently perform no functions as an accredited veterinarian. The Accreditation program has provisions for re-accreditation of those with expired accreditation.

Although it is clear from the language that disciplinary action is intended for those whose accreditation has been revoked, as opposed to expired, the section title currently could be interpreted to involve those who received lifetime accreditation but then the accreditation rules changed – their accreditation may have expired. I believe that under the current provisions of the Accreditation Program, this section should have a new title: Revocation of Accreditation

Rewording will provide a clear distinction between veterinarians whose jobs do not involve participating in the National Veterinary Accreditation Program and veterinarians who have had their accreditation revoked as a result of failure to comply with the required standards in performing the duties of an accredited veterinarian.

Tracy R. Walker, DVM, March 30, 2016 - 3.7 Accreditation (Old)
This rule should be removed entirely. USDA Accreditation is an adjunct special certification for specific USDA procedures. It is not required to practice veterinary medicine and has no bearing on a veterinarian's ability to practice medicine.

Kathleen Anderson, DVM – American Association of Equine Practitioners, April 4, 2016 - 3.7 Accreditation (Old)
Rustin M. Moore, DVM, PhD, Diplomate ACVS, Dean, College of Veterinary Medicine April 11, 2016 - 3.7 Accreditation (Old)
We have concerns regarding the proposed changes that mandate disciplinary action against veterinarians when his/her accreditation is revoked.

Clara Ann Mason, DVM, April 05, 2016 - 3.7 Accreditation (Old)
Though my accreditation status is current and in good standing and I have never been subject to suspension or disciplinary actions by the USDA, I argue that the Board has no jurisdiction to take disciplinary action against a veterinarian that has his/her accreditation revoked. In order for the applicant to reapply for accreditation, he/she must have a current state license. If you discipline a veterinarian, the Board will have successfully hobbled his/her attempt to reapply. If the Board assumes the responsibility of issuing disciplinary action against a veterinary license based on an accreditation complaint, the state of WV will be legally liable if the revocation becomes *over*- turned on appeal. This is beyond the scope of jurisprudence for the vet board.

We changed the wording.

George R. Seiler, DVM, April 8, 2015 – 3.8 Responsibility for Acceptance of Medical Care (New)
Frank J. Cary, DVM, April 11, 2016 – 3.8 Responsibility for Acceptance of Medical Care (New)
Suggestions: omit medical- omit professional capacity. The veterinarian may have the professional capacity to treat a case, but may choose not to treat a case by the abusive nature of a particular client.

Daniel Cain, DVM April 11, 2016 – 3.8 Responsibility for Acceptance of Medical Care (New)

Upon reviewing the changes made to the Practice Act, I would like to pose these sections for discussion. These sections should be reviewed, clarified, questioned, and some changed or remain unchanged.

3.8 Responsibility for acceptance of medical care. A veterinarian shall decide what cases will be accepted. In the event the veterinarian chooses not to provide services or discontinue services the client shall be notified from the contact information provided.

We changed the wording.

George R. Seiler, DVM, April 8, 2016 – 3.13. Honesty, Integrity and Fair Dealing (Old)
Frank J. Cary, DVM, April 11, 2016 – 3.13. Honesty, Integrity and Fair Dealing (Old)
The amount charged should be left to free trade. It is already covered in the "fair dealing" statement. Adding the burden to determine the amount to be charged to a client in a particular case by the Board of Veterinary Medicine is unwarranted. The Board would then have to stipulate what "fair fees" are.

Suggested: 3.13 Honesty, integrity, and fair dealing. A licensed veterinarian shall conduct his or her practice with honesty, integrity, and fair dealing to clients in time and services rendered.

We changed the wording.

Dr. Shawn D. Sette April 11, 2016 – 3.14. Observance of Confidentiality (Old), 3.16 Release of Records (New)
26-4-3.14 I suggest you add "Unless required by law" to the end of this rule. It appears that Rule 26-4-3.16 violates rule 26-4-3.14

We changed the wording in 3.16 so that it no longer violates 3.14.

Tracy R. Walker, DVM, March 30, 2016 – 3.15 Specialty Area (New)
I realize that the WV Board of Veterinary Medicine only governs licensed professionals and not unlicensed lay people. However, it seems ironic that a lay tooth fairy may refer to themselves and advertise as an "equine dental specialist or equine dentist" with no consequence. This is confusing to clients, even those that are well educated. It would seem that since there is a newly designated board specialty for equine veterinary dentistry, that it would be illegal at worst and misleading at best for a non-boarded lay person to advertise as an "equine dentist, equine dental specialist, or equine tooth specialist". I would suggest that these titles be highly protected like "nurse" is highly protected in the human counterparts. I would propose changes in the board definitions to protect clients and more importantly horses from the whims of a tooth fairy.

We made no change. As stated by the respondent, the Board does not have any jurisdiction over the action of lay persons therefore it is not appropriate to include language concerning the actions of lay persons in the Rule.

Daniel Cain, DVM April 11, 2016 – 3.16. Release of Records (New)

Upon reviewing the changes made to the Practice Act, I would like to pose these sections for discussion. These sections should be reviewed, clarified, questioned, and some changed or remain unchanged.

We changed the wording.

Jim Henderson, DVM March 21, 2016 – 5.4.f. Large animal or farm practice mobile units (Old), 2.10. "Limited veterinary practice", 4.2.a. Large Animal Classification, Limited Practice, 8.3. House call practices (New)

My main concern is the striking of the language in article 5.4.f regarding description of a large animal or farm practice mobile units not being considered mobile clinics for the purpose of the rule. There is no new language present with specificity regarding large animal/farm animal practices. It appears to be rolled in together with the limited practice language in section 8 and makes no differentiation from small animal mobile clinics/limited practices and seems to make the same requirement specifically regarding written affiliation with a veterinary practice in the same region of the state or surrounding states. That would have no bearing on my practice and those other similar large animal practices.

Requiring affiliation would likely be an undue hardship for the mobile practitioner to obtain. What would be the need for a small or mixed practice to be an affiliate? No services pertinent to the large animal practice would be available there, nor would there be any expectation of same. It seems to also present an unwanted potential liability for the facility to undertake-likely no one would be interested in that relationship. If the concern is follow-up care/emergent situations/specialty services availability, I am personally available 24 hours a day for my clients as well as those folks who aren't my clients. Believe it or not, I even answer my own phone when by my desk or retrieve messages and make call-backs from my cell phone when on the road. I do have an ongoing, though unwritten, relationship with Ohio State and other specialty large animal practices for in depth diagnostics and specialized treatment/surgeries that I cannot provide out here in the "real world".

Tracy R. Walker, DVM, March 30, 2016 - 4.2.a. Large Animal Classification (New)

A fourth designation of House call or Farm call practice should be included here. Per your prior definitions of mobile practice, it is not common for a large animal facility to move from farm to farm to provide service.

We removed 2.5. "Full-service practice" and 2.10. "Limited Veterinary Practice" definition. We added "ambulatory practice", "emergency clinic", "mobile", "stationary facility" and "veterinary practice" definitions.

We changed the classification of Veterinary Practices.

Dr. Shawn D. Sette April 11, 2016 - 4.4. Immunization Clinics Listed in Classification of Veterinary Practice (Add)
26-4-4 Immunization Clinics should be listed in the Classification of Veterinary Practices so that when groups of clinics are referred to in other sections these clinics are not forgotten or left out in being required to perform in certain ways. They should be required to do many of the things that full service practices do. Record keeping, provide emergency care, etc. As we all know, immunization clinics (and "spay/neuter" facilities) end up examining, consulting, diagnosing, treating, dispensing.....just like a regular hospital, but without all the legal requirements. We should be working towards improving animal care throughout the state and not allowing avenues to circumvent good medical practice.

We changed 26-4-4 Classification; however, we did not include immunization clinics because 3.9. direct responsibility to the client, addresses this issue.

