Dear Dr. Aspros and New York State Board of Veterinary Medicine Members,

The New York State Veterinary Medical Society (NYSVMS) has continued to discuss the Board of Veterinary Medicine (BVM) proposal to allow for virtual establishment of a Veterinary Client Patient Relationship (VCPR) since the September BVM meeting. NYSVMS members continue to make it clear to the NYSVMS Board that they are passionately opposed to a change in Practice Guidelines to allow for a VCPR to be established without an in-person examination. NYSVMS shares the goal of BVM to ensure access to quality veterinary care in New York State but cannot support the virtual establishment of a VCPR at this time nor can we support the specific language presented by BVM.

Is now the right time for an unproven medical modality?

Treating a veterinary patient without an in-person examination is widely regarded as an unproven new medical modality, with no conclusive evidence that supports either side of the argument. We do not want to continue to debate whether a virtual VCPR will be overall beneficial to the health of NY animals; nobody knows the answer to that question yet, and the September meeting made it clear that BVM and NYSVMS are unlikely to come to an agreement on the topic. Instead of continued debate, NYSVMS hopes we can build common ground and harmony by focusing together on the following question:

“What is the optimum path for NY State to benefit from telehealth while managing the inherent risks of introducing a nascent modality that is not yet evidence-based to the public?”

Data is available that can quantify the risks and benefits.

The answer to this question comes from evaluating the potential benefits vs the risks:

- Although there is a current crisis in emergency medicine in parts of NY, a virtual VCPR will not be an effective solution for emergency care. (Appendix A)
- There is plenty of available information to understand the risks to the public by looking at the track-record of Direct-to-Consumer (DTC) providers in human medicine. (Appendix B)
- The current or projected future shortages of veterinarians are not large enough to justify the risks of introducing a virtual VCPR to NY. (Appendix C)
- There are currently several States introducing a virtual VCPR to their entire population, so there is a clear route to gathering more data that will further clarify the balance between the risks and the benefits. The data from Ontario is not adequate for this purpose. (Appendix D)

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The risks will be significantly lower if we wait for results from other States

NYSVMS believes that the benefits of legalizing a virtual VCPR (See footnote) in 2024, as opposed to waiting a few years, are minimal, while the risks to the public are significant. We advise waiting for additional data from other States who are currently implementing a virtual VCPR before enacting a virtual VCPR in New York.

Concerns about enforcement

Further, NYSVMS would like to see the New York State Department of Education make a significant and unique contribution toward the successful application of a virtual VCPR by addressing an inherent problem that is plaguing our industry. There are already cases of unlicensed practice where DVMs without a New York license are providing telemedicine to animals located in New York. We call on the Board of Veterinary Medicine to advocate to the Office of the Professions and Board of Regents to develop effective ways to enforce the existing laws and protect animals from the increased risk of unlicensed practice due to telemedicine. If we cannot protect the public from unlicensed practice, then our Practice Guidelines and Laws have no value other than to put licensed veterinarians at a disadvantage against out-of-state predatory practice. Establishing a means to enforce telemedicine guidelines must be a precursor to introducing those guidelines.

A final word – Guardrails

Finally, we recognize that despite our deep misgivings, BVM might still decide that the risks to the public are justified and move forward with implementing the ability to establish a VCPR virtually in New York State.

If you do take this step, we urge the Board to consider that the safest way to mitigate the risk of a new medical technology would be with the most stringent set of guardrails and protection in place. We strongly believe that as a minimum New York should provide the same level of risk mitigation from new medical technology as other US States.

Sincerely,

Dr. Paul Amerling
President, New York State Veterinary Medical Center

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Appendix A

A VCPR without in-person examination will not be an effective solution to help emergency hospitals, or animals in areas where there are no emergency facilities.

One of the most urgent problems in veterinary medicine to address in NY State is the lack of availability of urgent and emergency care in areas of Upstate New York.

