Standards Committee
Agenda for meeting to be held on 1 May 2014

1. Apologies for absence, declarations of interest and minutes of the meeting held on 23 January 2014
   Paper attached

2. Professional Conduct Update
   Paper attached

3. Matters for decision:
   (a) Animal Insurance
   (b) Vaccination Record Cards
   (c) Removing Microchips: Guidance Review
   (d) Specialists and Advance Practitioners
   (e) VNs and Anaesthesia
   Papers attached

4. Matters for report
   (a) Advisory Report
   (b) Disciplinary Committee Report
   (c) Riding Establishments Sub Committee Report
   Papers attached

5. Confidential matters for report
   (a) Certification Sub Committee Report
   (b) Recognised Veterinary Practice Sub Committee Report
   (c) Register and Registration Sub Committee Report
   Papers attached

6. Any other business and date of next meeting 7 October 2014
Standards Committee 2013 / 2014

Chairman: Mrs Clare J Tapsfield-Wright BVMS MRCVS
Vice-Chairman: Mrs Caroline N Freedman BSc(Hons) MRPharmS

Members:
Mr Christopher Barker BVSc MLitt CertVR MRCVS
Prof Malcolm Bennett BVSc PhD FRCPath DipECVPH MRCVS
Ms Elizabeth A Branscombe DipAVN (Surgical) RVN
Professor Ewan Cameron BVMS PhD MRCVS
Mr Peter C Jinman OBE BVetMed DipArb FCIarb MRCVS
Mr Peter Robinson BVMS MRCVS
Dr Thomas Witte BVetMed DipACVS DipECVS FHEA PhD MRCVS
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Standards Committee
Minutes of the meeting held on 23 January 2014

Members:
Mrs Clare Tapsfield-Wright - Chairman
Mrs Caroline Freedman - Vice-Chairman
Mr Christopher Barker
Professor Malcolm Bennett* - Veterinary Nurses Council Representative
Miss Elizabeth Branscombe
Professor Ewan Cameron*
Mr Peter Jinman
Mr Robert Partridge
Dr Thomas Witte

*Absent

In attendance:
Mr Gordon Hockey - Registrar / Head of Legal Services
Ms Eleanor Ferguson - Head of Professional Conduct
Ms Laura McClintock - Advisory Solicitor/Committee Secretary
Ms Rebecca Hall - Advice Officer

Present for Agenda Item 3 (f):
Mr Jeff Gill - Policy Consultant
Ms Nicola South - Customer Experience Manager
Ms Theresa Walker - Disciplinary Committee Clerk
Welcome, Apologies and Declarations of Interest

1. The Chairman welcomed everyone to the meeting and reminded members to ensure that their declarations of interest are kept up to date. There were no new declarations of interest for the meeting.

2. Apologies were received from Standards Committee members Professor Ewan Cameron, Professor Malcolm Bennett and from observer Professor Stuart Reid.

Minutes

3. The Committee adopted the minutes of the meeting held on 24 September 2013.

4. Clarification was sought on the role of veterinary nurses in pain scoring, specifically whether they may assess pain and prescribe in accordance with a general protocol. It was agreed that veterinary nurses play a role in recognising and assessing pain. However, what they must not do is make a diagnosis or give advice based on a diagnosis. It was agreed that a patient-specific prescription, based on a prior discussion between the veterinary surgeon and nurse about what to do if a pain score reaches a certain threshold, is acceptable (even if drawn as widely as this), but a general protocol applicable to all patients is not.

5. It was asked whether RCVS Council members had been reminded that any comments relating to the Standards Committee papers should be submitted via the Committee Secretary. It was noted that comments are not being encouraged as the system for circulating papers has changed. Standards Committee papers remain available to all Council members on the Intranet, but are not specifically circulated in advance of the meetings.

6. There was further discussion about the status of observers, particularly whether their comments should be clearly identified in the minutes. It was commented that this can be difficult to write up as individuals are generally not identified when the minutes are taken. There was also discussion about where observers should sit during the meeting, and how they sit separately in some other Committees. It was noted that Standards Committee is a much smaller group than other Committees.

7. It was also asked whether the pages in the combined PDF of papers could be individually numbered. It was commented that each paper is numbered and headed separately and the PDF contains bookmarks for navigation, but we will look into including an additional system of numbering.

Professional Conduct Update

8. The Committee noted the report. The following issues were highlighted:

   a) 24/7 Fact Finding Exercise – The Committee noted that to date the RCVS has received 82 responses (70 from veterinary surgeons and 12 from members of the public). The Committee also noted a petition from veterinary surgeon Joanna Dyer which calls for the removal of ‘mandatory house visits’ from the Code of Professional Conduct. It was noted
that the number of signatures received, and the comments of the signatories, will be fed into the material reviewed by the Standards Committee, alongside all of the formal responses to the call for evidence (including a brief analysis) and views gathered from animal-owner research. It was agreed that the Committee should receive one batch of comments following the meeting, with the remaining provided at the close of the fact finding exercise.

b) **Veterinary Students Fitness to Practice Working Party** - The Committee noted that the next meeting is scheduled for 7 March 2014. In response to a question, it was explained that those studying for a veterinary degree (who do not intend to pursue a clinical career) must still be fit to practise at the point of qualification / graduation. There was also discussion of fitness to practice procedures at university level as well as the disclosure requirements expected of students applying to register with the RCVS.

c) **Animals (Scientific Procedures) Act Working Party** – The Committee noted the update. It was explained that revised RCVS guidance is nearing completion; however, a number of sections cannot be signed-off until the Home Office agrees the final correlating parts of its own statutory guidance. Once this happens, the outstanding sections will be updated and draft guidance will be circulated to the Committee for approval.

d) **Feline Renal Transplants** - The Committee noted that the Science Advisory Panel (which had been asked to consider the issue of feline renal transplants) will meet for the first time on 28 January 2014. It was agreed that the Secretary to the Science Advisory Panel should be reminded that Dr Tracy Hill, Senior Lecturer in Small Animal Medicine and Interventional Radiology at the Royal (Dick) School of Veterinary Studies would be willing to discuss her experience in this area, and that there may be additional information available following on from a recent symposium in Liverpool (October 2013), which included discussions on ethics.

**Use of anaesthesia-free dental procedures (cats and dogs)**

9. The Committee considered the amendments to the statement relating to the problems associated with anaesthesia-free dental procedures for cats and dogs. It was noted that the original statement had support from the European Veterinary Dental College (EVDC), the European Veterinary Dental Society (EVDS), the current Recognised Specialists in Veterinary Dentistry practising in the UK, and the British Veterinary Dental Association (BVDA).

10. There was discussion of the second page of the statement, which aims to provide advice to the public, who need to be aware of the relevant legal restrictions. It was confirmed that simple cleaning procedures may be carried out by lay people such as groomers, but they may not undertake sub-gingival procedures. It was agreed that the advice to the public should be expanded to say that sub-gingival scaling amounts to the practise of veterinary surgery.

11. The Committee agreed the new wording of the statement, a copy of which is attached at Annex A.

**Action: Professional Conduct Department**
Top Ten Medicines

12. The Chairman introduced the paper, noting that in April 2013, RCVS Supporting Guidance Chapter 10 was updated to say that veterinary practices no longer have to include information on a poster in their waiting rooms to tell clients what the top ten medicines they supply are, and their costs. At that time, it was agreed with the OFT that the change would be implemented for a six-month period, during which time the RCVS would monitor the situation. Provided there was no appreciable level of complaint from the public, either to the RCVS or the OFT, the change would become permanent. Neither organisation has received complaints and the OFT has now agreed that the change can become permanent.

13. The Committee endorsed the decision of the OFT and agreed that the change to the Code should become permanent. It was highlighted that the Top Ten list was originally introduced as a method to allow members of the public to compare prices of medicines, but it is no longer meaningful, particularly where there are often differences in the way Top Ten lists are interpreted. It was noted that even though this requirement will disappear, there are still core professional responsibilities in the Code and Supporting Guidance to ensure that clients have access to sufficient information to be able to decide where to obtain veterinary prescriptions and medicines.

14. It was suggested that an additional article in RCVS News may be helpful to highlight the change to the guidance as well as the remaining responsibilities.

Action: Professional Conduct Department

Pet Insurance

15. The Chairman introduced the paper, noting that the Committee has been given three tasks: (1) to consider Chapter 9 of the Supporting Guidance generally as part of the RCVS commitment to carry out a rolling review of the Supporting Guidance (2) to consider whether the current Supporting Guidance dealing with pet insurance should be strengthened in light of the recent disciplinary case relating to Mrs Brimelow and to approve draft amendments, and (3) to consider, at the request of the Preliminary Investigation Committee, whether it is appropriate for veterinary surgeons to ask clients to sign blank insurance forms for ongoing treatment.

16. There was discussion about the strength of the current guidance in relation to completing insurance claim forms. It was commented that veterinary surgeons are in a position of trust when completing insurance forms and should do so accurately and honestly, and exercise particular care when dealing with their own animals or those of close friends or family. It was suggested that the current guidance should be further strengthened to say veterinary surgeons who complete insurance forms fraudulently or dishonestly may be liable to disciplinary action.

17. In response, it was commented that the current principles of practice already include a requirement that veterinary surgeons must act honestly and with integrity, and that they must certify facts and opinions honestly and with due care. In the Brimelow case, the allegation was dismissed by the Disciplinary Committee, who noted that there were no clear guidelines from Ms Brimelow’s employing practice about how claims should be handled and that the Police had
decided that there was no public interest in proceeding with the matter. However, decisions do vary and each case must be considered on its own merits.

18. There was also discussion of Supporting Guidance Chapter 9.7 which states “all invoices should be itemised showing the amounts relating to goods including individual relevant medicinal products and services provided by the practice. Fees for outside services and any charge for additional administration or other costs to the practice in arranging such services should also be shown separately”. In light of the Brimelow case, it was suggested that this might be amended to say “goods actually charged”.

19. There was discussion about whether it is appropriate for veterinary surgeons to ask clients to sign blank insurance forms for ongoing treatment. It was explained that the Preliminary Investigation Committee had raised concerns as issues had arisen in cases where clients had been asked to pre-sign the blank claim form to confirm that the details of the treatment administered are correct before the details have been added.

20. It was commented that in cases where the bill is sent to the client to submit to the insurance company, it is sensible for veterinary surgeons to retain a copy of what they have provided to the client. This means the veterinary surgeon has a copy of original bill in the event that the client attempts to amend the details. Likewise, in cases where the veterinary surgeon submits the claim directly to the insurer, a copy should be sent to the client. It was commented that where bills are submitted electronically, a copy should still be available for the client.

21. There was discussion about how information is transferred between the client, the veterinary surgeon and the insurance company. It was commented that generally the insurance company will notify the client if they are paying the veterinary surgeon directly. The client will then have an opportunity to query the cost, which acts as another barrier to prevent insurance fraud. It was commented that it is good practice for the client to see the form before it is submitted to the insurance company, particularly as the client may not wish to claim for all of the treatment.

22. There was also discussion of preferred supplier lists, as used in the medical world and questions surrounding fixed maximum fees.

23. Overall, the Committee agreed that it would be helpful if the Supporting Guidance included a separate chapter on ‘animal insurance’. It was agreed that a new section will be drafted and returned to the Committee for approval in due course.

Action: Professional Conduct Department

Vaccination Record Cards

24. The Chairman introduced the paper, noting that over the past year, the RCVS has received a number of queries from the profession about the responsibilities associated with completing vaccination record cards. In particular, the RCVS has been informed that a number of veterinary surgeons have found themselves in the position of being asked to provide a follow-up vaccination
to a patient who is accompanied by a signed but otherwise blank vaccination card, i.e. a card that does not identify the patient.

25. There was discussion of vaccination record cards, certificates and the twelve principles of certification, including issues surrounding the identification of animals. It was suggested that veterinary surgeons should encourage their clients to permanently identify their animals.

26. It was commented that there may be some situations when the veterinary surgeon feels unable to give the second vaccination because he/she cannot be reasonably sure that the vaccination card relates to the same animal. It was agreed that in such situations, veterinary surgeons must use their own professional judgment and discretion to decide how much weight to attach to the record card and may, in certain situations, decide to advise the client to re-start the course of vaccinations.

27. Overall, it was agreed that new guidance should be produced and returned to the Committee in due course.

28. There was also discussion about the age at which pups may be microchipped. Concerns were raised about pups being microchipped at a young age (under 8 weeks) and/or under a certain weight, particularly whether this could amount to the practise of veterinary surgery. If so, it would not be appropriate for lay people to carry out the procedure unless there was a suitable exemption under Schedule 3 of the Veterinary Surgeons Act 1966. It was commented that the Microchip Alliance Group may be able to provide further information, including information about microchip failures. It was agreed that the matter should be referred to the Science Advisory Panel, who may be best placed to consider an evidence based review of microchipping pups at a young age or certain weight.

Action: Professional Conduct Department

Breeding, Sale and Supply of Dogs – Advisory Council Recommendations to Governments

29. The Chairman introduced the paper, noting that the Advisory Council on the Welfare Issues of Dog Breeding (DAC) has carried out a review of legislation relating to the breeding, sale and supply of dogs, and has recently published its ‘Review of Regulation – Recommendations to Governments’. The report includes recommendations in relation to veterinary surgeons and how the DAC believes veterinary surgeons can play a role in improving the welfare of dogs.

30. The Committee noted the report. It was commented that the role of veterinary surgeons can be overestimated, particularly as the animals are often bred before visits to the surgery or practice are carried out. It was also asked whether the RCVS could do more to pro-actively promote animal welfare to the public, owners and breeders. The Committee noted that while the report appears to have been redrafted, it was disappointing that the Committee did not have the opportunity to see the final draft before it was published.
Review of Registration Regulations

31. The Committee noted the paper and revised regulations following on from its last meeting in September. The Chairman explained that since the Committee papers were circulated two weeks ago, the Operational Board has considered the revised regulations.

32. On the issue of Registration fees for nationals of developing countries, it was explained that it would not be right for the RCVS to make new regulations which refer to a list of developing countries when there is none, but equally it is not right that eligibility for a financial concession which may be significant for the individuals concerned should be so loosely defined. It was explained that all that is necessary, in fact, is to give the individuals concerned temporary registration with a time-limit of six months, as incorporated into the revised regulations.

33. The Committee also noted that temporary registrations are currently referred to on the website and on the forms as ‘Restricted (temporary) registrations’. However, Section 2 of the Act refers to the temporary list which means the Regulations will still need to refer to temporary registrants.

34. In response to a question, it was agreed that the RCVS should clarify whether the bye-laws had changed in relation to the quorum and numbers for an Annual General Meeting (AGM).

35. There was discussion about the publication of the Register and the limited information available on the RCVS website, in particular the lack of register address. It was suggested that as a minimum members of the RCVS should have access to the information out of hours, particularly as this may be need for ongoing cases. It was also suggested that this could be done via a secure and confidential online log-in. One member suggested that this could perhaps be linked to a member’s unique electronic signature and that information relating to the costs for such as system (e.g. Co-Sign) had been sent to the CEO.

36. It was explained that the register address is still available to those who ask (although this will not be available out of hours). It was explained that if an individual required more information, the RCVS could ask the registrant for permission to disclose this.

37. Overall, it was agreed that the Registration Department would consider the practical and legal considerations to facilitate password protected member access to Register details, and the use of fully electronic signatures, with input from the Operational Board as to funding.

38. The Committee endorsed the draft regulations for presentation to RCVS Council.

Action: Registration Department

Matters for Report

39. The Committee considered the following matters for report:

   a. Disciplinary Committee Report
The Committee noted the report. There was discussion of the disciplinary hearing relating to Mr Edward Gillams (December 2013). It was commented that this case has caused a significant debate in the profession, particularly in relation to the time taken for the case to reach the hearing stage. It was also commented that the complainant had indicated that they would not have made the complaint had they known what the disciplinary process entailed. In response, it was explained that on occasion a complainant might express this thought due to the nature of the process and the need to attend and give evidence at a hearing. There was also discussion about the Standards Committee process for considering disciplinary cases. It was agreed that the Committee will continue to receive a summary report with links to the full case.

b. Advisory Report
The Committee noted the report. It was explained that the current system records statistics linked to the categories of advice as contained in the old Guide to Professional Conduct. The Prof Con system is under review and we are looking at new ways to record and analyse the information.

c. RCVS/BVA Riding Establishments Committee
The Committee noted the report. It was commented that it would be interesting to know what additional costs the RCVS has incurred since the work has been taken back 'in-house'.

d. Joint Measurement Board (JMB)
Mr Jinman informed the Committee he represents the RCVS at JMB meetings (and is also a JMB Steward). Any matters of relevance / interest will be reported back to the Committee.

Confidential Matters for Report

40. The Committee considered the following confidential matters for report:

a. Certification Sub-Committee
The Committee noted the report. The ongoing work of the Sub Committee in relation to electronic signatures was highlighted. It was explained that draft guidance has been prepared for Committee approval, but this is on hold as there are ongoing discussions with AHVLA concerning their electronic systems for export certification. It appears that the Centaur system used by AHVLA may not be going forward at present due to resourcing issues.

It was also suggested that the RCVS may wish to consider a review of the 12 Principles of Certification. Eight of the 12 principles are included in the EU Directive 96/93/EC, but there is a risk that some of the principles may now be outdated. It was agreed that this will be considered at some point in the future.

b. Register and Registration Sub Committee Report
The Committee noted the report. It was commented that a rigorous system is required for decisions in relation to temporary registration.

Any other business

41. There were two items of business:

a. Vet Record Article
   There was discussion of a Committee member’s recent article published in the Veterinary Record relating to the language used in the RCVS Code of Professional Conduct and Supporting Guidance. It was explained that the full paper was not published. This was not intended as a critique of the current guidance; rather an ethical and philosophical review of the language. It was commented that the language in the previous guidance was interchangeable. The new Code sought to remedy that problem by applying a ‘must’ to the core principles and a ‘should’ to the Supporting Guidance.

b. 2014 Survey of Professions / Questions on 24-Hour Emergency Cover
   The Committee considered the draft questions for the 2014 survey and suggested a number of amendments to seek to ensure that the returned data is relevant and worthwhile. It was agreed these amendments would be passed to the Communications Department.

Date of the next meeting

42. The next meeting is scheduled for 1 May 2014.
A Statement on “Anaesthesia-Free Dental Procedures” for Cats & Dogs

The RCVS Standards Committee supports the following statement due to the animal welfare issues associated with anaesthesia free dental procedures for cats and dogs.

Oral diseases (including dental and periodontal disease) represent some of the most common and important health issues affecting pets in the UK and Europe. Effective treatment is an important part of healthcare. A professional dental examination and cleaning (“scaling and polishing”) forms an essential part of treatment.

The most important area to examine and clean effectively is the gingival sulcus or periodontal pocket. This is the area below the gum line surrounding the teeth. The delicate periodontal tissues attaching the tooth to the jaws are easily damaged. This can then result in pain and possible tooth loss. Tooth scaling requires the use of sharp instruments and/or ultrasonic or sonic scalers cooled by water jets. Small, uncontrolled movements of the head during effective tooth scaling could easily lead to periodontal damage. Cleaning below the gum line is always uncomfortable. It is possible to perform scaling without anaesthesia in man, as we willingly co-operate. Pets not under anaesthetic usually will not willingly remain stationary whilst the procedure is performed.

Simply removing the visible calculus (tartar) from above the gum line is not effective or useful in tackling dental disease. The process simply makes the teeth look better, creating a false sense of confidence and security for owners and may cause harm by delaying effective treatment that can only be given by a professional veterinary health care provider.

Many oral problems can only be diagnosed during complete examination under general anaesthesia. Parts of the mouth simply cannot be seen without anaesthesia. Some early oral cancers can only be seen when the pet is under chemical restraint. Delaying diagnosis of these problems can mean that they become far more difficult to treat, or may even become untreatable. Many oral diseases can only be diagnosed by x-ray examination. This is only possible in an anaesthetised pet.

Modern anaesthetic procedures, together with appropriate monitoring and support, carry very low levels of risk. In general terms the benefits of effective dental and periodontal treatment far outweigh the risks of the anaesthetic. Use of intubation – where a tube carries the anaesthetic gases directly into the trachea (wind-pipe) protects the patient from inhalation of dental debris, or the bacteria-rich aerosol, created during the dental procedure.

In summary, “anaesthesia-free dental procedures”:

- cannot allow full oral examination to be performed and vitally important diagnoses may be missed or delayed;
- do not allow full and effective cleaning of the most important sub-gingival areas;
- may actually cause damage to the tissues surrounding the teeth;
- may cause discomfort, pain and/or distress to the animal;
- are likely to delay clients accessing effective, proper oral care;
- if performed under the guise of a “Dental Treatment” could be considered misleading; unless the owners are made aware of the inadequate and potentially injurious nature of the procedure.

This statement is issued with the agreement of:

EVDC (European Veterinary Dental College)
EVDS (European Veterinary Dental Society)
The current recognised Specialists in Veterinary Dentistry practising in the UK
BVDA (British Veterinary Dental Association)
Additional advice for members of the public

- RCVS considers that “anaesthesia-free dental procedures” for cats and dogs, are not in the best interests of the health and welfare of patients.

- Members of the public considering providing anaesthesia-free dental services should be aware of their responsibilities under the Veterinary Surgeons Act and also the potential dangers of causing harm to pets which could lead to actions under the Animal Welfare Act.

- Specifically performing sub-gingival scaling (scaling the pocket between the gums and the teeth), which is necessary for proper oral hygiene, and any extraction of teeth using instruments are Acts of Veterinary Surgery. Acts of Veterinary Surgery can only legally be performed by a veterinary surgeon.

- Members of the public considering allowing someone to perform an anaesthesia-free dental procedure on their cat or dog should be aware that the procedure may cause harm to their pet and that, as owners, they also have a responsibility under the Animal Welfare Act to avoid this.

- Members of the public should be aware that a professionally performed dental examination and cleaning procedure, carried out under anaesthesia, is usually the recommended approach to tackling the important issue of oral disease.
### Meeting
Standards Committee

### Date
1 May 2014

### Title
Professional Conduct Update

### Classification
Unclassified

### Summary
This paper provides a brief update on relevant ongoing matters, which the Standards Committee is asked to note.