Tracy R. Walker, DVM, March 30, 2016 – 4.5-5.10 (Old) Full Service and Emergency
This is very confusing to follow. There are no references to items that are moved to different sections. I would like to review this section again after 1st draft revisions to ensure that important factors have not been omitted.

Under 26-4-5., "Mandatory Standards for the Practice of Veterinary Medicine" we moved all the mandatory standards for services that are performed from section 26-4-6 "Full Service and Emergency – Mandatory Facility Standards" and 26-4-7 "Full Service and Emergency – Mandatory Practice Standards. All mandatory standards required for ambulatory practices are addressed in 26-4-5.

We changed the titles for 26-4-6 to Mobile and Stationary Facility Standards and kept the additional facility requirements for mobile and stationary. We deleted section 26-4-7 "Full Service and Emergency – Mandatory Facility Standards" and 26-4-8 "Limited Practice – Mandatory Standards".

Jim Henderson, DVM March 21, 2016 – 4.8. Embryo Transfer (Old)
The language in section 4.8 being struck regarding embryo transfer only being performed by a licensed veterinarian is not revisited in new language elsewhere. If for no reason other than training/capability, let alone the use of several prescription medications needed to provide this service, the veterinarian needs to be the professional of choice for this aspect of large animal medicine and revised language should reflect that.

Tracy R. Walker, DVM, March 30, 2016 – 4.8. Embryo Transfer (Old)
This procedure should only be conducted by a licensed veterinarian. This procedure requires extensive knowledge of the equine reproductive cycle, technical expertise in conducting and interpreting ultrasound, technical expertise in completing the embryo recovery and implant safely and successfully, and use of multiple prescription medications. It would be a great disservice to the welfare of the animal to remove this from the practice act. What is the board's reasoning for omission of this from the practice act?

Kathleen Anderson, DVM – American Association of Equine Practitioners, April 4, 2016 – 4.8. Embryo Transfer (Old)
Rustin M. Moore, DVM, PhD, Diplomate ACVS, Dean, College of Veterinary Medicine April 11, 2016 – 4.8. Embryo Transfer (Old)
We are concerned that the proposed changes would remove embryo transfer from the practice of veterinary medicine and potentially allow non-veterinarian, non-licensed, and unregulated providers to provide these services.

Clara Ann Mason, DVM, April 05, 2016 – 4.8. Embryo Transfer (Old)
Embryo transfer requires the hormonal manipulation (through various drug injections) of a livestock or horse's reproductive cycle. In addition, embryos require grading and if transferred out of state, an accredited veterinary signature on health papers. In all aspects, embryo transfer is the practice of veterinary medicine and should only be performed by a licensed veterinarian.

George R. Seiler, DVM, April 8, 2016 – 4.8. Embryo Transfer (Old)
Frank J. Cary, DVM, April 11, 2016 – 4.8. Embryo Transfer (Old)
Leave this section in the standards- this is a highly specialized procedure to be performed by trained and skilled veterinarians.

Lynne Sparks, DVM, April 11, 2016 – 4.8. Embryo Transfer (Old)
There is tremendous risk involved to mares who are palpated and ultrasounded rectally by untrained people. It is exceedingly easy to tear the rectum, causing life threatening consequences. To properly perform embryo transfers in mares, rectal palpations/ultrasounds will be necessary to assess the ovaries to time inseminations and the flushing of the embryos. It is also necessary to palpate/ultrasound the recipient mares. In addition, in all species it is common to have to administer hormonal therapy to influence the reproductive cycles of both the donors and recipients. These hormones are only available through veterinarians with a valid veterinarian client patient relationship. This is a complicated medical procedure and should not be turned over to the laymen to perform.

Jenna Palmer, DVM, April 11, 2016 – 4.8. Embryo Transfer (Old)
I'm not sure why this was removed from the Standards of Practice. This is a procedure that should be performed by a Veterinarian only. Many of my colleagues have spent valuable time and money doing extra veterinary training on this procedure to be able to perform it correctly. This also requires the use of prescription medication to be performed. Removing it leaves an opening for a nonprofessional to begin performing these procedures.

Justine Saville, DVM, April 11, 2016 – 4.8. Embryo Transfer (Old)
Rule 4.8: This is also confusing. Who is permitted to do Embryo Transfer? Again, is this something that any individual can partake in? This rule, being changed as it has been suggested, leaves it very encouraging to laymen, unqualified individuals, to provide this service. I have traveled to Wisconsin and been professionally trained after veterinary school to feel qualified to do embryo transfer. I find it insulting personally and damaging to the embryo transfer procedure to allow laymen to provide this service. Qualified persons, reproductive physiologist, would be understandable.

We did not add this section back because we are concerned that there are so many fields, that if we single out one, it may imply that other procedures are not the practice of veterinary medicine.

Lynne Sparks, DVM, April 11, 2016 – 4.10. Advertising (Old)
A veterinarian may not initiate or knowingly participate in any form of advertising or solicitation that contains a false, deceptive or misleading statement or claim. As veterinarians in a field that is rapidly changing and being challenged by laymen who are taking over more and more of our services in this state, it is imperative that we are professionals with our advertising. Having a statement such as this in the practice act helps to ensure that this continues to occur.

This language has just been moved to section 3.17.

George R. Seiler, DVM, April 8, 2016 – 5.1.b. Veterinary Medicine (New)
Frank J. Cary, DVM, April 11, 2016 – 5.1.b. Veterinary Medicine (New)
Suggested: 5.1.b. A veterinarian shall preform all aspects of veterinary medicine in a manner compatible with current veterinary medical practice of the region.

Dr. Shawn D. Sette, April 11, 2016 – 5.1.b. Veterinary Medicine (New)
I suggest that you end this rule stating that the comparison of veterinary work will be with other work in WV. Since we have no veterinary school or referral specialist hospitals in our state, we should not be held to a standard that may be done in a veterinary teaching hospital in other states. As many of you know, client finances dictate decisions veterinary medicine more than anything else.

We changed the wording.

Sherry, Blenden, DVM, March 31, 2016 – 5.1.c.1. Farm Animals (New)
I agree with West Virginia Board of Veterinary Medicine's proposed rule changes to the Standards of Practice Act 26-4-1. However, I propose one additional change in the new section 5.1.c.1 which states "A group of farm animals of one species under single ownership may be considered a single entity."

I propose that the section instead read "A group of animals of one species under single ownership may be considered a single entity."

Eliminating "farm" eliminates confusion about the definition of farm animals as some species are both 'farm animals' and companion animals (ie horses, goats, etc). Also and more importantly, allowing a broader definition allows veterinarians to treat and set protocols legally for animals of one species that are owned by single rescue/pound/shelter. This allows herd management of other species besides 'farm' animals that are being housed in herd management situations and will improve veterinary care and protocols at animal shelters with limited resources. In other words, a shelter can have a regular relationship with a veterinarian that makes regular visits to manage the shelter animals thus establishing a VCPR very similarly to a large-animal veterinarian providing care for a commercial dairy cow operation. I feel strongly that species other than 'farm animals' are frequently housed in herd management situations and will strongly benefit from the same level of veterinary care that is afforded to the more obvious farm-animal herd situation.

Dr. Shawn D. Sette, April 11, 2016 – 5.1.c.1. Group of Animals (New)
In this rule, a group of farm animals of one species under single ownership, may be considered as a single entity. I feel this rule should apply to all types of animals and not be limited to farm animals. A good example may be a litter of puppies or a small household of pet birds.

We removed “farm” from “farm animals”.

George R. Seiler, DVM, April 8, 2016 – 5.1.i Equipment in Working Order
Frank J. Cary, DVM, April 11, 2016 – 5.1.i Equipment in Working Order
Suggested: 5.1.i. All equipment in patient use shall be maintained in working order within manufacturer guidelines.