Closer to the ocean these problems are far less acute. Groups like BondVet, Guardian Veterinary Specialists and VEG have been extremely successful at recruiting enough veterinarians to make urgent care readily available in the areas they serve.

Meanwhile, closer to Lake Ontario there have been emergency hospitals either closing altogether or reducing service hours. Pet owners in those regions may have to drive for several hours to reach an open emergency room. Fortunately we are already hearing reports of new emergency hospitals being established to help fill the gaps.

Most owners will take their pet to the emergency room or urgent care when they are seeing symptoms that are serious and need to be examined and treated in-person.

Telehealth Triage services help filter pets arriving at an emergency hospital

A virtual VCPR is not suitable for treating serious cases, but virtual triage services provide a legal way for emergency hospitals to manage high-demand for their services.

For example, animal owners who go to the [website](#) for the Companion Animal Hospital at Cornell University College of Veterinary Medicine see a prominent box that says “Is your pet experiencing an emergency?” This directs owners to a 3rd party triage service that has been outsourced to VetTriage.

Triage services typically decide if the symptoms indicate that an owner should go straight to the emergency hospital, or whether they can wait until they can get an appointment with a veterinarian.

When Triage directs owners away from the emergency hospital

If the triage service advises the owner that they don’t need to go to the emergency hospital, what happens next? The answer is different for the two groups below:

- A. Owners who already have a veterinarian (existing clients)
- B. Owners who do not have a regular veterinarian

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A. Owners who already have a veterinarian (existing clients)

A recent NYSVMS member survey indicates that 52.5% of hospitals will see an existing client the same day that they call with a sick animal. A total of 91.3% of hospitals will see that client within 2 days of the call. There is little difference in the data between the various regions of New York.

If an owner already has a regular veterinarian, then they should have no difficulty getting an appointment in a reasonable time. Although wait-times to see your own veterinarian grew longer during the pandemic, this is no longer the case.

One of the concerns of NYSVMS members is what might happen if the Triage service their clients called were also able to diagnose and prescribe. This might mean that animals that might otherwise have been seen by their regular veterinarians are instead treated by online veterinarians who do not know their medical history. The regular veterinarian will most-likely never hear about any medications prescribed.

Direct-to-Consumer (DTC) telehealth companies tend to have large advertising budgets, and also tend to promote a subscription model that encourages the owner to use the DTC for the majority of their regular care. The regular veterinarian is positioned as a provider of blood-work and other in-person annual checks.

This means that the overall impact of allowing DTC companies to enter the market is to move owners away from their regular veterinarians, even though those veterinarians have the capacity to provide treatment. The net effect will be a lower standard of medical care, and less money going to maintain the existing in-person hospitals.

B. Owners who do not have a regular veterinarian

Some of the patients who are directed away from an emergency hospital by teletriage will not have a regular veterinarian. In this situation, the best medical outcomes will be provided by making sure they do go to see a veterinarian and have a long overdue in-person examination. Because their pet is sick they now have a strong incentive to take their pet to a veterinarian where it will receive a long overdue in-person examination.

These same owners are highly likely to make use of a virtual VCPR should it be available. The incentive to take their pet to the veterinarian has been eliminated, because now they can call an online prescriber.

Because online DTC companies typically invest heavily in online advertising, owners will come to believe that an in-person examination and a relationship with a veterinarian is no longer necessary. They will see online the offer of “Online vet care & prescriptions, when you need it. Meet with a top-rated online vet to get customized prescription treatment plans to solve your pet’s needs.”

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Appendix B

Information from human healthcare that helps us understand the potential risks of a virtual VCPR

Human healthcare has already deregulated the requirement for in-person examinations for many situations. This is perhaps the best available data available on which to base a decision on whether this is the right time to eliminate the requirement for in-person examinations in veterinary medicine.

The data and case-studies presented below illustrate the risks that a virtual VCPR will bring to animals in New York.