### Decisions required
None

### Attachments
- Annex A: Minutes of the Student Fitness to Practise Group meeting held on 7 March 2014
- Annex B: Minutes of the Practice Standards Group meeting held on 4 March 2014

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Professional Conduct Update (May 2014)

Below is a brief report updating the Standards Committee on a number of relevant ongoing matters since the date of the last meeting on 23 January 2014. There are also some additional matters which the Committee is asked to note.

a) 24/7 Fact Finding Exercise – The Committee held three days of meetings from 26 to 28 March 2014 and heard from thirty-three witnesses in total (veterinary surgeons, veterinary nurses, members of the public and representatives from stakeholder organisations). The Committee will be meeting again on 23 April and 30 April 2014, in private, to discuss the evidence in more detail and to formulate its recommendations to RCVS Council for its June meeting.

b) Veterinary Students Fitness to Practice Working Party – The group met for the second time on 7 March 2014 to consider a first draft of a student charter based on broad fitness to practice principles, which is intended to be common to all UK veterinary schools. The minutes of the meeting are attached at Annex A. The group is now working on the final draft of the document, which will be circulated to the Standards Committee for approval when complete. RCVS representatives are also meeting with the Medical Schools Council (MSC) on 16 April 2014 to discuss veterinary education and student fitness to practice. The MSC is providing support to the recently set up Veterinary Schools Council, which is chaired by Professor Gary England.

c) Practice Standards Group Update – Work in relation to the development of a modular format for the Practice Standards Scheme (PSS) is ongoing. The minutes of the last PSG meeting held on 4 March 2014 are attached at Annex B.

d) Feline Renal Transplants - The Science Advisory Panel (SAP) has been discussing the scientific and ethical issues surrounding feline renal transplantation. The SAP divided the issue behind feline renal transplants into the following key areas: (a) is the intervention beneficial to the recipient? (b) is the intervention harmful to the donor? (c) Is the intervention ethical? (d) is the intervention legal with regards to the Animal Welfare Act? The SAP considered that question (d) was the most relevant going forward. If indeed the procedure was found to be illegal under the Animal Welfare Act then there would be no need to perform an ethical assessment. As such, the SAP has now asked the Professional Conduct Department to seek an external legal opinion on the legality of the procedure before any other steps are taken to commission an ethical review. Further updates will be provided in due course.

e) Minimum age / weight for microchipping – The Committee will recall that at the last meeting there was discussion about the minimum age and/or weight for microchipping. Particular concerns were raised about whether microchipping pups under a certain age or weight could amount to the practise of veterinary surgery and therefore require a suitable exemption under Schedule 3 of the Veterinary Surgeons Act 1966 to allow lay people to do this. As agreed by the Committee, the matter has now been referred to the Science Advisory Panel (SAP), who the Committee felt are best placed to consider an evidence based review. Updates will be available from the SAP in due course.
f) **Animals (Scientific Procedures) Act Working Party** – Revised RCVS guidance on Named Veterinary Surgeons (NVS) has been drafted, which mirrors the new Home Office statutory guidance. However, as yet the HO statutory guidance has not been finalised and approved. This means that RCVS guidance cannot be signed-off until we receive clearance from the Home Office. In March 2014, the Home Office indicated that it will be working on the outstanding sections over the coming months and that further advice will be provided on keeping animals alive for potential re-use. RCVS guidance will have to remain on hold until the HO fully completes its statutory guidance.

g) **Reporting Prescription Misuse**: The RCVS and the Veterinary Medicines Directorate (VMD) have been working together to highlight issues surrounding prescription misuse to the profession. Such misuse can include the alteration of an existing prescription, or fraud, such as supplying the same prescription to multiple retailers or forging the signature of a veterinary surgeon, pharmacist or suitably qualified person. Generally, the VMD deals with unauthorised prescription alterations via a warning letter (for the first offence) although repeat offences and fraud will be passed to Defra Investigation Services. There were 230 cases of potential misuse between April and December 2013. The RCVS has highlighted, via RCVS News, how veterinary surgeons can deal with suspected prescription misuse and will continue to work with the VMD on these matters.

h) **Cases of TB in domestic cats** – The Committee is asked to note that Public Health England and Animal Health and Veterinary Laboratories Agency (AHVLA) have reported the first documented cases of cat-to-human transmission (27 March 2014). The report indicates that two people in England have developed tuberculosis after contact with a domestic cat infected with ‘Mycobacterium bovis’ (‘M. bovis’). A copy of the full report is attached at Annex C.
Student Fitness to Practise (SFTP) Working Party
Minutes of the meeting held on 7 March 2014

Members:

Professor David Church - Chairman and RVC Representative
Professor Jim Anderson - Glasgow
Dr Sarah Freeman - Nottingham
Professor Alistair Barr - Bristol (standing in for Dr Rose Grogono-Thomas)
Dr Claire Phillips - Edinburgh (standing in for Professor Susan Rhind)
Dr Kieron Salmon - Liverpool
Professor Alun Williams* - Cambridge
Ms Jennifer Brazier* - Association of Veterinary Students
Mrs Clare Tapsfield-Wright - Chairman, Standards Committee
Dr Jerry Davies - Chairman, PIC
Mrs Lynne Hill - Chairman, RVN PIC
Mrs Katherine Kissick* - Chairman, VN Council
Mrs Elizabeth Figg - VN Council

*Absent

In attendance:

Ms Eleanor Ferguson - Head of Professional Conduct
Ms Laura McClintock - Advisory Solicitor
Ms Rebecca Hall - Solicitor/Advice Officer
Apologies and Declarations of Interest

1. Apologies were received from Professor Alum Williams, Mrs Kathy Kissick and Ms Jennifer Brazier.

General thoughts

2. It was agreed that the draft guide was useful and that the exercise was worthwhile. It was suggested that the draft guide was commendably brief and that this was particularly beneficial for students, who may be intimidated by the concept of fitness to practise proceedings.

Audience

3. There was discussion about the intended audience for the document and whether it were to be dual purpose, it would be preferable to have two separate documents – one for the veterinary schools and one for veterinary students.

4. Some members of the working party suggested that the guide should be for the veterinary schools only, who will incorporate the principles by way of their student charters. A comparison was however drawn with the GMC’s student fitness to practise guide, which is one document for students and anyone else involved in the process. It was suggested that the principles in the guide would have a good impact if they were addressed to the students. In addition, it was noted that students will also need to know about the fitness to practise process.

5. It was agreed that the guide did not need significant modifications with regards to its intended audience, but that thought was needed about how it is disseminated to students. It was agreed that the document could be split into two parts: one with emphasis on the vet school and one with emphasis on what is expected of the student.

Standard of proof

6. There was discussion about the standard of proof that should be endorsed by the guide. It was acknowledged that the university veterinary schools use the same civil standard of proof adopted by their medical schools i.e. ‘on the balance of probabilities’. It was suggested therefore that there was a potential disparity between the fitness to practise process for student veterinary surgeons and the fitness to practise process for qualified veterinary surgeons, for whom the standard of proof is the higher civil standard of ‘so as to be sure’ (which is tantamount to applying the ‘criminal standard’).

7. It was agreed that it would make sense for the guide to endorse the higher standard of proof, so that fitness to practise cases about student veterinary surgeons are judged on the same standard as the profession. The representatives from the veterinary schools agreed to take this back to their respective boards.
Disclosure of adverse findings

8. There was discussion about students who perform academically very well but about whom there are fitness to practise concerns. There was some uncertainty about where university regulations would lie with the suggestion in the draft guide that a student will not be able to graduate until the conclusion of any fitness to practice investigation.

9. It was explained that the RCVS would expect a veterinary school to investigate any fitness to practise concerns as it is the role of the RCVS to decide whether an individual can be registered as an MRCVS. In the past, graduation from a UK veterinary school automatically led to being registered with the RCVS but applicants to the Register now have to declare any cautions, convictions or adverse findings.

10. There was discussion as to what is meant by ‘any adverse finding’. It was suggested that clarification was required as to whether this was a finding made by a fitness to practise panel or whether it included a decision to manage an ongoing condition/issue.

Mental health

11. There was discussion of mental health concerns (e.g. depression) and whether or not veterinary schools may shy away from the fitness to practise process due to concerns that to manage the issue formally in this way could result in a ‘black mark’ for the student.

12. It was explained that if a condition is managed, and does not go before a fitness to practise panel, the RCVS does not need to know about it. If, however, the condition was sufficiently serious and has to go to a Panel with a finding made against the student, then it is sufficiently serious for the RCVS be informed. It was explained that it might not be an issue (and there may not be any action on the part of the RCVS), but we need to know about it nonetheless when the student applies for registration.

13. One member noted that the concept of the health case is relatively new. It was suggested that the RCVS is able to offer a continuum of support from university to professional life and that this should be seen as a benefit of informing the RCVS of health issues. It was therefore suggested that the guide should include some wording to this effect, to emphasise that the disclosure to the RCVS allows for continuing support. It was agreed that this would go far to reassure students that support is available.

Disclosure by students and veterinary schools

14. It was acknowledged that currently, the obligation is on the individual student to disclose any caution or conviction or adverse finding which may affect registration, whether in the UK or overseas. It was explained that an ‘adverse finding’ includes any finding within veterinary school or university fitness to practise procedures, in the UK or overseas.
15. The question was asked whether there was a desire for the veterinary schools to inform the RCVS directly if there had been a fitness to practise concern about a student and there was discussion about the potential methods of disclosure by a school. Some felt that veterinary schools should only be required to inform the RCVS of adverse findings and health cases under management.

16. It was explained that veterinary schools are not compelled to disclose information to the RCVS and it is for the individual student to make a self-declaration on application to register with the RCVS. However, on disclosure, the Registrar may seek additional information, as required (e.g. from the veterinary school).

**English language skills**

17. There was discussion about whether the guide should refer explicitly to a need for English language skills. It was, however, acknowledged that this is considered by the veterinary schools during the admissions process and is considered throughout the course. It was felt sufficient that the guide refers to the need for ‘effective communication’.

**Suggestions for amendments**

18. One member suggested that the introductory paragraphs regarding the status of the guidance could be softened and replaced with wording similar to that used by the GMC i.e. that although the guidance is not mandatory, it would be surprising if a university thought it sensible to disregard the advice. Others members agreed and suggested that the guidance should state that it is adopted by all UK vet schools, who agree to abide by the general principles.

19. One member suggested that the sections on ‘principles of behaviour’ for students should be ordered – people, private and student life and then practice.

20. It was agreed that the guide needs to have a definition or at least clarification as to what an adverse finding was. It was suggested that we could adopt the approach of the GMC, who mark a threshold on their flowchart.

21. It was suggested that emphasis should be made on the ability of the RCVS to offer support should it be notified of a health concern.

22. It was suggested that the need for confidentiality should be expressly highlighted at the ‘behaviours’ section of the ‘practice’ page.

23. A request was made for reference to ‘mental and physical health’ at the private and student life page, as well as specific reference to drugs and alcohol and other substances that can impair performance.

24. It was commented that it is not appropriate for student fitness to practise hearings to be held in public; this is not how they are conducted. It was requested that the guide is changed in this regard.
There was discussion about the issue of insight and it was suggested that insight dictates a student’s progression through the process i.e. it is relevant not just at the sanction stage but also throughout the treatment of the concern. It was felt necessary for the guide to reflect this.

It was felt necessary to include a stand-alone requirement on the private and student life page that students disclose to their school if they receive a conviction or caution during the course.

It was suggested that the ‘graduation’ section was changed to say ‘may’ not be able to graduate but acknowledged that the Privy Council rules may need to be consulted. This is because some students may be able to graduate with ‘exit’ degrees rather than professional degrees.

Any other business

There was no other business.

Next Steps

It was agreed that the comments and suggestions would be taken on board and that a revised draft would be circulated for approval.
PRACTICE STANDARDS GROUP

Minutes of the meeting held on 04 March 2014

Present:

- Jacqui Molyneux - Chair
- Anna Judson - SPVS
- Martin Smith - BVHA
- Kirstie Shield - BVNA
- Robin Hargreaves - BVA
- Caroline Freedman - Lay representative
- Pam Mosedale - BSAVA
- Tim Mair - BEVA
- Liz Cox - VNC
- Renay Rickard - VPMA
- Rita Dingwall - VPMA

In attendance:

- Eleanor Ferguson - Head of Professional Conduct
- Natalie Jenkins - PSS Project and Implementation Manager
- Emma Lockley - Senior Practice Standards Officer
- Lizzie Lockett - Head of Communications (attended discussions on the module structure and branding)
- Nick Stace - Chief Executive (attended discussions on the module structure and branding)

Apologies:

- Tim Potter - BCVA
- Toby Birch - BAVECC

Declaration of Interest

1. There were no declarations made.
Minutes of the last meeting

2. Minutes of the last meeting were approved.

Matters arising from the minutes of the last meeting

3. The Chair welcomed two new representatives from VPMA, namely Rita Dingwall and Renay Rickard.

4. It was confirmed that the position regarding storage of medicines had not changed. ie that if medicines were stored behind a reception desk they should not be accessible by the public and that this requirement would be met if there was a physical barrier eg a reception desk between the clients and the medicines. For consulting rooms the same requirement for non accessibility was needed so that quantities should be kept to a minimum, and that not in use stored in drawers / cupboards. It was accepted that in some practices without a separate dispensary, (usually small branch premises) there were particular problems as consulting rooms sometimes doubled as ‘pharmacies. In this situation, there could be some flexibility; provided a client was not left alone at any time and strict protocols were in place to ensure this - then medicines might in exceptional circumstances be stored on open shelves. It was noted that the RCVS position accorded with the best practice recommended by the VMD in its inspections.

5. There was discussion regarding the use of x-ray grids for digital systems in  EQ practices. It was agreed that ‘if taking x rays of lower limbs of horses, no grid was needed, but that differing views had been expressed by practitioners about the benefits of a grid where xrays were taken of neck, back and abdomen. It was suggested that not all EQ practitioners had grids and of those that did only a relatively small proportion actually used it. It was noted that this perceived lack of benefits differs from the technical views expressed and the current requirements for SA. Practices. It was suggested that obtaining evidence to substantiate the position one way or another regarding the use of grids would be helpful and that this might be something that RCVS Knowledge could take up.

Matters for discussion

PSS Project Update

6. Inspector Training: It was confirmed that companies had been invited to tender to supply services to support recruitment and training for Inspectors under the new Scheme. It was
noted that presentations had been given by those shortlisted (2 companies) and that a decision on appointment would be confirmed shortly. Similarly re supply of a new ITT system to meet the needs of the new scheme, the Group was advised that following a tendering process, three companies had been shortlisted, had given presentations and that a decision would be made by the next PSG meeting in April.

7. The naming of the role of ‘Inspector’ was discussed. A range of options were suggested with the Group agreeing that ‘Assessor’ and ‘Lead Assessor’ (for what is now the Senior Inspector role) would be most appropriate. It was considered that these more accurately reflected the role anticipated in the new Scheme of checking compliance with behavioural and other standards in a supportive and not unduly pejorative manner.

8. The Group was advised that the possibility of a smaller pool of Assessors doing more frequent inspections was being considered as was the cost/benefit of one or more (possibly the Lead Assessor) being part-time employees of the College.

Specialists and Hospital Categories

9. The Chair introduced Professor Dick White and Mr Ian Wright representing a group of specialist practitioners aiming to set up a British College of Veterinary Specialists whose aim it would be to promote specialists and ensure that standards of specialist practice are implemented. They indicated that they saw a future role for the organisation in providing input to PSS in the area of specialist practice.

It was suggested that they could assist by providing a list of equipment they considered necessary for each of the specialist areas.

Module Structure

10. The Chairman thanked all the members of the sub-groups for their hard work in drafting modules to date. There was a recap of the structure that had formed the basis for the draft modules to date – ie Core applying across all species, covering mainly legal and Code requirements; GP (SA/FA/EQ) with three categories - Bronze, Silver and Gold. (GP bronze needing compliance with standards across all modules): and thereafter a points system to ‘qualify’ for Silver and Gold; and Hospitals (SA and EQ) also differentiated into Silver and Gold through a points system.

11. It was noted that some opinions had been expressed that ‘Bronze’ within this structure could be perceived negatively. The Chairman indicated that there had been some discussion.
internally within the College whether a possible alternative to remedy this would be for Core to be renamed Bronze; and the three GP categories to become Silver; Silver Plus and Gold and the Hospital category designated as Platinum.

12. It was further explained that at a recent College open day aimed at non – vets (which included representatives of the Kennel Club, Governing Council of the Cat Fancy, Blue Cross, Dogs Trust, Dogs Today magazine, Animal Behaviour and Training Council, British Horseracing Authority, PDSA, Dog-Ed and the Dog Union). There had been an update on PSS and the plans to evolve the PSS and the current proposed structure had been outlined to them.

13. Initial reaction was confusion – too many different things going on and a lack of clarity over what the different categories meant. There was also a fear expressed that Bronze, Silver, Gold would be taken to relate to how much it would cost to use the practice. Most importantly, they felt that the proposed structure did not address their primary concern as animal owners, which was a clear signaling of the levels of care that the practice can deliver- one of the main changes that the new Scheme wants to address. It was noted that these views about the importance of care were matched with feedback from the College’s 2012 consultation – and previous focus groups, where care has always been at the forefront of owners’ minds.

14. It was noted that these animal owners were rather better informed than the average, given their roles in the organisations and also the fact that many were breeders and were not necessarily representative of the wider general public.

15. The suggestion arising out of the discussion was for a system mirroring to an extent the arrangements under Ofsted for awards for schools: Outstanding (Gold) / Good (Silver) etc ie:

- Silver and Gold to be used as ‘awards’ relating to care – (with the Bronze category dropped as it would not be seen as a positive attainment.)

- All categories of practice to be able to achieve Silver or Gold Awards with the requirements applying across the board regardless of practice type (Core / GP / VH).

- Core, GP and Hospital: to remain as categories which reflect the facilities and services on offer with the ‘awards’ given on top of this ‘base’ accreditation.

- Core to be renamed RCVS Accredited Practice.
16. A number of other refinements were put forward -
   - Every practice should be required to meet a proportion of care standards as a mandatory requirement (even if they did not wish to achieve a care award)
   - Accreditations and awards should be judged per premises;
   - There would need to be flexibility within the modules – particularly re GP, EQ, FA and ambulatory practices to ensure that facility requirements did not preclude accreditation at GP level.

17. There was discussion about the overall nomenclature of the scheme and whether ‘RCVS Practice Standards Scheme’ was meaningful. **RCVS Good Practice Scheme** was proposed as an alternative, though it was noted that any change in ‘brand’ would lose any recognition gained for the existing name and on a practical level, practices which had already paid for signage etc would not welcome the additional expense of a change.

18. The Group was of the view that the suggestions at 14-17 above merited further consideration by the organisations. There was considerable discussion over what a ‘care’ award might mean. It was agreed that it should include animal care but also (through points in the Customer Experience module), take into account ‘customer care’.

19. It was agreed that focus groups to test animal owners perception of any new proposals were desirable. It was also agreed that the forthcoming PSS lecture at BSAVA congress might also provide a forum to test views.

20. It was agreed that a paper outlining the proposed structure would be circulated to the organisations in the Group so that they could obtain views before the next meeting. **Action**

**Date of next meetings**

Friday 11 April 2014  
Thursday 15 May 2014

E. Ferguson  
March 2014
Press release

Cases of TB in domestic cats and cat-to-human transmission: risk to public very low

Organisations:

Public Health England and Animal Health and Veterinary Laboratories Agency

Page history:
Published 27 March 2014
Policy: Reducing bovine tuberculosis
Topics: Public health, + 2 others

These are the first documented cases of cat-to-human transmission.

Two people in England have developed tuberculosis after contact with a domestic cat infected with 'Mycobacterium bovis' ('M. bovis'), Public Health England (PHE) and the Animal Health and Veterinary Laboratories Agency (AHVLA) have announced. ‘M. bovis’ is the bacterium that causes tuberculosis (TB) in cattle (bovine TB) and in other species.

Nine cases of ‘M. bovis’ infection in domestic cats in Berkshire and Hampshire were investigated by AHVLA and PHE during 2013. PHE offered TB screening to 39 people identified as having had contact with the infected cats as a precautionary measure. 24 contacts accepted screening. Following further investigations, a total of 2 cases of active TB and 2 cases of latent TB were identified. Latent TB means they had been exposed to TB at some point but they did not have active disease. Both cases of active TB disease have confirmed infection with ‘M. bovis’ and are responding to treatment.

There have been no further cases of TB in cats reported in Berkshire or Hampshire since March 2013. PHE has assessed the risk of transmission of ‘M. bovis’ from cats to humans as being very low.

Dr Dilys Morgan, head of gastrointestinal, emerging and zoonotic diseases department at PHE, said:

It’s important to remember that this was a very unusual cluster of TB in domestic cats. ‘M. bovis’ is still uncommon in cats - it mainly affects livestock animals. These are the first documented cases of cat-to-human transmission, and so although PHE has assessed the risk of people catching this infection from infected cats as being very low, we are recommending that household and close contacts of cats with confirmed ‘M. bovis’ infection should be assessed and receive public health advice.

The findings of the animal health aspects of this investigation are published in The Veterinary Record today, 27 March 2014.

Molecular analysis at AHVLA showed that ‘M. bovis’ isolated from the infected cats and the human cases with active TB infection were indistinguishable, which indicates transmission of the bacterium from an infected cat. In the other cases of latent TB infection, it is not possible to confirm whether these were caused by ‘M. bovis’ or the source of their exposure.

Transmission of ‘M. bovis’ from infected animals to humans can occur by inhaling or ingesting bacteria shed by the animal or through contamination of unprotected cuts in the skin while handling infected animals or their carcasses.

Professor Noel Smith, Head of the Bovine TB Genotyping Group at AHVLA, said:

Testing of nearby herds revealed a small number of infected cattle with the same strain of ‘M. bovis’ as the cats. However, direct contact of the cats with these cattle was unlikely considering their roaming ranges. The most likely source of infection is infected wildlife, but cat-to-cat transmission cannot be ruled out.
Cattle herds with confirmed cases of bovine TB in the area have all been placed under movement restrictions to prevent the spread of disease.

Local human and animal health professionals are remaining vigilant for the occurrence of any further cases of disease caused by 'M. bovis' in humans, cats or any other pet and livestock animal species.

Notes to editors

- A summary of the public health investigation can be found in the PHE Health Protection report. Read the HAIRS risk assessment.
- TB caused by 'M. bovis' is diagnosed in less than 40 people in the UK each year. The majority of cases are in people over 65 years old, most likely due to reactivation of latent infection acquired many years ago before the introduction of control measures, including the routine pasteurisation of milk. Overall, human TB caused by 'M. bovis' accounts for less than 1% of the total TB cases diagnosed in the UK every year. Those working closely with livestock, or regularly drinking unpasteurised (raw) milk have a greater risk of exposure.
- Information about 'M. bovis' infection in humans is available on the PHE website.
- Advice for pet owners about 'M. bovis' infections in companion animals is available on the AHVLA website.
- The article 'An unusual cluster of Mycobacterium bovis infection in cats' will be published in The Veterinary Record today, 27 March 2014. Advice from the Chief Veterinary Officer Nigel Gibbens is being provided to vets in a letter to The Veterinary Record. This will include a recommendation that cats diagnosed with a ‘Mycobacterium bovis’ infection should be euthanased. This is due to the lack of effective drugs licensed in the UK for treatment of TB in animals and to minimise the risk of infection to other animals or humans.
- Information about bovine TB is available on the Defra website.