Dr. Shawn D. Sette April 11, 2016 – 5.1.i Equipment in Working Order
There are times that non-working equipment is kept in the hospital in order to be harvested for parts so that other equipment can be maintained. There should be a statement that allows non-working equipment to be kept, harvested, and stored until disposal or sale. Maybe it should be required to mark this old equipment in an obvious manner.

We changed the wording.

Tracy R. Walker, DVM, March 30, 2016 - 5.1.g Disposal (New)
"and provide refrigeration exclusively for carcasses of companion animals that require storage for 12 hours or more"
This is unnecessary. In our practice, we do not keep carcasses. For small animal carcasses, owners must pick them up or they are sent for immediate cremation at the owner's expense. Large animals are either picked up by the owner or a qualified disposal service.

We made no changes. There are always situations where the vet cannot contact the owner or owner request disposal; therefore needs refrigeration.

George R. Seiler, DVM, April 8, 2015 – 5.2.b. Patient Records (New)
Frank J. Cary, DVM, April 11, 2016 – 5.2.b. Patient Records (New)
Facility owner may be different from practice owner. Practices sold and staying at the same location would not need client notification. Specified time period for record retrieval.
Suggested: 5.2.b. The practice owner shall keep and maintain current patient records on the business premises for a period of 3 years beyond the last patient visit and the records are the responsibility and property of the owner of the veterinary practice. If the practice is closing or being sold and the location of the practice moving, clients shall be notified a minimum of four weeks prior to a permanent practice closing or moving as to how they may acquire a copy of their patient records on their animal(s). Records must be made available for client retrieval at convenient accessible times for a period of no less then one month.

We changed the wording.

Dr. Shawn D. Sette April 11, 2016 – 5.2.a. Individual Records (New)
Is cloud storage of date (offsite storage) covered and permitted with this rule?

We made no change because there many acceptable ways of maintaining records.

Daniel Cain, DVM April 11, 2016 – 5.3.a. Legend Drug (New)
Upon reviewing the changes made to the Practice Act, I would like to pose these sections for discussion. These sections should be reviewed, clarified, questioned, and some changed or remain unchanged.

We removed "healthcare provider" from the Rule; so no change is needed.

Kim Smith, MS, DVM March 24, 2016 – 5.3.d Drugs storage and administration (New)
I would like clarification on 5.3 d. Is this written documentation regarding the drug or is the label on the medication considered sufficient?

We changed the wording

George R. Seiler, DVM, April 8, 2015 – 5.3.g. Repackaged Legend Drugs (New)

Frank J. Cary, DVM, April 11, 2016 – 5.3.g. Repackaged Legend Drugs (New)
Suggested: 5.3.g. All repackaged legend drugs dispensed by the veterinary dispensary or healthcare provider shall be labeled with the following:

Daniel Cain, DVM April 11, 2016 – 5.3.g. Repackaged Legend Drugs (New)
Upon reviewing the changes made to the Practice Act, I would like to pose these sections for discussion. These sections should be reviewed, clarified, questioned, and some changed or remain unchanged.

We changed the wording.

Daniel Cain, DVM April 11, 2016 – 5.3.h.1. Prescribing Veterinarian (Old)
Upon reviewing the changes made to the Practice Act, I would like to pose these sections for discussion. These sections should be reviewed, clarified, questioned, and some changed or remain unchanged.

The Board has reviewed and since there was no comment for change, we have made no changes.

George R. Seiler, DVM, April 8, 2016 – 5.3.h.4. Dosage of Medicine
Frank J. Cary, DVM, April 11, 2016 – 5.3.h.4. Dosage of Medicine
I would leave this information to be addressed in the medical record. It adds another line on an already extended controlled substance log entries.

We made no changes because this language has been added to remain in compliance with current DEA requirements.

Tracy R. Walker, DVM, March 30, 2016 – 5.3.j. Prescriptions (New)
This must be modified. The current wording implies that all prescription refills must be refilled up to one year, regardless of the number of authorized refills available. Prescriptions should be refilled up to one year or for the maximum number or authorized refills, whichever occurs first.

George R. Seiler, DVM, April 8, 2015 – 5.3.j. Prescriptions (New)
Frank J. Cary, DVM, April 11, 2016 – 5.3.j. Prescriptions (New)
If it is worded with just "prescriptions may be filled for one year" clients may construe that to mean they are entitled to refills for one year without a veterinary examination- even if the veterinarian needs to examine the animal to meet current standard of care guidelines.
Suggested: 5.3.j. Prescriptions may be refilled for up to one year from the exanimation at the prescribing veterinarians discretion. After 1 year, the patient shall be re-examined before an additional prescription is ~~written~~ validated.

We changed the wording.

Tracy R. Walker, DVM, March 30, 2016 – 5.4. and 5.4.a Laboratory Services (New)
This section should be moved and redefined under requirements for each type of practice. It would be reasonable to require "full-service stationary" hospitals to have basic in-house laboratory equipment as defined by the section 5.2.h that was omitted. It would be prudent to define minimum standards for mobile practice as well.

George R. Seiler, DVM, April 8, 2016 – 5.4.a Laboratory Services (New)
Frank J. Cary, DVM, April 11, 2016 – 5.4.a Laboratory Services (New)

Suggested: 5.4.a. Each practice shall maintain laboratory services using an in-house and/or an outside laboratory in order to meet the current standards of care for the profession.

We changed the wording.

Lynne Sparks, DVM, April 11, 2016 – 6.1. Large and Small Animal Full Service and Emergency Facilities (New)
Large animal facilities are separated out in 6.2 as a separate entity, which they should be as needs are different.

We removed 6.1 and 6.2.

We changed the classification of Veterinary Practices.

Daniel Cain, DVM April 11, 2016 – 6.1.b. Examination Room (New)
Upon reviewing the changes made to the Practice Act, I would like to pose these sections for discussion. These sections should be reviewed, clarified, questioned, and some changed or remain unchanged.

We changed the wording.

George R. Seiler, DVM, April 8, 2016 – 6.1.b.2. Convenient Access (New)
Frank J. Cary, DVM, April 11, 2016– 6.1.b.2. Convenient Access (New)
Suggested: ~~5.2~~ 6.1.b2. ~~-~~Convenient access to a sink with hot and cold running water.

We changed the wording.

Lynne Sparks, DVM, April 11, 2016 – 6.1.f. Method of Weighing (New)
I agree with this statement as it pertains to small animals, but it is impractical for all clinics to have a scale that will correctly weigh all animals, nor is it absolutely necessary for the treatment of large animals. This explanation is voided if the wording of 6.1 is changed to omit large animal facilities.

No changes were made. The Board acknowledges that there are alternative ways to estimate the weight of large animals. Large animal veterinarians certainly give some consideration to animal weight by some method: such as visual observation, weight tape, etc.

Daniel Cain, DVM April 11, 2016 – 6.1.g. Isolation Area (New)
Upon reviewing the changes made to the Practice Act, I would like to pose these sections for discussion. These sections should be reviewed, clarified, questioned, and some changed or remain unchanged.

The Board has reviewed and since there was no comment for change, we have made no changes.

George R. Seiler, DVM, April 8, 2016 – 6.2. Limited and Full Service Large Animal Practices (New)
Frank J. Cary, DVM, April 11, 2016 – 6.2. Limited and Full Service Large Animal Practices (New)
Mobile large animal practices do not need facilities to house the species they serve.
Suggested: 6.2. Limited and full service large animal practices are required to have facilities or access to facilities that meet standards of care for instrument cleaning, sterilization, drug and equipment storage needs.

Daniel Cain, DVM April 11, 2016 – 6.2. Limited and Full Service Large Animal Practices (New)
Upon reviewing the changes made to the Practice Act, I would like to pose these sections for discussion. These sections should be reviewed, clarified, questioned, and some changed or remain unchanged.

We removed 6.1 and 6.2.

