RCVS

International Postgraduate Veterinary Education (PGVE) Symposium

Ironmongers' Hall, London

Tuesday 18 November and
Wednesday 19 November 2025

"Sparking conversations, sharing evidence, building a community of practice"

Foreword by Dr Linda Prescott-Clements, RCVS Director of Education

It is my pleasure to introduce the proceedings of the inaugural international Postgraduate Veterinary Education (PGVE) symposium, held 17 to 19th November 2025 at Ironmongers Hall, London, UK.

This is an exciting time in veterinary education. As the needs and expectations of animals and their owners in society continues to evolve, so do the requirements for the education and development of veterinary professionals. In order to meet the demands for high quality education, training and support, there is a growing need for educational scholarship and research, to ensure initiatives are effective and aligned with international best practice. Although a community of practice for undergraduate veterinary education is more established, through university networks and events such as the annual 'VetEd' meetings, there is a notable gap when considering postgraduate veterinary education (PGVE). The absence of a dedicated space for PGVE, where educational innovation, development, evaluation and research can be shared with like-minded colleagues and stakeholders, led to the inception of this symposium.

Our belief that there was a growing need for a dedicated event for PGVE was soon confirmed; despite only limited advertising, tickets were sold out within a week and additional places to enable over 100 delegates to attend were soon snapped up by colleagues from across the world. Attendees from Australasia, Canada, the United States, Europe, South Africa and Asia, including veterinary practitioners involved in workplace-based learning and support, academics from universities, specialist training providers and private providers of postgraduate qualifications and CPD, all joined the event.

To ensure the breadth of PGVE was represented, the symposium was organised into four themes depicting the continuum of a professional's career, where education has a vital role, ie (1) Graduate transition into the workplace, (2) Postgraduate veterinary education and training, (3) Continuing education / professional development, and (4) Licensure and revalidation.

Foreword

The success of this event was, without doubt, down to the incredible speakers who agreed to share their expertise. I am especially grateful to our plenary speakers, Prof. John Norcini (USA), Prof. Martin Cake (Australia), Prof. Jane Sykes (USA), Wendy Preston (UK), Prof. Lambert Schuwirth (Australia), Prof. Olle ten Cate (Netherlands), Prof. Suzanne Chamberlain (UK), Dr Lyndsay Sproule (Canada) and Dr Amy Farmer (USA), for their excellent and thought-provoking contributions.

Delegates were captivated by the wide range of topics in the sessions across the two days, including areas such as best practice in coaching, supervision, workplace-based learning, assessment, feedback, programme design, entrustability, artificial intelligence, learning transfer and more. The high-quality speakers and the diversity of the audience enabled this to be an event which was truly inspiring. The innovations and experiences shared by the plenary speakers and other presenters were both engaging and the messages transferable across different aspects of PGVE.

My sincere thanks also go to my colleagues in the organising committee; Prof. Kent Hecker (Canada), Prof. Harold Bok (Netherlands), Prof. Martin Cake (Australia) Director of Veterinary Nursing Julie Dugmore and the Royal College of Veterinary Surgeons (RCVS) events team, for their time reviewing abstracts, and making sure everything ran smoothly.

As hosts of this inaugural event, the RCVS received overwhelmingly positive feedback from delegates afterwards. The clear message from delegates wholeheartedly confirmed our view that this symposium should not be an isolated event, but held periodically in order to grow this vibrant community of educators and share best practice scholarship to advance PGVE worldwide.

As our attention now turns to planning the next international PGVE symposium, I hope you will enjoy reading these proceedings and the wide range of presentations to continue to inspire your own work.

Dr Linda Prescott-Clements

Day 1

Introductions

Welcoming everyone to the inaugural International Postgraduate Veterinary Education (PGVE) Symposium, held in the historic setting of the Ironmongers' Hall in the City of London, RCVS President Professor Tim Parkin FRCVS described the 'transformative' effect of the teaching he had been given early in his veterinary career, noting: "The impact of early influence on career choice from key mentors should never be underestimated."

However, he went on to say that while veterinary professionals' initial training was essential to setting them on the right path, postgraduate education helped them find their niche, thrive, and become the best vet or veterinary nurse they could be.

The symposium was "truly spoiled" to have some of the world's most distinguished veterinary and medical educators, professionals, and researchers under one roof, he continued. Two "fantastic" days lay ahead, offering amazing presentations primed to produce insightful discussions. Encouraging everyone to engage fully with the programme and with each other, he concluded by saying he hoped the symposium would inspire a collaborative approach to understanding and developing best practice and innovation in postgraduate education through an international community of practice.

Dr Linda Prescott-Clements, RCVS Director of Education, then extended her own welcome to those attending. The symposium had been "pretty much a year in the making," she said and she hoped it would "shine a light" on the postgraduate education setting. She explained most publications about veterinary medical education were relevant to the undergraduate phase. Yet when the typical 40-year veterinary career was looked at as a whole, only about 12% of that time was spent in undergraduate education. Although these years were arguably the most intense period of education within an individual's career and vitally important, she pointed out that: "Postgraduate education touches everybody for the rest of their career."

She also pointed out that while excellent research and scholarship in the field of postgraduate veterinary education was being carried out, it was not being shared as much as it could be to help people around the world learn from one another. The symposium aimed to ensure postgraduate veterinary education received the attention it deserved, and gave delegates the chance to learn about current approaches and best practice and to discuss new ideas and innovations.

"Most of all," she said, "what I would really like is for this symposium not to be a one-off event, but a platform for future events to create a network, a community of practice, internationally whereby people that are involved in postgraduate veterinary education can share ideas and can develop new ideas."

She concluded by encouraging everyone attending to consider what this community of practice might look like and how it could be taken forward.

Plenaries

The history and evolution of workplace-based assessment

Professor John Norcini, Upstate Medical University, New York, USA

The first plenary lecture of the PGVE symposium was given by Professor John Norcini, who considered the past, present, and potential future of workplace-based assessment. Explaining that he had spent 25 years working for the American Board of Internal Medicine (ABIM), which certifies physicians in internal medicine, he described how the emphasis of the board's assessment methods had evolved from one of measuring knowledge to one of assessing learning.

Looking at the past, Professor Norcini explained that until 1970, the ABIM had used oral and written examinations to measure a trainee's knowledge. For the oral examination candidates had to examine and work up a patient case, before being questioned about the case by an examiner. Challenges with this approach included inconsistency between examiners and variability among patients – candidates who had straightforward cases were more likely to pass than those with complex cases.

In 1970, candidate numbers and the complexity of organising the examination had increased, so the ABIM delegated responsibility for assessing trainees' clinical skills to the directors of hospital internal medicine training programmes. Faculty members had to find suitable cases for a trainee to examine and write up, before being questioned about the case. By the late 1980s, both programme directors and patients were unhappy with this approach.

However, Professor Norcini explained, by this time there was a better understanding of three key factors associated with assessment:

- Once is not enough;
- One is not enough;
- Reality matters.

Expanding on these, he explained that performance was case-specific. How a trainee dealt with one patient did not predict how they might deal with another. Consequently, to gain a good understanding of a trainee's skills they should be assessed more than once. Likewise, opinion varied between examiners and a good evaluation of a trainee needed more than one opinion. It was also important to assess in real-world settings, for example, under the normal time constraints of a consultation.

This greater understanding resulted in the development of the 'mini CEx' (clinical examination) assessment. Multiple faculty members observed and evaluated multiple brief trainee–patient encounters, providing feedback each time. Professor Norcini explained that by the late 1990s, the mini CEx was an accepted alternative to the traditional CEx in the USA.

However, it was not the only method of workplace-based assessment available, he continued. Others included direct observation of procedural skills, chart-stimulated recall (called 'case-based discussion' in the UK) and 360-degree

feedback. These were often used together with the mini CEx because they covered all the competences a trainee required.

All the methods incorporated evaluation of a trainee's performance, provided a basis for judgment, and required feedback to be given throughout. The feature that was common to them all was the faculty member(s) involved. This, Professor Norcini said, meant: "You, the faculty member, the evaluator, is actually the method. All those [other] methods are just ways of structuring observation and collecting information. The bottom line is that the person who is doing the observation is the method. And because you are the method, faculty development is absolutely crucial."

He went on to explain that research into methods of assessment had identified some key issues, including infrequent observation of trainees, and infrequent feedback even where there was observation. Feedback was essential, he pointed out; it had a significant influence on achievement, was one of the biggest drivers of learning, and was an incredibly powerful tool for teachers. Meanwhile, studies looking at the timing of learning had found that short, intense courses led to faster learning and greater confidence and satisfaction, but temporally spaced sessions resulted in better retention of knowledge and performance. This was reflected in workplace-based assessment where observations and feedback were spaced over time. "It's not good enough to just take things in," he said, "you have to practise taking them out again."

Professor Norcini then looked to the future, saying that one of the greatest challenges to workplace-based assessment was implementing it. In turn, challenges to implementation included logistics, misalignment between purpose and activity, lack of a strong alliance between educational faculty and trainees, and a lack of bidirectional feedback. Implementation science offered a way of addressing these challenges, he continued. It focused on evidence-based interventions and how they were adopted into the real world. There were frameworks available to guide the translation of research into practice considering predisposing factors such as knowledge, attitudes, and beliefs; reinforcing factors like social support and economic awards; and enabling factors such as the availability of resources.

He explained that predisposing factors needed in implementing workplace-based assessment included committed faculty members who themselves had the competences they were assessing. Longitudinal relationships between trainees and their supervisors were also important as was the selective use of patients and the involvement of other healthcare professionals to enable multisource feedback.

Reinforcing factors included training, monitoring, and feedback for the faculty members performing the evaluations to ensure consistent standards and processes. Enabling factors included creating a system of assessment that had clear values and support from workplace leaders, and recognised and incentivised the involvement of faculty members.

Summarising, Professor Norcini reiterated his key points:

- For good measurement in workplace-based assessment, faculty is the key;
- Assessment has to be more than once, more than one, and the tasks must be realistic;
- Workplace assessment is the best tool available for learning;
- Implementation is a challenge that can be addressed systematically.

In the questions that followed, several delegates highlighted differences between human medical and veterinary medical settings. For instance, in some veterinary settings, there might be only a single assessor, making it impossible to offer multisource feedback, or anonymised feedback.

The assessor might also be the trainee's mentor, meaning they held potentially conflicting roles. Professor Norcini was asked for his advice on dealing with these situations. In response, he highlighted the importance of separating and being clear about the purpose of each assessment – was it to give feedback to help the trainee improve, or was it to make a decision about the trainee? People were more open to receiving feedback to help them improve but could be more defensive if they felt that an assessment was going to be used as part of a decision-making process.

Summitting Mount Miller – recalibrating outcomes beyond graduation

Professor Martin Cake, Murdoch University, Perth, Australia

Learning was described as "a great journey" by Professor Martin Cake in the second plenary lecture of the first day of the PGVE symposium. He explained that this journey could be framed by three questions: "Where am I now? Where am I heading? How do I get there?" Numerous models and frameworks supported this journey, including the influential Miller's Pyramid, which offered a structured approach to assessing clinical competence in human medicine, integrating traditional and workplace-based methods of assessment. Although modified since its introduction, the pyramid remained one of the most important models for assessment in medical and veterinary education.

Professor Cake noted that when Miller's Pyramid was introduced in 1990, its highest level – 'Does' – had been "uncharted territory". Since then, assessment of the integration of performance into practice had become more common. While still highly relevant, he argued that the pyramid no longer did "all of the work that we need it to do" when it came to assessing clinical competence in veterinary postgraduate education. He asked: "How can we add to this pyramid and find some new words or verbs that extend this pyramid for the purpose of postgraduate veterinary education?"

He invited the audience to suggest outcomes that could 'supersede 'Does' as the pyramid's highest level.' Suggestions from the audience included 'Explains', 'Creates', 'Refines', 'Teaches', and 'Adapts'. Welcoming these, he then considered one extension – 'Trusted' – that had been proposed in the veterinary literature by Professor Ollie ten Cate [who gave a subsequent plenary lecture at the symposium]. 'Trusted' recognised the concept of entrustment and entrustable professional activities (EPAs), units of professional practice that could be entrusted to trainees with the aim of judging the level of supervision they required.