Infections press office

PHE press office - infections
61 Colindale Avenue
London
NW9 5EQ

Email infections-pressoffice@phe.gov.uk

Phone 020 8327 7901

Out of hours 020 8200 4400

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Published: 27 March 2014

Organisations:
- Public Health England
- Animal Health and Veterinary Laboratories Agency

Policy:
- Reducing bovine tuberculosis
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<td>Summary</td>
<td>At its last meeting in January 2014, the Committee agreed that it would consider adopting a new chapter of Supporting Guidance on animal insurance.</td>
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| Attachments   | Annex A: Extract from minutes of last meeting of Standards Committee  
|               | Annex B: Suggested amendments and additions to the Supporting Guidance at chapter 9 and 9A |
| Author        | Rebecca Hall    
|               | Advice Officer  
|               | 0207 227 3503    
|               | r.hall@rcvs.org.uk |
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Animal insurance

Background

1. A recent Disciplinary Committee case concerned a veterinary surgeon’s conduct in connection with pet insurance claims. Following this particular case, it was suggested that the Committee should be asked to consider strengthening the existing Supporting Guidance on pet insurance. The PIC has also asked the Committee to consider whether it is appropriate for veterinary surgeons to ask clients to sign blank insurance forms for ongoing treatment.

Current Position

2. There is a section of guidance on pet insurance at Chapter 9 of the Supporting Guidance – fees and related matters.

3. At its last meeting, the Committee had a preliminary discussion on this topic. An extract from the minutes is provided at Annex A.

4. A number of points were raised. It was decided that given the significance of pet insurance, it would be sensible to have a new, separate chapter of Supporting Guidance on the topic, and that this should reinforce the potential for disciplinary action if a veterinary surgeon acts dishonestly or fraudulently. It was felt that it would be better to refer to ‘animal’ insurance rather than ‘pet’ insurance. The Committee also agreed that there should be guidance to veterinary surgeons dealing with claims for their own animals, or the animals of family and friends.

Areas for discussion

5. The Committee may like to consider if the proposed new Supporting Guidance acts to strengthen the existing guidance on pet insurance and serves to offer further practical advice for veterinary surgeons.

6. A copy of the proposed new Supporting Guidance is attached as Annex B.

Recommendations

7. Standards Committee is asked to approve the suggested amendments to the Supporting Guidance at Chapter 9 and the proposed addition of Chapter 9A.
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6. A copy of the proposed new Supporting Guidance is attached as Annex B.

Recommendations

7. Standards Committee is asked to approve the suggested amendments to the Supporting Guidance at Chapter 9 and the proposed addition of Chapter 9A.
Extract from the minutes of Standards Committee meeting of 23 January 2014

Pet Insurance

1. The Chairman introduced the paper, noting that the Committee has been given three tasks: (1) to consider Chapter 9 of the Supporting Guidance generally as part of the RCVS commitment to carry out a rolling review of the Supporting Guidance (2) to consider whether the current Supporting Guidance dealing with pet insurance should be strengthened in light of the recent disciplinary case relating to Mrs Brimelow and to approve draft amendments, and (3) to consider, at the request of the Preliminary Investigation Committee, whether it is appropriate for veterinary surgeons to ask clients to sign blank insurance forms for ongoing treatment.

2. There was discussion about the strength of the current guidance in relation to completing insurance claim forms. It was commented that veterinary surgeons are in a position of trust when completing insurance forms and should do so accurately and honestly, and exercise particular care when dealing with their own animals or those of close friends or family. It was suggested that the current guidance should be further strengthened to say veterinary surgeons who complete insurance forms fraudulently or dishonestly may be liable to disciplinary action.

3. In response, it was commented that the current principles of practice already include a requirement that veterinary surgeons must act honestly and with integrity, and that they must certify facts and opinions honestly and with due care. In the Brimelow case, the allegation was dismissed by the Disciplinary Committee, who noted that there were no clear guidelines from Ms Brimelow’s employing practice about how claims should be handled and that the Police had decided that there was no public interest in proceeding with the matter. However, decisions do vary and each case must be considered on its own merits.

4. There was also discussion of Supporting Guidance Chapter 9.7 which states “all invoices should be itemised showing the amounts relating to goods including individual relevant medicinal products and services provided by the practice. Fees for outside services and any charge for additional administration or other costs to the practice in arranging such services should also be shown separately”. In light of the Brimelow case, it was suggested that this might be amended to say “goods actually charged”.

5. There was discussion about whether it is appropriate for veterinary surgeons to ask clients to sign blank insurance forms for ongoing treatment. It was explained that the Preliminary Investigation Committee had raised concerns as issues had arisen in cases where clients had been asked to pre-sign the blank claim form to confirm that the details of the treatment administered are correct before the details have been added.

6. It was commented that in cases where the bill is sent to the client to submit to the insurance company, it is sensible for veterinary surgeons to retain a copy of what they have provided to the client. This means the veterinary surgeon has a copy of original bill in the event that the client attempts to amend the details. Likewise, in cases where the veterinary surgeon submits the claim directly to the insurer, a copy should be sent to the client. It was commented that where bills are submitted electronically, a copy should still be available for the client.
7. There was discussion about how information is transferred between the client, the veterinary surgeon and the insurance company. It was commented that generally the insurance company will notify the client if they are paying the veterinary surgeon directly. The client will then have an opportunity to query the cost, which acts as another barrier to prevent insurance fraud. It was commented that it is good practice for the client to see the form before it is submitted to the insurance company, particularly as the client may not wish to claim for all of the treatment.

8. There was also discussion of preferred supplier lists, as used in the medical world and questions surrounding fixed maximum fees.

9. Overall, the Committee agreed that it would be helpful if the Supporting Guidance included a separate chapter on ‘animal insurance’. It was agreed that a new section will be drafted and returned to the Committee for approval in due course.

Action: Professional Conduct Department
9. Practice information and fees

Practice information

[9.1] Veterinary practices should provide clients, particularly those new to the practice, with comprehensive written information on the nature and scope of the practice’s services, including:

a. the provision, initial cost and location of the out-of-hours emergency service;
b. information on the care of in-patients;
c. the practice’s complaints handling policy, and could also provide full terms and conditions of business, to include for example:
   i. surgery opening times
   ii. whether open or by appointment
   iii. fee or charging structures
   iv. procedures for second opinions and referrals
   v. use of client data
   vi. access to and ownership of records

Freedom of choice

9.2 Veterinary surgeons should not obstruct a client from changing to another veterinary practice, or discourage a client from seeking a second opinion.

9.3 If a client’s consent is in any way limited or qualified or specifically withheld, veterinary surgeons should accept that their own preference for a certain course of action cannot override the client’s specific wishes, other than on exceptional welfare grounds.

Fees

9.4 The RCVS has no specific jurisdiction under the Veterinary Surgeons Act 1966 over the level of fees charged by veterinary practices, unless they are so extreme as to constitute disgraceful conduct in a professional respect. There are no statutory charges and fees are essentially a matter for negotiation between veterinary surgeon and client.

9.5 Fees may vary between practices and may be a factor in choosing a practice, as well as the practice’s facilities and services, for example, whether the veterinary surgeons make home visits routinely and what sort of arrangements are in place for ‘out-of-hours’ emergency calls (eg are emergency consultations at the practice premises, or by another practice at another location).

9.6 Veterinary surgeons should include any estimated charge or fee on a consent form. In the event of a fee dispute, whether a client must pay a bill is a matter to be resolved between the parties or by the civil courts, therefore, in most cases, disputes about the level of veterinary surgeons’ fees fall outside the jurisdiction of the RCVS.

Invoices

9.7 All invoices should be itemised showing the amounts relating to goods including individual relevant medicinal products and services provided by the practice. Fees for outside services and any charge for additional administration or other costs to the practice in arranging such services should also be shown separately.
(Fair-trading requirements)

Unpaid bills

9.8 A veterinary surgeon is entitled to charge a fee for the provision of services and, where the fee remains unpaid, to place the matter in the hands of a debt collection agency or to institute civil proceedings.

9.9 In the case of persistently slow payers and bad debtors, it is acceptable to give them notice in writing (preferably by recorded delivery) that veterinary services will be no longer provided.

Holding an animal against unpaid fees

9.10 Although veterinary surgeons do have a right in law to hold an animal until outstanding fees are paid, the RCVS believes that it is not in the interests of the animal so to do, and can lead to the practice incurring additional costs which may not be recoverable.

Prescriptions

9.11 Veterinary surgeons may make a reasonable charge for written prescriptions. (Prescriptions for POM-V medicines may be issued only for animals under the care of the prescribing veterinary surgeon and following his or her clinical assessment of the animals.)

9.12 The Supply of Relevant Veterinary Medicinal Products Order came into force on 31 October 2005 and is enforced by the Office of Fair Trading. It implements recommendations from the Competition Commission and provides that veterinary surgeons must not discriminate between clients who are supplied with a prescription and those who are not, in relation to fees charged for other goods or services.

Re-direction to charities

9.13 All charities have a duty to apply their funds to make the best possible use of their resources. Clients should contact the charity to confirm their eligibility for assistance. The veterinary surgeon should ensure that the animal's condition is stabilised so that the animal is fit to travel to the charity, and provide details of the animal's condition, and any treatment already given, to the charity.

9.14 If the client is not eligible for the charitable assistance and no other form of financial assistance can be found, euthanasia may have to be considered on economic grounds.

Securing payment for veterinary services

9.15 A client is the person who requests veterinary attention for an animal, for example when a veterinary surgeon is called to the scene of a road traffic accident by the police or by the RSPCA, the organisation in question will be liable to pay for any emergency treatment and for the call out, even if the animal owner is subsequently identified (because the owner had no opportunity to consent to treatment).

Pet insurance

9.16 Veterinary surgeons and veterinary nurses should not be seen to favour any particular insurer, unless registered with the Financial Conduct Authority or formally linked with a registered insurer. It is prudent for a practice to display a range of promotional literature so as to avoid any implication of bias, financial advice, or brokering. If any commission may be paid to the veterinary surgeon, veterinary nurse or support staff in the event that a particular policy is taken out, this should be disclosed.
9.17 Pet insurance schemes rely on the integrity of the veterinary surgeon who has a responsibility to both the client and the insurance company, and any material fact which might cause the company to increase the premium, or to decline a claim, must be disclosed.

9.18 Veterinary surgeons treating an animal covered by pet insurance should charge the normal practice fee rate, with any additional or administrative charges shown separately. In cases where the bill is sent direct to the insurance company, a copy should be sent to the client.

9.19 Pet insurance may enable relevant veterinary work to be carried out in circumstances where otherwise fees might be an issue for the animal owner. But, a veterinary surgeon should consider that such work is relevant; pet insurance should not result in work being carried out that does not promote the patient’s welfare.

9.20 Allegations of fraud against veterinary surgeons and clients are criminal allegations for police investigation. In the event that the police decide not to prosecute, the RCVS may consider referring such matters to the RCVS Disciplinary Committee.

EU Directive 2006/123/EC on the provision of services

9.21 The EU Directive on services requires that service providers, which include veterinary surgeons, must give clients relevant information, such as their contact details, the details of their regulator and the details of their insurer. Certain information must be provided on request, such as the price of a service or, if an exact price cannot be given, the method for calculating the price.
9A. Animal insurance

9A.1 An animal insurance policy is a contract between the animal owner and the insurer. The veterinary surgeon is a third party to this contract. Animal insurance schemes rely on the integrity of the veterinary surgeon, who has a responsibility to both the client and insurance company.

9A.2 Veterinary surgeons must act with integrity in all dealings with an animal insurance policy. They must complete claim forms carefully and honestly. A veterinary surgeon who acts dishonestly or fraudulently may be liable to criminal investigation and/or disciplinary action.

9A.3 Veterinary surgeons treating an animal covered by an animal insurance policy should charge the normal practice fee rate. When completing the insurance claim form, the veterinary surgeon should include the amounts actually paid or, in the case of direct claims, the amounts actually charged, with any additional or administrative charges shown separately. Any material fact that might cause the insurance company to increase the premium or decline a claim must be disclosed. Failure to complete claim forms in this way may raise suspicions of dishonesty or fraud, and may result in a complaint being made to the police and/or RCVS. A veterinary surgeon in any doubt as to how to complete a particular claim form accurately should, wherever possible, discuss this with the insurance company.

9A.4 In cases where the veterinary surgeon is treating an animal with a long-term or ongoing health condition under an animal insurance policy, the practice of asking clients to pre-sign blank claim forms for subsequent completion and submission by the veterinary surgeon may expose the veterinary surgeon to suspicions of dishonesty or fraud. If the veterinary surgeon adopts this method, or indeed in any situation where the veterinary surgeon will send the claim directly to the insurance company, it is good practice to send a copy of the completed claim form to the client before submission so that they can check the details of the claim. In the reverse situation, where the client submits the claim form directly to the insurance company, it is advisable for the veterinary surgeon to keep a copy of what they send to the client so that there is a record in the event of any subsequent queries.*

9A.5 Particular care should be taken when the veterinary surgeon is treating their own animal, or an animal belonging to a family member or a close friend, and that animal is covered by an animal insurance policy. Generally, such conflicts of interest should be avoided. For that reason, it is advisable to get another veterinary surgeon to complete, sign and submit the claim form, wherever possible. Where this is not possible, the veterinary surgeon should state on the form the ownership of the animal.

9A.6 Animal insurance may enable relevant veterinary investigations or treatment to be carried out in circumstances where fees might otherwise be unaffordable for the animal owner. A veterinary surgeon should, however, ensure that the investigation or treatment is appropriate and is in the animal’s best interests.

9A.7 Veterinary surgeons and veterinary nurses should not be seen to favour any particular insurer, unless they are registered with the Financial Conduct Authority or formally linked with a registered insurer. It is prudent for a practice to display a range of promotional literature so as to avoid any implication of bias, financial advice, or brokering. If any commission may be paid to the veterinary surgeon, veterinary nurse or support staff in the event that a particular policy is taken out, this should be disclosed.

*It would be inappropriate for a veterinary surgeon, as a professional person, to sign a blank insurance claim form.
### Reporting Details

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<th>Standards Committee</th>
</tr>
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<td>1 May 2014</td>
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<tr>
<td><strong>Title</strong></td>
<td>Vaccination Record Cards</td>
</tr>
<tr>
<td><strong>Classification</strong></td>
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</tr>
</tbody>
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### Summary

At its last meeting in January 2014, the Committee agreed that it would consider adopting supporting guidance on good practice for the completion of vaccination record cards.

### Decisions required

The Committee is asked to approve the proposed additions to Chapter 13 at Annex A.

### Attachments

Annex A: Proposed amendments to RCVS supporting guidance on clinical and client records – Chapter 13

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Vaccination Record Cards

Background

1. In recent months, the RCVS has received a number of queries from veterinary surgeons about the professional responsibilities associated with completing vaccination record cards. It seems that a number of vets are seeing vaccination records cards that do not identify the animal. This can cause difficulties for a veterinary surgeon who is asked to provide a subsequent vaccination.

2. The Committee discussed this at their previous meeting:

(Extract from the minutes)

Vaccination Record Cards

1. The Chairman introduced the paper, noting that over the past year, the RCVS has received a number of queries from the profession about the responsibilities associated with completing vaccination record cards. In particular, the RCVS has been informed that a number of veterinary surgeons have found themselves in the position of being asked to provide a follow-up vaccination to a patient who is accompanied by a signed but otherwise blank vaccination card, i.e. a card that does not identify the patient.

2. There was discussion of vaccination record cards, certificates and the twelve principles of certification, including issues surrounding the identification of animals. It was suggested that veterinary surgeons should encourage their clients to permanently identify their animals.

3. It was commented that there may be some situations when the veterinary surgeon feels unable to give the second vaccination because he/she cannot be reasonably sure that the vaccination card relates to the same animal. It was agreed that in such situations, veterinary surgeons must use their own professional judgment and discretion to decide how much weight to attach to the record card and may, in certain situations, decide to advise the client to re-start the course of vaccinations.

4. Overall, it was agreed that new guidance should be produced and returned to the Committee in due course.

5. There was also discussion about the age at which pups may be microchipped. Concerns were raised about pups being microchipped at a young age (under 8 weeks) and / or under a certain weight, particularly whether this could amount to the practise of veterinary surgery. If so, it would not be appropriate for lay people to carry out the procedure unless there was a suitable exemption under Schedule 3 of the Veterinary Surgeons Act 1966. It was commented that the Microchip Alliance Group may be able to provide further information, including information about microchip failures. It was agreed that the matter should be referred to the Science Advisory Panel, who may be best placed to consider an evidence based review of microchipping pups at a young age or certain weight.

Action: Professional Conduct Department
Current Position

3. It is acknowledged that the public will generally consider a vaccination record card to be a certificate; a proof of vaccination. This can therefore place a veterinary surgeon in a difficult position when suggesting to a client that a new course of vaccinations is started.

4. Veterinary surgeons who have found themselves in this situation consider that there should be a responsibility on the veterinary surgeon performing the first vaccination to ask the client to record identifying details including the sex, breed and colour of the animal.

5. This would enable the second veterinary surgeon to identify the animal presented to them and verify that the vaccination record card relates to that animal.

Areas for discussion

6. At their previous meeting, the Committee requested new guidance.

7. A copy of proposed additions to Chapter 13 (clinical and client records) of the supporting guidance is attached as Annex A.

Recommendations

8. The Committee is asked to approve the suggested additions to the supporting guidance on clinical and client records – Chapter 13.
Suggested additions to the Supporting Guidance

(New text in red)

13. Clinical and client records

13.1 Clinical and client records should include details of examination, treatment administered, procedures undertaken, medication prescribed and/or supplied, the results of any diagnostic or laboratory tests (including, for example, radiograph, ultrasound or electrocardiogram images or scans), provisional or confirmed diagnoses, and advice given to the client. It is prudent to include plans for future treatment or investigations, details of proposed follow-up care or advice, notes of telephone conversations, fee estimates or quotations, consents given or withheld and contact details. Ideally, client financial information should be recorded separately from clinical records.

13.2 The utmost care is essential in writing case notes or recording a client’s personal details to ensure that they are accurate and that the notes are comprehensible and legible. Clinical and client records should be objective and factual, and veterinary surgeons should avoid making personal observations or assumptions about a client’s motivation, financial circumstances or other matters.

13.3 Clinical and client records including radiographic images and similar documents, are the property of, and should be retained by, veterinary surgeons in the interests of animal welfare and for their own protection.

13.4 Copies with a relevant clinical history should be passed on request to a colleague taking over the case.

13.5 Where a client has been specifically charged and has paid for radiographic images or other reports, they are legally entitled to them. A practice may choose to make it clear to clients that they are not charged for radiographs or laboratory reports, but for diagnosis or advice only.

13.6 The Data Protection Act 1998 gives anyone the right to be informed about any personal data relating to themselves on payment of an administration charge. At the request of a client, veterinary surgeons must provide copies of any relevant clinical and client records, including radiographic images and similar documents. This also includes relevant records which have come from other practices, if they relate to the same animal and the same client, but does not include records which relate to the same animal but a different client.

Vaccination record cards

13.7 A vaccination record card held by the animal owner may be considered part of the clinical record and may be signed by a veterinary surgeon or a veterinary nurse (see supporting guidance 18.10 - 18.12). If a veterinary nurse signs the record, it is good practice to add the words ‘under the direction of ...’ and name the directing veterinary surgeon.

13.8 The animal should be identified on the vaccination record card and RCVS advice on identification of animals (see supporting guidance 21.12 – 21.15) states:

21.12 If an alleged identification mark is not legible at the time of inspection, no certificate should be issued until the animal has been re-marked or otherwise adequately identified.

21.13 When there is no identification mark, the use of the animal’s name alone is inadequate. If possible, the identification should be made more certain by the owner inserting a
declaration identifying the animal, so that the veterinary surgeon can refer to it as ‘as described’. Age, colour, sex, marking and breed may also be used.

21.14 The owner’s name must always be inserted. (In the case, for example, of litters of unsold puppies this will be the name of the breeder or the seller.)

21.15 Where microchipping or tattooing has been applied it should be referred to in any certificate of identification.

13.9 The animal may be presented to a different veterinary surgeon for a subsequent vaccination. To be useful, the vaccination record must be such as to allow the veterinary surgeon to identify the animal, if necessary, following any additional reasonable enquiries.
### Meeting
- **Standards Committee**

### Date
- 1 May 2014

### Title
- Removing Microchips: Guidance Review

### Classification
- Unclassified

### Summary
In September 2012, the Standards Committee (at that time the Advisory Committee) approved new guidance stating that the removal of microchips for anything other than clinically justified reasons would be considered an unnecessary mutilation. Recently, the RCVS Communications Department received an enquiry from a journalist relating to the College’s current position on removing microchips, highlighting that one reader (who is a dog owner) feels that the guidance is unduly burdensome.

### Decisions required
Given the recent enquiry, the Standards Committee is asked to review the current guidance and decide whether it remains appropriate.

### Attachments
- None

### Author
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Removing Microchips

Background

1. In September 2012, the Standards Committee (at that time the Advisory Committee) approved new guidance stating that the removal of microchips for anything other than clinically justified reasons would be considered an unnecessary mutilation. This advice is currently found in Chapter 14 of the Supporting Guidance to the Code of Professional Conduct, which states:

   14.29 Because of the importance attached to the accurate identification of animals and the potential for fraud, a microchip must only be removed where this can be clinically justified. This justification should be documented and where required another microchip or alternative method of identification used.

   14.30 Removal of a microchip in any other circumstances would be an unnecessary mutilation. While the insertion of a second microchip may be problematic, this in itself does not justify removal of a microchip and an audit trail must be maintained.

2. One reason for removing microchips is to enable reading and subsequent identification of the animal where the microchip has failed. Prior to the new RCVS guidance, Defra advice on dealing with an animal travelling under the Pet Passport Scheme where the microchip has failed stated that the microchip should be removed and a new microchip inserted. Defra also recommended that the new microchip should be checked before insertion and the faulty microchip returned to the manufacturer for identification. If the manufacturer was able to read, or otherwise identify the microchip, a written record of the microchip’s identity should be obtained and the new number should be recorded in the passport with the following annotation “new microchip inserted following failure of original, in accordance with Defra instructions.” If the manufacturer could not read the microchip the PETS qualification process must be repeated and a new passport issued.

3. In February, Defra representatives confirmed that when the new RCVS guidance was introduced, they updated their position to say that in the event that the vet is unable to scan and read the original microchip, the pet must be re-chipped. If the pet has been previously prepared for travel, then it must be re-prepared in accordance with pet travel rules and a new pet passport issued. The vet is now required to note in the pet passport that there is another microchip present that cannot be scanned and read, in case the fault is intermittent and the chip is picked up at the port when the pet is checked for compliance for entry to the UK. In effect, faulty microchips should not be removed (as in the past) unless required on welfare grounds.