B.1 The risk of Direct-to-Consumer (DTC health-care companies)

B.2 Pediatrics

B.3 DTC and over-prescribing antibiotics

B.4 Mental Health and ADHD

B.5 Dermatology

B.6 Ketamine

B.6 Telehealth Fraud

In human healthcare, most of the negative consequences do not come from established medical practices who extend their care to new clients. The equivalent in veterinary medicine would be an animal hospital that sets up a virtual care service as part of new patient onboarding. This is the type of virtual VCPR that is currently permitted in Ontario, CA, where only accredited facilities may provide veterinary services.

In human healthcare, most of the poor medical outcomes reported below arise from Direct-to-Consumer (DTC) healthcare delivery models, such as Teledoc, Cerebral and MDLive. We have already seen a limited number of DTC companies offering veterinary care in New York. The problems with human DTC medicine outlined below are likely to occur in veterinary medicine under a virtual VCPR.

B.1 The risk of Direct-to-consumer (DTC) health-care companies

The deregulation of virtual care in human health has enabled a vast new sector of Direct-to-Consumer (DTC) medication sales companies to emerge. These usually have no connection with existing healthcare providers who operate hospitals and clinics. Instead, they are driven by ecommerce companies and the

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capital investors who seek to profit through the exponential rise of start-up businesses. DTC companies have already migrated from human healthcare into the veterinary medicine market. They exploit the relaxed laws in some States around a virtual VCPR to offer virtual appointments and prescribe medications. As more US State permit DTC veterinary medicine, it will become more attractive for other corporations to invest in veterinary DTC services. Some of these are likely to be extensions of the large online pharmacy companies that already provide a large share of veterinary medications and will have massive budgets to drive business growth.

B.2 Pediatrics

**Data Source:** American Telemedicine Association - Operating Procedures for Pediatric Telehealth

The American Telemedicine Association has issued operating procedures for pediatric telehealth. This states that “Telehealth services should not be provided to children under two years of age in their home or other non-clinical setting except when the provider or their surrogate has a previously established in-person relationship with the patient or when the PCMH has referred them for subspecialty consultation.”

One of the justifications we have heard for a virtual VCPR is that the situation is analogous to pediatrics where the patient is unable to verbally communicate their symptoms.

B.3 DTC and over-prescribing antibiotics

**Data source:** Access and Quality of Care in Direct-to-Consumer Telemedicine; Telemedicine Journal and E-Health 2016, Pines et Al

This study focused on outcomes from a large DTC company, Teledoc. It found that Teledoc providers were less likely to order diagnostic testing and had poorer performance on appropriate antibiotic prescribing for bronchitis.

One of the most striking results was that Teledoc’s user group appeared to be evenly spread across demographics. The results imply that contrary to expectations, the users of virtual care services like this aren’t the people who weren’t able to access in-person care. Instead, they were attracting patients who could just have easily gone to their own doctor.

If these patients had gone to their own doctor, the study showed that they would have got much better treatment. Physicians’ offices frequently tested patients presenting with bronchial ailments for strep. For bronchitis diagnoses, Teledoc prescribed antibiotics 84% of the time, compared to 72% of the time for in-person visits. Neither result is great since antibiotics are never appropriate for acute bronchitis.

Teledoc sometimes tell patients to see their primary care doctor for testing, but compliance is poor.

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This paper brings together a number of studies on over-prescribing in human medicine, with a particular focus on antibiotics. Rather than set out all the separate references in this document, we have highlighted some of the data that Hoffman extracted from those references. Full references are available in Hoffman’s article.

- Children who were seen at a DTC telemedicine provider were prescribed antibiotics for respiratory infections at a rate of 52% compared to 31% at their primary care physician.
- Shorter appointment times and financial incentive structures incentivize DTC physicians to prescribe more antibiotics.