We changed the classification of Veterinary Practices.

Kourtney Morrissette, DVM, March 23, 2016 – 6.4. Emergency facility mandatory standards (New) - 5.4.a.1 Mobile Veterinary Facility Standards (Old)
I think that this statement is too restrictive on our places of business. Many veterinary practices work with a solo practitioner. Is one veterinarian expected to never leave the building for lunch, to pick up a child from school, to leave for a personal appointment, or to have a half day off? We are required to leave our practices every year for continuing education – are we supposed to now bear the burden of closing our practice during this time if we cannot hire a relief veterinarian (which is always at a higher cost than an employed associate veterinarian)?

Many veterinary practices stay open to sell food/prescription medicines/over the counter medications, answer phone calls from clients with medical questions, and create appointments when a veterinarian is not on the premises. They also direct clients to emergency services and animal poison control when needed. If a business could not operate without a veterinarian on the premises it would be a financial burden – our employees would work less hours, less jobs would be filled at veterinary offices, clients would receive much worse and much more limited customer service and overall quality of care for our patients would decline.

Why are these items deleted from our Standards of Practice? They are excellent standards for mobile/limited practice/clinics to follow to keep our patients

Holly Kossuth, April 11, 2016 – 6.4.b. Emergency facility mandatory standards – Veterinarian on Premises (New)
Clarifying that this is for emergency facilities and not all practices as I could not leave for errands, attending CE or a much needed vacation.

No change was made. This falls under emergency facilities.

Kourtney Morrissette, DVM, March 23, 2016 – 7.1 (New) The separation between a "Full" and "Limited" veterinary practice. Specifically my concerns are:
That the definition of "sedation" is not specific enough – if the only factor that diffentiates the two is whether or not ventilation is needed then many different procedures can be performed under sedation rather than general anesthesia. We all know of hospitals that perform full spays/neuters under just injectable drugs (by your definition, "sedation"). I feel that this language is far to non-

specific. In addition, it opens the door for "Limited" practices to legally now perform procedures below an anesthetic standard of care.

That any practice that decides to "sedate" an animal should have be required to have endotracheal tubes, ventilation, emergency drugs for resuscitation (atropine, epinephrine, naloxone, etc), and oxygen available. Without these things, a patient that might experience an unexpected "sedation" event could die. In your new practice act I do not see these things as being required by what you now define as a "limited" practice. As I have previously mentioned, these items are inexpensive, readily available, require no training if used by a veterinarian, are made for mobile/farm practices that need small spaces, and are portable.
The language around "limited" veterinary hospitals does not address whether or not minor surgery is permitted. This needs to be clarified. My opinion would be that NO surgical procedures (either Minor Surgery or Surgery by your definitions) should be allowed in these hospitals – especially if they are not required to have clearly defined laws about equipment, sterilization, resuscitation, oxygen, ect.

We removed the wording "Full Service" and "Limited".

Under 26-4-5., "Mandatory Standards for the Practice of Veterinary Medicine" we moved all the mandatory standards for services that are performed from section 26-4-6 "Full Service and Emergency – Mandatory Facility Standards" and 26-4-7 "Full Service and Emergency – Mandatory Practice Standards. All mandatory standards required for ambulatory practices are addressed in 26-4-5.

We changed the titles for 26-4-6 to Mobile and Stationary Facility Standards and kept the additional facility requirements for mobile and stationary. We deleted section 26-4-7 "Full Service and Emergency – Mandatory Facility Standards" and 26-4-8 "Limited Practice – Mandatory Standards".

George R. Seiler, DVM, April 8, 2016 - 7.1.a.2. Radiographs (New)
Frank J. Cary, DVM, April 11, 2016 - 7.1.a.2. Radiographs (New)
Occasionally animals will kick the intended marker off the film or plate. Making the marker an obligation will add unneeded radiation exposure to the patient and staff
Suggested 7.1.a.2. All radiographs in any format shall have a permanent identification bearing the clients name, the patients name and the date. Left and right markers are recommended.

No change was made because of legality. Markers are necessary for identification purposes.

Lynne Sparks, DVM, April 11, 2016 – 7.1.a.4.C Radiation Exposure Badges (New)
This should be omitted from the practice act. Explanation: As a solo practitioner with no employees it should be up to my discretion whether or not I wish to wear a radiation detection badge. This should be the responsibility of each practice owner to decide if it is necessary within their practice. In my practice radiographs are taken infrequently. Radiation badges would only add to the expense of the radiographs which would then have to be passed on to the client.

No change was made because this is an OSHA standard-federal requirement.

Tracy R. Walker, DVM, March 30, 2016 - 7.1.b Anesthesia/Ventilation Services (New)
Large animal veterinarians routinely perform general anesthesia in the field for routine procedures such as castrations. This general anesthesia is accomplished through a combination of sedation, analgesia, local anesthetics and injectable anesthetics. It impractical to require a large animal ambulatory veterinarian to administer supplemental oxygen (section 7.1.b.1.A), provide inhalational anesthesia with scavenging system (7.1.b.1.B), or provide assisted ventilation via resuscitation bags and endotracheal tubes.

George R. Seiler, DVM, April 8, 2016 - 7.1.b Anesthesia/Ventilation Services
Frank J. Cary, DVM, April 11, 2016 - 7.1.b Anesthesia/Ventilation Services
Suggested: 7.1.b.1. Anesthesia/Ventilation Services ~~required~~ require the following equipment:

This wording has been removed.

George R. Seiler, DVM, April 8, 2016 - 7.1.b.1.C. Support Equipment (New)
Frank J. Cary, DVM, April 11, 2016 - 7.1.b.1.C. Support Equipment (New)
Many veterinarians use the rebreathing bag from their anesthesia machine or an automated mechanical ventilator rather then a resuscitation bag for patient ventilation support and rescue.
Suggested: 7.1.b.1.C. Support equipment required for the delivery of assisted ventilation including resuscitation bags of appropriate volumes, or equivalent and an assortment of endotracheal tubes of various sizes for each species serviced.

This wording has been removed; so there will be no need for a change.

Kourtney Morrissette, DVM, March 23, 2016 - 7.1.b.2 Pre-surgical assessment (New)
I do not agree with the language used in this statement. Specifically, I do not agree that the term "pre-surgical assessment" is specific enough. Does this mean a full exam (examination of heart, lungs, ears, eyes, skin, mouth, dental, lymph nodes, abdominal palpation, rectal exam, reproductive exam, ect; all written in the record as such) or a brief exam (temperature, pulse, and respiration). Does this exam need to be performed by a veterinarian or is a technician sufficient? Does that technician need to be licensed?

In addition, I feel that an exam within 12 hours of the procedure may be too limiting for elective procedures in which a pet was examined within 60 days and deemed to be healthy. Are owners expect to pay for another physical exam the day of surgery (in my office, this is at a cost of $45.00)? Are the spay and neuter only clinics going to be held to this standard as well as more traditional practices – is a medical record with this exam expected for every patient? Who will be policing whether or not these examinations are done and how thoroughly they are performed? In addition, the addition of a full examination (with the owner present, I am assuming so that they are fully informed) would be rather time consuming (and again, if it takes time we will have to charge clients MORE money for surgical procedures). Perhaps this line should be removed entirely or should be more specific about the type of exam, who does it, and the timing of that exam for elective v/s non-elective/emergency procedures.

Eric D. Perry, DVM, April 8, 2016 - 7.1.b.2 Pre-surgical assessment (New)
Can this exam be performed right before surgery, also having to detail such things as temperature will make things more difficult when dealing with aggressive dogs or fractious cats? There is also the time and more expense. May of the patients I deal with are already coming in with low-income forms for greatly reduced prices for surgeries. That detailed exam will require charging the clients who are already on limited funds.

No change was made. Standard of care dictates that an animal should be evaluated immediately prior to the induction of anesthesia. This is not intended to be a full examination of all systems but an evaluation of the cardiovascular and respiratory systems and the overall health status of the animal.