4. When RCVS guidance was changed, we understand that no objections were raised by Defra or any other veterinary organisations or representative bodies.

Current Position

5. Recently, the RCVS Communications Department received an enquiry from a journalist relating to the College’s current position on removing microchips. It appears that one of their readers (who is a dog owner) feels that the guidance is unduly burdensome. We understand that, in this particular case, the owner returned to the UK from South Africa and, on entry, the dog’s microchip failed. The owner commented that until the end of 2012, cases like this could have been solved by removing the faulty microchip and returning it to the manufacturers for identification meaning early release from quarantine and less cost to the owner. The owner in...
this case also indicated that his veterinary surgeon would be raising concerns with the RCVS although to date nothing has been received.

Areas for discussion

Clinical justification for removal

6. In the UK animal welfare legislation prohibits mutilations on animals subject to certain exceptions. "Mutilation" covers any procedure that involves interference with the sensitive tissues or bone structure of an animal other than for therapeutic purposes (medical treatment):

   a) In England and Wales, the Animal Welfare Act 2006 prohibits mutilations "otherwise than for the purpose of its medical treatment" or permitted by specific regulations (Section 5).
   b) The Animal Health and Welfare (Scotland) Act 2006 prohibits mutilations except "where they are carried out for the purpose of the medical treatment of an animal" or permitted by specific regulations (Section 20).
   c) The Welfare of Animals (Northern Ireland) Act 2011 provides that a prohibited procedure is one which involves interference with the sensitive tissues (for example skin) or bone structure of the animal, other than a procedure carried out by a veterinary surgeon, for the diagnosis of disease, for the purpose of its medical treatment or is specified in regulations made by the Department (section 5(4) and section 5(5) of the Act).

7. There are still some procedures which are technically mutilations, but are exempt from the ban due to long-term welfare or animal management benefits and there are specific requirements on how many of these procedures are performed. These procedures are listed in the various UK regulations. Removal of microchips is not included.

8. The RCVS generally provides advice that in order to justify a procedure as being medical treatment and therefore not an unnecessary mutilation, it must be on the basis that the intervention is necessary, truly therapeutic or prophylactic (i.e. to prevent disease or injury) and is not carried out solely for the convenience of the owner.

9. When the Committee discussed this matter in 2012 there was also agreement that the removal of a microchip for any reason other than a clinical one is an unnecessary mutilation. At that time, it was also commented that it is appropriate to remove a microchip only where it can be clinically justified and that it is not appropriate to anaesthetise an animal to remove a microchip for non-clinical reasons.

10. While the owner in this case might seek to argue that the animal's emotional welfare is best served by removal (i.e. due to potential early release from quarantine), there remains an argument that removal cannot be clinically justified in the circumstances and may be contrary to current animal welfare legislation.

Manufacturers' ability to read faulty microchips

11. To assist with discussions, we also contacted a number of leading UK microchip manufacturers to find out more about their ability to read faulty microchips. All of the UK microchip manufacturers who responded to our enquiries confirmed that it is impossible to guarantee removed microchips will be readable.
12. One manufacturer explained that they should be able to undertake certain tests to try to retrieve the number of a failed microchip and there are procedures to ensure continuity from point of removal to completion of the analysis and any result. However, they indicated that reading the number certainly cannot be guaranteed as this will depend on what is wrong with the microchip and, in some case, retrieval is simply not possible.

13. Another manufacturer explained that, in effect, their engineers have to try to rebuild the microchip and their ability to do this will depend on the extent of the damage to the microchip. Microchips are encapsulated and a failure to retrieve data could be caused by a hairline fracture in the casing, or where the microchip has been damaged during implantation, or where the animal has had an accident. The company explained that engineers are sent to the Quarantine Unit to check the microchip is unreadable before any removal by a veterinary surgeon is considered. It was commented that when a microchip can be successfully rebuilt, company engineers will provide a certificate, which means the animal might be removed from quarantine sooner.

14. As to the extent of the problem, the same manufacturer did say that in reality they see very few cases of failed microchips (with only a handful in over 10 years). However, numbers can increase if a company issues a batch of microchips with functionality problems.

15. It was also explained that the owner is ultimately responsible for the any costs of removal by a vet and there may additional costs payable to the manufacturer for rebuilding and analysing the microchip. It was commented that in some situations fees could reach up to £5,000 (e.g. where one company is asked to rebuild a microchip issued by another manufacturer). For the owners, it seems there is no guarantee that removing a microchip will cost less than the costs of quarantine (with private companies charging different quarantine fees).

Recommendations

16. Given the recent enquiries to the RCVS, the Standards Committee is asked to review the current guidance and decide whether it remains appropriate.
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<tr>
<td>Date</td>
<td>1 May 2014</td>
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<tr>
<td>Title</td>
<td>Specialists and Advanced Practitioners</td>
</tr>
<tr>
<td>Classification</td>
<td>Unclassified</td>
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<tr>
<td>Summary</td>
<td>At its meeting on 25 September 2012, the Standards Committee (at that time the Advisory Committee) was asked to approve, in principle, amendments to the Code of Professional Conduct and Supporting Guidance following the recommendations of the Specialisation Working Party. These changes were approved in principle pending implementation of the mechanisms to accredit advanced practitioners. The mechanisms are now in place and as a result, it is time for the Code and Supporting Guidance to be updated accordingly.</td>
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<td>Decisions required</td>
<td>To endorse the previously agreed amendments to the Code and Supporting Guidance</td>
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<tr>
<td>Attachments</td>
<td>Annex A: PDF of the original paper (September 2012) and meeting minutes</td>
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<td>Annex B: Revised Code (3.5) and Supporting Guidance Chapters 1, 11 and 23</td>
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<tr>
<td>Author</td>
<td>Laura McClintock</td>
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<tr>
<td></td>
<td>Advisory Solicitor</td>
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<td>0207 202 063</td>
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<td><a href="mailto:l.mcclintock@rcvs.org.uk">l.mcclintock@rcvs.org.uk</a></td>
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Specialists and Advanced Practitioners
(Updates to the Code 3.5 and Supporting Guidance Chapters 1, 11 and 23)

Background

1. At its meeting on 25 September 2012, the Standards Committee (at that time the Advisory Committee) was asked to approve, in principle, amendments to the Code of Professional Conduct 3.5 and Supporting Guidance (Chapters 1, 11 and 23) following the recommendations of the Specialisation Working Party, as approved by RCVS Council.

2. The Committee approved the recommendations pending implementation of the final mechanisms to accredit advanced practitioners. The Committee also agreed some additional minor changes to the guidance relating to referrals and second opinions, and communication and consent. The original paper and minutes of the meeting are attached at Annex A. These set out the agreed changes in more detail.

Current Position

3. The criteria and procedures for applicants to become "RCVS Advanced Practitioners" have now been agreed and the Education Department is on target to receive the first applications this autumn. Decisions on AP accredited status will be made by a panel, and publication of the first list of APs will follow in Spring 2015.

4. The mechanisms for specialists and advanced practitioners are now in place, it is time for the Code and Supporting Guidance to be updated accordingly. Copies of the revised Code and Supporting Guidance showing the proposed changes are attached at Annex B.

Recommendations

5. The Committee is asked to endorse the previously agreed amendments to the Code of Professional Conduct and Supporting Guidance.

6. Furthermore, as part of the RCVS’s commitment to reviewing the Supporting Guidance on a rolling basis, the Committee is asked to highlight any additional changes to other areas in Chapters 1, 11 and 23 that may be required.
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<tr>
<td><strong>Title</strong></td>
<td>Implementation of Specialisation Working Party recommendations</td>
</tr>
<tr>
<td><strong>Classification</strong></td>
<td>Unclassified</td>
</tr>
<tr>
<td><strong>Summary</strong></td>
<td>This paper sets out proposed amendments to the Code of Professional Conduct and supporting guidance dealing with specialist claims following the recommendations made by the Specialisation Working Party, which were approved by RCVS Council</td>
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<td><strong>Decisions required</strong></td>
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<tr>
<td><strong>Attachments</strong></td>
<td>Annex A: Report and Recommendations of the Specialisation Working Party</td>
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| **Author**  | Laura McClintock  
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Implementation of the Specialisation Working Party recommendations

Background

1. At its meeting on 7 June 2012, RCVS Council approved the recommendations made by the Specialisation Working Party. The Specialist Working Party was established by RCVS Council to “consider veterinary specialist qualifications with a view to making recommendations for a simplified structure for possible inclusion in new legislation and/or a new Charter”.

2. The Review of the Guides to Professional Conduct Working Party had always anticipated that any recommendations made by the Specialisation Working Party would need to be reflected in revisions to the new Code of Professional Conduct and Supporting Guidance.

3. A copy of the Report and Recommendations from the RCVS Specialisation Working Party are attached as Annex A.

Current position

4. The Code of Professional Conduct currently sets out professional responsibilities for veterinary surgeons, including those relating to veterinary surgeons and the profession as follows:

3. Veterinary surgeons and the profession

3.5 Veterinary surgeons must not hold out themselves, or others, as having expertise they cannot substantiate, or call themselves or others a “specialist” or similar, where to do so would be misleading or misrepresentative.

5. Similarly, Chapter 23 of the supporting guidance to the Code of Professional Conduct deals with advertising and publicity and provides:

Specialist claims

23.4 Veterinary surgeons must not hold out themselves or others as having expertise they cannot substantiate, or call themselves or others a “specialist” or similar, where to do so would be misleading or misrepresentative.

6. There is further guidance in Chapter 1 of the supporting guidance to the Codes of Professional Conduct, which deals with referrals and second opinions and also Chapter 11, which deals with communication and consent.

Discussion / issues

Recommendations of the Specialisation Working Party

7. Recommendation 29 of the Specialisation Working Party suggests strengthening the wording of professional responsibility 3.5 to reflect the new terminology and lists for specialists and advanced practitioners. The following wording has been suggested by the Specialisation Working Party:
“Veterinary surgeons must not hold out themselves, or others, as having expertise they cannot substantiate, or call themselves or others a ‘specialist’, or similar expression that implies specialist standing unless they have been accredited as specialists and where to do so would be misleading or misrepresentative.”

8. The Committee may consider that the suggested amendments in Recommendation 29 are appropriate and provide clarity on the understanding that the word ‘and’ in the 3rd line is replaced with a comma.

9. The Committee may therefore consider that a consequential amendment should be made to paragraph 23.4 of the supporting guidance on advertising and publicity to reflect changes to the wording of professional responsibility 3.5 as recommended by the Specialisation Working Party.

10. Recommendation 31 of the Specialisation Working Party suggests strengthening the wording of the supporting guidance on referrals and second opinions to reflect the new terminology and lists for specialists and advanced practitioners. The Committee may consider that the suggested amendments in Recommendation 31 (set out in Table 1) are appropriate and provide clarity.

11. Recommendations 30 and 31 suggest that consideration should be given to strengthening chapter 11 of the supporting guidance on communication and consent. The Working Party has stressed the importance of informed client consent as part of the referral process and suggests it should be explicit that veterinary surgeons should include an explanation of the level of expertise and facilities available to treat an animal within the options presented to a client. The Committee may consider that this additional information should be included in paragraph 11.2 of the supporting guidance.

12. The Committee should note that the revisions to the Code of Professional Conduct and supporting guidance are dependent on the mechanisms for accreditation of specialists and advanced practitioners being finalised and established. There is more work to be done on this and the Committee may consider that this will need to be completed before corresponding changes can be made to RCVS guidance. However, the Committee may consider that it is important to consider the Specialisation Working Party Report and Recommendations in principle at this stage to ensure the veterinary profession is aware of the changes that will be made and the need to seek specialist or advanced practitioner status.

Additional Suggestions arising from RCVS Council

13. At its meeting on 7 June 2012, RCVS Council approved the recommendations made by the Specialisation Working Party as set out above. However, additional comments were made concerning the content of the report.

14. Attention was drawn to paragraph 25 of the report, which stated “neither a second opinion veterinary surgeon nor a referral practice should ever seek to take over the case, unless the client

\[1\] Terminology to be subject to market testing as described earlier.
chooses to change practices”. It was commented that this advice is not currently set out in the Code of Professional Conduct.

15. The Committee should note that this advice appeared previously in the Guide to Professional Conduct, but it is not included in the new Code of Professional Conduct and supporting guidance. The Committee may consider that this advice should be re-introduced when the revisions to the Code of Professional Conduct and supporting guidance arising from the Specialisation Working Party are carried out.

16. It was also agreed at Council that the Advisory Committee would review the terminology in respect of second opinion referrals to improve the public’s understanding.

17. Supporting guidance 1.9 states that “veterinary surgeons should follow similar procedures for second opinions and ensure that any differences of opinion between the veterinary surgeons are discussed and explained constructively” (set out at paragraph 1.6 in Table 1).

18. The Committee may consider that the wording of this paragraph could be amended to improve the public’s understanding of second opinion referrals. This could reflect that veterinary surgeons may follow similar procedures for second opinions and that they should ensure that any differences of opinion between the veterinary surgeons are discussed and explained constructively.

**Recommendation**

19. Advisory Committee is asked to consider and approve in principle the proposed revisions to the Code of Professional Conduct and supporting guidance contained in the Recommendations of the Specialisation Working Party, and arising from Council, to be implemented once the mechanisms for accreditation of specialists and advanced practitioners have been finalised and put in place.
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<tr>
<td>Title</td>
<td>Recommendations from the Specialisation Working Party</td>
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<tr>
<td>Classification</td>
<td>Unclassified</td>
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<tr>
<td>Summary</td>
<td>The paper presents the 26 recommendations of the working party covering the specialist list and level of specialisation, proposals for a list of „advanced practitioners“ to be subject to revalidation, titles and designations, the number of specialists, the referral process, the RCVS Fellowship, and the replacement of the existing RCVS subject boards. EPSC considered these recommendations at its meeting on 9 May and agreed to recommend them to Council with two minor amendments:</td>
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<tr>
<td></td>
<td>• Page 17 para. 20 line 3 – insert the word „normally“ before the word „includes“</td>
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<td>• Page 22 para. 1.6 – insert the word „arranging“ in brackets after the word „referring“ for clarification</td>
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<td>Since EPSC’s meeting, some market research has been carried out into the terminology proposed, and the results are attached at Annexes B and C.</td>
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<tr>
<td>Decisions required</td>
<td>Council to approve the recommendations, as amended, for implementation.</td>
</tr>
<tr>
<td>Attachments</td>
<td>• Annex A: Responses to the consultation paper (nb. due to its length- over 500 pages - this annex is only available electronically).</td>
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<tr>
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<td>• Annex B: Summary of animal owner market research re. terminology for proposed new structure &amp; recommendations</td>
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<td>• Annex C: Summary of research (slides)</td>
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<tr>
<td>Author</td>
<td>Freda Andrews</td>
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<td>Head of Education</td>
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<td><a href="mailto:f.andrews@rcvs.org.uk">f.andrews@rcvs.org.uk</a></td>
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Report and Recommendations from the RCVS Specialisation Working Party

Introduction

1. The Specialisation Working Party was set up by RCVS Council “to consider veterinary specialist qualifications with a view to making recommendations for a simplified structure for possible inclusion in a new legislation and/or a new Charter.” (Full terms of reference are at Annex 1.) It held its first meeting under the chairmanship of Professor Sir Kenneth Calman in July 2010, and met a further six times between September 2010 and January 2012. A meeting with various stakeholders was held in March 2011, and a consultation document was published in October 2011, which elicited nearly 300 responses. Having considered the feedback from this consultation, the working party produced a progress report in January 2012 summarising its thinking to date. Education Policy & Specialisation Committee discussed this in February 2012 and encouraged the working party to finalise its proposals along the lines suggested in the progress report.

2. Those who responded to the consultation provided a wide range of views. Although many responses did not answer the specific questions that had been asked, the responses nevertheless provided a useful indication of the concerns that the working party needed to address. Many of the responses received were detailed and carefully thought out and the working party would like to thank all those who took the time to respond to this important set of proposals.

3. In the meantime, RCVS Council has agreed a revised Code of Professional Conduct and supporting guidance which were the subject of a separate consultation and discussions by RCVS committees in 2011. The new Code states at paragraph 3.5 that “Veterinary surgeons must not hold out themselves or others as having expertise they cannot substantiate, or call themselves or others a ‘specialist’ or similar where to do so would be misleading or misrepresentative.” The proposals that follow, if agreed by EPSC and Council, will need to be reflected in revisions to the Code and to its supporting guidance.

4. This paper summarises the working party’s conclusions and recommendations for Education Policy & Specialisation Committee’s consideration, and if appropriate, for Council’s ratification. It does not attempt to rehearse all the background to the specialisation debate, as this was fully described in the October 2011 consultation paper which can be accessed here: http://www.rcvs.org.uk/document-library/specialisation-in-the-veterinary-profession/
5. Although it has set out the principles and recommends actions which it thinks should now be pursued, the working party suggests that further work needs to be done on the details by other committees or task groups within RCVS. Education Policy & Specialisation Committee may also wish to consider further some of the ideas concerning the Fellowship that emerged during the working party’s discussions but which went slightly beyond the working party’s remit.

6. The working party is aware that some of the terminology which it suggests should be adopted, first needs to be professionally “market tested” with the public before final changes are implemented. This task needs to be undertaken by those with experience of qualitative market research and the working party suggests that this should be done if EPSC and Council agree to the proposals set out below. Fine-tuning of terminology can be agreed by EPSC and Council later if these proposals are accepted.

7. Finally, the working party’s was tasked in its remit to consider which of its recommendations “could be implemented on a voluntary basis or under RCVS’s current legislative framework”. Given the recent change to the Code of Professional Conduct, and Counsel’s legal advice on RCVS’s jurisdiction, the working party is of the view that all its recommendations can be implemented without a change to primary legislation. Suggestions are made below concerning further changes to wording of the Code and its supporting guidance that will be needed to support the proposals.

Summary of recommendations

A summary of the working party’s recommendations is listed below. These are reproduced from the sections on each of these issues described in the following paper.

8. The working party recommends to Education Policy and Specialisation Committee:

   The specialist list and level of specialisation
   (see page 12)

   a. RCVS should continue to publish and promote a list of veterinary specialists. The list should include all those who are currently accredited as specialists by RCVS, or by a European speciality College. The purpose of the list is to provide a clear indication to the profession and the public of those veterinary surgeons who have been accredited as specialists by the RCVS, by virtue of having demonstrated achievement at diploma level (doctorate level 8 in the national qualifications framework, FHEQ; Level 12 in the Scottish Credit
Qualifications Framework, SCQF)\(^1\), who are currently active as referral specialists and leaders in their specialty.

b. Those who are on the list should be entitled to call themselves “RCVS specialist in <subject area and/or species>” (the title to be subject to further market research testing with members of the public and may be revised in the light of that feedback).

c. Entry to the list will require individuals to hold a postgraduate qualification at level 8 (doctorate level) in the national qualifications framework (see Annex 2 below for a full definition of this level) and/or to present evidence to a credentials committee that they have the equivalent specialist experience and training at level 8. Evidence could take the form of a portfolio of work, which would be subject to examination including an oral assessment. Applicants must currently be practising in the specialty and available to provide their specialist service to the public and/or the profession.

d. Continued inclusion on the list of specialists will require the individual to be periodically revalidated, at least every 5 years (as now). This will require evidence of a commitment to, and strong record of, continuing professional development, continued contribution to the specialty, as well as continued availability to provide their specialist service.

e. Holders of European Specialist status who are practising in the UK should automatically be eligible for inclusion on the RCVS list, provided that they maintain their European Specialist status by being revalidated by their European College. Revalidation by a European College should be accepted as being equivalent to revalidation by RCVS and require no further evaluation by RCVS, apart from administrative checks to confirm continued availability to provide their service to the profession and/or public in the UK, and contact details.

f. There should continue to be an application and revalidation fee payable by those applying to join or remain on the list to cover administrative costs.

The list of “advanced practitioners” – an accredited ‘middle tier’ of expertise
(see page 13)

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\(^1\) FHEQ = Further and Higher Education Qualifications framework, applying to England, Wales and Northern Ireland; SCQF = Scottish Credit Qualifications framework. The two frameworks are equivalent, but start at different points hence level 8 in the FHEQ equates to level 12 in the Scottish framework; level 7 in the FHEQ equates to level 11 in the Scottish framework. For ease of reference, the FHEQ numbers are used in this paper.
g. RCVS should set up, publish and promote a new list of “advanced practitioners”. The purpose of the list will be to provide a clear indication to the profession and the public of those veterinary surgeons who have been accredited at postgraduate certificate level (Masters level 7) by the RCVS, by virtue of having demonstrated knowledge and experience in a particular area of veterinary practice (including general practice) beyond their initial primary veterinary degree. Inclusion on the list will demonstrate that the individual holds an appropriate qualification and that they have stayed up to date in their field of practice since achieving their certificate level qualification.

h. Those who are on the list should be entitled to describe themselves as “advanced practitioner in <subject area and/or species>” (this title to be subject to further market research testing with the public and may be revised in the light of that feedback).

i. Entry to the list of advanced practitioners will require individuals to hold an appropriate qualification at postgraduate level 7 in the national qualifications framework in their subject/species area (equivalent to level 11 in the Scottish Credit and Qualifications framework). Those on the list must currently be practising in the named subject/species area and demonstrate a commitment to, and strong record of, continuing professional development.

j. Continued inclusion on the list of advanced practitioners will require the individual to be periodically revalidated, at least every 5 years, with evidence provided of ongoing continuous professional development as well as continued involvement in the subject/species area.

k. RCVS should continue to liaise with the appropriate European associations that are developing the concept of the „European Acknowledged Veterinarian‟, with the aim of establishing equivalence between the two systems in terms of level and purpose. If equivalence is eventually established to the satisfaction of RCVS, then holders of the European status who are practising in the UK should automatically be eligible to join the RCVS list of advanced practitioners, provided that they maintain their European acknowledged status by a process of revalidation by the appropriate European body. (This parallels the recommendation relating to European Specialist status above, but is dependent on ongoing work and agreement being reached on equivalence.)

l. There should be an application and revalidation fee payable by those applying to join or remain on the list, but this fee should be kept as low as possible so as not to discourage eligible applicants.