Hoffman concluded that “Collectively, these research studies suggest problems with prescribing in the DTC telemedicine context, in particular with the potential for overprescribing and inappropriate prescribing.”

Data source: Differences in antibiotic prescribing rates for telemedicine encounters for acute respiratory infections, J Telemed Telecare 2022, Li et al,

This paper compares the performance of prescribers working for a DTC provider to the performance of telehealth prescribers that are affiliated with medical centers. All the prescribing activity is the result of telehealth appointments, and the study focuses on antibiotics prescribed for patients presenting with acute respiratory infections.

Their conclusion was that patients of the DTC prescribers were 2.3 times more likely to be prescribed antibiotics than those served by the medical center.

The study justifies the fear of NYSVMS and its members that unrestricted availability of a virtual VCPR will result in their current clients going instead to new DTC companies. Based on this data we are concerned that these companies will prescribe antibiotics unnecessarily, while failing to provide the correct treatment for the animal.

B.4 Mental Health and ADHD

Data source: Startups Make it easier to get ADHD drugs, WSJ, Winkler and Walker, 2022

A number of media stories from the Mental-health and ADHD world illustrate how commercial pressures within DTC companies result in over-prescribing and poor medical care.

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Two companies in particular have attracted negative publicity. “Done” has a business model that focuses on maximizing sales of Adderall. Cerebral also sells Adderall along with other mental-health medications.

There is a law-suit against Cerebral in which a former VP at Cerebral was fired after he complained about the company’s internal processes to maximize drug sales.

In March 2022, the Wall Street Journal reported on complaints from prescribers at both companies that they felt pressured to diagnose mental-health conditions in brief online consultations. There were internal processes that required medical employees to justify why they did not prescribe a drug. A leaked best-practices document said that even if patients didn’t meet the criteria for the medical diagnosis for a condition, “it might be worth doing a medication trial”. Prescribers were also pressured to refill without even a video check-up with the patient. One prescriber is managing 2,300 patients and processes a renewal every 2 minutes, earning her $20,000 a month.

The impact of Cerebral and Done on the overall market is significant. Prescriptions of Adderall jumped by 10%. Within 2 years, Cerebral became one of the largest providers of mental-health care.

We are concerned about a bleak future for veterinary medicine. Will our colleagues spend their futures having to cling onto their jobs by churning out prescriptions based on inadequate virtual examinations? These risks must be carefully evaluated. At a minimum, should a virtual VCPR be legalized, it must be with very clear and enforceable guardrails that ensure that NY animal owners are not exploited by new market entrants like Cerebral and Done. We are already concerned about NYSED’s inability to enforce existing laws against DTC veterinary services and think that priority should be given to enforcement and protection.

B. 5 Dermatology

Data Source: Choice, Transparency, Coordination, and Quality Among Direct-to-Consumer Telemedicine Websites and Apps Treating Skin Disease, JAMA 2016, Resneck et Al,

As early as 2016 an article in the Journal of the American Medical Association highlighted concerns about direct-to-consumer telemedicine and apps treating skin disease. They found that Sixty-two simulated encounters to 16 DTC telemedicine websites resulted in care that often lacked patient choice of clinician, transparency of clinician credentials, or care coordination. Many incorrect diagnoses were proffered without reasonable attempts to ask basic medical history follow-up questions, treatment recommendations sometimes contradicted evidence-based guidelines, and prescriptions frequently lacked disclosure of possible adverse effects and pregnancy risks.

Data Source: Journal of American Academy of Dermatology

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An October 2021 letter in the Journal of American Academy of Dermatology notes that the business model used by DTC dermatology providers relies for success on patients purchasing pills. “Given the lack of transparency regarding profit models, we remain concerned that these companies’ models incentivize increasing profit margins through increasing the number of prescriptions. Patients may feel unsure if their care recommendations are driven by profit rather than by high-quality dermatologic care” (arun K. Ranpariya, BA, a and Jules B. Lipoff, MD b,c. From the Rutgers Robert Wood Johnson Medical School, Piscataway, New Jersey)

B. 6 Ketamine
There is a substantial body of research that indicates that under medical care, Ketamine can be used successfully to enhance outcomes in the treatment of anxiety, depression and other disorders.