Professor Cake explained that trust helped manage risk and uncertainty by integrating aspects such as the idea of evaluating both past performance and future performance in unfamiliar contexts, and trusting that a trainee had the morals, ethics, and motives required for practice and would seek help if needed. "If we're going to trust them, we need to know they will

know when they are out of their depth, that they will seek help and that they will basically be self-regulating in terms of what they attempt," he said.

Trust also encompassed confidence, which he described as an important moderator of competence. There was no particular 'right' level of confidence, but both over- and under-confidence could impair performance. There was an optimal balance between the two extremes, but trainees could not accurately self-assess whether they had achieved this balance. Feedback was essential to ensure alignment between confidence and competence.

Turning to another proposed extension to Miller's Pyramid, 'Is/Being', Professor Cake explained that trainees should not only do the things expected of a clinician, but should also think, act, and feel like a clinician. This reflected the central role of professional identity formation.

He noted that the concept of professional identity had replaced traditional ideas of professionalism, and professional identity formation had been described as "the highest purpose of medical and veterinary education". However, measuring or assessing professional identity formation posed major challenges. "Just like trust, we're interpolating a lot of what's inside a person's head. We're interpolating motives, values, and attitudes – and they're all inside a person's head... So how do we measure it, and how do we work with that?"

Professional identify formation was a highly individualised and personalised developmental process requiring holistic assessment over time. It became a more important factor after graduation.

Professor Cake then referred to Maslow's Hierarchy of Needs – another pyramidal model – highlighting that the tip of this pyramid was 'Self-actualisation': achieving one's best self or one's true potential, characterised by creativity, spontaneity, and problem-solving. He linked this to the concept of 'eudaimonia' (an ancient Greek word for a state of happiness, wellbeing, or flourishing), which encompassed the idea that wellbeing and happiness were found through striving to be one's best possible self.

Returning to professional identity formation, he noted that there were no highly validated measures for assessing it. He cited a study (doi: 10.1080/10872981.2019.1649571) that used a visual analogue scale to assess final-year medical students' professional identity as physicians (how they saw themselves in relation to physicians as a group – did they see themselves as part of the group or separate from it?) and how they viewed the relationship between their personal identity and their professional identity. Although both measures considered professional identity formation, the study had found little correlation between them, he said. There was also wide variation. Some students on the cusp of graduation felt "next to no connection to being a doctor – which is actually quite shocking", he commented.

Overall, the results showed that professional identity formation was variable, non-linear, and often occurred after graduation.

Professor Cake also discussed a study of recent veterinary graduates (doi: 10.1136/vr.104724), which identified two dominant identities. The first was a diagnosis-focused identity that valued finding correct answers. "That's perhaps the prevailing identity of clinicians in referral hospitals," he commented. The other was a challenge-focused/problem-solving identity that prioritised technical competence and decision-making. The researchers suggested that this identity was more likely to be fulfilled in general practice and to be associated with better wellbeing and job satisfaction. The study had suggested the existence of "maladaptive identities" or identities "that don't fit with reality" and highlighted that identity formation could be disruptive and needed to adapt to different environments.

A further study in the medical field (doi: 10.1097/ACM.0000000000000731) had identified reflection, relationships, and resilience as key

influences on professional identity formation. This had subsequently been endorsed by a study (doi: 10.3389/fmed.2024.1385489) demonstrating strong associations between professional identity formation and resilience.

Professor Cake continued by explaining that professional identify formation was central to wellbeing and professional learning. He referred to Ryan and Deci's self-determination theory, which identifies competence, autonomy, and relatedness as fundamental psychological needs. Humans inherently desired mastery, he said. They wanted to be good at what they did; they wanted to be in control, make their own choices, and do things they found valuable; and they wanted to find happiness in social situations. The theory distinguished between intrinsic and extrinsic motivation, linking wellbeing to truly intrinsic motivations and to internalised extrinsic motivations, such as veterinarians' desire to help animals – in essence, activities that are enjoyable or interesting and aligned with personal values. He noted that self-determination theory underpinned several wellbeing models and gave some examples.

He then showed a taxonomy of positive mental health developed by an Australian research group, which captured all the elements associated with wellbeing (available at www.bewellco.io/wp-content/uploads/2025/03/BeWellCo_Taxonomy_of_Positive_Mental_Health-30Sept_compressed.pdf). It encapsulated everything being discussed in postgraduate education – not just feeling good (happiness) but also congruence with self (integration of personal and professional self, values, and your happiness with your life).

Returning to Miller's Pyramid, Professor Cake proposed two further possible extensions: 'Does better' and 'Keeps doing'. He suggested that many professionals preferred to seek to improve or sustain their existing practice rather than continually acquire new skills. A study looking at defining quality veterinary care (doi: 10.1002/vetr.1174) had suggested that quality included not only patient outcomes, safety, and efficacy, but also efficiency, timeliness, and sustainability for the veterinarian. "'Keeps doing' reminds us that it's not enough just to do something well once; we have to do it day after day, week after week, year after year without draining the system. We must have a sustainable model," he said.

He cited Bradley Viner's 'Success in Veterinary Practice', in which a formula for long-term, sustainable success proposed that efficient, high-quality work must be provided in harmony with personal values, goals, and enjoyment – essentially, being good at one's work and enjoying it.

Professor Cake moved on to discuss employability, which he explained encompassed success and satisfaction in work. Sustainable employment required a balance between the value an employee gave and received, he said. He referenced a widely cited definition of employability: "A set of adaptive personal and professional capabilities that enable a veterinarian to gain employment, contribute meaningfully to the profession, and develop a career pathway that achieves satisfaction and success." This meant there were certain attributes (such as skills and knowledge) that made an individual more likely to choose, secure, and sustainably work as a veterinarian and be satisfied and successful in doing so. However, beyond these skills, reflective self-evaluation, self-efficacy, and self-esteem were also important.

He then introduced the VetSet2Go project, which had originally focused on the transition into practice, but could also be applied across a whole career, including postgraduate veterinary education. The project defined employability as "The capacity [of an individual] to sustainably satisfy the optimal balance of all stakeholder demands and expectations in a work context, including their own." Its evidence-based model of veterinary employability proposed five overlapping domains with 18 associated capabilities that captured the elements needed to succeed at work. Professionalism was at the

centre, recognising that reflective professional identity formation and a confident professional identity were at the heart of all learning.

The model also recognised that success at work depended on the work itself, its efficacy and sustainability, and the people involved. Professor Cake noted that many of the ideas in the VetSet2Go model had been incorporated into the RCVS's Day One Competences framework.

In closing, Professor Cake reflected on the "What, why, and how" of postgraduate education. The "what", were "the headwinds at the top of Mount Miller", essentially the challenges graduates experienced – complexity, developing independence, self-regulation, confidence, and efficiency, finding balance between competing demands, and integrating into a system or team. The "why" reflected motivations for further learning, including improving the quality of care, building trust and entrustment, developing new or existing skills, and achieving self-actualisation. Evaluation of professional identity formation, entrustment, reflective self-awareness, feedback, and mentoring were how the aims would be achieved.

Concluding, he challenged his audience to consider if they were fully meeting trainees' needs and wants.

There was no time for questions after Professor Cake's lecture.

Parallel sessions (Banqueting Hall, morning): Graduate transitions

For part of each day of the PGVE Symposium, delegates had a choice of sessions to attend. During these parallel sessions, they had the opportunity to hear more about research projects and initiatives that had been, or were being, carried out in the field of postgraduate education.

Professional identity: so, what's new?

Dr Rachel Davis, Senior Lecturer in Veterinary Education, Royal Veterinary College, UK

Dr Rachel Davis presented research conducted with Dr Liz Armitage-Chan MRCVS exploring professional identity and professional identity formation in the veterinary and allied professions. Their aim was to better understand current thinking in this area. A systematic literature review initially identified an overwhelming volume of materials, so they narrowed their search period from five years to 18 months, before refining their strategy even further because so many papers were identified. Ultimately, they reviewed only papers with professional identity in the title, keywords, or abstract.

Commenting that "the literature base has exploded!" Dr Davis noted the breadth of activity in this field. Encouragingly, there was growing attention on creating teaching and learning experiences in authentic workplace environments. The literature also highlighted the prevalence of feelings of dissonance or tension when developing professional identity, and increasing recognition of how varied and complex these tensions might be.

The literature confirmed that professional identity formation was a complicated and dynamic process. It indicated a growing global understanding of professional identity, as well as of the diversity and importance of the experiences of tension that trigger the formation of professional identity, the importance of the learning environment, and the emergence of the minority voice.

Welcoming this global perspective, Dr Davis explained that it helped show how the understanding of professional identity differed across countries. Acknowledging these differences could inform the development of curricula that equipped students of different nationalities to return to their communities, work effectively, and establish their professional place.

The review also showed that tensions triggering professional identity formation varied depending on the environment in which individuals worked. This suggested that there would be no single best way of preparing students for these experiences. "We need to open up to the fact that this is going to be very individual, and it's about acknowledging those tensions," she said. Tensions might arise between personal wellbeing and the wellbeing of clients, owners, or practices; between feelings of confidence and competence; or in relation to neurodiversity and disability.

What was less clear in the literature was how to resolve those tensions. How could learners and new graduates be best supported as they moved into the workplace and helped to navigate, work, and grow through the tensions they would experience?

In addition, the complexities of the workplace were becoming clearer. The literature showed workplaces adapting to generational, socioeconomic, and political change.

Dr Davis stressed that new graduates needed to recognise professional identity formation as an additional part of their role that they needed to accommodate. Forming a professional identity required energy and this energy had to be expended on top of all the other demands associated with assimilating into the workplace. "It's an important part, but it can sometimes feel like the straw that breaks the camel's back," she said. The literature suggested that individuals varied in how well they adapted to particular environments, reinforcing the importance of sociocultural context.

There was also increasing evidence of the minority voice in the literature. Dr Davis commented that if forming a professional identity was accepted as yet another job that new graduates had to take on, this job became even harder if an individual did not feel they belonged in a workplace.

Concluding, she observed that professional identity had always meant different things to different people, but people were now beginning to understand more about it, embrace it, and acknowledge it. Identity tensions were an important part of professional identify formation but their diversity and individuality made it impossible to specifically teach to them. Instead, new graduates needed to be equipped with the skills to recognise that identity formation was a normal part of assimilating into a profession and a workplace.

During discussion, Dr Davis was asked if the literature identified consequences of failing to form a professional identity. Commenting that this was a "really big question", she said there was plenty of evidence of identity formation not going well but she was unsure whether the consequences of a failure to form a professional identity had been pinpointed. She certainly did not think they had been measured. However, professional identity formation was a dynamic journey and even experienced professionals would have encountered times when the journey had not gone well. Normalising these challenges and recognising "the complexity of the self" could help support individuals, she suggested.

Responding to a question about whether including career management in the postgraduate curriculum might help individuals "find their tribe", or where they fitted best, Dr Davis said helping students understand that they should not be afraid to look for their tribe was a good idea, describing it as part of the developmental process.

Evaluating the impact of introducing a mandatory, national graduate support programme in the UK: VetGDP

Dr Linda Prescott-Clements, Director of Education, RCVS

Presenting an initial analysis of the impact of the RCVS's Veterinary Graduate Development Programme (VetGDP), Dr Linda Prescott-Clements began with an overview of the programme, which was introduced in the UK in 2021. By making completion of the VetGDP a requirement in the *RCVS Code of Professional Conduct*, the RCVS ensured it became mandatory for all new graduates entering clinical work in the UK to be supported in their transition into the workplace.

Dr Prescott-Clements emphasised that all new graduates required support to build confidence, independence, skills, and experience. Evidence showed that workplace support was directly linked to wellbeing, retention ("finding your tribe"), job satisfaction, and return on investment for employers, with well-supported graduates becoming more efficient and effective clinicians.

She explained that the VetGDP had replaced the previous Professional Development Phase (PDP), which had aimed to support new graduates in developing Year-One Competences. Under the PDP, which had been recommended rather than mandated, graduates had been assigned an online postgraduate dean. This had worked well up to a point, but while the remote deans could provide feedback on a graduate's reflections, they could not observe or provide feedback on workplace performance. Defining the Year-One Competences had also been problematic, she continued, as many were context specific and not all tasks were relevant across all roles. Graduates had attempted to "tick off" competences, but some may not have been achievable in their particular practice. Consequently, the PDP essentially became a tick-box exercise.