**Titles and designations**
(see page 15)
m. Only those who are on the list of specialists should describe themselves as specialists, and veterinary surgeons should not refer to another colleague as a specialist unless that colleague is on the list. Similar considerations should apply to those on the list of advanced practitioners.

n. Veterinary surgeons who cease to be on the lists of either specialists or advanced practitioners should no longer describe themselves as specialists/advanced practitioners, nor describe themselves to clients or other professional colleagues as being specialists or having specialist expertise (or advanced practitioner status, as appropriate) in the subject/species area concerned.

o. RCVS should simplify significantly the listing of postnominal letters for qualifications against Members’ names in the published Register and on the RCVS website (Findavet). Official lists should show only the registerable degree (eg. BVMS, or DVM, or BVetMed etc), followed by either MRCVS or FRCVS, and indicating whether the individual is on the list of specialists or the list of advanced practitioners. Thus:
   i. John Brown, BVSc, MRCVS
   ii. Jane Smith, BVM&S, MRCVS, Advanced Practitioner in Small Animal Surgery
   iii. Peter Jones, MVB, FRCVS, RCVS Specialist in Anaesthesia

p. RCVS should cease awarding additional subject/species designations and subject/species specific postnominal letters with the Certificate in Advanced Veterinary Practice. Holders of the CertAVP who have achieved particular combinations of modules, and who are admitted to the list of advanced practitioners, may show the subject area with the advanced practitioner title (eg. advanced practitioner in equine medicine).

The number of specialists
(see page 17)

q. RCVS should promote – both to the profession and to the public - the lists of specialists and advanced practitioners, to encourage all veterinary surgeons who are eligible to join one or other of the lists. With the introduction of a new tier of expertise - the advanced practitioner - the working party does not believe that additional measures, such as „grandparenting”, need to be taken to increase the number of veterinary specialists beyond those who may already be eligible, or who are able to present acceptable evidence and be assessed to show that they meet the level descriptor. All those who are currently qualified at level 8 and practising as specialists, or who are qualified
at certificate level (level 7) and taking referrals must be encouraged to join one or other of the lists. This will provide better assurance to the public and clearer information that those who are taking referrals at either level are up to date and active in their field.

The referral process
(see page 19)

r. It should continue to be a matter of professional judgement for the veterinary surgeon as to whether a case would benefit from being referred to another veterinary surgeon. RCVS should not stipulate that particular types of cases should be referred, nor should it dictate to whom they should be referred. In making such judgements, the veterinary surgeon should take account of their responsibilities set out in the Code of Professional Conduct. In particular, the supporting guidance on referrals and second opinions, and on communication and informed consent will be important in this context. This guidance will need to be revised to reflect the new terminology for veterinary specialists and advanced practitioners, and to make it clear that only those on the lists should be referred to as specialists or advanced practitioners as appropriate. (The guidance with suggested amendments highlighted is reproduced below at Table 1.)

Specialist practices and facilities
(see page 25)

s. The working party recommends that further work should be undertaken by the RCVS Practice Standards Group on standards for specialist practices.

RCVS Diploma of Fellowship – FRCVS and Honorary FRCVS
(see page 25)

t. RCVS should actively promote – both to the profession and to the public - the Diploma of Fellowship as the highest award issued by the College. Achievement of the Fellowship should continue to be one of the routes for clinicians to gain veterinary specialist status. This is particularly important as RCVS phases out its Diplomas in favour of European Diplomas.

u. Further work should be undertaken by RCVS to develop additional routes to the Fellowship to make it an award that more practising clinicians can achieve. For example, the existing routes of Fellowship by Thesis, and by Meritorious Contributions to Learning, could be supplemented by a new route
to recognise “meritorious contributions to clinical practice”. A working group should be formed to develop the criteria for this new route to the Fellowship with a view to producing explicit statements on the standards required for each route and guidance for examiners, in line with the level 8 descriptor. Revised byelaws will also be needed to enact these changes. Periods of clinical training under supervision should be included in the requirements.

v. Veterinary specialists who have been on the RCVS list of specialists for a continuous period of 10 years should be awarded the title of RCVS Honorary Fellow (HonFRCVS), to recognise their longstanding contribution to their specialty. This will require a change to the RCVS byelaws for the Fellowship, which currently restricts the award of Honorary Fellowships to three per year.

Promotion and publicity
(see page 27)

w. The RCVS should make the list of specialists and the list of advanced practitioners readily available and searchable through its website, and consider developing some unique branding to set these lists apart from the standard Register of Members. The lists need to be more immediately visible for the public and not just be seen as an internal reference tool for the veterinary profession.

x. The RCVS should publish some simple materials (eg. leaflets, posters) designed for the public explaining in simple terms the various levels of veterinary qualifications and the factors to be taken into account when considering a referral. Such materials should be made readily available for veterinary practices to give to their clients.

y. In order to raise general awareness of the framework for specialisation, the RCVS should promote veterinary specialisation and the existence of the two lists on an ongoing basis, for example through published materials, news stories, press releases, at conferences and by social media as considered appropriate.

The RCVS subject boards
(see page 27)

z. Drawing on the membership of the subject boards and other sub-committees within RCVS, a large panel – or pool of specialists and Fellows should be appointed for a rolling fixed term, from which smaller sub-groups can be brought together to advise on subject specific matters when required by the College. Credentials committees should be formed from members of the panel, according to the subject areas under consideration, to evaluate
applications for specialist status and advanced practitioner status. Ideally, the panel should comprise a broad range of veterinary surgeons who themselves have been accredited as specialists and/or Fellows.
Background to the recommendations

Principles

The following set of principles should apply to a framework for specialisation. A version of these was set out in the working party’s consultation paper in October 2011. The principles below have been amended slightly to take account of feedback received and should be taken into account by future working groups/committees when considering how these proposals should be implemented in the future.

- Veterinary practice is grounded in ensuring first class animal welfare, and any proposals must see improving treatment for the benefit of animal patients as central to any changes in education and organisation.

- Clients should have access to the most appropriate level of expertise that is available for each case.

- There must be recognition of the importance of developing new methods of treatment and investigation and the pursuit of research to improve clinical practice.

- All veterinary practitioners should continue to learn and improve their practice through educational programmes and regular audit review of their work. This should form the basis of ensuring, for the public, the quality of care provided.

- Such programmes and audit reviews should also focus on ethical issues and on the ability to communicate to clients and the public. In particular the importance of clients’ informed choice and consent in referring animals to specialists or other colleagues should be emphasised.

- This requires a process of regular revalidation of the specialist practitioner, and all practitioners who wish to promote the provision of their expertise to the profession at large on a regular basis.

- The vet-client relationship is based on trust and, when referring to others or when claiming specialist expertise, this is of paramount importance.

- The structures for veterinary specialisation should be understandable to the public and the profession. Clarity is required and the system adopted should be associated with full information and publicity for the public and the profession.
The specialist list and the level of specialisation

1. There was considerable consensus among respondents to the consultation that the level for specialist status and qualifications should be set at level 8 in the national qualifications framework. This is equivalent to “doctorate” – including professional doctorates, but should not be interpreted simplistically as being the same as PhD. A full level descriptor has been provided, adapted from the QAA definition of level 8 in the Further and Higher Education Qualification framework (FHEQ) for England, Wales and Northern Ireland and there was general agreement from those who responded to the consultation that this level was appropriate.

2. Some respondents commented that involvement in research should not be a requirement for specialist status, and the working party wishes to clarify that the descriptor does not require involvement in fundamental or laboratory based research, but “original research OR clinical studies”. The working party is of the view that the creation and interpretation of new knowledge in order to extend a discipline or area of practice is an important feature at this level. An understanding of techniques for research and clinical enquiry is also important if the specialist is to be able to interpret latest research and use this to evidence developments in clinical practice.

3. The working party therefore recommends that:

   a. RCVS should continue to publish and promote a list of veterinary specialists. The list should include all those who are currently accredited as specialists by RCVS, or by a European speciality College. The purpose of the list is to provide a clear indication to the profession and the public of those veterinary surgeons who have been accredited as specialists by the RCVS, by virtue of having demonstrated achievement at diploma level (doctorate level 8 in the national qualifications framework, FHEQ; Level 12 SCQF), who are currently active as referral specialists and leaders in their specialty.

   b. Those who are on the list should be entitled to call themselves “RCVS specialist in <subject area and/or species>” (the title to be subject to further market research testing with members of the public and may be revised in the light of that feedback).

   c. Entry to the list will require individuals to hold a postgraduate qualification at level 8 (doctorate level) in the national qualifications framework (see Annex 2 below for a full definition of this level) and/or to present evidence to a credentials committee that they have the equivalent specialist experience and training at level 8. Evidence could take the form of a

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2 Level 8 in the FHEQ equates to level 12 in the Scottish Credit and Qualifications Framework (SCQF)
portfolio of work, which would be subject to examination including an oral assessment. Applicants must currently be practising in the specialty and available to provide their specialist service to the public and/or the profession.

d. Continued inclusion on the list of specialists will require the individual to be periodically revalidated, at least every 5 years (as now). This will require evidence of a commitment to, and strong record of, continuing professional development, continued contribution to the specialty, as well as continued availability to provide their specialist service.

e. Holders of European Specialist status who are practising in the UK should automatically be eligible for inclusion on the RCVS list, provided that they maintain their European Specialist status by being revalidated by their European College. Revalidation by a European College should be accepted as being equivalent to revalidation by RCVS and require no further evaluation by RCVS, apart from administrative checks to confirm continued availability to provide their service to the profession and/or public in the UK, and contact details.

f. There should continue to be an application and revalidation fee payable by those applying to join or remain on the list to cover administrative costs.

The list of “advanced practitioners” – an accredited ‘middle tier’ of expertise

4. There was support, particularly from the organisations that responded to the consultation, for the introduction of an accredited “middle tier” of veterinary surgeons to be subject to periodic re-validation. This is in line with current thinking elsewhere in Europe, where systems to accredit “European Acknowledged Veterinarians” at certificate level are being developed. The working party is not comfortable with the proposed European terminology which may mean little to many people in the UK, but we are aware that discussions on this are continuing and that RCVS will be involved in piloting the draft European criteria for accreditation at this level.

5. The introduction of this new middle tier will enable the profession and their clients to see not only that someone has achieved a certificate level qualification, but more importantly that they have maintained their involvement in the named area of practice and continue to develop their professional skills and knowledge through a commitment to ongoing CPD. This is more informative than the current list of certificate holders which merely records that someone passed their certificate in the
past, although they may no longer be working in that area or may not have kept themselves up to date with the subject at certificate level.

6. The working party therefore recommends:

   a. RCVS should set up, publish and promote a new list of “advanced practitioners”. The purpose of the list will be to provide a clear indication to the profession and the public of those veterinary surgeons who have been accredited at postgraduate certificate level (Masters level 7) by the RCVS, by virtue of having demonstrated knowledge and experience in a particular area of veterinary practice (including general practice) beyond their initial primary veterinary degree. Inclusion on the list will demonstrate that the individual holds an appropriate qualification and that they have stayed up to date in their field of practice since achieving their certificate level qualification.

   b. Those who are on the list should be entitled to describe themselves as “advanced practitioner in <subject area and/or species>” (this title to be subject to further market research testing with the public and may be revised in the light of that feedback).

   c. Entry to the list of advanced practitioners will require individuals to hold an appropriate qualification at postgraduate level 7 in the national qualifications framework in their subject/species area (equivalent to level 11 in the Scottish Credit and Qualifications framework). Those on the list must currently be practising in the named subject/species area and demonstrate a commitment to, and strong record of, continuing professional development.

   d. Continued inclusion on the list of advanced practitioners will require the individual to be periodically revalidated, at least every 5 years, with evidence provided of ongoing continuous professional development as well as continued involvement in the subject/species area.

   e. RCVS should continue to liaise with the appropriate European associations that are developing the concept of the ‘European Acknowledged Veterinarian’, with the aim of establishing equivalence between the two systems in terms of level and purpose. If equivalence is eventually established to the satisfaction of RCVS, then holders of the European status who are practising in the UK should automatically be eligible to join the RCVS list of advanced practitioners, provided that they maintain their European acknowledged status by a process of revalidation by the appropriate European body. (This parallels the recommendation relating to European Specialist status above, but is dependent on ongoing work and agreement being reached on equivalence.)
f. There should be an application and revalidation fee payable by those applying to join or remain on the list, but this fee should be kept as low as possible so as not to discourage eligible applicants.

Titles and designations

7. The question about qualification titles and postnominal letters also elicited general support for simplification, although some strong views were expressed about the need to retain "designations" within qualification titles and postnominals – particularly at Certificate level - so that vets and clients can see the subject of a vet’s further qualifications.

8. The working party believes these issues are linked. If there is agreement to the development of a middle tier (for which the term “advanced practitioner” received the most support), further work will be needed to set out the detailed criteria and procedures for accreditation at this level, and this will need to include consideration of the list of subjects, disciplines and/or species designations to be included. It was always the working party’s intention that this middle tier status would include the subject area (eg. “Advanced Practitioner in Equine Practice”), in the same way that the current list of Recognised Specialists indicates a subject area. The question to be decided is the degree of detail to be included. The working party was originally of the view that only broad areas of practice should be promoted at the middle tier, but acknowledges that there is a valid argument about the benefit of more specific descriptors (eg. “small animal dermatology”, rather than just “small animal practice”) – especially if this is to be the prime means of describing the veterinary surgeon’s area of expertise.

9. It has not been proposed to restrict vets from listing their various qualifications on their personal stationery if they wish to do so, but if a new middle tier of “advanced practitioner” is introduced alongside the specialist list, with the subject or species area indicated as part of the title, it is not then necessary to list the details of the qualifications which led to accreditation at each level. Accreditation and continued accreditation as advanced practitioner or as specialist should be the trigger that allows the individual to include a particular "designation" with the title showing their area of practice or discipline.

10. As regards the title for those accredited at specialist level: the working party is in favour of dropping the word “recognised” from the current title. The preference is for a simpler “veterinary specialist in…..” designation. However, this needs to be subjected to some market testing with the public and it is proposed that some research is undertaken before the final terminology is agreed. This will be done if EPSC and Council agree to the general principle.

11. The working party is also in favour of bringing together the system for European specialists and RCVS specialists, such that those accredited as European
Specialists should have an automatic route onto the RCVS list, and that the paperwork for re-accreditation should converge. It has been reported that some European Specialists in some specialties may have slightly less experience in clinical practice when they first pass their European Diploma than those with RCVS Diplomas and that RCVS should therefore require them to gain additional experience before being accepted onto the RCVS list of specialists. However, the working party believes that they should automatically be eligible for RCVS listing, as it is in the general interest to work towards a single list of specialists practising in the UK, rather than the current confusing position. European Diploma holders are entitled to call themselves “European Specialists” whilst they are practising in the UK, whether they are on the RCVS list or not.

12. In the interests of transparency and clarity for the public, the working party is of the view that the RCVS Code of Professional Conduct and its supporting guidance should make it clear when it is acceptable for veterinary surgeons to describe themselves as specialists. This does not prevent veterinary surgeons referring cases to colleagues who are not specialists under this definition, but it would introduce greater clarity and remove any room for doubt or confusion on the part of the public as to the accredited level of expertise being presented. The working party does not believe it is necessary to push for new legislation to achieve this aim, as the same end could be met by greater clarity in the Code of Professional Conduct.

13. The working party therefore recommends that:

a. Only those who are on the list of specialists should describe themselves as specialists, and veterinary surgeons should not refer to another colleague as a specialist unless that colleague is on the list. Similar considerations should apply to those on the list of advanced practitioners.

b. Veterinary surgeons who cease to be on the lists of either specialists or advanced practitioners should no longer describe themselves as specialists/advanced practitioners, nor describe themselves to clients or other professional colleagues as being specialists or having specialist expertise (or advanced practitioner status, as appropriate) in the subject/species area concerned.

c. RCVS should simplify significantly the listing of postnominal letters for qualifications against Members’ names in the published Register and on the RCVS website (Findavet). Official lists should show only the registerable degree (eg. BVMS, or DVM, or BVetMed etc), followed by either MRCVS or FRCVS, and indicating whether the individual is on the list of specialists or the list of advanced practitioners. Thus:

   iv. John Brown, BVSc, MRCVS
   v. Jane Smith, BVM&S, MRCVS, Advanced Practitioner in Small Animal Surgery
   vi. Peter Jones, MVB, FRCVS, RCVS Specialist in Anaesthesia
d. RCVS should cease awarding additional subject/species designations and subject/species specific postnominal letters with the Certificate in Advanced Veterinary Practice. Holders of the CertAVP who have achieved particular combinations of modules, and who are admitted to the list of advanced practitioners, may show the subject area with the advanced practitioner title (e.g. advanced practitioner in equine medicine).

The number of specialists

14. The consultation paper asked whether there was a need to increase the number of specialists, and if so, whether interim measures should be pursued (“grandparent rights”) through credentials committees. Whilst there was some support for an increase in numbers, this was not as strong as the support expressed for other aspects of the proposals. Some respondents were of the view that there was no need to increase the number of specialists; some objected to the notion of “grandparent rights”.

15. The working party accepts that, if the concept of the middle tier is agreed, there may not be a need to apply “grandparent rights” at the specialist level. Attention will be better focused at the middle tier to ensure that all those with appropriate qualifications and experience become accredited at that level, and that clear criteria and procedures are defined to ensure fairness.

16. The working party is, however, of the view that those who believe they are working at specialist level and who wish to be admitted to the list, but who do not for various reasons hold a formal level 8 qualification, should be allowed to present a portfolio of evidence demonstrating how they meet the level descriptor, and undertake an oral examination to validate their application. This route to the specialist list should be allowed for a limited period only, until such time as a new route to the Fellowship is agreed.

17. There is still scope for confusion from the fact that there are a number of Diploma holders who may be working as referral specialists who do not appear on the RCVS list of specialists: they have either never applied, or have been on the list in the past but not renewed their formal specialist status. This should be regularised. RCVS needs to promote the list of specialists, as well as the list of advanced practitioners, so that it is worth their while joining it. The process for applying to be a specialist needs to be as simple as possible (provided all the eligibility criteria are met), as does the procedure for revalidation. Costs need to be kept as low as possible in order not to discourage applicants. Furthermore, if the Code of Professional Conduct
makes it clear that only those who are on the list of specialists may describe themselves as such, this will provide a further incentive for those who consider themselves to be specialists to become formally accredited.

18. The working party also suggests that alternative routes to specialist status should be opened up in order that practitioners can aspire to specialist status in the future. The working party noted comments from the consultation responses about the practical difficulties for some practitioners in pursuing a Diploma qualification, whether RCVS or European. The RCVS has recently agreed that RCVS Diplomas should be closed to new enrolments from November 2012 in favour of the European Diploma system, so this will no longer be an option for new candidates in the future. The European College system of Diplomas does allow an “alternate” route for Diploma candidates in practice who are not following a traditional residency programme, but this is still at a relatively early stage of development and acceptance, and there is a perception that some practitioners may have difficulty having their alternate route approved by a European College. This route will need to be discussed with colleagues at a European level with the aim of protecting and developing it further and making it more achievable by those in practice.

19. The working party proposes that an alternative is for practitioners, who are unable to work towards a Diploma, to be encouraged to work instead towards the RCVS Fellowship. Given that the Fellowship is already one of the possible routes to specialist status, then achievement of the Fellowship (perhaps by thesis, or by a new route of “meritorious contributions to clinical practice”), rather than Diplomas, may be a more accessible route for those who are otherwise unable to follow the usual residency path. This will require consideration by other RCVS committees/working groups to define the changes that would be needed to the Fellowship byelaws.

20. Whatever routes or qualifications are allowed for specialist status, however, the level 8 descriptor will need to be satisfied. It will be important that any alternative route normally includes a requirement for a significant amount of supervised training under the guidance of an existing specialist in that field.

21. Finally, some respondents commented that whatever frameworks for specialisation are in place, it makes no difference unless RCVS regulates and enforces the Code of Professional Conduct. It needs to be emphasised that RCVS’s disciplinary process is reactive, ie. it is triggered when a complaint is received. It is for members of the profession as well as the public to use these systems. RCVS regulates and enforces, but it is up to individuals to use the systems in place. Greater clarity in the Code of Professional Conduct and supporting guidance on these points will help to make it clear when lines have been crossed.

22. The working party therefore recommends that:

a. RCVS should promote – both to the profession and to the public - the lists of specialists and advanced practitioners, to encourage all veterinary surgeons who are eligible to join one or other of the lists.
With the introduction of a new tier of expertise - the advanced practitioner - the working party does not believe that any additional measures, such as 'grandparenting', need to be taken to increase the number of veterinary specialists beyond those who may already be eligible or who are able to present acceptable evidence and be assessed to show that they meet the level descriptor. All those who are currently qualified at level 8 and practising as specialists, or who are qualified at certificate level (level 7) and taking referrals must be encouraged to join one or other of the lists. This will provide better assurance to the public and clearer information that those who are taking referrals at either level are up to date and active in their field.

The referral process

23. In most cases, animal owners will first see their veterinary general practitioner – the "primary" veterinary surgeon - when their animal needs treatment. It will be the primary veterinary surgeon who will usually examine and treat the animal in the practice and, in most cases, will undertake whatever procedures might be necessary him or herself. If a case is complicated, the primary vet may still be able to treat the animal depending on their expertise; but occasionally they may recommend that the animal is seen by a 'specialist' or by someone who has had more experience of dealing with complex or unusual cases or may have special facilities or equipment. In some instances, the animal owner may generate the request for referral.

24. This is where confusion can sometimes arise and where clients may not be clear about their options or about the different levels of expertise that might be available. Some animal owners may be confused about the difference between getting a second opinion, and referring the case to a specialist.

25. If a client asks for a second opinion, it must be made clear that a second opinion is for confirmation or review of a diagnosis only, whereas a referral to a specialist or other colleagues with more expertise will be for diagnosis and possible subsequent treatment, after which the case will be referred back to the original practice. Neither a second opinion veterinary surgeon nor a referral practice should ever seek to take over the case, unless the client chooses to change practices. In most cases, referral practices will not be in a position to accept the permanent transfer of the case.

26. A frequent criticism of the working party's consultation proposals was in relation to one of the principles originally set out in Chapter 3. This suggested that "clients should have access to the highest level of expertise for every case", and later in Chapter 9 it was suggested that, when discussing whether to refer a case, clients should be presented with a range of choices with veterinary specialist "always being the preferred route". The working party wants to make it clear that it was not its intention to suggest that every case should be referred to a specialist, nor that the
role of the general practitioner veterinary surgeon should be diminished, nor that certificate holders are not doing excellent work and should not take referrals. The principle is better expressed as clients being made aware and having access to the most appropriate expertise that is available for each case.

27. The working party acknowledges that there are many shades of complexity involved in the referral process, with issues of cost, time, availability and geographical factors involved. In some cases, referral may not be an option for many reasons. It is also recognised that there are some veterinary surgeons whose caseload is centred on particular procedures or in a narrow area of practice and referral to such “niche experts”, who may not be on the specialist list, may be an appropriate option for a given case. The key point that must be emphasised is the importance of informed client consent – and hence, as set out in the principles, the importance of trust between the veterinary surgeon and the client.