Unfortunately, many people suffer from depression that has proven resistant to other treatments. So a site like Mindbloom that promises to “Free yourself from anxiety and depression” creates a demand from patients seeking help.

The prescribers on these sites are not asking “What is the best treatment for this patient?” or even “Will Ketamine help this patient?” The only questions of relevance are whether they can get enough boxes checked on the intake form to justify prescribing the drug.

An unnamed emergency physician was quoted in MedPage Today as saying “If you market yourself as only prescribing one thing (ketamine, testosterone, Adderall, etc) then you're not a doctor, you're a drug dealer.”

That may be an over-dramatic way of expressing it – but we ask BVM not to open up NY to exploitation by businesses more concerned with selling a narrow range of medications than offering veterinary medicine.

B.6 Telehealth Fraud
mHealth Intelligence recently reported a Department of Justice action against 11 people who were engaged in telehealth fraud schemes worth $2 billion.

Fraud schemes that exploit a legalized virtual VCPR are an unknown risk that cannot be quantified or evaluated. Since other States are moving forward with legalizing a virtual VCPR, we recommend taking a pause to see what types of fraudulent activity develops to exploit new opportunities. Then steps can be taken to protect the public from fraud should NY move forward at a later stage.

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Appendix C

Models that predict a severe shortage of veterinarians are over-exaggerated and should not be used as a justification for establishing a virtual VCPR.

A justification for telehealth services in human medicine is to provide care when there are not enough doctors. This same argument is being used in veterinary medicine.

MDLive provides patients with an online primary care physician, although they do require the patient to go to a lab for bloodwork. Several other direct-to-consumer companies provide a similar hybrid model combining a visit to a lab for bloodwork with an online consultation. (Direct-to-consumer is the human medical version of a virtual VCPR.)

A 2020 Forbes Article featured MDLive and contrasted it with an early study in human medicine where in 63% cases of medical error the cause was the failure to do a physical examination.

The response from MDLive was damning.

“When you look at the quality of this, you have to not measure it against what would have happened in the office,” says Lyle Berkowitz, chief medical officer at MDLive. “You have to measure what would have happened if this was not available. The likelihood that the patient would not get any kind of care screening at all.”

It is concerning to us that MDLive, a leading provider of telehealth services, says that because the medical outcomes are so much worse with telehealth, the only way to justify it is when there aren’t enough doctors available for in-person medical care.

This same argument is being used in veterinary medicine.

But is it true that there aren’t enough veterinarians available for in-person veterinary care to warrant the risk of virtual VCPR?

Our analysis below shows that demand for veterinary care is currently higher than the capacity of the veterinary industry in NY. The emergency care system is severely under-capacity in some areas. However, the emergency care shortfall cannot be addressed by a virtual VCPR. For general care our survey data indicates that NY veterinarians are filling the gap by working longer hours than they wish to make sure animals get the care they need.

While this is unsustainable, we believe that improvements in team efficiency and the use of new time-saving technologies will lead to better outcomes overall.

We are very concerned that virtual telehealth companies will draw recruits from the pool of in-person doctors, deepening the shortages.

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How severe is the current shortage of veterinarians?

We draw the conclusion from multiple surveys of our NYSVMS members that there is still high-demand for veterinary services that are keeping many animal hospitals stretched. Although veterinarians are struggling with staff shortages and difficulties recruiting, they are still managing to provide timely in-person veterinary services in most of the service segments that we looked at.

Our member veterinarians are not asking for us to advocate for a virtual VCPR to help them manage the shortages. On the contrary, they are strongly opposed to a virtual VCPR and do not believe it to be an appropriate response to the staffing shortages.