Eric D. Perry, DVM, April 8, 2016 – 7.1.b.3. Observing Every Animal (New)
To require every animal to be individually monitored while recording form anesthesia, not while performing the surge, would be impractical. The wording states "continually", not just keeping attention of the animals. If I perform 5 surgeries that morning, besides assisting myself, I would have to have an employee for every animal that was waking up from anesthesia.

This would be financially impracticable. We already check on them, but to continually monitor on an individual basis would be cost prohibitive, especially when injectable anesthesia is used, as compared to gas anesthesia.

We must always balance the welfare of our patients with practical and financial considerations. If this wording is kept in as written, I will have no alternative to charge a great deal more my services.

We are losing enough money performing low-income and humane society adoptions. My practice does not have a mixture of wealthy to low income clients to offset the reductions I am already receiving for services.

We changed the wording.

Kourtney Morrissette, DVM, March 23, 2016 - 7.1.c. Surgical Services (New)
For clarification, does this include what you define as "minor" surgery? If so, the title should say "Surgical Services, including Minor Surgery" If it doesn't, it implies, by sheer lack of clarity, that a "Minor" surgery does not need to adhere to the same standards of care as "Surgery."

Again, if "Minor" surgeries are not included in this list of requirements I think that they should be. No veterinary facility should be performing any surgery (whether "Major" or "Minor") without the requirements of anesthetic monitoring, the ability to provide ventilation/oxygenation, appropriate rescue drugs in the case of unanticipated anesthetic events, sterile gloves/gown/procedures, appropriate lighting, running water….. ect. As I have said before, these items are inexpensive, readily available, require no training for anyone with a veterinary degree, and are available as portable items for even the smallest mobile/farm unit.

We removed the definition of "minor surgery"

Kim Smith, MS, DVM March 24, 2016 – 7.1.c.6 Post Treatment (New)
Section 7.1.c.6 states that the veterinarian must provide a way for a client to obtain advice on a 24 hour basis after a surgical procedure or treatment. Perhaps a time limit can be set on this. A single practitioner, or even a multiple doctor situation, cannot be available for consult at all times. Certainly we should be available for follow up or offer other options, but an emergency clinic is not available in all areas of our state and it would be difficult for an individual to be available for consult continuously.

George R. Seiler, DVM, April 8, 2016 – 7.1.c.6 Post Treatment (New)
Frank J. Cary, DVM, April 11, 2016 – 7.1.c.6 Post Treatment (New)
Do not like the word "advice", clients may perceive the word advice as verbal advice over the phone and demand the veterinarian give them verbal advice- if verbal advice is incorrect the veterinarian may be held liable for giving the incorrect advice without a patient examination. Most "advice" is given after an examination. Advice doesn't treat a patient with an immediate surgical need. Clients and patients need to have emergency care provisions- especially after surgical procedures.
Suggested: 7.1.c.6. <u>The veterinarian shall provide a method for the client to obtain emergency veterinary services pertaining to surgical and post treatment problems on a 24- hour basis after the animal is released to the owner or agent following the completion of the surgery or treatment. Veterinarians, staff or designated Emergency Veterinary Facility must respond to client inquiries within a reasonable length of time from contacting the veterinary facility. Veterinary facilities or veterinary service providers that do not provide 24- hour emergency service to patients must have a written agreement with a facility in the county or adjoining county in which the services were provided to provide 24- hour emergency care for their patients when they are not available to provide emergency services. If such services do not exist the veterinary provider may get an annually renewed written waiver of service approved by the Board.</u>

Dr. Shawn D. Sette April 11, 2016 – 7.1.c.6. Advice
This rule states that the veterinarian must provide a way for a client to obtain advice on a 24 hour basis after a surgical procedure or treatment. In areas close to an Emergency Room, this would be the case. But what if the owner does not want to travel to the ER? What if the ER DVM does not feel it is appropriate to give advice over the phone without a Client-Patient-Relationship, which should include an exam. A single practitioner, or even a multiple doctor situation, cannot be available for consult at all times. Especially in rural areas where there is not an emergency clinic. It would be difficult for an individual to be available for consult continuously.

Daniel Cain, DVM April 11, 2016 – 7.1.c.6. Advice
Upon reviewing the changes made to the Practice Act, I would like to pose these sections for discussion. These sections should be reviewed, clarified, questioned, and some changed or remain unchanged.

This wording was removed and wording regarding emergency care was added to 3.9.

George R. Seiler, DVM, April 8, 2016 - 7.1.c.2.B. Wear Clean Clothing (New)
Frank J. Cary, DVM, April 11,2016- 7.1.c.2.B. Wear Clean Clothing (New)
Suggested: 7.1.c.2.B. A veterinarian shall wear clean clothing. Sterile gloves shall be worn with each individual patient. A sterile surgical gown with long sleeves is recommended.

We changed the wording.

Gary McCutcheon, DVM March 14, 2016 – 7.1.c.3 Surgery Doors (New)
I wanted to comment on rule 7.1.c.3, which states concerning a surgery suite, "A room designated solely for surgery, separated by doors, and distinct from all other rooms."

The addition of "separated by doors" can create a substantial hardship when transporting animals from the surgery prep area to the surgical room, especially when some of the dogs weigh in excess of 100 lbs. and must be transported on stretchers, using two or more people. A closed door becomes a significant obstacle and danger to those doing the transporting, while an open door would function as having no door at all.

Tracy R. Walker, DVM, March 30, 2016 – 7.1.c.3, 7.1.c.3.A, 7.1.c.3.B, 7.1.c.3.E, 7.1.c.5 Surgery Procedures (New)
Large animal veterinarians routinely perform surgical procedures in a field setting. Requiring a surgical suite (7.1.c.3), surgical lighting (7.1.c.3.A), a surgery table (7.1.c.3.B), suitable walls and flooring (7.1.c.3.E) is certainly not practical for any farm, stable or barnyard where by nature surgery in Farm Call practice takes place.

In addition, section 7.1.c.5 requires use of sterilization indicators which work only with ethylene oxide gas or pressurized steam sterilization methods. Many instruments used in large animal medicine are simply too large for these types of sterilization. Therefore, cold sterilization is still utilized where appropriate. Section 7.1.c.5 should be omitted.

Lynne Sparks, DVM, April 11, 2016 – 7.1.c.3.B. – Surgery Table (New)
This statement is true for small animal practices but is not necessary for all large animal practices to have. In equine surgeries, there are many that may be performed with the animal on the ground on mats made of impervious material. It is optimal to have the animal on a table for many more invasive procedures, however getting them on a table is not always indicated or safe as they must be hoisted on a pully system with ropes or straps attached to their lowerlimbs.

Daniel Cain, DVM April 11, 2016 – 7.1c.3.A. – Lighting (New)
Upon reviewing the changes made to the Practice Act, I would like to pose these sections for discussion. These sections should be reviewed, clarified, questioned, and some changed or remain unchanged.

We made no changes. The Board feels that a door in the surgery room is necessary for the safety and health of the animals having surgery.

Kim Smith, MS, DVM March 24, 2016 – 7.1.c.3.a Lighting (New)
7.1.c.3.a. Clarification of backup emergency lighting

We changed the wording.

Kim Smith, MS, DVM March 24, 2016 – 7.1.d.3. Sterilization (New)
7.1.d.3 Define sterilization. I do not believe it is standard of care for dental instruments to be autoclaved.

Lynne Sparks, DVM, April 11, 2016 – 7.1.d.3. Sterilization (New)
7.1.d.3 Dental instruments shall be cleaned between patients and sterilized when possible. There are many equine dental instruments that, due to the makeup of the equipment, it is impossible for them to be fully sterilized. The Powerfloat is one such example.