In contrast, the VetGDP aimed to provide meaningful, effective support to new graduates and promote a workplace culture where mistakes were viewed as learning opportunities for everyone. It also helped employers understand the support needs of graduates. Dr Prescott-Clements outlined the programme's format and design principles, noting that initially there had been no time limit set for completion. However, as graduates' confidence and independence increased, motivation to complete their portfolio and reflect decreased, and some forgot to submit the portfolio for independent peer-review and final "sign-off". Subsequently, an 18-month time limit had been introduced, which could be extended if a graduate had required a period of absence.

Dr Prescott-Clements noted that there was no formal assessment or "ratings" associated with the VetGDP. Instead, it emphasised feedback, coaching, reflection, and progression. A benchmark for reflection was provided via feedback from a graduate's VetGDP adviser, making it essential for advisers to be based in the workplace.

She then outlined the research questions that had been used to evaluate the impact of the programme:

- Is the online training to prepare VetGDP advisers to coach graduates useful and effective?
- Has VetGDP increased the amount of support given to new veterinary graduates in the UK?

- Are graduates provided with a range of support activities in VetGDP?
- Is there a positive learning culture in workplaces where VetGDP is implemented?

The evaluation drew on 930 responses to the VetGDP evaluation questionnaires collected between 2021 and 2023, and 3000 responses to a questionnaire evaluating VetGDP adviser training over the same period.

After providing a brief overview of the online training for advisers, Dr Prescott-Clements reported very positive feedback, with a median score for the usefulness of the training of 4 out of 5 across all of the learning objectives. While 80% of the advisers reported previous experience as either supervisors, coaches, or mentors, 62% had received no previous training for these roles. Many therefore found the VetGDP training useful.

When assessing whether the VetGDP had increased the support given to new veterinary graduates, comparisons had been made with PDP participants, Dr Prescott-Clements explained. The data showed a substantial increase in support provision under the VetGDP. For example, only 15.8% of PDP graduates reported receiving at least one hour's support in practice each week, compared with 50.8% of VetGDP graduates. Noting that the questionnaire was completed at the end of the VetGDP and relied on graduates recalling how much support they had been given, she said there was a tendency to underestimate. Graduates' comments reflected this, suggesting they tended to count only scheduled (i.e. "formal") support meetings, overlooking informal discussions with their adviser in practice, their adviser's availability for advice or to answer questions, or feedback following observation of practice or co-working. VetGDP, she said, was fundamentally about these "in the moment" interactions, which were incredibly valuable for new graduates.

The data showed that VetGDP participants were "absolutely" provided with a range of support activities , typically delivered often (twice a month) or very often (weekly). "This is really good news," she commented.

The presence of a learning culture was assessed through graduates' responses to statements describing possible reactions on realising they had made a clinical mistake resulting in a negative outcome for an animal or in a client complaint. Dr Prescott-Clements said it was "really, really good news" that very few respondents said they would be unlikely to tell anyone in the workplace because they feared negative repercussions. However, some respondents still reported fragile confidence despite a positive learning culture. Encouragingly, many respondents said they would reflect on the incident and seek advice from colleagues or their adviser.

Overall, the VetGDP was proving successful, though admittedly, there was scope for improvement. Around two-thirds of participants were being provided with excellent support in practice, delivered in varied, real-time ways. Qualitative feedback had shown that graduates who were not receiving support were more likely to leave the practice and seek an alternative position. This came through strongly, Dr Prescott-Clements said, and would be investigated further, but was a useful message to employers about the benefits of investing time into graduate support, beyond doing it simply because it was the "right thing to do". Somewhat disappointingly though, the qualitative feedback also indicated that some graduates viewed the VetGDP as "having to complete the portfolio", believing that the other support activities had "always been there", not realising they were integral to the programme.

There was no time for questions following this presentation.

How well are UK graduates being prepared for their first role in the veterinary profession?

Kirsty Williams, Education Quality Improvement Manager, RCVS, UK

Introducing her presentation, Kirsty Williams said the research not only looked at how well veterinary graduates felt prepared for their first professional role, but also how well prepared their Veterinary Graduate Development Programme (VetGDP) advisers felt them to be.

She explained that data had been gathered using a survey that graduates were required to complete before accessing the portfolio element of the VetGDP. As part of the *RCVS Code of Professional Conduct*, VetGDP completion was mandatory for all graduates beginning work in the UK, meaning that completion of the survey was also compulsory. However, graduates from UK schools who went to work overseas did not need to complete the VetGDP or the survey, and while graduates from overseas vet schools who came to work in the UK had to complete the VetGDP and the survey, these data had not been included in the initial analysis. As a result, the dataset covered every graduate from a UK vet school who began work in the UK after graduation – a 100% response rate. She noted that this level of response from graduates was "pretty unique".

The survey assessed how well prepared the graduates were for their first role by asking about general professional activities expected of new graduates in practice. Identical questions were asked of graduates and their advisers to allow direct comparison of their perspectives. Having been introduced in 2021, the survey had generated five years of data. Data were shared annually with each of the UK vet schools to offer feedback on their programmes, but were not used to rank or benchmark the different schools. Some demographic data had also been collected but had not yet been analysed.

"We have this massive amount of data, and we have only just scratched the surface as to what we can do with it," Mrs Williams said, adding "It's pretty exciting as to what we can understand from this information."

Initial analysis had compared how well graduates and advisers felt they were prepared for nine key professional activities: taking a history, performing a clinical examination, determining differential diagnoses, developing a treatment plan, performing simple surgeries, developing a preventative healthcare plan, animal handling, considering client financial constraints when treatment planning, and professional skills (such as communication, recognising personal and professional limits, asking for advice, and teamwork).

For each skill, graduates and advisers answered three or four questions for each species domain (companion, equine, and production animal). Preparedness was scored on a Likert scale with 1 indicating feeling completely unprepared and 5 indicating completely prepared.

The average scores for each species domain for all graduates across all UK schools had been mapped to provide a UK-wide picture and a comparison of graduate and adviser perceptions of preparedness across both skills and species domain. Mrs Williams presented graphs comparing the average scores given by graduates and by advisers for each professional skill for each year between 2021 and 2025.

She highlighted that scores for considering the financial constraints of the client and for professional skills and attributes were fairly high and similar between graduates and advisers. However, when it came to clinical skills, some patterns began to emerge. Most scores fell between 3 and 4, showing a positive level of preparedness, but graduates generally felt they were slightly better prepared than their advisers did. Graduates and advisers gave higher preparedness scores in the companion animal domain than in the equine and production animal domains (mixed practice data had not yet been examined).

Scores were slightly lower when it came to preparedness to develop and implement a treatment plan and fell further for preparedness to perform basic surgery. "This is where the graduates and their advisers are feeling they are least prepared," Mrs Williams said, but she did not speculate on why this might be the case. Both graduates and advisers suggested they were better prepared to perform basic surgery in companion animals than in equine and production animals.

Graduates' and advisers' scores for preparedness to create a preventative healthcare plan were closely aligned in the companion animal domain, but in the production animal domain advisers gave distinctly lower scores than graduates gave themselves.

The same data had been analysed in a binary manner, with scores of 1 and 2 classified as "broadly unprepared" and scores of 3 to 5 as "broadly prepared". This allowed a more granular examination of preparedness within specific sectors. Mrs Williams presented charts comparing graduates' and advisers' perceptions of preparedness across skills and domains indicating where these aligned or diverged. In the equine domain, graduates perceived themselves to be more prepared than their advisers did.

In summary, Mrs Williams concluded that graduates generally rated their preparedness slightly higher than their advisers. Knowledge-based tasks that could be learned and practised in advance, such as history taking or clinical examination, tended to score more highly. Preparedness was generally lower in the equine and production animal domains than in companion animal practice, which may be reflective of the proportion of the veterinary programme dedicated to these areas.

During questions, Mrs Williams was asked how the assessed skills had been chosen. She explained that they were broadly based on the RCVS Day-One Competences. Rather than asking about general confidence, graduates and advisers were asked about preparedness for specific tasks, such as taking a history of a dog presenting with a cough, or a cat presenting with a skin condition.

She was also asked why taking a history or performing a clinical examination were considered knowledge-based tasks. She replied that these were skills that could be learned and practised in advance – for instance, through roleplay for taking a history, or on models for a physical examination. The delegate asking this question commented that they felt there was a lot of clinical reasoning involved in these tasks and questioned the characterisation of such skills as "knowledge-based", pointing out that they were not purely based on knowledge.

A comparison of VetGDP adviser and recent graduate reported preparedness for their first role by field of practice

Alexander Corbishley, Professor of Infectious Diseases and Education, University of Edinburgh, UK

Continuing the focus on the Veterinary Graduate Development Programme (VetGDP), Professor Alex Corbishley MRCVS explained his aim was to show how information gathered from the postgraduate education setting was being used to inform the undergraduate curriculum. His study used data for the Royal (Dick) School of Veterinary Studies (R[D]SVS) gathered from the VetGDP survey described by Dr Prescott-Clements and Mrs Williams. The numbers of R[D]SVS graduates remaining in the UK after graduation were quite small, he said, so four years of data had been pooled. Survey questions had also been broadly recategorised into the themes of medicine, anaesthesia/first aid, surgery, preventative medicine/epidemiology, handling/postmortem, and professional attributes, and median preparedness scores were calculated. He noted that there was also one question dealing with graduates' confidence to work independently.

Professor Corbishley noted that about half of R(D)SVS graduates undertook the VetGDP, with the remainder working internationally or in roles that did not require the VetGDP. Of those entering clinical practice, just over half went into companion animal practice, just under one-third into mixed practice, and the remainder into equine or production animal practice or other areas of veterinary work.

Over 90% of VetGDP advisers for R(D)SVS graduates in the companion animal and production animal domains responded to the RCVS's preparedness survey, but about one-quarter of advisers in the equine and mixed practice domains did not. However, the RCVS data showed adviser engagement had increased over time.

Examining graduates' confidence in their ability to work independently, Professor Corbishley said few felt extremely confident. Most clustered in the middle – they felt "OK to work alone" but wanted someone to keep an eye on them. A small number felt very underconfident in their first role.

The preparedness data had been broken down by area of practice. This showed that graduates in production animal practice felt well prepared and, generally, their advisers agreed, he reported. However, in the area of preventative medicine/epidemiology, both graduates and their advisers indicated noticeably lower levels of preparedness in production animal nutrition. Advisers "were really telling us as an undergraduate programme, please get them doing more on nutrition", he said.

Graduates doing solely small animal work also felt well prepared and, again, their advisers generally agreed. Some discrepancy had been seen in the areas of anaesthesia and preventative medicine/epidemiology. Professor Corbishley explained this feedback had already driven curriculum change at the R(D)SVS, with a community practice and shelter medicine rotation introduced to strengthen population-level skills applicable in a small animal context. In anaesthesia, advisers highlighted a need for graduates to be better prepared in local anaesthesia. "That gives us an area of focus in

our curriculum," he said. "Vets are telling us that when they take on a new graduate, they would like them to be better prepared at local anaesthesia."

In equine practice, the findings were "really interesting", he commented. Graduates reported feeling well prepared, "but their advisers really don't agree with them". Although his data were specific to the R(D)SVS, a similar pattern had been identified across the vet schools as discussed earlier by Mrs Williams. "So, what's going on in equine?" he asked. "Why do we have a group of graduates who feel well prepared… but when we hear their advisers… there is a noticeable difference in that level of preparedness?"

Graduates entering mixed practice reported feeling generally well prepared for the small animal aspects, and their advisers agreed with them. As with small animal-only practice, discrepancies were seen in preventative medicine/epidemiology. However, both graduates and advisers reported lower levels of preparedness for the large animal elements (equine and production animal) of mixed practice. "There's something different about that experience, that level of preparedness, when going into mixed practice compared to when you're going into production animal-only practice," he said.

The findings were being used to inform curriculum development at the R(D)SVS. In addition to the greater emphasis on small animal local anaesthesia and production animal nutrition, preparedness for postmortem examination of small animals and horses had been identified as an area for improvement.

Professor Corbishley then encouraged some audience participation, asking delegates to stand or raise their hands before asking those who felt that ovariohysterectomy and pyloro-/omentopexy were both major abdominal surgeries to sit down. About two-thirds of the audience sat down. He then asked those who believed only ovariohysterectomy was a major abdominal surgery to sit down; only a small number did so.