Our most recent member survey evaluated the veterinary shortage by evaluating the following questions:

- How do shortages affect the delivery of veterinary services to the public?
- How do shortages affect veterinarians?

How do shortages affect the delivery of veterinary services to the public:

The biggest change we see in member surveys is that wait times have significantly reduced since the height of the pandemic and that existing clients get seen very quickly as noted in the first chart. However, many of these hospitals won’t necessarily be as quick to see a new client as noted in the second chart.

“"If an existing client calls in the morning with a sick animal requiring an in-person examination, what is the usual wait-time for an appointment."”

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<table>
<thead>
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</thead>
<tbody>
<tr>
<td>Same day</td>
<td>90</td>
<td>(53.3%)</td>
</tr>
<tr>
<td>Within 2 days</td>
<td>65</td>
<td>(38.5%)</td>
</tr>
<tr>
<td>Within 4 days</td>
<td>7</td>
<td>(4.1%)</td>
</tr>
<tr>
<td>Within 8 days</td>
<td>4</td>
<td>(2.4%)</td>
</tr>
<tr>
<td>Within 16 days</td>
<td>3</td>
<td>(1.8%)</td>
</tr>
</tbody>
</table>

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The second chart indicates that many of these hospitals won’t necessarily be as quick to see a new client.

“If a new client calls in the morning with a sick animal requiring an in-person examination, what is the usual wait-time for an appointment?”

<table>
<thead>
<tr>
<th>Wait Time</th>
<th>Count</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Same day</td>
<td>31</td>
<td>18.5%</td>
</tr>
<tr>
<td>Within 2 days</td>
<td>44</td>
<td>26.2%</td>
</tr>
<tr>
<td>Within 4 days</td>
<td>19</td>
<td>11.3%</td>
</tr>
<tr>
<td>Within 8 days</td>
<td>11</td>
<td>6.5%</td>
</tr>
<tr>
<td>Within 16 days</td>
<td>8</td>
<td>4.8%</td>
</tr>
<tr>
<td>We are not accepting new clients on an urgent/emergency/same-day sick basis</td>
<td>55</td>
<td>32.7%</td>
</tr>
</tbody>
</table>

The owners who will be most affected by veterinary shortages are those that have no current veterinarian. Their animals may already be long overdue for an in-person examination. Their owners have most likely not sought help when the animals have had mild conditions before and may have simply waited for the animal to recover by itself. Once these owners seek care, it is more likely that the animal has been sick for a while without improving. While it is important to address the number of sick pets who may not have access to veterinary care, we do not believe introducing a virtual VCPR is the right way to go about it. Due to the evidence provided in Appendix B, we believe that there is an increased risk of misdiagnoses and over-prescribing medications.

The animals who can be most safely treated by a virtual VCPR are those who are already receiving regular care from their local veterinarian. The last thing we want to see is the number of veterinarians available to provide in-person care reduced because companies offering virtual VCPR solutions have taken away their clients.

Finally, in the emergency and urgent care setting, there are higher wait times. Most of these animals have more severe symptoms and are unsuitable for a virtual VCPR.

**How do shortages affect veterinarians?**

During November 2023, we surveyed our members. There is still a shortage of veterinarians, although we are seeing improvements from the same survey questions a year ago.

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• Members still report problems with burnout and long hours.
• Members still have to send some patients to other hospitals when they don’t have capacity themselves.
• But members report that when they do turn patients away it is much more likely now that they will find a nearby hospital.

Future Predictions for veterinary shortages
If there is going to be a massive shortage of veterinarians in the future, the argument goes, then we need to prepare now by establishing a virtual VCPR that can serve all those clients left without a local veterinarian.

Dr. James Lloyd has been financed by Mars Veterinary Health to publish the most commonly quoted research that predicts a future shortage of veterinarians.