Dr. Shawn D. Sette April 11, 2016 – 7.1.d.3. Sterilization (New)
It is not possible to autoclave some dental instruments like my large IM3 machine or even the handle coming from the device.

We changed the wording.

Clara Ann Mason, DVM, April 05, 2016 – 8.1 Limited Practices (New)
The term "Limited Practice" does not exist under WV law. The WV code sections as cited above do not include any limitations on the practice of veterinary medicine. The rule-making authority as set forth in 30-10-6 does not authorized the Board of Veterinary Medicine to change the definition or nature of veterinary practice as set forth in the WV Code. A change such as the Board is attempting to promulgate would of necessity, require an act of the WV legislature. The Board is exceeding its' authority for rule-making and is attempting a substantive change in the WV law. Per your directive, there is no difference in the mandatory standards of the Limited verses Full Service Practice. Assessing the title of Limited Veterinary Practice to an ambulatory practitioner will baffle the public and assign limitations to the practitioner's services. It is the ambulatory practitioner that serves many of the rural areas of West Virginia. Often, these dogs and cats are referred by us (ambulatory practitioner) to a small animal clinic or referral center for further diagnostics or treatment.

Jenna Palmer, DVM, April 11, 2016 – 8.1 Limited Practices (New)
I think it is ridiculous to imply that mobile practices have oxygen supply, scavenger systems, sterile tables, etc. This is impractical and many clients in rural WV don't have the ability to transport animals to Veterinary facilities to have surgical procedures performed. Imposing this change will mean the vast majority of us practicing mobile large animal medicine will no longer be able to perform these services which opens the door to an untrained person to perform these services inhumanly. For example: tying a horse up in a stock trailer and castrating it with a pocket knife. You may think this is an over-exaggeration but if you talk to any large animal veterinarian I'm sure they can attest to a similar story or one just as savage.

We removed the wording "Full Service" and "Limited".

We changed the wording for "examination table".

Tracy R. Walker, DVM, March 30, 2016 – 8.2. List of Services (New)
This statement is nonsensical and should be removed. It would be unnecessary and impossible to list all services not offered by particular practice. This offers no advantage to the patients or clients.

Clara Ann Mason, DVM, April 05, 2016 – 8.2. List of Services (New)
This change is nonsensical and has no merit.

Jenna Palmer, DVM, April 11, 2016 – 8.2. List of Services (New)
This statement needs to be removed. I'm not sure what the benefit of posting services NOT available at a clinic is? Wouldn't this be as redundant as going to a restaurant and seeing a list of food they don't serve posted on the menu/wall?

Daniel Cain, DVM April 11, 2016 – 8.2. List of Services (New)
Upon reviewing the changes made to the Practice Act, I would like to pose these sections for discussion. These sections should be reviewed, clarified, questioned, and some changed or remain unchanged.

We deleted this wording.

Jim Henderson, DVM March 21, 2016 – 8.3. House Call Practices (New), 5.4.f. Large animal or farm practice mobile units
It also seems to open up the question of inspection of the mobile "facility" which has no reasonable purpose. I feel the language in 5.4.f needs to be added to 8.3 to return a sense of reasonable purpose to the amendments. If not that specific wording, something that is appropriate to the practice of mobile large animal medicine needs added.

Tracy R. Walker, DVM, March 30, 2016 – 8.3. House Call Practices (New)
Section 8.3 Regarding mandatory standards of limited practice.
This is an unreasonable and unnecessary requirement. Advancements in technology facilitate many services on the farm without the need of a building. For ten years, I have operated my ambulatory large animal practice without an affiliation with a brick and mortar practice. Cases requiring care not available by my practice were offered referral to secondary and tertiary institutions such as Virginia Maryland College of Veterinary Medicine. For ten years, I was available to my clients any time 24 hours a day, 365 days a year with rare exceptions when I was travelling for continuing education. When I would travel I would make several provisions to my clients including: provide information on a phone message and social media directing clients to a neighboring practice or referral center in my absence, answer the phone myself to triage cases and provide referral information, paid a technician to answer the phone and provide referral information. I would argue that my availability to my clients and patient's needs has and still to this day, exceeds many small animal practices that close at 5 PM and refer to emergency clinics.

This requirement would restrict a veterinarian's ability to make a living in a free market. Established practices would have unreasonable control over new developing practices in the area by refusing to cooperate with an affiliation. Ultimately, this would prevent competition and result in a monopoly by the established practice, which is certainly not beneficial to the animals.

Kathleen Anderson, DVM – American Association of Equine Practitioners, April 4, 2016 - 8.3. House Call Practices (New)
Rustin M. Moore, DVM, PhD, Diplomate ACVS, Dean, College of Veterinary Medicine April 11, 2016 - 8.3. House Call Practices (New)
We have concerns regarding the proposed changes that may limit the practice status for ambulatory practitioners, require written affiliation with a brick and mortar clinic.

Clara Ann Mason, DVM, April 05, 2016 - 8.3. House Call Practices (New)
I often administer annual and rabies vaccinations to farm dogs and cats. In addition, I perform approximately 75 in-home small animal euthanasia services annually. This is a necessary (non-transportable pets), requested and desirable service offered by my practice. Most of the euthanasia appointments are per referral from small animal practices. Why should I affiliate myself with any small animal clinic? Instead, I propose that all small animal clinics associate themselves with a large animal ambulatory practice.

Rose Marie Henderson, April 6, 2016 - 8.3. House Call Practices (New)
If the authors of these changes would step back a bit from their own practice models and read these changes it appears that with the new wording they are adverse to there being any Mobile practices in our State that are not an extension of a stationary clinic. How can you as the board or the Legislature propose to change/dictate how a Fellow Veterinarian practices as long as they are Licensed and practicing within their scope of practice? I am fully aware that there are emergencies that arise as I am aware that there are numerous Facilities throughout our great state and in neighboring states to handle these emergencies if the mobile Veterinarian would happen to be unavailable at the time. Requiring an "Affiliation" should not be required.

Lynne Sparks, DVM, April 11, 2016 - 8.3. House Call Practices (New)
This does not apply to mobile large animal practices. It is not necessary for an excellent mobile practitioner to have a facility. Most good mobile large animal practitioners are too busy doing farm calls to need or want a stationary hospital. In order to operate a stationary hospital most of us would have to have an associate and would be unable to operate as solo practitioners. My mobile clinic is fully equipped to perform high quality medicine and surgery that meets or far surpasses the current minimum standards of care. It is a temperature controlled Bowie truck bed insert that has electric, hot and cold water and refrigeration capabilities.

Jenna Palmer, DVM, April 11, 2016 - 8.3. House Call Practices (New)
This statement needs to be removed. Those of us providing large animal ambulatory care also provide emergency services for our clients with the exception of a few days out of the year in which we are in mandatory classes or the occasional vacation. During these times we provide other options for referral for our clients to neighboring practices or referral centers. We offer referral to Ohio State University for animals needing care/services I am not able to give.

Dr. Shawn D. Sette, April 11, 2016 - 8.3. House Call Practices (New)
You many need to define “same location” by making a linear mileage definition or radius.