Thanking his audience, he explained that the exercise was not about what was right or wrong but about understanding collective perceptions. He noted that the RCVS Day-One Competences expected new graduates to be able to perform simple, elective surgeries, but asked how simple, elective surgery was defined. Given the diversity of views in the room, could major abdominal surgery simultaneously be considered simple and elective? The R(D)SVS data showed that both graduates and their advisers reported similar (lower) levels of preparedness to perform a lumpectomy and a cat spay: "If you're similarly prepared to do a cat spay as a lumpectomy, where do those sit between major abdominal surgery versus simple, elective surgery?" he asked.

Turning to expectations in the production animal domain, Professor Corbishley cited research in which production animal veterinarians had ranked practical skills for new farm animal veterinary graduates. Managing a left displaced abomasum (LDA) or performing a caesarean were not considered Day-One Skills, and the ability to safely perform general anaesthesia ranked low. However, the RCVS VetGDP survey included questions on preparedness for LDAs, caesareans, and production animal general anaesthesia, despite general anaesthesia being uncommon in this area of practice.

Concluding, Professor Corbishley said it would be interesting to compare the R(D)SVS findings with data from other UK vet schools. From a programme perspective, data from postgraduate education could usefully inform undergraduate curricula but better alignment was needed between Day-One Competences, VetGDP survey questions, published literature, and expectations of what veterinary training aimed to achieve.

During discussion, a delegate asked how the equine advisers were selected. Dr Prescott-Clements explained this, noting that every

practice employing a new graduate must have at least one trained VetGDP adviser, so who became a new graduate's adviser depended on who had done the training. In larger corporate groups, one adviser might cover several practices, but would still have to be available to directly observe graduates. She added that graduates completed the preparedness survey within the first few weeks of starting the VetGDP, while advisers completed their survey several months later to allow time for observation and accurate feedback.

Qualified but not yet competent? Towards a new continuum of veterinary education and training

Professor Harold Bok, Vice Dean for Education, Faculty of Veterinary Medicine, Utrecht University, The Netherlands

Professor Harold Bok began his presentation with a personal reflection on his early career. After graduating from Utrecht University in 2005, he was acutely aware that he lacked the knowledge and skills to practise unsupervised, but according to his diploma, he was fully qualified. Consequently, he was promptly promoted to running a branch practice. "If it had not been for the highly experienced veterinary nurse who assisted me and frequently helped me out, I would not have survived," he said.

He explained that the Netherlands was facing significant challenges related to early careers in veterinary primary care. A recent survey by the Dutch Association for Veterinary Medicine showed that the highest risk of negative wellbeing outcomes was seen among early-career veterinarians in salaried positions. Other studies indicated that graduates often felt insufficiently competent to perform simple, common clinical tasks independently, and that there was a mismatch between the expectations of young veterinarians and their employers, particularly around guidance and support. Attrition was also markedly higher among veterinarians than among general practitioners (GPs) in human medicine: approximately one in six veterinarians left practice within five years of graduation, compared with one in 20 GPs. These losses contributed to workforce shortages, which in turn increased stress and workload in primary care practice.

Professor Bok asked why veterinarians in the Netherlands were affected more negatively than other healthcare professionals. Over the past 25 years, the veterinary profession had evolved rapidly and, in addition to their responsibilities for animal health and welfare, veterinarians were increasingly contributing to interdisciplinary societal issues such as public health, environmental sustainability, and climate change. Knowledge had expanded exponentially, while technological advances followed one another at high speed, now further accelerated by artificial intelligence. At the same time, owners and farmers had become more demanding, and a new generation of students placed greater emphasis on work-life balance and personal

development. “More and more is being added, while little can be removed,” he said. That led to the “inconvenient truth” that the six-year undergraduate veterinary programme in the Netherlands may no longer be sufficient to prepare graduates for unsupervised, fully licensed practice.

As a result, the gap between education and independent practice had become too large for graduates to bridge. This carried substantial societal costs, including wasted educational investment when graduates left practice early; economic losses from workforce shortages and the costs of recruitment; and healthcare costs associated with poor wellbeing or mental health issues.

Given limited public resources in the Netherlands, Professor Bok argued that investment in veterinary education needed to be both effective and efficient, requiring a more structured solution. He suggested looking to other healthcare professions for guidance. After six years of undergraduate education, veterinarians were fully licensed to work with at least seven species and were also expected to function as anaesthesiologists, radiologists, and pharmacists. In contrast, in human medicine, it had been recognised in the 1960s that six years of undergraduate education in a single species was insufficient. In 1973, general practice was formally designated as a medical specialty, and completion of a postgraduate training programme became mandatory for GP registration. All other healthcare professions in the Netherlands followed a similar model, combining a foundational degree with several years of postgraduate training before independent practice.

Professor Bok therefore advocated for the introduction of a formal postgraduate programme in primary care veterinary medicine in the Netherlands to follow the six-year undergraduate programme. He proposed a two-year trajectory, with flexibility for earlier completion if learning objectives were achieved sooner. Veterinarians in training would primarily work in certified primary care practices. Alongside clinical work, they would participate in regular training days with peers, focusing on deepening knowledge and peer reflection using cases from their own practices. This approach would foster a supportive network of early-career veterinarians learning and developing together. As with the Veterinary Graduate Development Programme, trainees would progress step by step towards independence and full competence in core professional activities required of primary care practitioners.

This proposed educational continuum aligned closely with Utrecht University’s updated educational vision, which emphasised a strong disciplinary and interdisciplinary foundation, active engagement with societal challenges, and space for individual development. This vision had been built on three inter-related educational domains – qualification, socialisation, and subjectification. Professor Bok explained that, for veterinary medicine, qualification concerned the knowledge and skills essential to the veterinary profession. Socialisation involved learning to function within the tradition, norms, and values of the professional community, something that took time in a profession as deeply rooted in tradition as veterinary medicine. Subjectification focused on personal development and professional identity, addressing questions such as how veterinarians related to society and to their profession; what and why they wanted to learn; and who they wanted to become.

A mandatory postgraduate programme would create the space and time needed to address not only qualification but also – and possibly more importantly – socialisation and subjectification, he said.

In conclusion, he suggested that redesigning the veterinary educational continuum to include a mandatory postgraduate programme for primary care practice could help bridge the gap between veterinary school and clinical practice,

reduce attrition in the first five years after graduation, improve long-term employability and quality of care, support better remuneration for early-career veterinarians, and reduce work-related stress and workload. It could also enable more effective and efficient use of both public and private funds.

Finally, noting that these challenges were not unique to the Netherlands, Professor Bok called for international collaboration. He proposed establishing an international special interest group focused on postgraduate training in veterinary primary care, and encouraging colleagues to share ideas and best practice, and learn from one another. Anyone interested was invited to email him (G.J.Bok@uu.nl).

After the presentation, Vicki Bolton, the RCVS's Research Manager, asked whether vets who left clinical practice left the veterinary field completely, or moved into non-clinical roles. Professor Bok replied that the literature showed a mixed picture. Most vets who left practice in the first five years went to other roles within the profession, but there was little research about why they left practice and whether they made a positive choice to move to another role within the veterinary field, or whether they moved because they did not like clinical practice.

Another delegate commented that it was important to understand why vets were leaving practice, pointing out that non-clinical vets could help elevate the status of veterinarians in society in different ways. Was it a problem if vets were leaving clinical practice and moving to parts of society that also needed them?

Professor Bok was also asked how his idea had been received in the Netherlands and whether there was motivation to implement it. He explained that the conversation was in its early stages, but said there had been broad support for the idea. However, the biggest challenge would be implementation. There were many legal issues to overcome and he would like to learn how other countries had dealt with similar problems.

Parallel sessions (Court Room, morning): Graduate transitions

Preparedness of veterinary students for the transition into clinical practice

Dr Paul Wood, Veterinary Reader, Scotland's Rural College School of Veterinary Medicine and Biosciences, UK

Having worked as a clinical farm vet in vet schools across the UK, Dr Paul Wood said he had mentored and trained many students and had seen some leave, and others not even join, the profession. As part of his research for his PhD, he had investigated whether students felt prepared to join the profession after graduation and whether there were particular areas where they felt unprepared and where additional focus at undergraduate level might help.

Dr Wood had gathered initial data using a survey adapted from the Preparedness for Hospital Practice Questionnaire used in medicine. Several cohorts of veterinary undergraduates at the Royal (Dick) School of Veterinary Studies had used a Likert scale to rate their responses to 41 wide-ranging statements which were mapped to eight subscales, as well as to the RCVS Day-One Competences and the American Association of Veterinary Medical Colleges' core competences.

In general, Dr Wood reported, responses to the statements had been positive, with mean scores of 3 (neither agree nor disagree) or above (agree or strongly agree) although certain themes attracted lower scores. There were also differences between cohorts, with final-year students in the 2023 cohort giving significantly higher scores in the subscales relating to "confidence and coping skills" and "prevention" than respondents in other years.

However, he said that despite generally positive responses, some students strongly disagreed with some of the survey statements. In some subscales, more than 25 per cent of responses were negative to some statements; in others, it was more than 10 per cent. This indicated that many students did not feel prepared for clinical practice in these particular areas.

He then undertook some qualitative research using interviews and focus groups with graduates to evaluate their lived experience of transitioning into practice. The key themes from these conversations were identified using thematic analysis and an attempt was made to link them to the survey data.

The key themes identified were 'graduate experiences', where participants talked about responsibility and their knowledge and skills, and generally how they found entering the profession. 'Support and wellbeing' also came up, with graduates reporting struggles with work-life balance in the initial transition period and varying levels of practice support. 'Difficult conversations' was a further theme identified, particularly relating to difficult owners, euthanasia, and finances.

Dr Wood noted that both 'support and wellbeing' and 'difficult conversations' linked to subscales in the survey associated with 'confidence and coping skills' and 'interpersonal skills' and said that the impact of restrictions associated with

the COVID-19 pandemic could not be ignored here. Students had missed out on opportunities to observe interactions between vets and clients dealing with these issues.

Summarising, he said students felt unprepared for several aspects of practice, but these were very individual. Sweeping changes to undergraduate curricula appeared unnecessary, although there were components that might be improved. Given the heterogeneity of the responses, however, there was perhaps a need to consider individualised learning journeys.

In discussion, Dr Wood was asked why the 2023 cohort stood out. He noted that these students had experienced a "more normal" final year after the easing of pandemic restrictions, potentially leading to them giving higher scores in certain areas.

He was also asked whether his research might influence future change in the veterinary curriculum. He explained that he had joined Scotland's Rural College's new veterinary school in Aberdeen and had been reviewing its curriculum to see where students could be best prepared for the challenges he had identified. He had also been considering the best time to assess students' preparedness to identify where individuals might need more support before they made the transition to clinical practice.

Developing cultural humility – a small first step

Neerja Muncaster, Senior Lecturer in Veterinary Clinical Practice, University of Surrey Veterinary School, UK

One of the RCVS's Day-One Competences for new veterinary graduates states they should 'demonstrate inclusivity and cultural competence'. However, introducing her presentation, Dr Neerja Muncaster MRCVS said there was no simple definition of 'culture'. Culture referred to the way things were done within a workplace, or a community; it was the framework within which groups worked, how people were treated and interacted with, and their underpinning values and beliefs. Cultural humility was the lens through which processes and behaviours associated with the successful achievement of cultural competence were understood and implemented. When shown by healthcare professionals, cultural humility increased the willingness of patients to seek care, supported better compliance with treatment and improved outcomes, and resulted in better-bonded clients.

Dr Muncaster explained that a faith and culture session had been developed for fourth-year vet students at the University of Surrey as part of a One Health module. It had been inspired by a similar initiative at the University of Liverpool. Before the session, students were introduced to concepts such as bias and implicit bias – the subconscious preconceptions relating to stereotypes around race, gender, etc. that unconsciously affect understanding, actions, and decision-making.

The session had initially taken the form of topic-based discussions with panellists representing

local faith groups. When run for a second time, related scenarios had been introduced to support the discussions and give them context. These also helped panellists understand situations that might arise in practice and the conversations that might take place around issues such as euthanasia, neutering, blood transfusion, and humane slaughter. Students could submit anonymous questions before and during the session, which was followed by an informal networking and debriefing event.

Giving feedback on the session, 87% of students attending it in 2024, and 94% of those attending in 2025 agreed it was relevant to veterinary careers, and 86% in 2024 and 96% in 2025 supported its inclusion in the curriculum. Students' understanding of key topics in the context of faith and culture also increased following the sessions.