28. The RCVS’s Code of Professional Conduct (revised and agreed by RCVS Council, March 2012) now encompasses many of the above principles endorsed by the working party. There are important emphases in the new Code on animal health and welfare, on vets keeping within their area of competence, and the importance of informed client consent. Breaches of these principles in the Code may lay a veterinary surgeon open to disciplinary proceedings.

- “Veterinary surgeons must make animal health and welfare their first consideration when attending to animals.
- Veterinary surgeons must keep within their own area of competence and refer cases responsibly.
- Veterinary surgeons must provide veterinary care that is appropriate and adequate.
- Veterinary surgeons must not hold out themselves, or others, as having expertise they cannot substantiate, or call themselves or others a ‘specialist’ or similar where to do so would be misleading or misrepresentative.”

(paragraphs 1.1 – 1.3, and 3.5, Code of Professional Conduct for Veterinary Surgeons)

29. The supporting guidance published with the new Code of Professional Conduct sets out the expectations for referrals and second opinions (see Table 1). This guidance will need to be amended as indicated in the table to make reference to the new terminology for specialists and advanced practitioners, and to make it explicit that only those on the lists should describe themselves as specialists. The wording in the Code would also benefit from strengthening to make it clear that only those who are on the list may describe themselves or colleagues as specialists. The following is suggested:

“Veterinary surgeons must not hold out themselves, or others, as having expertise they cannot substantiate, or call themselves or others a ‘specialist’, or similar expression that implies specialist standing unless they have been
accredited as specialists and where to do so would be misleading or misrepresentative."

30. Nowhere within the new Code or supporting guidance does it indicate that referrals can only be made to specialists, nor does it constrain the professional clinical judgement of the primary veterinary surgeon as to when to refer, or to whom, provided the Code of Professional Conduct is followed. The Code and supporting guidance emphasises the importance of providing clients with clear information about the options available – and this must include clarity about the level of expertise available to treat the client’s animal. Whilst this point is covered by the Code, the guidance on communication and consent would benefit from strengthening to make it explicit that the veterinary surgeon should include an explanation of the level of expertise and facilities available to treat an animal within the options presented to a client.

- “Veterinary surgeons must be open and honest with clients and respect their needs and requirements.
- Veterinary surgeons must provide independent and impartial advice and inform a client of any conflict of interest.
- Veterinary surgeons must provide appropriate information to clients about the practice including the costs of services and medicines.
- Veterinary surgeons must communicate effectively with clients and ensure informed consent is obtained before treatments or procedures are carried out” (paragraphs 2.1 – 2.4, COPC)

Supporting Guidance:
- “Informed consent, which is an essential part of any contract, can only be given by a client who has had the opportunity to consider a range of reasonable treatment options, with associated fee estimates and had the significance and main risks explained to them, including the level of expertise of the treating veterinary surgeon” (para 11.1, supporting guidance)

31. The working party therefore recommends that:

a. It should continue to be a matter of professional judgement for the veterinary surgeon as to whether a case would benefit from being referred to another veterinary surgeon. RCVS should not stipulate that particular types of cases should be referred, nor should it dictate to whom they should be referred. In making such judgements, the veterinary surgeon should take account of their responsibilities set out in the Code of Professional Conduct. In particular, the supporting

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3 Terminology to be subject to market testing as described earlier.
guidance on referrals and second opinions, and on communication and informed consent will be important in this context. This guidance will need to be revised to reflect the new terminology for veterinary specialists and advanced practitioners, and to make it clear that only those on the lists should be referred to as specialists or advanced practitioners as appropriate. (The guidance with suggested amendments highlighted is reproduced below in Table 1)
Table 1 - Extract from the supporting guidance for the Code of Professional Conduct (2012) with proposed amendments

(Underlined italics indicates suggested change to wording)

### 1. Referrals and second opinions

#### Introduction

1.1 Veterinary surgeons should facilitate a client’s request for a referral or second opinion.

1.2 Referral may be for a diagnosis, procedure and/or possible treatment, after which the case is returned to the referring veterinary surgeon, whereas a second opinion is only for the purpose of seeking the views of another veterinary surgeon.

#### When to refer

1.3 Veterinary surgeons should recognise when a case or a treatment option is outside their area of competence and be prepared to refer it to a colleague whom they are satisfied is competent to carry out the investigations or treatment involved.

1.4 The referring veterinary surgeon has a responsibility to ensure that the client is made aware of the level of expertise of appropriate and reasonably available referral veterinary surgeons, for example, whether they are RCVS Recognised Specialists, European specialists or certificate holders, veterinary specialists or advanced practitioners. They must not describe a referral veterinary surgeon as a specialist, or as an advanced practitioner, unless they are accredited as such and are listed on the respective RCVS list.

1.5 Both the referring veterinary surgeon and the referral veterinary surgeon have a responsibility to ensure that the client has an understanding of the likely cost arising from the referral.

#### Referring a case

1.6 The initial contact should be made by the referring (arranging) veterinary surgeon, and the client and the referral veterinary surgeon should be asked to arrange the appointment.

1.7 The referring veterinary surgeon should provide the referral veterinary surgeon with the case history and any relevant laboratory results, radiographs, scans etc. Any further information that may be requested should be supplied promptly.

1.8 The referral veterinary surgeon should discuss the case with the client including the likely costs of the referral work and promptly report back on the case to the primary veterinary surgeon.

#### Second opinions

1.9 Veterinary surgeons should follow similar procedures for second opinions and ensure that any differences of opinion between the veterinary surgeons are discussed and explained constructively.
Specialist practices and facilities

32. Another theme that emerged from responses was the part played by the facilities and environment where specialists may be working – that it is not enough solely to look at an individual’s qualifications or status when deciding where to refer, but that specialists need access to appropriate support and equipment. Equally, it is accepted that referral to a specialist clinic, hospital or practice may not in itself ensure that the client sees a named specialist: the case may be handled by a resident or other staff in training under specialist direction or supervision. The working party of course acknowledges the link between facilities and the individuals working there, and suggests that further work is needed by the RCVS Practice Standards Group on standards for specialist practices.

33. In the meantime, however, the working party’s view is that this is still a matter of informed client consent and the facilities available will be factors to be taken into account by the referring vet when recommending to the client the most appropriate referral route for a particular type of case. The working party is not proposing a prescriptive algorithm for referrals – but rather that referring vets should be able to explain the most appropriate options to their client. The fact that cases may be seen by a resident in a referral hospital would be a factor to be taken into consideration. It is equally incumbent on the referral veterinary surgeon only to accept a case if they are satisfied that they have adequate facilities and support to deal with the case and its immediate aftercare.

34. The working party recommends that further work should be undertaken by the RCVS Practice Standards Group on standards for specialist practices.

The RCVS Diploma of Fellowship – FRCVS and Honorary FRCVS

35. The question of whether those who are accredited as specialists should also be entitled to be called Fellows of the Royal College elicited strong views both for and against. Most responses from organisations were against this proposal, as were many from existing Fellows, suggesting either that it added confusion, or that it undermined the efforts of those who had already achieved FRCVS by other means.
36. The working party is still of the view that there would be great value in increasing the Fellowship of the College to include greater numbers of clinically active veterinary surgeons who are accredited at the highest specialist level. To be accredited formally as a specialist indicates not only a high level achievement including the production of original work that is suitable for publication, but also demonstrates a continuing contribution to knowledge and leadership within the specialist field – characteristics which are entirely worthy of the title Fellow of the Royal College of Veterinary Surgeons. However, rather than propose an automatic FRCVS award upon accreditation as a specialist, as originally suggested, the working party proposes that the Honorary Fellowship title should be considered for those who have remained active on the specialist list for a number of years. This could provide an added incentive for some diplomates to join the list and keep their accredited specialist status active.

37. The working party therefore recommends that:

a. RCVS should actively promote – both to the profession and to the public - the Diploma of Fellowship as the highest award issued by the College. Achievement of the Fellowship should continue to be one of the routes for clinicians to gain veterinary specialist status. This is particularly important as RCVS phases out its Diplomas in favour of European Diplomas.

b. Further work should be undertaken by RCVS to develop additional routes to the Fellowship to make it an award that more practising clinicians can achieve. For example, the existing routes of Fellowship by Thesis, and by Meritorious Contributions to Learning, could be supplemented by a new route to recognise “meritorious contributions to clinical practice”. A working group should be formed to develop the criteria for this new route to the Fellowship with a view to producing explicit statements on the standards required for each route and guidance for examiners, in line with the level 8 descriptor. Revised byelaws will also be needed to enact these changes. Periods of clinical training under supervision should be included in the requirements.

c. Veterinary specialists who have been on the RCVS list of specialists for a continuous period of 10 years should be awarded the title of RCVS Honorary Fellow (HonFRCVS), to recognise their longstanding contribution to their specialty. This will require a change to the RCVS byelaws for the Fellowship, which currently restricts the award of Honorary Fellowships to three per year.
Promotion and publicity

38. In order to support the framework for specialisation, including the new list of advanced practitioners, RCVS must ensure that the system is well promoted and publicised, both to the profession and to the public.

39. The working party recommends that:

a. The RCVS should make the list of specialists and the list of advanced practitioners readily available and searchable through its website, and consider developing some unique branding to set these lists apart from the standard Register of Members. The lists need to be more immediately visible for the public and not just be seen as an internal reference tool for the veterinary profession.

b. The RCVS should publish some simple materials (e.g. leaflets, posters) designed for the public explaining in simple terms the various levels of veterinary qualifications and the factors to be taken into account when considering a referral. Such materials should be made readily available for veterinary practices to give to their clients.

c. In order to raise general awareness of the framework for specialisation, the RCVS should promote veterinary specialisation and the existence of the two lists on an ongoing basis, for example through published materials, news stories, press releases, at conferences and by social media as considered appropriate.

Future of the RCVS Subject Boards

40. The working party's terms of reference invited us to consider the future of RCVS's subject boards. RCVS has a number of small subject boards that to date have managed the various subject specific certificate and diploma examinations. The old style RCVS certificates managed by these boards have been phased out (last examinations 2012), together with some Diplomas, which have given way to equivalent European College Diplomas. So the main role of many of these boards is coming to an end. There will still be a need, however, for some boards to continue to manage the ongoing Diploma examinations.

41. The boards are composed of small teams of experienced RCVS Certificate and Diploma holders and examiners who have brought significant expertise to the College. This expertise will continue to be important for RCVS and could continue to be used to consider veterinary surgeons’ credentials for accreditation as a specialist
or „advanced practitioner“. It may be sensible to reconstitute these boards into a more flexible panel or panels with a wider remit than the current boards. The tasks to be undertaken would include:

- managing the remaining Diploma examinations including appointing examiners and approving enrolments
- considering applications for specialist status and applications for revalidation
- if the idea is accepted – considering applications for „advanced practitioner“ status and associated revalidation processes
- approving enrolments for the Fellowship, overseeing candidates’ progress and appointing FRCVS examiners, including the new route of „meritorious contributions to practice“
- advising the CertAVP sub-committee on subject specific issues related to the Certificate in Advanced Veterinary Practice.

42. The working party recommends that:

a. Drawing on the membership of the subject boards and other sub-committees within RCVS, a large panel – or pool of specialists and Fellows should be appointed for a rolling fixed term, from which smaller sub-groups can be brought together to advise on subject specific matters when required by the College. Credentials committees should be formed from members of the panel, according to the subject areas under consideration, to evaluate applications for specialist status and advanced practitioner status. Ideally, the panel should comprise a broad range of veterinary surgeons who themselves have been accredited as specialists and/or Fellows.
Annex 1

Terms of reference and membership of the RCVS Specialisation Working Party

Prof Sir Kenneth Calman, KCB, DL, FRCP, FRCS, FRSE (Chairman)
Mr Ralph Abercromby, MRCVS – small animal practitioner and RCVS certificate holder
Mr David Catlow, MRCVS – large animal practitioner
Dr Jerry Davies, MRCVS – small animal practitioner and former RCVS Recognised Specialist, European Specialist
Mr Richard Davis – lay member of RCVS Council and dairy farmer
Prof Tim Greet, FRCVS – equine practitioner and RCVS Recognised Specialist, European Specialist
Prof Michael Herrtage, MRCVS – academic, RCVS Recognised Specialist, European Specialist
Prof Andrea Nolan, MRCVS – academic, RCVS and European Diplomate in anaesthesia
Mr Chris Tufnell, MRCVS – mixed practice general practitioner
Ms Judith Webb MBE - lay member of RCVS Council

The membership of the working party was selected to cover a range of representative designations: practitioners from small animal, large animal and equine practice; practitioners and academics with a knowledge of specialist training in the UK and Europe; those with additional postgraduate qualifications at certificate and diploma level, and those without; those with knowledge of the RCVS Fellowship as candidate and examiner, "lay" members, and an independent chairman external to the veterinary profession but with experience of the development of the specialist hierarchy in human medicine. The working party was supported by Janet Etheridge, specialisation manager at RCVS, and Freda Andrews, Head of Education at RCVS.

Terms of Reference (agreed by RCVS Council, March 2010)

To consider the veterinary “specialist” qualifications with a view to making recommendations to Education Policy & Specialisation Committee for a simplified structure for possible inclusion in new legislation and/or a new Charter. Specifically, the working party should consider the following:

- seek to define the term specialist in the context of cognate professions, UK custom and practice, as well as against the wider EU legal definitions
- the operation of the current RCVS list of Recognised Specialists and what arrangements are needed to meet the future needs and diversity of the profession and its clients
- whether there is scope for greater and faster harmonisation of RCVS Diplomas with European College Diplomas
• the place of the RCVS Fellowship within RCVS’s framework of qualifications, and whether there is a need for new, different or alternative routes to the RCVS Fellowship
• the future role and structure of subject boards:– what is the most appropriate structure to provide the College with access to advice on matters relating to species, subjects, disciplines; as well as subject specific advice on certificate module development & assessment, Fellowship and Specialist applications
• in the light of recommendations the working party makes about specialists, the amendments that will be needed to the Guide to Professional Conduct
• whether RCVS should pursue powers to establish a statutory register of specialists

In making its recommendations, the working party should identify which, if any, could be implemented on a voluntary basis or under RCVS’s current legislative framework.
Annex 2

Level definitions for RCVS Certificate, Diploma and Fellowship

Diplomas and RCVS Fellowship – leading to Specialist status

The definition below is adapted from the Quality Assurance Agency’s level descriptor for doctoral degrees.

RCVS Diplomas and Fellowships are awarded to veterinary surgeons who have advanced training in the specialty and have contributed significantly to the development of the specialty by teaching, research or practice.

RCVS Diplomates and Fellows will have demonstrated:

- a high level of competency through teaching, research or practice in the specialty
- acquisition and understanding of a substantial body of knowledge which is at the forefront of the area of veterinary professional practice
- the ability to apply high level knowledge and skills at the forefront of the specialist area to their own professional work
- a high level of clinical expertise in their specialty area including the ability to deal with non-routine and complex cases
- the creation and interpretation of new knowledge, through original research or clinical studies, of a quality to satisfy peer review, extend the forefront of the discipline or area of professional practice, and merit publication
- a detailed understanding of applicable techniques for research and clinical enquiry, including ability to design and implement a project for the generation of new knowledge, clinical methodologies and techniques at the forefront of the professional area.

Typically, holders of the Diploma and Fellowship will be able to:

- make informed judgements on complex issues in their specialist field, often in the absence of complete data, and be able to communicate their ideas and conclusions clearly and effectively to specialist and non-specialist audiences, including clients
• continue to undertake research and/or clinical studies in their field at an advanced level, contributing substantially to the development of new knowledge, techniques, ideas or approaches in the specialty.

• Achievement of this level of qualification would usually only be achieved after a considerable number of years experience of working in the veterinary profession.

Route to Diplomas and Fellowships:

• RCVS Diploma holders will have undertaken a programme of advanced level training under the supervision of another Diplomate. They will have passed an examination in their specialty area testing their knowledge, clinical and practical skills and will have presented either a dissertation or published papers as evidence of their original research.

• RCVS Fellows will have chosen their own field of study for their dissertation which must demonstrate all the characteristics outlined above.

• Alternatively, the Fellowship can be awarded for “Meritorious Contributions to Learning” upon examination of a collection of original work over a 15 year period, which overall must satisfy the above criteria.

Certificate In Advanced Veterinary Practice

This is the agreed definition for the level of the CertAVP upon which all assessments are based. It was adapted from the Quality Assurance Agency’s benchmark for university Masters level qualifications.

Candidates need to demonstrate:

• a thorough understanding of the knowledge base and a critical awareness of developments at the forefront of their area of professional practice;

• a comprehensive understanding of techniques applicable to their own area of practice;

• originality in the application of knowledge, together with a practical understanding of how established techniques of research and clinical enquiry are used to create and interpret knowledge in their professional area;

• conceptual understanding that enables them to
  – evaluate critically current literature and research in their professional area and
  – evaluate clinical methodologies and techniques, and develop critiques of them and, where appropriate to propose new approaches to professional practice.

Typically, holders of the qualification will be able to:
• deal with complex issues in an organised and creative manner, make sound judgments in the absence of complete data, and communicate their conclusions clearly to veterinary colleagues and to non-veterinary audiences, including clients;
• demonstrate self direction and originality in tackling and solving problems, and act autonomously in planning and implementing tasks in their professional area of work;
• continue to advance their knowledge and understanding, and to develop new skills to a high level;

and will have the qualities and transferable skills necessary for professional veterinary work requiring:

• the exercise of initiative and personal responsibility;
• decision-making in complex and unpredictable situations; and
• the independent learning ability required for continuing professional development.
Annex 3

Individuals and organisations that responded to the consultation

The responses will be available to read in full, through a link on the RCVS website, except where respondents have asked for their comments not to be published. Some respondents asked for their names to be withheld and these are accordingly not included in the lists below.

List of organisations and groups that responded to the consultation:

Amlin Plus
Association of Veterinary Specialist Practitioners
Association of Veterinary Anaesthetists
British Cattle Veterinary Association
British Equine Veterinary Association
British Small Animal Veterinary Association
British Veterinary Association
British Veterinary Hospitals Association
British Veterinary Nursing Association Council
British Veterinary Union
European Board of Veterinary Specialisation
Edinburgh Small Animal clinicians
Goat Society
Improve International
Kennel Club
National Farmers Union
North Downs Specialist Referrals
Peoples Dispensary for Sick Animals
Society of Practising Veterinary Surgeons
The World Association for Transport Animal Welfare Studies (TAWS)
Veterinary Defence Society
Veterinary Cardiology Board
Veterinary Ophthalmology Board
Veterinary Public Health Board

Two organisations asked to remain anonymous.
**List of individuals who responded to the consultation**

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<td>Keesjan Cornelisse</td>
<td>Adam Hargreaves</td>
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<td>Marco Duz</td>
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Yvonne McGrotty
Malcolm McKee
Pauline McNeil
Nicci Meadows
Fraser Menzies
Andrew Miller
Marni Miller
Jon Mills
Andy Moores
Tim Morris
Shane Morrison
Liz Mossop
Kate Murphy
Sue Murphy
Prue Neath
Melanie Norris
Graham Oliver
Mark Owen
John Parker
Kevin Parsons
Bob Partridge
Sue Paterson
Brian Patterson
Mark Payne Johnson
Robin Peal
Chiara Penzo
Patrick Pollock
Jonathan Prior
Jock Queen
Ian Ramsey
Nikki Reed
Alasdair Renwick
Joan Rest
Wynne Richards
Patrick Ridge
Chris Riggs
Veronica Roberts
Tom Robertson
Matthew Robin
Andrew Robinson
Simon Roch
Paul Roger
Peter Rossdale
Eric Rouviere-Almazan
Victoria Rudolph
Clare Rusbridge
Scott Rutherford
Jane Sansom
Neil Sargison
Tobias Schwarz
Peter Scott
Phil Scott
Cheryl Scudamore
Chris Shales
Stephen Shaw
Susana Silva
Geoff Skerritt
Tim Skerry
Alistair Smith
Kent Smith
Matt Smith
Paul Smith
Sionagh Smith
Mary Stallbaumer
Paul Stevenson
Mark Straw
Kit Sturgess
William Swann
Simon Swift
Hannes Tanzer
Severine Tasker
Bruce Tatton
Des Thompson
Colin Thomson
Andy Torrance
Sandy Trees
Chris Trickey
Phil Tricklebank
Rachel Tucker
Glenys Vaughan
Lorenzo Viora
Chris Vogt
John Walmsley
Sheena Warman
Sarah Warren
Charlotte Whatmough
Helena White
Colin Whiting
Lizzy Whiting
Andrew Whittingham
Roger Wilkinson
Ruth Willis
Anna Willmott
Jeremy Wills
Hamish Wilson
Neil Wilson
Roger Wilson
Agnes Winter
Paul Wotton

A further 25 individuals asked to remain anonymous.
Extract from Advisory Committee Minutes

25 September 2012

Specialisation Working Party

1. The Chairman introduced the paper, indicating that the Committee has been asked to approve in principle the amendments to the Code of Professional Conduct and supporting guidance following the recommendations from the Specialisation Working Party, as approved by RCVS Council. The Committee considered the report of the Working Party as well as the additional recommendations arising from Council.

2. Attention was drawn to the report of the Specialisation Working Party, Table 1 - Extract from the supporting guidance to the Code of Professional Conduct (2012) with proposed amendments, paragraph 1.6 which has been amended to say that the initial contact should be made by the arranging veterinary surgeon and the referral veterinary surgeon should be asked to arrange the appointment.

3. Particular attention was also drawn to paragraph 39 (c) of the report, which states ‘in order to raise general awareness for the framework of specialisation, the RCVS should promote veterinary specialisation and the existence of the two lists on an ongoing basis, for example through published materials, news stories, press releases, at conferences, and by social media as considered appropriate’. It was suggested that while it is appropriate to raise awareness for the new specialisation scheme, it might not be appropriate to promote one practitioner at the expense of another.

4. There was discussion of paragraph 25 of the report, which deals with the difference between a second opinion and a referral. There was agreement that neither a second opinion nor a referral practice should seek to take over a case; however, the client should still retain freedom to change practices. The Committee noted that a member of RCVS Council highlighted that this reference has been removed from the current Code of Professional Conduct and supporting guidance. It was explained that this paragraph had been included in previous guidance, but appeared to have been omitted during the introduction of the new Code of Professional Conduct. The Committee agreed that this advice should be reintroduced when the revisions to the Code and supporting guidance arising from the Specialisation Working Party are carried out.

5. The Committee considered the recommendation from Council as to whether the terminology concerning second opinion referrals could be reviewed to better improve the public’s understanding. It was suggested that the advice could be amended to say that differences of opinion should be discussed and explained constructively to the client. It was suggested that this may help improve the public’s understanding.