Dr. Audra Melton, April 11, 2016 – 8.3. House Call Practices (New)
I have been a practicing veterinarian in WV for 8 years and have had the opportunity to work in a variety of practice settings – from private practice to relief work and in an emergency clinic setting as well. While brick and mortar practices have been the standard business model of our profession for years and WV’s practice act is designed specifically around that type of model, in the last 15 years, mobile practices even for small animals have become much more prevalent through out the United States. I feel that the proposed changes when applied in the real world, will make it very difficult if not almost impossible for a small animal mobile practitioner to ply his or her trade in WV. I feel that the proposed changes are so restrictive that they reach the level of restraint of trade and thus I question their legality.
While I have specific concerns about the proposed changes as they apply to large animal practitioners, I believe that most large animal veterinarians would not typically have any difficulty finding a small animal brick and mortar practice that would be willing to affiliate with them because there is no direct competition between those two entities. While the proposed changes raise issues of liability for the brick and mortar practice, from an economic stand point the large animal practitioner isn't really in competition with a brick and mortar small animal practice. However, in stark contrast, as a mobile small animal practitioner, I don’t foresee any small animal clinic voluntarily affiliating with me because I am in direct competition with them. When I do a patient assessment, I determine if my current level of medical capabilities can provide the highest standard of care for my patient. If I believe the patient needs services that I am currently unable to provide, I recommend a local veterinarian close to them or, as my patients are typically in the Fairmont area, I refer them to the emergency clinic at the Pricket’s Fort exit if it is after hours. I am currently outfitting a 2013 Mercedes Sprinter van with complete surgical, radiograph, and blood work capabilities. From a quality of care perspective, I do not believe that a brick and mortar the practice offers any quality of care services that I can not readily provide myself. Like any brick and mortar practitioner, I assess the urgency of the patient’s condition and either schedule my driving to their location in a timely manner, refer them to a specialist, or have them contact an emergency clinic. I am available 24 hours a day and answer my own phone. Being a mobile clinic in no way hinders my ability to provide clients with quality care for their pets at the same level as a traditional brick and mortar the practice.

My understanding is that the WV board of Veterinary Medicine’s main purpose is to provide the public with safe and professional veterinary care. These proposed changes on the face of it, do not achieve those goals. If there is no quality of care issue with my practice, the board is overstepping their authority by telling me I must align with some outside corporate entity. The same could be said for the proposed changes that non-veterinarians can practice equine dentistry. I would note that both these areas of proposed changes are diametrically opposed to every other state I have been able to inquire with, in that those states allow independent

mobile practices both small and large. and the general trend of restricting equine dentistry to licensed veterinarians. It is my hope that the board will discern that these changes are of a business/economic nature as opposed to a quality of care issue and substantially modify them so that the number of people desiring veterinary services in rural West Virginia have that option. I also believe that if the board modifies these proposed changes, it will greatly reduce the board from becoming embroiled in legal entanglements that will distract them from providing a quality veterinary environment for West Virginians

We deleted this wording.

George R. Seiler, DVM, April 8, 2016 –8.4. Emergency 24-Hour (Add)
Frank J. Cary, DVM, April 11, 2016 –8.4. Emergency 24-Hour (Add)
Suggested: 8.4 In the case of limited and mobile veterinary practices emergency 24- hour services must be provided within the county or adjoining county from where the services were provided. If the veterinarian preforming the services is not available to provide 24 emergency veterinary services then they must have a written agreement with a veterinary provider that will provide 24-hour emergency services in the county or an adjoining county where the services were provided. Veterinarians, staff or the designated Emergency Veterinary Facility must respond to client inquiries within two hours of contacting the veterinary facility. If such services do not exist then the veterinary provider may get an annually renewed written waiver to not provide such service approved by the Board.

We added emergency care wording to 3.9.

George R. Seiler, DVM, April 8, 2016 –11.1. Abandoned Animal (New)
Frank J. Cary, DVM, April 11, 2016 –11.1. Abandoned Animal (New)
Change Boarded to boarded

Dr. Shawn D. Sette April 11, 2016 –11.1. Abandoned Animal (New)
I feel you should remove the list of specific reasons why a pet has been left with a vet and merely state that if a pet is placed in the care of the facility. I have had multiple episodes in 23 years when a client brought in a stray or their own pet and claimed that they needed to return to work or go get money for the care of the pet and we offered to hold the pet while they were gone. When they don't return, we are in a dilemma as to what are responsibility is.

We changed the wording.

Jim Henderson, DVM March 21, 2016 – 12.1. Community Service Immunization Clinics (New)
A final concern regards the new language in section 12.1 regarding community service immunization clinics and the need for the veterinarian performing the service to have a licensed facility in the county or adjacent county.
I have done Rabies vaccination clinics for 3-4 local community service groups, 4-H and parent/youth groups and the like, for many years-both as a public service as well as a fund raising effort for the kids who help with the paperwork and facilitation of the event.

I am available for any reactions on a 24 hour basis as discussed above and have only had a handful of calls in the last 25-30 years. Anything that would need to be seen, I could take care of at their home. If anything was serious and needed hospital care, I would do what any of the local clinics would do with these potential problems after hours on a Saturday afternoon or evening (which is when most vaccination clinics are held) and that is refer to the local emergency clinic. I see no difference in standard of care in this case.

Tracy R. Walker, DVM, March 30, 2016 – 12.1. Community Service Immunization Clinics (New)
This rule should be removed. The entire purpose of a mobile veterinary practice is to provide services to areas where there are no other veterinary services available or in instances where animals may not be safely, comfortably or practically transported to facility. It is often impractical, inefficient and not cost effective for facilities to send doctors and staff out of the facility to offer these clinics. This rule would ultimately result in fewer vaccination clinics, and fewer preventative rabies vaccinations which is certainly not in the best interest of public safety.

Richard A. Lechliter, DVM, April 4, 2016 – 12.1. Community Service Immunization Clinics (New)
I am concerned that the number of permitted Rabies Clinics in 26-4-12.1 would cause Mineral County to face the danger of a great number of unvaccinated pets. Currently, I am President of the County Commission and Chairman of the Board of Health. Previously, I was the County Veterinarian and was the clinic vaccinating veterinarian for 19 years. Currently, Mountainview Veterinary provides the veterinarians for our many clinics. Last year, 10 clinics were held around the County, and this year we have already prepared for eight. There was a time in the mid 1990's that Mineral County retained me for 18 clinics, when we tested multiple dogs positive for Rabies. Even though we now have two Veterinary Facilities in Mineral County, a proactive Health Department informing citizens of the importance of complying with the Rabies Vaccination Law and Animal Control Officers who write tickets to noncompliant pet owners that carry stiff fines and enforce strict confinement orders of suspected rabies exposed pets, without these clinics, many Mineral County pet owners will not have their pets vaccinated as they do not use the services of the veterinarians in and around our County.

In conclusion, please reconsider this number restriction, to allow each County to hold the number of clinics they believe necessary, for compliance of vaccinated pets and the protection of the owners and the general public of each County.

Rose Marie Henderson, April 6, 2016 – 12.1. Community Service Immunization Clinics (New)
My next concern addresses the Immunization Clinics. Rabies vaccines are to be given by a licensed Veterinarian why do they have to own a clinic to do so. I do agree that they should be licensed and have a practice in the State and county that they hold these events but to say they need a facility to do this is a bit extreme. Lastly where does twice a year come from? From the semi-lay persons view of reading this it appears petty, as though you don't want anyone vaccinating dogs that might come to your Clinics. Is it not best to stop rabies by having these Clinics so that more animals are vaccinated or let rabies become an even bigger problem?

George R. Seiler, DVM, April 8, 2016 – 12.1. Community Service Immunization Clinics (New)
Frank J. Cary, DVM, April 11, 2016 – 12.1. Community Service Immunization Clinics (New)
Suggested: 12.1. Immunization clinics shall be operated by a veterinarian licensed by the Board who has a licensed facility in the county or adjoining county where the clinic is being held, or a veterinarian with a written agreement with a full service veterinary facility in the county or surrounding counties providing 24 hour client/ patient response who will care for any emergencies after the immunization clinic has closed. Veterinarians must have lifesaving emergency drugs and equipment on site to handle any adverse patient reactions. Equipment shall include but not limited to endotracheal tubes of sufficient sizes, a method for emergency resuscitation. Portable oxygen supplementation availability recommended.

Holly Kossuth, DVM, April 11, 2016 – 12.1. Community Service Immunization Clinics (New)
Historically Brooke County holds immunization clinics for multiple days, during a week in June.