But any model that predicts the future depends on assumptions. A standard approach to modeling the future would be to build a model and then test how the result looks based on a variety of assumptions.

The assumptions that go into a model include:

• Annual increase in class size
• Proportion of graduates choosing companion-animal medicine
• Foreign graduates earning ECFVG
• Growth in the percentage of families owning pets
• Population growth
• Improvements in the efficiency of veterinary medicine (ie: vet per pet)
• Extent to which vets who want to worker shorter hours actually get to reduce their hours
• Changes in the infrastructure of veterinary care delivery
• Improving retention of veterinarians by making the industry less stressful

A forecasting model like this is easy to build. You just plug in estimates for the factors that change demand over time, and the growth in the number of veterinarians. Dr. Lloyd used a set of assumptions numbers that forecasts a large increase in the shortfall.

The AVMA have run a similar model with a wider set of assumptions and do not believe this shortfall is the most likely prediction.

The NYSVMS ran our own models exploring what factors made the biggest difference. The Lloyd model predicts that the increase in the number of veterinarians needed is closely related to the forecasts for the growth in overall spending on veterinary care. However, we believe that the growth in veterinary spending is strongly driven by the availability of new tests and treatments which in turn leads to more

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efficient medicine and a decrease in the number of veterinarians required per pet. Therefore we support the predictions from AVMA that there will not be a large shortage of veterinarians in future years.

The demand for veterinary services may decrease significantly over the next few years as spending on pets is sensitive to the economy and world events. Unfortunately these predictions don’t seem to be balanced by expected events that might increase the demand.

Conclusion from supply-demand models

Introducing a virtual VCPR to the NY public introduces an unknown risk. That risk could be justified if we were anticipating a future in which there will be a deep and desperate shortage of veterinarians.

NYSVMS believes that the predictions of future shortfalls are not convincing enough to be used as a justification for increasing the risk to the public from an unproven methodology.

Furthermore there are plenty of other approaches that the veterinary industry is working on that will address the supply/demand imbalance and that remove the need for a virtual VCPR to be introduced.

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Appendix D. Other States and Ontario

Some have cited the experience with the virtual VCPR guidelines in Ontario as sufficient evidence to support moving forward in New York. However, we do not feel this comparison can be made:

- Ontario requires that veterinary services be delivered by accredited veterinary facilities. This may explain why that market has not yet seen significant activity by Direct-to-Consumer (DTC) services. NY State does not have a comparable system of accredited veterinary facilities. Therefore the risks to the public from DTC providers is much higher in NY. Although there are opportunities for DTC companies to apply for accreditation, it is not yet clear if any have done so, or what the requirements are.
- Because the current providers of virtual VCPRs must be accredited hospitals, there aren’t likely to be so many situations where a virtual VCPR is currently being used. People tend to adopt new online services when there has been extensive advertising. Existing animal hospitals are unlikely to invest that same level of money to try to attract owners away from their existing veterinarian to an online service. Therefore the market penetration of new online VCPRs will be relatively small.
- OVMA ran a survey of Pet Owners in 2021. They found that of those owners who ordered a telemedicine consultation, 93% received it from their existing veterinarian.

The reports we hear back from OVMA are that their members have the same fears as NYSVMS members. They are concerned that the regulator is going to be ineffective at enforcing existing laws against the veterinary equivalent of Direct-to-Consumer providers.

Several other States have recently moved forward with regulations or legislation that permits a virtual VCPR. None have been doing it long-enough to result in high quality research.

Most, if not all, have incorporated a wide-range of safeguards into the language. As a simple example, they make sure that a virtual VCPR is performed using appropriate video or photographic equipment, not the telephone.

Footnote: “Virtual VCPR” refers to a VCPR established via telehealth without an in-person examination. “Direct-to-Consumer (DTC)” refers to providing medical or veterinary treatment via a virtual VCPR by online service companies who do not operate medical/veterinary facilities in NY State.
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