Concluding, Dr Muncaster stressed that vets were not expected to know everything about every culture, and the intention was not to increase the load on the profession. Instead, cultural humility was about seeing where space might be made in vets' busy lives to make connections. It was also a reminder of the importance of looking at situations through a One Health lens.

After her presentation, Dr Muncaster was asked what employers could do to support new graduates in developing cultural humility. She suggested reaching out to local faith leaders to build connections, noting that in her own local community, faith leaders already supported Q&A sessions with medical professionals and were keen to do the same with veterinary professionals.

She was also asked how the concept of cultural humility might be transferred into postgraduate veterinary education and translated into veterinary teams. In response, she said new graduates should be empowered to be change makers in practice, have the confidence to open up authentic conversations, learn and evolve, and make space and small connections.

The final question asked why faith had been the initial focus of the cultural humility session. Dr Muncaster replied that as well as taking inspiration from the approach at Liverpool, she had become aware of reports from colleagues in the pathology team at the University of Surrey that final-year students were struggling to navigate the topic of humane slaughter. By focusing on faith first, the session had given students the chance to ask questions on this topic in a sympathetic environment. She appreciated there were other areas to cover, but it had been felt best to cover one concept initially and "do it well".

Evolution of a veterinary graduate development programme, utilising the 70:20:10 workplace education model and its potential impact on graduate attrition

Rob Kelly, Clinical Lecturer and RCVS Advanced Practitioner, Royal Dick School of Veterinary Studies, University of Edinburgh, UK

Veterinary graduate development programmes aim to offer new graduates a more structured transition from veterinary school to professional life but, as acknowledged by Dr Rob Kelly MRCVS in the introduction to his presentation, there has been little assessment of how these programmes are perceived by participants or of their impact on graduate attrition.

Explaining that his study had been carried out while he was employed by the corporate veterinary group CVS, Dr Kelly said the group's graduate development programme was the longest-established such programme in the UK. It had been integrated with the RCVS Professional Development Phase in 2013 and then with the RCVS Veterinary Graduate Development Programme (VetGDP) in 2021. His focus was on CVS's graduate programme for companion animal vets, but the group also offered programmes for equine, farm animal, and mixed practitioners.

Known as the In Practice-Graduate Development Programme (IP-GDP), the programme was based on a widely used 70:20:10 educational model. This proposed that approximately 70% of graduate learning should be "on the job", 20% should be social learning through interactions with mentors and others, and 10% should be formal learning. This had been adapted for the IP-GDP, with new graduates spending 70% of their time on case-based experiential learning and reflection on these cases, 20% in 1:1 mentored learning, and 10% undertaking structured/ focused learning mapped to the entrustable professional activities (EPAs) within the VetGDP.

Dr Kelly explained that the IP-GDP began with a two-week onboarding phase comprising structured, taught components, skills acquisition, and a residential element. New graduates then joined their practice, spending a week shadowing different individuals to understand practice protocols, etc. In the fourth week, they began work; they were given longer consultation times and structured times for performing surgeries, and established how they would interact with their VetGDP adviser and set their own goals.

Eighteen months-to-two years were then spent in the "in-programme" phase, during which the graduates worked in practice and completed structured taught courses on clinical and non-clinical professional topics. Learning resources were available on a central hub and tutor groups allowed graduates to share their experiences and learn from cases they had seen. VetGDP advisers offered mentored support and graduates' line managers also checked in with them regularly, while a wider pastoral support team was available if required.

Describing his study, he explained that he had gathered qualitative and quantitative data about the graduate programme before and after its integration with the VetGDP in 2021. His aim had been to assess how the programme was perceived by graduates and their VetGDP advisers and its impact on graduate attrition.

Responses to a survey of graduates who undertook the programme after its integration with the VetGDP were mainly positive, he reported, although issues around communication and graduates taking ownership of the in-house structured learning programme were identified. Mentoring was viewed very positively, but advisers said they needed more time to deliver mentored learning to their graduates. "I think this is a key message," Dr Kelly said. "Mentors want to be able to support their new graduates, but they need more time to be able to do that."

A survival analysis of attrition data gathered from human resources records had found no difference in how long graduates remained in practice before or after the IP-GDP's integration with the VetGDP. The message was that "Graduates get that itch around two to two-and-a-half years in practice," Dr Kelly said. Graduates' previous associations with a practice (eg through extramural studies), staffing levels, and perceptions of a practice had no significant effect on attrition. More research was therefore needed to establish why graduates were moving on.

Concluding, Dr Kelly said the IP-GDP continued to evolve, with enhancements in the areas of professional skills development and independent practice. To try to improve retention of graduates in clinical roles, CVS had now developed a three-year "lifelong career" programme to follow the IP-GDP.

There were no questions following this presentation.

Use of generative AI in postgraduate taught programmes at a UK vet school: a moment in time

Dr Victoria Lindsay-McGee, Programme Coordinator and Teaching Fellow, Royal (Dick) School of Veterinary Studies, University of Edinburgh, UK

"Artificial intelligence is a big buzzword at the moment, and it's everywhere," said Dr Victoria Lindsay-McGee. Although AI had been in development for many years and was not as new as it appeared, it was now becoming more mainstream, with its impact increasingly felt across the veterinary sphere. Given the speed of change, her study represented a snapshot in time, but she hoped it would encourage those responsible for postgraduate veterinary education to look ahead and guide the future development of teaching.

Studies examining generative AI (genAI) use by students in general had found that between 66% and 92% of UK students used genAI in their work and/or studies, and between 3% and 8% had submitted unedited AI-generated material for credit. However, a very recent study had shown that undergraduate veterinary students used AI less in their studies than the wider undergraduate population and felt strongly that they did not want to use it, saying it did not help them achieve their desired learning outcomes.

Dr Lindsay-McGee's study had focused on genAI use by postgraduate students undertaking taught courses at the Royal (Dick) School of Veterinary Studies. Many of the programmes

were taught online and involved part-time study. All postgraduate students enrolled on these courses were invited to complete an online survey and 87 responses were received from students across 13 programmes. Respondents came from 25 countries, although most were based in the UK and USA. The results had been analysed in an attempt to identify a 'typical genAI user'.

Describing her results, she said most respondents belonged to one of two age bands, either 26 to 35 years or 46 to 55 years, which she explained reflected the two key stages at which people tended to enter postgraduate education. Most students reported using genAI in the workplace and in their studies, and there was a strong correlation between workplace use and academic use. "This is something that we're going to have to accept when we're teaching postgraduate students who are also in, or have been in, the workplace," she said. Most students were using ChatGPT although some were using models specifically designed for clinical settings.

No correlation had been found between genAI use and any specific demographic variables: "It was across the board," she said.

Students were asked about their confidence in their fundamental knowledge of AI, and in areas such as ethics, clinical application, assessing accuracy, data privacy and security, and professionalism in relation to AI. In most areas, students reported feeling 'pretty confident', although they were less confident about clinical application and data privacy and security. When asked how useful they would find teaching about AI in these areas, there was strong agreement that such teaching was important and would be welcomed.

Dr Lindsay-McGee commented that principal component analysis had not identified any patterns from the results that would help predict which students were AI users.

Qualitative analysis of the data was ongoing, but she highlighted several student comments. One noted: "AI literacy is key, even if I do not want to use it myself. Clients, colleagues, students will use it and, especially in clinical work, clients will challenge what we do as ChatGPT said something else." She said this was particularly interesting, as it showed students were already anticipating this scenario, and educators therefore needed to consider how they might support students in responding to it.

Other comments indicated that some students were already being asked to use ChatGPT to check clinical cases despite concerns about the accuracy of the answers given. This was worrying, although it was positive that students recognised it was problematic. Another encouraging finding was that students were raising concerns around the sustainability of AI use and its potential to erode learning.

Concluding, Dr Lindsay-McGee said: "There was no typical profile of a generative AI user – they're all using it now, and I think we have to accept that."

In discussion, she was asked whether postgraduates should be taught more about academic literacies related to genAI use, so that they could use it to their advantage. She explained that specific teaching on genAI use was beginning to be embedded into postgraduate programmes at the University of Edinburgh, covering areas such as ethics and data security. The university had a policy outlining permitted levels of AI use in assessments and the intention was to apply this in a structured way that allowed students to develop appropriate skills. However, she noted that there was still considerable uncertainty around this.

Another delegate asked whether teaching should be extended to younger students so they could learn to use AI correctly. "They're going to use it anyway, so this is something that we need to get on top of," Dr Lindsay-McGee agreed. She said many students had a misconceived view of AI as searchable database when, in reality, it was a predictive algorithm designed to produce the most plausible-sounding answer – but not necessarily the correct one. Students therefore

needed guidance on using AI safely in ways that supported their studies but did not remove their ability to develop and learn.

A further question raised the concept of "the illusion of explanatory death" – a cognitive bias in which people thought they knew something better than they actually did. The delegate asking this question commented that learning could be undermined if, thanks to AI, students felt they knew something and did not need to seek out further learning. How could this be considered in teaching? Dr Lindsay-McGee replied that it was essential students learned to critique AI outputs. As part of her survey, she had asked how students evaluated different AI responses, and analysis of these data was ongoing.

The final question addressed how students were using AI, asking if it was mainly for information retrieval or content generation. Dr Lindsay-McGee replied that students seemed to be using AI for tasks such as summarising information and generating outlines.

You think graduates just leave? How support turns the tide

Alison Price, Graduate Development Programme Manager, Linnaeus, UK

Introducing her study, Alison Price MRCVS said that the transition from undergraduate student to practising professional was traditionally viewed as a pinch point in career progression. The first year as a veterinary surgeon was tough: it was the steepest part of the learning curve, confidence could plummet, imposter syndrome could kick in, the pressure of clinical work could be hard to deal with, and wellbeing often fell to its lowest point. "This is exactly where we need to show up for our new graduates," she said.

Describing Linnaeus's graduate development programme, which had been created in 2018 and integrated with the RCVS's Veterinary Graduate Development Programme (VetGDP) in 2021, she explained that it was a two-year pathway aiming to support a practical and comprehensive transition from classroom to consulting room. It encouraged individual growth by offering extensive, robust support to new graduates. The aim was to link all the education and training provided throughout the programme into five themes – mentoring support, clinical excellence, interpersonal excellence, recognition and reward, and career pathways.

"For us it is not a tick-box exercise," Miss Price said. "It's about investing in people from day one, giving them the structure they need to move forward for a fulfilling career in the veterinary profession."

A structured development pathway ran across the two years, which aligned with developmental competencies that could be used to assess progress. Graduates undertook 18 days of

theoretical and practical learning, aligned with VetGDP outcomes and tailored to individual needs. They received regular mentoring from trained mentors, with protected time for this. Graduates had a primary mentor in their practice, who was usually also their VetGDP adviser, with a separate mentor providing pastoral support. Wellbeing was a focus throughout, with normalised discussions around conflict, stresses, mental health, and wellbeing. Peer networking was also integral, allowing new graduates to form friendships within their cohort and support each other.

Since 2018, 260 graduates had enrolled on the programme. Sixty per cent of those who had enrolled in 2018 completed the programme in 2020. The numbers fell in 2021 (53%) and 2022 (46%), reflecting the impact of the COVID-19 pandemic, during which the programme had been delivered online and participants had been unable to benefit from the peer networking element. However, since then an uptick had been evident, with 74% of graduates completing the programme in 2023, rising to 84% in 2024 before declining slightly to 80% in 2025. "We've moved from almost half of our graduates leaving during the programme, to eight in 10 choosing to stay with us [within the Linnaeus group] after the programme finished," Miss Price said. "When we strengthened our support, retention followed."

She went on to say that, beyond the numbers, it was the human stories that mattered most. Feedback from graduates indicated that they felt supported and not alone in their experiences. Mentors wished a similar programme had been available when they were new graduates.

The aim was therefore to create long-term culture change, with support becoming the expected norm rather than the exceptional circumstance.

However, Miss Price commented that although the graduate development programme was proving successful, it was not "job done". Retention rates fell again about two years after programme completion, indicating a need for structured support during the transition from early-career to experienced vet. This was now an area of focus, she said, asking: "How do we keep their development alive beyond those early career years, and how do we help them achieve their career goals and support them to do so?"