Lynne Sparks, DVM, April 11, 2016 – 12.1. Community Service Immunization Clinics (New)
This does not apply to large animal vaccination clinics. I am asked to do several equine EIA (Coggins) test and vaccination clinics every year by different organizations. The actual physical address for my practice is in Nicholas County but my mobile practice encompasses all or part of many counties in the state including but not limited to: Nicholas, Braxton, Gilmer, Lewis, Roane, Webster, Barbour, Fayette, Raleigh, Clay, Mercer, Kanawha, Putnam and Wyoming. I should be able to do a vaccine clinic in any of the counties that I routinely work in or in any adjacent county to my normal service area. Many of these counties do not have any other

veterinarian who offers mobile equine services, nor do the adjacent counties. It is a convenient and necessary service for the horse people of our state. Some of the clinics that I have been asked to do had been covered by an out of state veterinarian in the past who had driven several hours to get there because a WV veterinarian was not available. I am closer to these clients and they can haul their horses to meet me within my practice area if the need arises and they have an emergency, rather than having to go out of state.

Jenna Palmer, DVM, April 11, 2016 - Community Service Immunization Clinics (New)
This should be re-written to say a "licensed veterinarian practicing in the county or surrounding counties." Those of us that are mobile veterinarians do not all have a licensed facility to which we are affiliated. I am held to the same standards of care in the field as I am in an exam room. Forcing me (and other large animal ambulatory veterinarians) to be tied to a clinic would only result in my inability to continue offering professional veterinary medicine to many patients.

We changed the wording.

Tracy R. Walker, DVM, March 30, 2016 – 12.2. Immunization Clinics (New)
This is confusing and should be re-worded. I would suggest re-stating "A veterinarian must be present to administer or directly supervise vaccine administration by a registered veterinary technician at all immunization clinics.

George R. Seiler, DVM, April 8, 2016 –12.2. Immunization Clinics (New)
Frank J. Cary, DVM, April 11, 2016 –12.2. Immunization Clinics (New)
Suggested: 12.2. Immunization clinics providing immunizations other than rabies vaccinations, vaccinations and other services shall be administered by a veterinarian, a registered veterinary technician or veterinary assistant directly supervised by the veterinarian.

Jenna Palmer, DVM, April 11, 2016 - –12.2. Immunization Clinics (New)
This reads that anyone can give the rabies vaccination but any other vaccinations must be given by a veterinarian or registered technician supervised by a veterinarian. It should state that rabies vaccination must be given by a veterinarian or under direct supervision of the veterinarian.

12.2. Immunization clinics providing immunization other than rabies vaccination shall be administered by a veterinarian or a registered veterinary technician supervised by that veterinarian.

We changed the wording.

George R. Seiler, DVM, April 8, 2016 - 4.13 Non-Typical Emergency and Disaster Situations (Add)
Frank J. Cary, DVM, April 11, 2016- 4.13 Non-Typical Emergency and Disaster Situations (Add)
26-4-13 Non- Typical Emergency and Disaster Situations- Temporary Wavier of Standards of Practice

13.1 In the event of a natural disaster or local malfunction of utilities veterinary practices may temporarily operate their businesses outside of theese standards of practice if the veterinarian makes amends to alleviate as much as possible the problems associated with the temporary loss of facilities, utilities or transportation. All efforts are directed to keep patients safe while continuing to provide needed veterinary and lifesaving services. Every effort will be made by the practice owner to bring the facility into full compliance with the standards of practice as quickly as possible.

We added wording.

George R. Seiler, DVM, April 8, 2016 - 4.14 Transportation of Animals (Add)
Frank J. Cary, DVM, April 11, 2016 - 4.14 Transportation of Animals (Add)
26-4-14 Transportation of Animals for Veterinary Healthcare Purposes

14.1 Veterinary healthcare providers providing transportation of animals for healthcare services shall do so in a safe and sanitary manner. All companion animals shall be housed individually in a clean compartment with adequate ventilation, climate control and sanitary bedding. Animals shall be ambulatory after anesthesia before they are transported. If the animals are transported greater than one county the healthcare provider must have a written agreement with a veterinary facility in the county or an adjoining county of the animals residence to provide 24 hour emergency veterinary care after medical or surgical services are provided

---

Tracy R. Walker, DVM, March 30, 2016 – Miscellaneous Comments

As I review the practice act and the suggested revisions, I do not see any reference to ancillary services that are becoming more common in veterinary medicine. Chiropractic, acupuncture, equine podiatry, laser therapy, shockwave therapy and other forms of alternative medicine are becoming commonplace as adjunct treatments in progressive veterinary practices.

In addition, the internet and particularly social media have provided a venue for underqualified unlicensed lay people to easily advertise and solicit business for these same alternative therapies on a “black market”. It is imperative that the board be proactive and address these modalities as the practice of veterinary medicine to protect the safety and wellbeing of patients and owners.

It would be prudent for the board to revisit the continuing education requirements as well. The current requirements of 18 hours annually do not encourage veterinarians to seek out education at larger national meetings. Most national meetings provide a minimum of 40 hours of continuing education. I would suggest a modification of the requirement to 36 hours of required continuing education bi-annually. This would encourage veterinarians to attend local meetings annually and a national meeting every two years.

Francis M. Curnutte, III, Esq, April 11, 2016 – Miscellaneous Comments
I am an attorney who has been in practice in West Virginia for thirty-six years. My wife is an equine veterinarian and she brought the proposed changes to my attention and asked me to look at them and to give her an opinion on their legal validity. It is my understanding, through conversation with my wife, that the object of the Board is to attempt to model the administrative regulations after those in the state of Virginia. Following a review of the proposed changes in regulations and the applicable laws in both West Virginia and Virginia, it appears that the board may have exceeded its authority and is going beyond making new administrative regulations, but rather is attempting to alter statutory law. The Virginia Regulations, which have been copied by this Board, are very different from West Virginia statutory law and the language of some of the regulations is in conflict with the West Virginia statutes. The proposed changes in the regulations actually constitute changes in the meanings of the statutes in Article 10, which the Board has no power to do, because statutes may only be changed by acts of the legislature. Often, an administrative body is unable to adopt rules from other states because the agency must follow the statutory law in their state. I will not address ways in which the specific proposed rules are flawed, rather I merely want to point out that there are flaws in some of the proposed

regulations because they conflict with the controlling statutory law. The Board is not a body which has the power to make laws. Lawmaking is reserved for the legislature. Instead, the Board merely has the power to make regulations to help implement the laws contained in the statutes which govern veterinary medicine. This is similar to laws which regulate various professions in all other states.

I hope that the Board reconsiders its position and submits a draft of the proposed changes which has been extensively amended, because the present draft needs many changes. Furthermore, in its present form, the proposed draft would probably not receive approval from the Rule-Making Committee of the West Virginia legislature.

An additional matter which I would like to bring to the attention of the Board is how large-animal veterinarians deal with, or actually fail or refuse to deal with, emergencies and/or calls after business hours. I have personal experience with calls in the middle of the night and on holidays and weekends, because my wife receives such calls that other veterinarians refuse to take from their clients. It seems to me that, if the Board really wants to protect the public, the Board should promulgate regulations for veterinarians which would result in rules or guidelines governing the responsibility of veterinarians to their clients after normal business hours. It does not seem right to me that large-animal veterinarians will deal with clients, who pay them to serve the needs of their animals, only at times which are convenient and feel free to ignore them during emergencies. Small animal emergencies have emergency clinics to give the necessary treatment, but large animals do not. Large-animal veterinary emergencies are not confined to office hours and the welfare of both animals and the public should not be compromised because some veterinarians do not want to be inconvenienced. It is obviously not in the best interest of the public to be left totally without veterinary services. Even if the veterinarian chooses not to treat an animal belonging to a client, a veterinarian should, a the very least, be available by telephone or have some type of answering service which gives the client some assistance or direction, such as providing the numbers of veterinary schools or large animal hospitals.