6. There was discussion of recommendation 29 of the Specialisation Working Party, which suggests strengthening the wording of professional responsibility 3.5 of the Code to reflect the new terminology and lists for specialists and advanced practitioners. It was suggested that the
reference to accreditation be removed. However, it was noted that this is required to reflect the new position that veterinary surgeons must not call themselves or others ‘specialists’ or similar expressions that imply specialist standing unless they have been accredited as specialists by the RCVS. It was agreed in principle that the amendments in the recommendation were appropriate subject to the word ‘and’ in the 3rd line replaced with a comma for clarity.

7. The Committee agreed in principle with the recommendations of the Specialist Working Party. There was agreement that this should be further reviewed once the mechanisms for accrediting advanced practitioners are implemented.
Previously agreed changes to the Code and Supporting Guidance

(New text in red)
(Deleted text in strikethrough)

Code of Professional Conduct

3. Veterinary surgeons and the profession

3.5 Veterinary surgeons must not hold out themselves, or others, as having expertise they cannot substantiate, or call themselves or others a ‘specialist’, or similar expression that implies specialist standing unless they have been accredited as specialists, where to do so would be misleading or misrepresentative.

Supporting Guidance

1. Referrals and second opinions

Introduction

1.1 Veterinary surgeons should facilitate a client’s request for a referral or second opinion.

1.2 A referral may be for a diagnosis, procedure and/or possible treatment, after which the case is returned to the referring veterinary surgeon, whereas a second opinion is only for the purpose of seeking the views of another veterinary surgeon. Neither a second opinion veterinary surgeon nor a referral practice should ever seek to take over the case, unless the client chooses to change practices.

When to refer

1.3 Veterinary surgeons should recognise when a case or a treatment option is outside their area of competence and be prepared to refer it to a colleague whom they are satisfied is competent to carry out the investigations or treatment involved.

1.4 The referring veterinary surgeon has a responsibility to ensure that the client is made aware of the level of expertise of appropriate and reasonably available referral veterinary surgeons, for example, whether they are RCVS Recognised Specialists, European specialists or certificate holders, veterinary specialists or advanced practitioners. They must not describe a referral veterinary surgeon as a specialist, or as an advanced practitioner, unless they are accredited as such and are listed on the respective RCVS list.

1.5 Both the referring veterinary surgeon and the referral veterinary surgeon have a responsibility to ensure that the client has an understanding of the likely cost arising from the referral.
Referring a case

1.6 The initial contact should be made by the referring veterinary surgeon, and the client and the referral veterinary surgeon should be asked to arrange the appointment.

1.7 The referring veterinary surgeon should provide the referral veterinary surgeon with the case history and any relevant laboratory results, radiographs, scans etc. Any further information that may be requested should be supplied promptly.

1.8 The referral veterinary surgeon should discuss the case with the client including the likely costs of the referral work and promptly report back on the case to the primary veterinary surgeon.

Second opinions

1.9 Veterinary surgeons may follow similar procedures for second opinions and should ensure that any differences of opinion between the veterinary surgeons are discussed and explained constructively.

11. Communication and consent

Informed consent

11.1 Informed consent, which is an essential part of any contract, can only be given by a client who has had the opportunity to consider a range of reasonable treatment options, with associated fee estimates, and had the significance and main risks explained to them.

Client relationship

11.2 The client may be the owner of the animal, someone acting with the authority of the owner, or someone with statutory or other appropriate authority. Care should be taken when the owner is not the client. Practice staff should ensure they are satisfied that the person giving consent has the authority to provide consent. The provision of veterinary services creates a contractual relationship under which the veterinary surgeon and/or veterinary nurse should:

a. ensure that clear written information is provided about practice arrangements, including the provision, initial cost and location of the out-of-hours emergency service, and information on the care of in-patients;
b. take all reasonable care in using their professional skills to treat animal patients;
c. keep their skills and knowledge up to date;
d. keep within their own areas of competence, save for the requirement to provide emergency first aid;
e. maintain clear, accurate and comprehensive case records and accounts;
f. ensure that a range of reasonable treatment options are offered and explained, including prognoses and possible side effects;
g. give realistic fee estimates based on treatment options;
h. keep the client informed of progress, and of any escalation in costs once treatment has started;
i. obtain the client's consent to treatment unless delay would adversely affect the animal's welfare (to give informed consent, clients must be aware of risks) (see 'Consent forms specimens' in the 'Related documents' box on the right-hand side);
j. ensure that all staff are properly trained and supervised where appropriate;
k. ensure that the client is made aware of any procedures to be performed by practice staff who are not veterinary surgeons;
l. recognise that the client has freedom of choice; and,
m. when referring a case, ensure that the client is made aware of the level of expertise of the referral veterinary surgeon

Communication

11.3  Veterinary surgeons and veterinary nurses should seek to ensure that what both they and clients are saying is heard and understood on both sides, and encourage clients to take a full part in any discussion. Veterinary surgeons and veterinary nurses should use language appropriate for the client and explain any clinical or technical terminology that may not be understood. Usually, the veterinary surgeon or veterinary nurse will have to be able to speak the English language to an appropriate standard. If there is any doubt about the client’s consent, efforts should be made to resolve this, which are then recorded.

11.4 Where the client’s ability to understand is called into question, veterinary surgeons and veterinary nurses will need to consider whether any practical steps can be taken to assist the client’s understanding. For example, consider whether it would be useful for a family member or friend to be present during the consultation. Additional time may be needed to ensure the client has understood everything and had an opportunity to ask questions.

11.5 If the client’s consent is in any way limited, or qualified, or specifically withheld, this should be recorded on the clinical records; veterinary surgeons and veterinary nurses must accept that their own preference for a certain course of action cannot override the client’s specific wishes, other than on exceptional welfare grounds.

11.6 Provision should be made for uncertain or unexpected outcomes. Clients should be asked to provide contact telephone numbers to ensure discussions can take place at short notice. Provision for the veterinary surgeon or veterinary nurse to act without the client’s consent if necessary in the interests of the animal should also be considered.

11.7 When arrangements have been made to bring an animal under the Animals (Scientific Procedures) Act 1986 for experimental investigation, the client should be made aware of the general provisions of the Act so that informed consent can be given.

11.8 When an animal is enrolled on a clinical trial, the client should be made aware of the general provisions of Good Clinical Practice and be supplied with any other relevant information, such as ethical guidelines and relevant contact details, so that informed consent can be given.

11.9 Practice staff may be the first to become aware of any misunderstanding by clients concerning a procedure or treatment. Veterinary surgeons and veterinary nurses should advise practice staff to communicate any concerns to the senior veterinary surgeon and ensure that the client is kept fully informed.

11.10 Veterinary surgeons and veterinary nurses in the veterinary team and different practices should be encouraged to work together to ensure effective communication with clients and with each other.

Discussion of fees

11.11 Discussion should take place with the client, covering a range of reasonable treatment options and prognoses, and the likely charges (including ancillary or associated charges, such as those for medicines/anaesthetics and likely post-operative care) in each case so as to ensure that the client is in a
position to give informed consent. The higher the fee, the greater is the necessity for transparency in the
giving of detailed information to the client.

11.12 It is wise for any estimate to be put in writing, or on the consent form, and to cover the approximate
overall charge for any procedure or treatment including VAT, pre- and post-operative checks, any
diagnostic tests, etc. The owner should be warned that additional charges may arise if complications
occur. If a quote is given, it may be binding in law.

11.13 If the animal is covered by pet insurance, it is in the interests of both veterinary surgeon and client
to confirm the extent of the cover under the policy, including any limitations on cost or any exclusions
which would apply to the treatment proposed.

11.14 If, during the course of treatment, it becomes evident that an estimate or a limit set by the client is
likely to be exceeded, the client should be contacted and informed so that consent to the increase may be
obtained. This should be recorded in writing by the veterinary surgeon.

Public health

11.15 Veterinary surgeons should inform clients and others as appropriate, of any human health care
implications arising from the condition, care, tests or treatment of animals, particularly those who may be
more at risk.

Young persons and children

11.16 Persons under the age of 18 are generally considered to lack the capacity to make binding
contracts. They should not be made liable for any veterinary or associated fees.

11.17 Persons under the age of 16 should not be asked to sign a consent form. Where they have
provided a signature, parents or guardians should be asked to countersign.

11.18 Where the person seeking veterinary services is 16 or 17 years of age, veterinary surgeons
should, depending on the extent of the treatment, the likely costs involved and the welfare implications for
the animal, consider whether consent should be sought from parents or guardians before the work is
undertaken.

11.19 Particular care should be taken when the treatment involves issues of health and safety, as for
supplying Controlled Drugs (within the meaning of the Misuse of Drugs Act 1971) to anyone under the
age of 18.

Consent forms

11.20 Consent forms may be used to record agreement to carry out specific procedures. They form part
of the clinical records. If any amendments are made subsequently, these should be made in ink, initialled
and dated and a note of subsequent conversations recorded on the clinical records.

11.21 For routine procedures, information leaflets can be useful to explain to clients what is involved with
a specific procedure, anaesthesia, expected outcome, after care etc. Clients should be given an
opportunity to consider this information before being asked to sign a consent form. Use of information
sheets should be encouraged, but should not be used as a substitute for discussions with individual
clients.

11.22 A copy of the form should be provided to the person signing the form unless the circumstances
render this impractical. The RCVS Practice Standards Scheme Manual provides that for ‘General
Practice’, signed consent forms are required for all procedures including diagnostics, medical treatments, surgery, euthanasia and when an animal is admitted to the care of a veterinary surgeon.

11.23 Specimen consent forms are available to download in the ‘Related documents’ box on the right-hand side.

**Mental incapacity**

11.24 The Mental Capacity Act 2005 (applicable in England and Wales) states: ‘A person lacks capacity in relation to a matter if at the material time he is unable to make a decision for himself in relation to the matter because of an impairment of, or a disturbance in the functioning of, the mind or brain. It does not matter whether the impairment or disturbance is permanent or temporary.’ The Adults with Incapacity (Scotland) Act 2000 provides that incapable persons are those aged 16 or over who lack one or more of: the capacity to act, make decisions, communicate decisions, understand decisions or retain the memory of decisions by reason of mental disorder or of inability to communicate because of physical disability. However, a person is not incapable only because of a lack of, or deficiency in, a faculty of communication if it can be made good by human or mechanical aid. There is currently no primary legislation dealing with mental incapacity in Northern Ireland.

11.25 Where it appears a client lacks the mental capacity to consent, veterinary surgeons should try to determine whether someone is legally entitled to act on that person’s behalf, such as someone who may act under an enduring power of attorney. If not, veterinary surgeons should act in the best interests of the animal and seek to obtain consent from someone close to the client, such as a family member who is willing to provide consent on behalf of the person.

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### 23. Advertising and publicity

**Introduction**

23.1 Publicity and advertising may involve many forms with the aim of providing information to others. Veterinary surgeons and veterinary nurses should ensure that publicity and advertising informs the general public and clients without exploiting their lack of veterinary knowledge.

23.2 All publicity should comply with the *British Code of Advertising, Sales Promotion and Direct Marketing*.

23.3 Any publicity should not be of a character likely to bring the profession into disrepute, eg unsolicited approach by telephone or visit, nor must it compromise the clinical care of animals.

**Specialist claims**

23.4 Veterinary surgeons must not hold out themselves or others as having expertise they cannot substantiate, or call themselves or others a ‘specialist’ or similar expression that implies specialist standing unless they have been accredited as specialists. where to do so would be misleading or misrepresentative.

**Medicines**
23.5 The legal restrictions on advertising medicines and publishing medicine prices are set out in the Veterinary Medicines Regulations and associated guidance.

Public life and interaction with the media

23.6 Veterinary surgeons and veterinary nurses can make a worthwhile contribution to the promotion of animal welfare and responsible pet ownership by taking part in public life, whether in national or local politics, community service, or involvement with the media (including press, television, radio or the internet).

23.7 In commenting to the media, veterinary surgeons and veterinary nurses should ensure they distinguish between personal opinion, political belief and established facts.

23.8 A veterinary surgeon or veterinary nurse should be careful not to express, or imply, that his or her view is shared by their respective profession, unless previously authorised, for example, by the RCVS, British Veterinary Association, British Veterinary Nursing Association or other professional body.

Endorsement

23.9 A veterinary surgeon or veterinary nurse should not endorse a veterinary product or service.

23.10 Endorsement of a product or service may take many forms, for example, celebrity endorsement, where the reputation of the veterinary surgeon or veterinary nurse is linked with the product or service; and/or professional, where the professional qualification is associated with the product or service.

23.11 Endorsement can be explicit or implicit, imperative or co-presentational.

23.12 Veterinary products and services may include the supply or prescription of medicines, the diagnosis of disease, the treatment and tests of animals, vaccination services and other activities that may be described as part of the practice of veterinary surgery. In addition, there are a number of retail products that may be sold by veterinary surgeons or veterinary nurses which may not be readily regarded as veterinary products or services, but when associated with, or sold by, veterinary surgeons or veterinary nurses may be regarded as ‘veterinary’ products, particularly if specific veterinary advice is given. These may include nutritional supplements, shampoos, dog leads, chewy toys and pet foods, including prescription diets.

23.13 Veterinary surgeons and veterinary nurses may endorse non-veterinary products and services, provided such endorsement does not bring the profession into disrepute.

Claims of general veterinary approval

23.14 An organisation claiming ‘general’ veterinary approval for a product or service has particular significance for veterinary surgeons or veterinary nurses employed by the organisation, which, for example, may be promoting its own range of veterinary products. The organisation will need to be able to justify any such claims made, for example, by market research. Any such endorsement should not erode the clinical freedom of individual veterinary surgeons or veterinary nurses employed by, or associated with, the organisation, or imply that veterinary surgeons or veterinary nurses employed or associated with the organisation endorse a veterinary product or service.
<table>
<thead>
<tr>
<th>Meeting</th>
<th>Standards Committee</th>
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<tr>
<td>Date</td>
<td>1 May 2014</td>
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<tr>
<td>Title</td>
<td>Veterinary Nurses and the practice of veterinary surgery</td>
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<tr>
<td>Classification</td>
<td>Unclassified</td>
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<tr>
<td>Summary</td>
<td>VN Council has asked for a review of veterinary nursing roles in relation to anaesthesia. If it were generally agreed that veterinary nurses should be able to induce and maintain anaesthesia under veterinary direction, amendments to current legislation would be required. This paper considers what changes may be desirable to paragraphs 6 and 7 of Schedule 3 to the Veterinary Surgeons Act, which allow veterinary nurses to practise veterinary surgery within certain limits. This paper presents two possible approaches to amending the legislation.</td>
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<td>Decisions required</td>
<td>The Standards Committee is asked to note the proposals, which will be considered by the Veterinary Nurses’ Council on 6 June 2014. If the Veterinary Nurses’ Council supports this proposition, it will be necessary to secure the endorsement of the RCVS Council.</td>
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<tr>
<td>Attachments</td>
<td>Annex A: Report on the practical aspects of anaesthesia</td>
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<tr>
<td>Author</td>
<td>Jeff Gill</td>
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<td>Policy Consultant</td>
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<td><a href="mailto:j.gill@rcvs.org.uk">j.gill@rcvs.org.uk</a></td>
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Practice of veterinary surgery by veterinary nurses: possible changes to Schedule 3 to the Veterinary Surgeons Act 1966

Introduction

1. This note considers what changes may be desirable to paragraphs 6 and 7 of Schedule 3 to the Veterinary Surgeons Act, which allow veterinary nurses to practise veterinary surgery within certain limits.

Background

2. Section 19 of the Act says that only registered veterinary surgeons shall practise veterinary surgery; but subject to a number of exceptions. One of the exceptions, in section 19(4)(b), is that a person other than a veterinary surgeon may do anything which is specified in Part I of Schedule 3 to the Act and not excluded by Part II of the Schedule.

Part I of Schedule 3: permitted procedures

3. Part I of the Schedule includes the following paragraphs:

"6. Any medical treatment or any minor surgery (not involving entry into a body cavity) to any animal by a veterinary nurse if the following conditions are complied with, that is to say—

(a) the animal is, for the time being, under the care of a registered veterinary surgeon or veterinary practitioner and the medical treatment or minor surgery is carried out by the veterinary nurse at his direction;

(b) the registered veterinary surgeon or veterinary practitioner is the employer or is acting on behalf of the employer of the veterinary nurse; and

(c) the registered veterinary surgeon or veterinary practitioner directing the medical treatment or minor surgery is satisfied that the veterinary nurse is qualified to carry out the treatment or surgery.

In this paragraph and in paragraph 7 below—

“veterinary nurse” means a nurse whose name is entered in the list of veterinary nurses maintained by the College.

7. Any medical treatment or any minor surgery (not involving entry into a body cavity) to any animal by a student veterinary nurse if the following conditions are complied with, that is to say—

(a) the animal is, for the time being, under the care of a registered veterinary surgeon or veterinary practitioner and the medical treatment or minor surgery is carried out by
the student veterinary nurse at his direction and in the course of the student veterinary nurse’s training;

(b) the treatment or surgery is supervised by a registered veterinary surgeon, veterinary practitioner or veterinary nurse and, in the case of surgery, the supervision is direct, continuous and personal; and

(c) the registered veterinary surgeon or veterinary practitioner is the employer or is acting on behalf of the employer of the student veterinary nurse.

In this paragraph—

“student veterinary nurse” means a person enrolled under bye-laws made by the Council for the purpose of undergoing training as a veterinary nurse at an approved training and assessment centre or a veterinary practice approved by such a centre;

“approved training and assessment centre” means a centre approved by the Council for the purpose of training and assessing student veterinary nurses.”

Part II of Schedule 3: excluded procedures

4. Part II of the Schedule is as follows:

"Nothing in section 19(4)(b) of this Act shall authorise—

(a) the castration of a male animal being—

(i) a horse, pony, ass or mule,

(ii) a bull, boar or goat which has reached the age of two months,

(iii) a ram which has reached the age of three months, or

(iv) a cat or dog;

(b) the spaying of a cat or dog;

(c) the removal (otherwise than in an emergency for the purpose of saving life or relieving pain or suffering) of any part of the antlers of a deer before the velvet of the antlers is frayed and the greater part of it has been shed;

(d) the desnooding of a turkey which has reached the age of 21 days;

(e) the removal of the combs of any poultry which have reached the age of 72 hours;
(f) the cutting of the toes of a domestic fowl or turkey which has reached the age of 72 hours;

(g) the performance of a vasectomy or the carrying out of electro-ejaculation on any animal or bird kept for the production of food, wool, skin or fur or for use in the farming of land;

(h) the removal of the supernumerary teats of a calf which has reached the age of 3 months; or

(i) the dehorning or disbudding of a sheep or goat, except the trimming of the insensitive tip of an ingrowing horn which, if left untreated, could cause pain or distress."

5. Thus the medical treatment or minor surgery which veterinary nurses are allowed to carry out under paragraph 6 or 7 does not include any of the specific procedures mentioned in the list. That is why veterinary nurses cannot castrate or spay cats or dogs.

History

6. The provisions relating to veterinary nurses were not originally part of the Act. Section 19(5), however, gives power for the making of Ministerial orders amending Schedule 3. Such orders are subject to affirmative procedure, that is, they have to be approved by a resolution in each House of Parliament. Following the report of the Page Committee in 1990 on its review of veterinary manpower and education MAFF consulted on proposals to enlarge the role of veterinary nurses, and the outcome was SI 1991/1412. This amended the Schedule so as to allow listed veterinary nurses to treat companion animals, subject to similar restrictions to those which apply now. Eleven years later, SI 2002/1479 removed the reference to companion animals and also provided for student veterinary nurses to practise under supervision.

Reasons for considering changes

7. Paragraphs 6 and 7 of the Schedule both use a verbal formula - "any medical treatment or any minor surgery (not involving entry into a body cavity)" - to define the permitted scope of a veterinary nurse. The trouble is that the meaning of any such formula is open to debate. There has in fact been considerable discussion in the past of what counts as "minor surgery" - for example in the context of dental procedures - and what is a body cavity. Any attempt to draw a line which a veterinary nurse should not cross is liable to be controversial, but the debate ought to concern substantive issues, not the meaning of words.

8. One question which has been much discussed over the years is the involvement of veterinary nurses in the induction and maintenance of anaesthesia. The College has taken the line that Schedule 3 does not put them in any special position on this: so far as the law is concerned, they can only do whatever would be lawful for any other non-veterinarian. Recent legal advice has confirmed that the induction or maintenance of anaesthesia is not "treatment" (except in a minority of cases where anaesthesia is carried out as an end in itself rather than as an adjunct to treatment). But the reality, as discussed in the attached note, seems to be that veterinary
surgeons are in practice likely to delegate to veterinary nurses the responsibility for maintaining anaesthesia by observing the relevant clinical signs and adjusting the dose as required. It would seem difficult for a veterinary surgeon carrying out a procedure of any complexity to take responsibility for the maintenance of anaesthesia at the same time. The note points out that veterinary nurses are trained to carry out this function.

Possible approaches

9. If it were generally agreed that veterinary nurses should be able to induce and maintain anaesthesia under veterinary direction, one way to do this would be to tack suitable words on to the formula in Schedule 3. It might, say, allow "any medical treatment or any minor surgery (not involving entry into a body cavity) or the induction or maintenance of anaesthesia". If this were thought to go too far, words could be added to clarify that any induction or maintenance of anaesthesia should only be carried out under direct, continuous and personal supervision of the registered veterinary surgeon or practitioner who has prescribed an anaesthetic protocol for the animal. This however is adding a lot of detail to the Act and if a new procedure were brought into use that did not fit the formula, and it were agreed that veterinary nurses should be able to do it, it would be necessary to add some more words. The longer the specification of the permitted scope of veterinary nurses became, the harder it would be to argue that there was any flexibility at all. Veterinary surgeons have always been advised to consider what can appropriately be delegated to a veterinary nurse, taking into account the training and experience of the individual concerned, and the College declines to publish a list of all the procedures it thinks a veterinary nurse should be able to carry out. It would be a pity to insert just such a list into Schedule 3.

10. In considering other ways forward it is relevant to consider how the provisions about veterinary nurses in Schedule 3 sit with the other contents of Part I of the Schedule. It says that -

- the owner of any animal, or a member of the owner's household or an employee, can give it minor medical treatment;

- owners of farm animals, and persons engaged or employed in caring for farm animals, can give them medical treatment or carry out minor surgery (not involving entry into body cavity), so long as this is not done for reward;

- anyone can give first aid in an emergency to save life or relieve pain or suffering;

- any adult can castrate or caponise any male animal (subject to the restrictions in Part II of the Schedule), or dock the tail of a lamb, or amputate a dog's dew claws before its eyes are open;

- agricultural students aged 17 or over can carry out those same procedures, and disbud calves, under under the direct personal supervision of a veterinary surgeon or instructor.