Summing up, she said there had been three major learnings from the experience of developing the veterinary graduate programme. First, graduates were less likely to leave when they felt supported. Second, structured mentorship built confidence and loyalty. Finally, investment in people was not a cost, but the foundation of retention and created a sense of belonging. However, support had to be intentional: "If we want our vets to stay, we have to show them that their growth and development matters to us."

Miss Price was subsequently asked if the reasons why graduates left the programme were related to the training, or to life choices. She replied that, in most cases, the decision to leave related to life choices, such as moving to be closer to a partner or family.

Another delegate asked whether online learning was still used as part of the programme, given the drop in retention during the COVID-19 pandemic. Miss Price said that graduates had recently expressed strong support for a hybrid learning model. Online learning was still used, but the peer networking element was in person as it was this that built connections.

Afternoon plenaries

Trends and challenges in veterinary specialty education: a North American perspective

Professor Jane Sykes, Director for the Center of Continuing Professional Education, University of California-Davis, USA

Following lunch, delegates gathered for the first plenary lecture of the afternoon, given by Professor Jane Sykes. She began by explaining that the evolution of veterinary specialty education in the USA was being driven by increasing demand for specialty care. This demand was underpinned by factors including rising pet ownership, the humanisation of pets, and greater uptake of pet insurance. These had stimulated advancements in procedures such as open-heart surgery, plasmapheresis, minimally invasive surgery, and even stereotactic brain surgery, she said.

To meet this demand, more fellowship programmes had been developed to train veterinary specialists. But, she continued, at the same time, veterinarians were seeking greater flexibility in training, improved work-life balance, more affordable pathways, and better working hours. Some also wished to work in specific locations, contributing to a shift of specialists from academia into private practice.

In response, corporate veterinary medicine training programmes were increasingly partnering with academic institutions to train specialists. She explained that these partnerships were attractive to academia because of the high costs of running teaching hospitals and the challenge of remaining profitable. Corporate support allowed more residents to be trained while remaining in private practice.

Alongside these academia–private practice partnerships, specialty organisations such as the European Board of Veterinary Specialisation (EBVS) had been developing more flexible, modular training programmes.

However, Professor Sykes explained that the growing diversity of training programmes had prompted calls for greater oversight to ensure consistency and quality. Concerns had been raised about a 'crisis in intern and resident wellbeing', and whether some specialty training programmes were supporting students as well as they claimed to be. Although the American Association of Veterinary Medical Colleges had developed guidelines for intern and resident wellbeing, these remained voluntary rather than mandatory standards.

Additional challenges included a national shortage of specialists, the loss of veterinary specialty educators, and a mismatch between the number of graduates completing internships and the availability of residency positions. Professor Sykes said that some students were completing multiple specialty internships to make themselves competitive for a residency programme. There had also been a proliferation of poorly defined fellowships, alongside confusion among animal owners about the varying levels of training and expertise associated with different training programmes.

Taken together, she said, these issues highlighted the need to balance flexibility – such as offering modular, distance-learning, and certificate

programmes – with rigour in specialty training. However, there was little research on the outcomes associated with different training models.

She then outlined the history of specialisation in human medicine in the USA, explaining that the first programme for educating and recognising specialists had been established in 1915, through a partnership between the Mayo Clinic and the University of Minnesota. It comprised two elements to assure quality: certification, for which those with further training were judged by selected peers, and accreditation to ensure quality at training institutions. Between 1915 and the 1950s specialty programmes proliferated, and by the late 1950s there were 18 certifying boards covering a range of specialties. By the 1960s, almost all medical graduates completed internships and residencies.

In 1962, amid concerns about fragmentation in postgraduate medical education, the American Medical Association commissioned an external review of internship and residency programmes. This led to internships being merged into residencies and to calls for an independent body to oversee postgraduate medical education. Ultimately, this resulted in the creation of the Accreditation Council for Graduate Medical Education (ACGME) in 1981 as an independent, not-for-profit organisation responsible for evaluating and accrediting graduate training programmes in the USA to ensure their adherence to specialty college requirements.

Professor Sykes explained that while training programmes did not have to be evaluated by the ACGME, programmes without accreditation could not access Medicare and Medicaid funding, and their trainees were not eligible for board examinations.

Returning to veterinary education, she noted that, in 2023, growing concerns around veterinary specialty education had prompted a call to action to the American Veterinary Medical Association (AVMA) for an accrediting body similar to the ACGME. One issue under discussion was the future of veterinary internships. Internships were less clearly defined than residencies, but there was agreement that improved oversight was required. In contrast to human medicine, it was unlikely that internships would be merged into residencies as, given the diversity of species veterinarians dealt with, they offered an important route for graduates to develop a species-specific focus if they wished. However, a question remained about whether internships might become a mandatory additional year of postgraduation training.

She went on to say that there was also a lack of clarity about residency programme requirements and about what was needed to become a registered veterinary speciality organisation offering advanced training and board certification. In contrast, ACGME accreditation required compliance with detailed common training programme requirements, including a competency-based framework encompassing six core competences: patient care and procedural skills; medical knowledge; practice-based learning and improvement; interpersonal and communication skills; professionalism; and systems-based practice.

These competences were assessed across five levels: novice, advanced beginner, competent learner, proficient learner, and expert.

Competency-based systems were learner-centred, Professor Sykes explained. Progression was based on mastering defined knowledge and skills and achieving milestones – observable markers of ability – within a particular competency rather than time spent in training.

She suggested that adopting a competency-based, learner-centred framework for veterinary specialty education would help ensure specialists attained appropriate levels of relevant ability, thus improving patient outcomes. It would also be less prone to rater bias arising from a supervisor's frame of reference. Such a framework would support individualised learning plans, provide a shared roadmap for

learners and educators, and ensure training in non-testable skills such as professionalism, communication, and scholarship.

Veterinary graduates in the USA were increasingly familiar with competency-based frameworks, she said. They expected similar approaches in advanced training. Multiple American veterinary specialty bodies and corporate veterinary groups were already moving in this direction. Developing shared frameworks also offered opportunities to use a common language, avoid pitfalls experienced by other health professions, and harmonise competencies.

Updating delegates on progress since the call to the AVMA for an oversight body for veterinary specialty education, Professor Sykes said multiple meetings had been held and three taskforces recommended: one focusing on internship oversight, one on common residency standards, and one on creating a shared investment plan to develop a customised data management platform. Guidelines for residency training programmes, including recommendations for competency-based assessment, were close to completion, she said.

She concluded by briefly addressing legal considerations associated with the evolving landscape of veterinary specialty education.

In discussion, a delegate noted that the American Association of Veterinary State Boards already operated the Registry of Approved Continuing Education (RACE) programme to develop and apply uniform standards for veterinary continuing education. They asked why RACE had evolved as a for-profit organisation, rather than a non-profit body as in the medical field. Professor Sykes clarified that RACE accredited continuing veterinary education programmes, for which providers paid accreditation fees. Veterinarians in the USA had to complete a set number of hours of RACE-accredited continuing education each year. This, she emphasised was fundamentally different from the accreditation of specialty education training programmes.

Advancing human nursing practice within the UK and wider

Wendy Preston, Head of Nursing Workforce, Royal College of Nursing, UK

To set the context for her presentation, Wendy Preston began by outlining her current roles. She was Head of Nursing Workforce at the Royal College of Nursing (RCN), the professional body for (human) nursing and the largest trade union in the UK, with nearly 600,000 members. She had worked at the RCN for nine years, but previously had been a full-time consultant nurse, a role she still held in an honorary capacity. She also worked as an advanced practitioner in primary care.

She explained that advanced nursing had existed for many years – about 50 years in the USA and parts of Canada – but had developed differently across the world. In Africa, for example, advanced nursing often focused on population health and rural communities, while on some Caribbean islands, an advanced nurse might be the only healthcare professional providing care.

For the past four or five years, Ms Preston had chaired the Advanced Practice Nursing Working Group convened by the European Federation of Nurses Associations (EFN), which represents the nursing profession across Europe. This work was linked to her PhD studies in nursing research.

The aim of the working group, which included representatives from 18 countries, was to develop and agree Europe-wide principles for advanced-level nursing practice to reduce variation across countries. Early survey work had revealed wide differences in understanding and implementation of advanced nursing practice. In some countries, including the UK and Estonia, advanced practice was well established, while in others it was not. For example, nurses in the UK were legally empowered to prescribe independently, but in some countries, they were permitted only to prescribe dressings.

Reducing this variation was essential to moving advanced nursing forward, she said, as it would allow a common training framework to be developed across Europe and globally. The EFN worked with the International Council of Nurses, which brought together national nursing associations worldwide.

The working group considered the education and capabilities required for advanced nursing practice and developed a toolkit of eight core competences and five country-level principles for all countries to work towards. These principles were:

- a minimum requirement of a full master's degree;
- protection of the role/title of advanced nurse;
- recognition of advanced practice nurses as autonomous clinical experts able to work to their full scope of practice, including diagnosis, prescribing, referral, and discharge;
- legislation to support independent nurse prescribing; and
- formal recognition of advanced practice nurses, with systems to ensure ongoing continuing professional development, competence, and currency of practice.

The toolkit, agreed by all 36 EFN members, reflected the cultural shift in nursing in recent decades, she said. In the UK, for example, few nurses held a degree before this became mandatory in 2013. Similarly, while diagnosis had historically been the preserve of doctors, Ms Preston commented that, nowadays, "I diagnose all of the time."

The working group had also developed a roadmap and milestones to support countries in achieving these principles.

With respect to the requirement for postgraduate education, she stressed the importance of ensuring consistent standards across Europe, particularly in the detail of master's degrees. A recent survey had suggested that "We're moving in the right direction," she reported.

She went on to say that there was a strong appetite across Europe for a common training framework for nursing, and she believed that the EFN work and her research would help demonstrate this. However, independent nurse prescribing remained a challenge. The UK had a good model, but internationally 'there's a long way to go'. A separate roadmap had been developed to support countries in implementing independent nurse prescribing.

Turning to the UK context, Ms Preston noted that, despite the RCN existing for more than 100 years, there had not previously been a UK-wide professional framework for nursing. In recent years, she had been leading work to develop such a framework. The first step had been to redefine nursing to reflect how it had changed since the previous definition over 20 years earlier. Three levels of nursing practice were established – enhanced, advanced, and consultant – aligning with levels used in other healthcare professions, such as pharmacy, physiotherapy, and radiology.

These levels were linked to the four pillars of nursing – clinical, research, education, and

leadership – with complexity within the pillars increasing with the levels of nursing practice. Research had been the most challenging pillar, she said, as many nurses had limited research involvement in their roles, although more nurse researchers were now emerging.

She gave some examples of advanced nursing practice across the UK, highlighting that in the Scottish islands, advanced nurses were sometimes the only clinicians available. In Wales, advanced district nurses led care across nursing and care homes, providing the daily and weekly rounds traditionally done previously by general practitioners. A similar model existed in Northern Ireland. In England, advanced nurses were leading same-day emergency care services.

Ms Preston then described her own role as an advanced practice nurse in an out-of-hours general practice service within the NHS 111 system. The service used a shared career and competency framework across medicine, nursing, and allied healthcare professions and operated a multiprofessional rota. She typically worked night shifts as the sole clinician for approximately 350,000 people, although workforce pressures meant she was often responsible for 500,000 people. "I have the authority and the responsibility and the autonomy to do what I need to do," she said, including assessment, diagnosis, and referral. A common audit process was used, regardless of the profession of the clinician.

She had worked in this role for 15 years. When she started, she had been introduced as a nurse. Now, all staff were referred to as clinicians. And, she said: "We've just achieved my wish – on our new cars, it doesn't say 'Doctor' on the top anymore, it says 'Clinician'."

In concluding, Ms Preston said developing the first UK professional nursing framework had required significant effort. The intention was that a shared professional language would spread across the UK and then Europe, enabling common standards and greater professional mobility for nurses.

During questions, Ms Preston was asked for advice on developing a common framework for veterinary nursing across Europe, with it being pointed out that, while the profession was well developed in the UK, in some countries veterinarians could work their entire career without veterinary nurses. She was also asked about the use of the term 'clinician' which, a delegate suggested, could boost the status of a nurse but also confuse clients.

In response, Ms Preston said "clinician" was a "really useful" cross-professional term. In human medicine, guidance referring specifically to a 'physician' excluded nurses from certain activities. It had taken sustained effort to change some of the language, she said. On developing a common framework, she advised taking "baby steps", pointing out that agreement from just nine countries was sufficient to establish a common training framework for a profession within the European Union.

A further question addressed the legislative changes required to support advanced nursing roles. Ms Preston explained that legislation enabling nurse prescribing in the UK had existed since about 1999, and had been extended in 2006 to allow independent prescribing. Further changes had allowed nurses to sign 'fit notes', although other legislation, including mental health law, still required updating.

Finally, a delegate observed that veterinary surgeons valued their close professional links with veterinary nurses and, in contrast, many of the developments in human healthcare seemed to be distancing nurses from doctors. Was this a conscious move or had it emerged in response to staffing challenges in the medical profession? Ms Preston said she felt the human medical and nursing professions had in fact grown closer, worked collaboratively, and shared elements of curricula. "It's not about pitching ourselves against doctors," she said, "it's about how we work collaboratively."

New ideas and innovations

Audience participation was very much encouraged in the next element of the symposium, with delegates being invited to contribute their comments and suggestions following short presentations during which a new idea or innovation for supporting postgraduate education was pitched to them.

Parallel postgraduate training for vets and nurses: building mutual understanding to improve team performance

Dr Peter Kronen, VASTA Founder and Director, Veterinary Anaesthesia School for Veterinarians and Nurses (VASTA)

The first innovation presented was that of parallel postgraduate training for vets and nurses. Introducing it, Dr Peter Kronen said the concept may seem "a bit provocative", but he explained, "We believe that it may lead to better mutual understanding and better team performance."

He showed an animated reconstruction of a Korean Airlines flight that had crashed on its approach to Guam airport in 1997. One of the reasons it had crashed, he said, was because the junior co-pilot had been afraid to correct the senior pilot when an incorrect approach to the runway had been taken. Dr Kronen suggested there were many similarities between this situation and what was seen in operating theatres.

Elaborating, he explained that the stages of anaesthesia were often compared with the stages of aeroplane flight – induction of anaesthesia was analogous to take-off, maintenance to the in-flight period, and recovery to the landing phase. Both environments were high risk, high tech and stressful, with similar problems and risk structures.

He suggested that separate anaesthesia training for vets and nurses could drive communication failure in the operating theatre. In contrast, a single training programme with parallel tracks for vets and nurses, led by specialists and delivered either nationally or regionally, would help define and protect the separate responsibilities of vets and nurses. It would also ensure common terminology and shared language when describing anaesthesia and anaesthesia-related complications, while promoting a "checklist culture" would develop teamwork and rehearsed responses.

Ultimately, the result would be role clarity, empowered voices, and safer patient care, he concluded.

Discussion

There was good support for Dr Kronen's proposal among the audience.

Several delegates asked how the training offered by the Veterinary Anaesthesia School for Veterinarians and Nurses, which Dr Kronen had founded, was implemented practically. Was it delivered in the clinic with teams that worked together on a day-to-day basis, or as a CPD programme bringing individuals from different teams together? Also, were nurses involved in leading or teaching some of the content? It was suggested that this would be valuable and support engagement with the training.

Responding, Dr Kronen explained that the training comprised several modules delivered

over the course of a year. Classroom-based education, simulations, and practical teaching were all used. "We clearly define the responsibilities, we clearly define the roles, we clearly define and train the interplay," he said. The intention was to deliver the course in different countries rather than making people travel to a central location. It would be 'great' if nurses could deliver the training, but he pointed out that specialist veterinary nurses were 'very rare' and not universally available.

One delegate noted that Dr Kronen's proposal focused on postgraduate training, and suggested that parallel training should actually start during undergraduate education. This would provide a foundation for a smooth transition to postgraduate settings, they said. Dr Kronen said he would welcome this; however, traditionally, undergraduate vets and nurses were educated separately and currently it was only after graduation that they worked together.

Following up on this remark, a delegate from the new UK veterinary school established by Scotland's Rural College commented that they were trying to embed joint training in their curriculum as they had the ability to deliver it. However, barriers were already being encountered and there seemed to be an ingrained mentality around separate training.

Another delegate noted that anaesthesia breakdowns, team failures, and anaesthetic deaths were frequently the subject of concerns raised with the RCVS and were often related to team dysfunction or a failure to challenge. They would therefore 'thoroughly support' the approach proposed by Dr Kronen.

Welcoming this comment, Dr Kronen said his ideal scenario for safety in veterinary anaesthesia provision would be one in which there was a dual approach to delivery, with a responsible veterinary surgeon – ideally a specialist veterinary anaesthetist – in a team with an anaesthesia nurse. However, this was not yet realisable in all countries.

Another delegate asked about the integration of checklists into veterinary practice. Dr Kronen said that checklists were particularly useful when those with safety-critical roles were tired or stressed as they helped avoid errors that must not happen (such as operating on the wrong patient). The purpose of a checklist was not to remove the need for human expertise, knowledge, or skills, he said, rather, it provided a consistent, stepwise approach to ensuring every essential element was considered. "We believe that a checklist is a possibility to avoid human error due to tiredness," he concluded.

To work collaboratively to create an international, shared resource for assessment items for specialty training

Dr Linda Prescott-Clements, Director of Education, RCVS

The second idea pitched to delegates was the creation of an international, shared resource that would help speciality veterinary colleges ensure consistent, high-standard assessment of their students.

Introducing the proposal, Dr Linda Prescott-Clements explained that creating, quality assuring and assessing good training programmes was effort-intensive, and not all specialty veterinary colleges had the same level of resources available – many relied heavily on volunteers. Creating an international bank of assessment items such as multiple-choice questions (MCQs) could help colleges address challenges around assessments in different geographical areas, ensuring the validity, reliability, and measurement of examinations, and the sharing of evaluation data. It could also support smaller colleges with limited resources to dedicate to quality assurance.

It was envisaged that the resource bank would be a collaborative effort, she said, with each member of the collaboration committing to submit a certain number of items to it each year. Items would be tagged not only in respect to clinical areas, but also to identify particular geographical or cultural contexts, to facilitate the selection of questions to use in assessments. Each specialty college's unique identity could be maintained through the use of college-specific blueprints for each examination and its own implementation conditions.

She went on to explain how the resource bank might operate. Commercial software would be used to develop a secure platform where colleges could import, write, and share questions, and a common, shared list of item tags would specify details of species, geographical region, etc., as questions were imported or created. Users could search the bank using these item codes and find questions to include in draft test forms tailored to their own blueprint and addressing any constraints they may have. The draft forms would be reviewed, with alternative questions substituted if required, before being finalised.

Specialty colleges would be able to export forms for publication and administration and import information on the performance (reliability) of items so that when other users came to choose questions from the bank, they would know how questions performed in different contexts.

Only authorised users would be able to access the shared bank of items, Dr Prescott-Clements said. Items would not be editable but they could be copied to create new questions if changes were required to make a question suitable for a particular college or local population. She reported that the International Council for Veterinary Assessment (ICVA) had a small pool of test questions that were appropriate for use by specialist colleges and would be willing to contribute these to the shared bank for wider use.

Discussion

Describing the proposal as potentially "a really exciting development", one delegate asked whether artificial intelligence (AI) could help populate the bank with resources. Responding, Dr Prescott-Clements said AI could be very helpful as the process of building up resource banks traditionally had been slow. However, performance data about the items developed with the support of AI had to be available to allow assessment of how well they were working and to check they were tagged appropriately.

Another delegate felt that the proposal was "really interesting" but asked whether it was a case of "the tail wagging the dog". Was there an argument to have a shared bank of learning outcomes, for example, rather than driving it by assessment?

There was an argument for this, Dr Prescott-Clements agreed, and a learning outcomes bank would help everyone work to the same outcomes. However, the idea for the assessment resources bank had been driven by the particularly labour-intensive nature of creating material for exams, even with the support of AI.

A different delegate asked whether there would there be any minimum contribution required by those taking resources from the bank, to ensure that users were contributing as well as taking.

Dr Prescott-Clements agreed that the bank would only work if colleges contributed resources as well as using them. She felt there should probably be a minimum contribution required, but this had to be achievable, so might vary depending on the size of the college.

"Why aren't you doing this at undergraduate level first?" was a further question, with the delegate asking it noting that there was huge variability in the quality and depth of knowledge across undergraduate education.

Responding, Dr Prescott-Clements said that, to her knowledge, the UK vet schools did share questions from final examinations between them. She was unsure whether this continued as it was difficult to maintain and keep up to date, and required resources to contribute questions and ensure they were performing as intended. This was where support from an experienced third party such as the ICVA might be valuable with respect to the postgraduate proposal.

In a follow-up remark, the same delegate said he agreed with the principle behind the proposal for the shared bank of assessment resources – writing exam questions was "incredibly difficult" – but collaboration was already happening. The American and European colleges of veterinary critical care were already collaborating on question banks, for example, and he was not sure there was scope for a new business model.

Another delegate pointed out that it was also very difficult to write milestones for competency frameworks. There was "real scope" to develop resource banks in this area, too, they suggested, and these would not need the same level of security as required for banks of exam questions.

Noting that the proposed bank would comprise resources such as MCQs and short answer questions, a delegate asked whether there would be scope to include resources for workplace-based assessments. Such a bank would be "a wonderful resource", but could it be used for programmatic assessment rather than the high-stakes end-of-training assessment?

Replying, Dr Prescott-Clements commented that workplace-based assessments were based on how a trainee dealt with a patient or case in situ. This did not lend itself to sharing so well, beyond a framework or specific format.

Finally, one delegate wondered whether, if the specialty colleges came on board with the idea, they might change their accreditation criteria to, say, require a specialist to contribute five referenced, peer-reviewed questions as part of their reaccreditation process.

Can we map postgraduate opportunities? Using European Board of Veterinary Specialisation (EBVS) data to optimise resident training and workforce balance

Julie Rosser, Chief Executive Officer, EBVS

Dr Julie Rosser began her presentation by asking how many delegates knew what the European Board of Veterinary Specialisation (EBVS) did. More than half indicated that they did so. For those who were not aware, she explained it was an umbrella organisation responsible for certifying 39 different specialties across 59 different countries. However, for the purposes of her proposal, she wanted to explore postgraduate education "from the bottom up" from the perspective of the value chain.

Looking at EBVS data on specialists by number across Europe, many (1,200 EBVS specialists of a total of over 5,000) were UK-based, she said. However, when examined as a proportion of the total number of vets in each country, a different picture emerged. Switzerland, for example, became a "huge outlier", with 16.6% of its vets being EBVS specialists, as compared with 4.7% in the UK.

How did this relate to postgraduate education? Dr Rosser explained that examining the granularity of the veterinary profession allowed potential opportunities and risk factors to be identified: "Are we training enough people? Are we training too many people? How many national specialists or certificate holders do we need? How many students can we expect to go into internships?"

There was a lot of information that was not being tapped into, she said, proposing that examining it in more detail and making comparisons between countries could help identify ranges for a healthy veterinary value chain in each country. There might be significant differences between cultures and systems in Europe. Establishing a picture of a healthy veterinary value chain for a country might identify additional opportunities for the profession and make it more resilient in the "inevitable veterinary business cycle, which we all know comes with ups and downs".

Dr Rosser added that it was possible to examine details such as the number of specialists per sector in a country – for example, Germany led Europe in terms of small animal specialists, and the UK was second behind France for equine specialists. This meant: "We can really dive into the detail and understand what we need from postgraduate education and ask what can we expect in the next three-to-five years of postgraduate education, and where are the risk factors?" she concluded.

Discussion

Following Dr Rosser's presentation, one delegate commented she had had to leave her home country of France to pursue specialty training in anaesthesia, but when she wanted to return to France, her skills had not been valued. She believed that the value of speciality training also needed to be communicated throughout the European veterinary community.

Acknowledging this, Dr Rosser reported that the EBVS was now hearing that residents in specialty training were concerned they would be unable to find a job at the end of their training. The EBVS's goal was to identify additional opportunities

that could be leveraged better across the entire veterinary value chain. “We need to have more information about our value chain so that we can identify where we’re missing opportunities, where there are risk factors,” she said. It was important to know how the market was developing and assess what action might be needed.

Another delegate asked about the situation in Switzerland – how was a small country supporting such a high level of specialisation? Dr Rosser replied that anecdotal feedback suggested consumers in Switzerland appeared to know what specialists were and understood their value. An extensive marketing audit of the entire veterinary value chain across Europe (not just EBVS specialists) had shown that: “None of us are particularly good at tooting our own horn”, she said. “Every stakeholder that I have engaged with at some level has expressed the feeling that society doesn’t understand the value that veterinarians contribute... it would make sense that if the feedback I get anecdotally from Switzerland is that clients know what specialists are and what they’re getting for that value, that their number might be so much higher than the rest of ours.”