11. So, setting to one side the provisions about young agricultural students, who not surprisingly can only carry out surgical procedures under supervision, the Schedule allows various things, including surgical procedures, to be done to animals without any veterinary involvement. Farm animals are liable to receive medical treatment or minor surgery not involving entry into body
cavity - the same formula which applies to veterinary nurses - from an untrained lay person, without veterinary direction or supervision. Yet qualified veterinary nurses can only give such treatment or carry out such surgery under the direction of an employing veterinary surgeon who has the animal under his or her care. Student veterinary nurses are subject to the same conditions, and in addition must be supervised. Any surgery carried out by a student nurse must be subject to direct, continuous and personal supervision.

12. There are historical reasons for this disparity. The Veterinary Surgeons Act 1948, which took the first step toward reserving the practice of veterinary surgery to veterinary surgeons, provided for this monopoly to be heavily qualified. An animal's owner could give it any treatment, and any adult engaged or employed in agriculture could do anything at all to a farm animal, apart from certain specified procedures. At that time of postwar recovery the Government and Parliament would no doubt have been reluctant to set tight limits on DIY veterinary care. Attitudes must have changed by the time of the 1966 Act, but the provisions of Schedule 3 still seem to imply that farmers should be free to give their animals routine healthcare without bringing in the veterinary profession. When, however, the Schedule was amended in 1991 it was thought necessary for trained veterinary nurses to act under the direction of an employing veterinary surgeon when giving medical treatment or carrying out minor surgery. The result does not make a lot of sense, when the Schedule is considered as a whole.

13. It may reasonably be argued that the provisions concerning veterinary direction for veterinary nurses are right as they stand, and that the rest of the Schedule ought to be reconsidered. It may also be observed that veterinary direction does not necessarily imply close oversight. A veterinary nurse who works within the terms of a protocol laid down by an employing veterinary surgeon who has the relevant animals under his or her care falls within the terms of the Schedule, even if the directing veterinary surgeon never personally sees the veterinary nurse at work. The veterinary profession might have reservations about changes in Schedule 3 which could be seen as opening the way to the delivery of veterinary care by veterinary nurses with only the nominal involvement of a veterinary surgeon. Whatever the merits of such arguments may be, it is perhaps realistic to look for ways to change the nursing provisions of the Schedule without disturbing what it says about veterinary direction and supervision.

A minimalist approach

14. The simplest way forward would be to remove the references to medical treatment and minor surgery in paragraphs 6 and 7. On reflection it is already anomalous that paragraph 6 restricts the scope of a qualified veterinary nurse in this way, given the requirement that the directing veterinary surgeon must be "satisfied that the veterinary nurse is qualified to carry out the treatment or surgery".

15. That requirement was added when the Schedule was amended in 2002, for a particular reason. Part of the object at that time was to enable veterinary nurses to treat animals other than companion animals, but there was some nervousness about simply removing that restriction without putting anything in its place. The solution was to allow nurses to treat animals of any species, provided they were trained to do so. The wording adopted went rather wider than that, however, in that it required the directing veterinary surgeon to be satisfied that the veterinary nurse was qualified to give the treatment in question, whatever it might be.
16. Now that that requirement is in place, it is hard to see any reason for the Act to specify which aspects of veterinary surgery a veterinary nurse may undertake. If a veterinary surgeon who has the relevant animal under his or her care thinks fit to direct a veterinary nurse to undertake a particular veterinary procedure or activity, and is satisfied that he or she is qualified to do so, that ought to be a sufficient safeguard. The veterinary surgeon will be answerable for that decision; and any registered veterinary nurse will be answerable in his or her own right for the action taken. The revised Royal Charter which the College proposes to seek would mean that all listed veterinary nurses became registered and subject to supervision of their professional conduct.

Next steps

17. The Standards Committee is asked to note the proposals, which will be considered by the Veterinary Nurses’ Council on 6 June 2014. If the Veterinary Nurses’ Council supports this proposition, it will be necessary to secure the endorsement of the RCVS Council.

18. If the College decided to seek a change in the Schedule it would be necessary to invite DEFRA to make an order for the purpose. The Department might well be sympathetic, having traditionally been inclined to favour broadening access to veterinary services, though it might also think it necessary to consider a general updating of the Schedule. That would imply a considerably bigger exercise, with wide public consultation.
Summary of information received from a specialist in veterinary anaesthesia regarding the practical aspects of anaesthesia

The Premedication (‘Premed’): Usually an intramuscular injection of a combination of the following drugs (all licensed in small animals):

- Methadone, buprenorphine, butorphanol, or pethidine
- Acepromazine, medetomidine or dexmedetomidine
- Ketamine

The premed is given at a defined dose; licensed dose ranges exist and can be accessed in documents such as the British Small Animal Veterinary Association (BSAVA) formulary or drug company marketing material. Typically practices develop their own standardised drug combinations and doses, which are used as the default for the majority of healthy patients undergoing elective procedures. The aim of the premed is to produce a state of sedation, but not general anaesthesia.

Anaesthesia induction: The drugs that are licensed for anaesthetic induction in small animals are propofol and alfaxolone. These are administered intravenously, often via an intravenous catheter. The aim of the induction agent is to induce a state of general anaesthesia, usually to the level at which the trachea (windpipe) can be intubated (a tube placed). Estimated dose ranges to produce this effect can be accessed in veterinary formularies as well as in the product information; however the exact dose required will vary between individuals.

Anaesthetic maintenance: A state of anaesthesia can be maintained by continuous or repeated injection of the induction agent (alfaxolone is licensed for this use and dose rates are provided), however it is much more usual to maintain general anaesthesia using a volatile (‘gas’) anaesthetic, delivered via the tube placed at induction. Licensed products are sevoflurane and isoflurane. The anaesthetic machine functions to vaporize the anaesthetic agent and deliver it in oxygen. Administration of the anaesthetic is controlled using a vaporizer, the dial of which is marked with percentage values. The amount of anaesthetic delivered in the oxygen/ anaesthetic mix is adjusted to maintain an appropriate depth of anaesthesia, such that the patient is neither awake (‘too light’) nor suffering excessive side effects (‘too deep’). Approximate percentage values required to achieve this state can be accessed in anaesthesia text books, and are taught as part of veterinary and veterinary nursing curricula. Exact titration of the anaesthetic depends on monitoring the patient, both for anaesthetic depth (using clinical patient parameters such as eye position and muscle relaxation) and presence of side effects (using devices to measure physiological parameters, which may include heart rate, blood pressure, oxygenation and respiratory rate). If the combination of anaesthetic depth and physiological parameters indicate the patient is too deep, anaesthetic delivery will be turned down using the dial on the vaporizer. If this information indicates the patient is too light, anaesthetic administration will be increased.

Monitoring Equipment: nurses are trained to assess physiological parameters using clinical indicators (pulse rate, pulse quality, mucous membrane [gum/lip] colour). Most practices that employ veterinary nurses have some form of additional electronic monitoring device, although obviously this
varies between practices - most have a pulse oximeter (pulse rate, oxygenation) and/or a capnograph (adequacy of breathing), some, additionally, have blood pressure devices and an increasing number have the same multi-parameter monitors that we have in our practice. Nurses are trained in the use of these as part of their degree courses.

**Medicines:** All the drugs referred to above are classified as the legal category POM-V (prescription only veterinary medicines). Current veterinary surgeon and veterinary nursing syllabi include the pharmacology of all these medicines (both pharmacokinetics and pharmacodynamics – i.e. drugs doses, patient factors that influence drug dose, effects and side effects) as well as relevant physiology (how the heart and lungs are affected by anaesthesia) and monitoring.

**Side Effects:** All anaesthetic and sedative (premed) agents have side effects, which include the following:

- Decreased heart rate
- Decreased blood pressure
- Decreased respiratory (breathing) rate
- Hypothermia (becoming cold)

Strategies to minimise these effects, and therefore prevent fatal or non fatal anaesthetic complications, include the administration of the anaesthetic at an appropriate level, and supportive measures such as administration of intravenous fluids and use of patient warming devices.

**Recovery Phase:** This is also now recognised as an important (but previously less prioritised) anaesthetic stage. There is evidence that this is the phase during which most anaesthetic deaths occur (presumably representing a shift away from the anaesthetic induction and maintenance phases because of improvements in patient monitoring and supportive measures).

**Large Animal and Equine Anaesthesia:** In general, the anaesthetic stages and definitions are the same as for dogs and cats. The drugs used for premedication (xylazine, detomidine) are given in small boluses, until the desired depth of sedation is achieved (i.e. are given ‘to effect’), and anaesthesia induction is achieved using a single injection of a predefined dose of drug (i.e. is not ‘to effect’). Anaesthesia induction is typically achieved using ketamine, which is licensed for this purpose in the horse. Anaesthetic maintenance and monitoring, as well as the supportive measures during these, are as for small animals.

**Analgesia:** Pain management, during and after surgery, is now recognised as an important part of anaesthetic care, and represents a significant change in veterinary practice over the past 5-10 years. The first stage of perioperative pain management occurs at the time of premedication, when an attempt is made to match the likely intensity of surgical pain to the strength and dose of analgesic (pain medication) provided in the premed. During surgery, the individual(s) responsible for monitoring the patient look for indicators that the animal may be feeling pain (e.g. increased heart rate, fluctuating blood pressure, altered respiratory pattern, tearing), and may decide to administer additional analgesics. If a surgery is anticipated to be particularly painful, the vet may elect to use continuous intravenous infusion(s) of analgesic drugs, which can be titrated up or down depending on the pain response in the patient. Analgesic infusions such as these were virtually untaught 10 years.
ago, but are now commonplace in both referral and first opinion practice. The drugs which are typically used for this purpose include lidocaine (prescription-only, uncontrolled), ketamine, morphine and fentanyl (all prescription-only and controlled medications). Doses for infusions of these can be found in the BSAVA manuals, BSAVA formulary and are frequently taught in CPD courses. Further options for augmenting analgesia, also representing relatively novel approaches to pain management in small animals, include epidural injections (usually morphine and/or a local anaesthetic) and local anaesthesia (injecting local anaesthetic around a nerve to help provide analgesia for a surgery). It is rare in small animal practice to perform procedures ‘under local anaesthesia’ (i.e. without a general anaesthetic, as occurs in people and large animals), but local anaesthetic techniques are instead used to provide additional pain relief.

Analgesic management continues after surgery, and very frequently incorporates pain assessment. Pain assessment is achieved by a variety of methods, all of which are taught in both veterinary and vet nursing curricula. In many practices, much of the pain assessment is performed by veterinary nurses, as they are the personnel most likely to be interacting with the patients in the hours after a surgery. Instructions for analgesic administration are frequently provided as a range, with the nurse dosing within the prescribed range (e.g. selecting a dose or a dosing frequency within provided limits), according to his or her assessment of the patient’s comfort level. Postoperative pain can be difficult to predict (for example, we often cannot predict how well a local anaesthetic nerve block will work, or how long an epidural injection will last, and animals vary widely in their response and tolerance to pain). The ability to provide a range of analgesic options, from which a nurse can select the most appropriate for an individual patient, therefore represents a superior approach compared to the use of inflexible analgesic prescriptions. Postoperative discomfort may arise from stimuli other than pain (for example a full bladder, inappropriately secured drains and dressings, high levels of noise or bright light, lack of soft bedding, nausea) and ensuring a patient is comfortable after surgery requires a multi-faceted and holistic approach to nursing care.

As veterinary nurses are performing pain assessments and selecting a dose or a dosing frequency within a provided limit/range, there is an argument that by extension the same applies to anaesthesia. Regarding the underlined sentences in the above paragraph, this is based on the assumption that nurses would use doses within a range ‘prescribed’ by the veterinary surgeon - whether this is on a case by case basis (i.e. the veterinary surgeon has indicated for the particular case that an infusion between x and y can be given) or indirectly by ‘practice policy’ doses – i.e. a range of doses for general use is agreed by the veterinary surgeons, and the nurses select from these (thereby one could still argue the dose range has been set by a veterinary surgeon).
### Summary
The Committee is asked to note the report, which sets out the categories and numbers of written advice requests handled by the Advice Team since the last meeting on 23 January 2014. The report also includes the figures reported at the January meeting for comparative reasons. In addition, the report includes some examples of enquiries on which veterinary expertise has been sought to inform the advice.

### Decisions required
None

### Attachments
Annex A: Numbers and Categories of Written Requests for Advice

### Author
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<td>1 May 2014</td>
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<tr>
<td>Title</td>
<td>Advisory Report</td>
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Advisory Report (January to May 2014)

Introduction

1. The role of the RCVS is to set, uphold and advance veterinary standards. The provision of advice and guidance to the public and the profession via the RCVS Codes of Professional Conduct plays a key part in this role. The Code and its Supporting Guidance is essential for veterinary surgeons in their professional lives and for RCVS regulation of the profession. For that reason, the Advice Team aims to give clear and practical advice on veterinary surgeons’ and veterinary nurses’ professional responsibilities and the proper standards of professional practice.

2. It is vital for our advice and guidance to meet the changing needs of the public and the profession. Legislative developments and changing public demands mean that the professional environment in which veterinary surgeons and veterinary nurses work continues to evolve, and with that so does our advice. It is important for our advice to be clear, practical and consistent, and our advisors aim to be forward-thinking, in touch with the profession, straight-talking, compassionate and to exercise good judgement.

3. To ensure that our advice meets the criteria outlined above, our advisors will facilitate veterinary experts to help inform the advice given where necessary. For example, input is regularly sought from veterinary surgeons, with the requisite experience, attached to RCVS Council or Committees. This includes the Standards Committee and the Preliminary Investigation Committee. Additionally, guidance is also sought from members of RCVS Subject Boards or other groups with member expertise such as the Recognised Veterinary Practice, Certification and Riding Establishments Sub Committees. For enquiries relating to veterinary nurses, input is also sought from members of VN Council or other relevant Sub Committees to ensure that the advice is up to date and in touch with the issues affecting nurses in practice today.

4. While the Advice Team will endeavour to assist so far as possible, there are inevitably some areas on which the RCVS is not in a position to offer advice. For example, purely legal matters such as employment law, maternity rights, or contractual or civil disputes. For advice on these types of questions, the Advice Team will ensure that the person making the enquiry is directed to other sources of support and guidance, for example, the British Veterinary Association Legal Advice Line or the Veterinary Defence Society.

Advice Report

5. The Advice Team in the Professional Conduct Department receives a large number of written requests for advice and information on a regular basis. Requests for advice are received from a wide range of individuals and organisations: members of the public, veterinary surgeons, veterinary nurses and other members of the veterinary team, veterinary organisations, professional bodies, and Government departments.

6. Attached at Annex A are the numbers and categories of written requests for advice handled in 2014 to date. [The Committee should note that the current Prof Con system is under review and the department is looking at new ways to record and analyse the information. Our ability to report more detailed statistics may change in the future].
7. From the date of the last Standards Committee in January, regular advice has been given to the profession and the public on the most common areas such as maintaining practice standards, running the business, treatment of animals by non veterinary surgeons (e.g. registered, listed and student veterinary nurses, lay staff and others such as physiotherapists etc) and the use of veterinary medicinal products.

8. In addition to the more common enquiries, advice has also been given on a number of more unusual areas (with veterinary expertise sought to help inform our response). The Committee may be interested to note some recent examples outlined below:

a) **Advice on canine reproduction**: Advice given to a veterinary surgeon and a breeding service operated by lay people on the collection of semen using digital pressure and massage, and swabbing vaginal cells for analysis. To ensure the advice was practical and appropriate, the Advice Team sought input from the Chairman of the Preliminary Investigation Committee and also an RCVS Specialist in Veterinary Reproduction and a Board Member of the European College of Animal Reproduction. Confirmed that the collection of semen is not regarded as an act of veterinary surgery in any species, unless it involves sedation and electro-ejaculation, which it does not in a dog. In terms of quality, the semen may be normal or abnormal, and the risk is that a non-veterinary surgeon might drift into making a diagnosis rather than simply reporting the semen quality results. For vaginal cytology there is no diagnosis to be made, simply an interpretation of the stage of the cycle with advice about when to breed. Taking a vaginal swab is no more invasive that a vaginal insemination and therefore does not contravene the Veterinary Surgeons Act 1966. Advice was also offered to the breeding service to ensure that they are working within the confines of the Veterinary Surgeons Act 1966.

b) **VNs administering blood transfusions**: Advice given to a registered veterinary nurse about whether RVNs may take blood from one dog and administer to another in a blood transfusion scenario (with the vet present to determine the amount of blood to be given). Input sought from a veterinary surgeon attached to the RCVS Council and advice given that informed consent must be sought on behalf of the donor; the act of collection is appropriate for an RVN; the administration should be determined by a veterinary surgeon - this is treatment (again informed consent required); and, blood can be administered by a RVN, but a veterinary surgeon should be on hand in case of anaphylactic reactions and also because any animal requiring transfusion is likely to be in a critical condition.

c) **Equine Microchipping**: Advice given to a member of the public, who asked for guidance on the technique required for the implantation, specifically whether the area should always be clipped and cleansed and appropriate aseptic technique used. The Advice Team sought input from an equine veterinary surgeon attached to the RCVS Council. Advice offered that clipping and swabbing is not routine practice prior to routine microchip insertion in horses. There is evidence to support the view that, in hair covered animals, unless a full surgical prep is carried out clipping / swabbing can increase the risk of infection. Full surgical preparation of the reception site is frequently impractical in field situations. To the best of our knowledge, complications following microchip implantation are extremely rare in animals where they are inserted without clipping or any form of site preparation. Recommended contact with the British Equine Veterinary Association (BEVA) for further input.

d) **Visible Implant Elastomers and Identification of Frogs**: Advice given to assist a veterinary surgeon with research into the use of subcutaneous visible implant elastomers to identify frogs. The Advice Team made enquiries with a member of one of the RCVS Subject Boards and put
the veterinary surgeon in touch with the Head of Exotics and Wildlife at another UK university, who has been carrying out similar research and has had input from the Home Office.

e) Animals used in advertising: Advice given to a member of the public about animals used in advertising and the role of veterinary surgeons. Linked up with recent advice from the Advertising Standards Agency, who say that while advertisers are perfectly free to use or depict animals in ads, they should make sure that they don’t inadvertently encourage or condone behaviour that might result in the poor treatment, and that advertisers using animals in their ads are also expected to have a vet on set during production to make sure the animals used are safe. Advice also issued to the profession via RCVS News urging any vets who are involved to give thought to the way in which the advert may be perceived, in addition to the health and welfare of the specific animal in their care, and raise any issues of concern with the advertisers.
Numbers and Categories of Written Requests for Advice

- Disclosure of Information
- Fees and Related Matters
- Promoting the Practice
- General Practice Standards
- 24-Hour Emergency Cover
- Euthanasia
- Communication / Consent
- Running the Business
- Treatment of animals by non vets
- Certification
- Use of Veterinary Medicinal Products
- Negligence / Misdiagnosis / Inadequate Care
- Conviction / Notifiable Occupation
- Health
- Appeal
- Performance
- Other
- Total

6 Sep 2013 - 8 Jan 2014
9 Jan 2014 - 11 April 2014
### Meeting

**Meeting**  Standards Committee

**Date**  1 May 2014

**Title**  Disciplinary Committee Report

**Classification**  Unclassified

**Summary**  The Committee is asked to note the report of the RCVS Disciplinary Committee, detailing all inquiries heard since the date of the last meeting on 23 January 2014.

**Decisions required**  None

**Attachments**  None

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Professional Conduct Department  
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Report of Disciplinary Committee Hearings since the Standards Committee meeting on 23 January 2014

Background

1. Since the last meeting of the Standards Committee, the Disciplinary Committee (‘the Committee’) has met on one occasion.

Mr Joseph Lennox Holmes

2. Mr Joseph Holmes had been removed from the Register in February 2012 after the then Disciplinary Committee found him guilty of multiple charges of serious professional misconduct at a hearing in January 2011. Mr Holmes lodged an appeal against this decision, which was heard and dismissed by the Privy Council in December 2011. He was removed from the Register thereafter.

3. At a restoration hearing held on 19-20 March 2014, the Disciplinary Committee was satisfied that Mr Holmes was now fit to be restored to the Register, and directed that he be restored.


Upcoming Hearings

5. There is a meeting of the Registered Veterinary Nursing Disciplinary Committee on 19-21 May 2014 to consider allegations against Kellie Price RVN.

Appeals

6. Mr Ian Beveridge had appealed to the Privy Council against the decision of the DC (made on 20 May 2013) to remove his name from the Register. Mr Beveridge recently applied to withdraw his appeal.

7. On 26 March 2014, the Privy Council considered his application and ordered that the appeal be withdrawn. Mr Beveridge's name was therefore removed from the Register once the sealed order was received from the Privy Council.

8. Dr G Samuel appealed to the Privy Council against the decision of the DC (made on 19th February 2013) to remove his name from the Register. The Appeal took place on 26 March 2014. Judgment was reserved.

Clerk to the Disciplinary Committee

9. The current clerk is leaving the RCVS on 10 April 2014. A replacement will be employed shortly.
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<td><strong>Title</strong></td>
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<td><strong>Summary</strong></td>
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<td><strong>Author</strong></td>
<td>Dr Bertie Ellis</td>
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RCVS/BVA RIDING ESTABLISHMENTS COMMITTEE

Report to Standards Committee – May 2014

Administration Reorganisation

The re-organisation of the administration of the Riding Establishments Inspectorate has gone smoothly with all records and documentation concerning the administration now with the RCVS. All email queries are now dealt with by the RCVS with input from the RE Committee.

Applications from new veterinary surgeons applying for admission to the Inspectorate can now download the application form from the RCVS website. All new applicants must attend an induction course prior to their admission.

Refresher/Induction Courses 2014

The organisation of this year’s refresher/induction courses is well under way. Currently there are 31 delegates who will attend the course at The Horse Trust, Princes Risborough, Buckinghamshire on Wednesday 25th June. There will also be representatives from the RCVS who wish to attend this course. Fifteen delegates will attend the course at SNEC (Scottish National Equine Centre), Oatridge Campus on Wednesday 9th July. There are 11 new applicants who have applied for admission to the Inspectorate.

The venues have equine facilities so there will be practical sessions by the saddlers, showing the fitting of tack on horses and ponies. This is an important aspect of the inspection process and has proved very useful. There will also be presentations by the Fire Services.

Insurance cover has been put in place by the RCVS and H&S assessments will be carried out before the courses take place. The administration and organisation of the courses is self financing and there is no requirement for financial help from the RCVS.

Newsletter

The 11th edition of the Riding Establishments Committee Newsletter has been emailed to all members of the Inspectorate. This newsletter provides all members with valuable information on a variety of subjects relating to the inspection process.

Dr Bertie Ellis
Vice Chairman
Riding Establishments Committee 1 April 2014