Finally, a delegate asked about making the route to specialisation more accessible, particularly for vets for whom a more traditional route was not possible.

In response, Dr Rosser noted that the EBVS now offered a flexible pathway to specialisation. When first developed, there had been concerns that it might be too accessible and too easy, but these had proved unfounded, she said. The pathway was extremely challenging, and: “What we have learned is that if a candidate has total ownership of their experience, it means that they are accountable alone for the entire thing,” she commented. Some countries did not have enough specialists, or lacked specialists in certain fields, and the EBVS hoped that the flexible pathway would offer more opportunities for more vets to train.

Veterinary postgraduate education: time to move past the 'stick-and-carrot approach' to a coaching approach?

Aurora Zoff, Veterinary Anaesthetist, North Downs Specialist Referrals, UK

Putting forward the final proposal of the session, Aurora Zoff MRCVS said that on being appointed intern director at North Downs Specialist Referrals she had enrolled on a coaching programme as she believed that integrating coaching into teaching was "a great idea".

Highlighting the advantages of a coaching approach she contrasted it with a traditional 'stick-and-carrot' teaching approach. In the latter, she said, learners were motivated through rewards and punishments whereas a coaching approach encouraged motivation through curiosity and self-reflection. A stick-and-carrot approach focused on compliance, while a coaching approach emphasised setting goals and achieving them through changes in behaviour – the focus was on intrinsic motivation. Leadership styles differed too, with leaders being instructors in the stick-and-carrot approach, while in coaching they acted as facilitators and partners, ensuring learners achieved their individual goals.

Feedback could be judgemental and corrective under the stick-and-carrot approach, she continued. In contrast, in coaching, feedback was exploratory and supportive, with curiosity around why something had happened. The stick-and-carrot approach also focused on short-term results, like daily successes or compliance with the teacher's instructions. With coaching the focus was on building long-term engagement and self-resilience so that learning continued beyond the end of the training programme. "We want to make sure that the learner has intrinsic motivation to keep on learning without their instructor present," Miss Zoff said.

Finally, the stick-and-carrot approach assumed that learners needed control, that they needed to be checked and approved. The assumption of the coaching approach was that learners needed accountability to achieve their goals.

Proposing, therefore, that it was time to integrate a coaching approach into postgraduate veterinary education, she said she was interested in hearing the experiences of qualified coaches in the audience and how they integrated this approach into veterinary medicine and education.

Discussion

Miss Zoff was asked what she thought the consequences of using a coaching approach might be for current systems of assessment. In response, she said that the coaching approach would not necessarily change what was being assessed but it might change "how we get the learners there".

One delegate asked how coaching skills could be facilitated in individuals who would be delivering such an approach to training. Miss Zoff commented that not everyone would have the drive or interest to become an accredited coach, and some learners actually preferred a stick-and-carrot approach and fared better with it. There were also some circumstances – in the emergency room, for example – where a more directive approach was required.

Another delegate pointed out that training people in giving good feedback was also an important element of developing a coaching approach.

Describing a coaching programme for vet students, one delegate explained that the students had access to a dedicated professional coach who was not one of their clinical instructors or mentors. The programme had been designed this way, and the role of the professional coach was to help students develop their professional identity. The delegate went on to say that much had been learned from implementing the programme in an educational setting, including that, if a genuinely authentic coaching relationship was the aim, some things could not be done – such as having coaches assess students. Coaching relationships needed to be based on trust, they said, and trust could be breached if a student felt their coach would ultimately be making a judgement about them.

"The best coaching relationship is with someone who doesn't understand your world, because they can't slip into that clinical mentoring [role]," the delegate said. Coaches could help with reflection, and ask what someone had learned from an experience, and what their action plan was, but this had to be disconnected from assessment.

Miss Zoff agreed, saying trust was very important in coaching and that a coach did not have to be a vet to coach a vet.

Finally, one delegate noted that there were multiple ways of teaching, including coaching, and learners' needs changed throughout their learning journey. For instance, initially, they would need a lot of direction. Then they might require someone who could flex around their needs. It was important to recognise this. Educators could and should develop their toolkit but they should be clear about their roles and what they were trying to do.

Parallel sessions (Banqueting Hall, afternoon): Postgraduate education (I)

The final sessions of the first afternoon of the symposium were again presented in parallel, giving delegates the chance to hear from a series of speakers on a range of topics.

A vision or a necessity? Strengthening the role of veterinary nurses in team-based veterinary healthcare

Jill Macdonald RVN, Veterinary Nursing Progression and Development Lead, RCVS

"This is not a fait accompli, this is a WIP – work in progress," began Miss Macdonald. "We don't have an answer yet, we're still asking the questions. But we are getting there."

She explained that the project had begun with a UK-wide series of events titled 'VN vision, the future of team-based veterinary healthcare' attended exclusively by registered (RVN) and student (SVN) veterinary nurses to gather their unfiltered views. Extensive data had been collected on how veterinary nurses envisaged the future of veterinary healthcare delivery. There had been "some amazing results", she said, which had been categorised into five key areas: culture, enhancing the veterinary nurse role, leadership, education, and regulation to support practice.

A key insight gained concerned responsibility and autonomy. Veterinary nurses said that the skills they acquired through their training were often underused in practice. However, they then suggested tasks that they wanted to undertake which, in reality, Miss Macdonald said, they were already permitted to do. Therefore, before exploring a future vision for veterinary nursing and how it might fit into veterinary healthcare delivery, the project had looked at what was currently happening, how veterinary nurses' skills might be used more effectively in practice, how veterinary nurses could be better integrated into multidisciplinary teams, and the steps needed to achieve this. The focus was on defining long-term goals and practical, context-sensitive steps, acknowledging that solutions might differ between practices. There was also a need for measurable indicators of success.

Subsequent workshops had involved all veterinary team members to develop a theory of change. Rather than imposing solutions, the project sought input from the professions on how to improve the situation and turn it around. While ensuring a strong veterinary nurse role was key, there was a broader aim too: fostering effective, collaborative, team-based veterinary healthcare delivery. "That would be our long-term goal," Miss Macdonald said.

The project examined the outcomes needed to achieve this goal, related activities, enablers, preventers, and underlying assumptions. Ideas from all workshop participants were pooled before participants were asked to choose the three that resonated most with them.

The key themes to emerge were culture, education, and mutual understanding. However, Miss Macdonald commented that "it's probably all about culture" – how team members worked together, and how they perceived, communicated with, respected, and trusted one another, as

well as confidence, competence, and practice hierarchy. She noted that less hierarchical practice structures encouraged more open communication and a more balanced team dynamic.

She went on to say interprofessional education and understanding had been emphasised in every workshop. This went beyond vets and nurses learning together; it meant truly understanding each other's roles. The question was how principles of team-based veterinary healthcare could be integrated into veterinary and veterinary nursing education. The RCVS was reviewing Day-One Skills and Competences for veterinary nurses to define a 'standard' and a 'more advanced' veterinary nurse. The role of animal nursing assistants (ANAs) was also being considered, as they were 'the foundations of healthcare delivery', allowing veterinary nurses to take on more advanced responsibilities.

Understanding was crucial. Both vets and veterinary nurses lacked confidence in interpreting Schedule 3 of the Veterinary Surgeons Act, she said, and as a consequence, delegation did not work well in practice.

Miss Macdonald then outlined some key questions around education: How to assure consistent, impactful interprofessional education? What should future Day-One Skills and Competencies include? How to structure the ANA role effectively? What continuing professional development (CPD) would support veterinary nurses' expanded roles and build trust with vets? How should post-registration qualifications be structured? Although a Level 6/7 Certificate in Advanced Veterinary Nursing existed, it currently did not alter veterinary nurses' practical responsibilities, she said. Finally, how could an Advanced Practitioner role be developed and integrated?

As for potential impacts, Miss Macdonald hoped the project would foster a culture that nurtured and developed all veterinary team members, promoted a genuine team-based approach to veterinary care, and resulted in increased role satisfaction and retention for both vets and veterinary nurses. Both would benefit, she said, because if nurses took on simpler tasks in practice, vets would be freed to focus on more complex cases. This would improve patient care and increase access to veterinary services, ultimately restoring public trust in the profession.

The plan was to continue data collection into 2026 before performing a thematic analysis. A theory of change would then be developed with the support of a consultant, after which the activities needed to achieve the outcomes would be considered, and success measures identified. Participants would receive regular updates about the project and there might be opportunities for them to contribute to the draft theory of change.

After Miss Macdonald's presentation one delegate asked whether there was any insight into where the confusion around Schedule 3 arose. Miss Macdonald noted that a 2017 survey had showed a persistent lack of understanding, with feedback describing Schedule 3 as 'too grey' or 'ambiguous'. Some vets and nurses felt confident interpreting it; others were hesitant about doing so, or were reluctant consult the RCVS for help. The same delegate then pointed out that *RCVS Code of Professional Conduct* guidance interpreted parts of Schedule 3 narrowly, which contrasted with comments about the lack of clarity. In this situation it was easy to see where the uncertainty arose.

Miss Macdonald replied that the issue was multifaceted. It was not just about a lack of understanding of Schedule 3 and the guidance, but also of nurses' capabilities, and a reluctance on vets' behalf to relinquish certain tasks. Many factors fed in to it.

Another delegate asked about the impact of revised 'under care' guidance. Miss Macdonald said this had "opened things up considerably", but it was unclear if practices had embraced it fully. Some had, but the RCVS might need to highlight the guidance and demonstrate how it could enhance veterinary nurses' autonomy.

From guidelines to growth: using care frameworks to support continuing professional development in first opinion practice

Stuart Garde, Head of Clinical Development, IVC Evidensia

Dr Stuart Garde MRCVS began by noting that, in 'The Hitchhiker's Guide to the Galaxy', the number 42 was quoted as the answer 'to life, the universe, and everything' but that no-one knew what the question was. For his presentation, the answer was not 42, it was 17 – 17 years to be precise – but what was the question?

Enlightening his audience, he explained that, according to a review by Morris et al. (doi: 10.1258/jrsm.2011.110180) 17 years was how long, on average, it took for new health research to make its way into clinical practice. In human medicine, this was rarely a problem, but in veterinary medicine, where patients' lifespans were measured in years rather than decades, it meant many animals did not benefit from the best available evidence in their lifetime.

Clinical research was translated into clinical decision-making via several steps, including guideline development. However, in primary care veterinary practice, the translation step was often "where things fall apart", he said. There were some excellent consensus statements and guidelines, but these tended to share common challenges – they may not be comprehensive, or were inaccessible, overly lengthy, and updating them could take time, making them difficult for busy clinicians to use effectively at the point of care. This gap between evidence and practice had motivated IVC Evidensia to develop care frameworks.

Care frameworks aimed to bridge research and real-world application by combining the best available evidence, expert advice, and practical experience in a concise, accessible format. IVC Evidensia's first care framework had been "born out of necessity", Dr Garde explained, from a quality improvement exercise for canine otitis externa care. This condition affected around 10% of dogs seen in primary care practice but was frustrating to manage, and clinical practice varied widely, with no specific, practical guidelines available on its management. A clinical audit across all of IVC Evidensia's nearly 1,000 practices had found that ear swab microscopy was performed in only 15% of cases despite dermatologists recommending that it should be performed for every case. Antibiotic ear drops were prescribed in over 70% of cases, much more than in Scandinavian countries, where diagnostic rates were higher and antibiotic use lower.

A pilot educational intervention, focusing on diagnostic approaches and rational prescribing, had successfully improved clinical measures, he continued. Use of ear swab microscopy increased and antibiotic prescribing fell. This success led to the formation of a multidisciplinary working group, including dermatologists, subject matter experts, and frontline vets and vet nurses, to develop a novel tool that combined the rigour of evidence-based guidelines with the practicality of concepts like care bundles – small sets of key evidence-based interventions that had been shown to improve patient outcomes drastically in human healthcare.

The result was the canine otitis externa care framework, which condensed a best practice

approach into 10 recommendations grouped under four headings across four categories: patient welfare, diagnostics, treatment, and client care. These were supported by detailed educational materials such as decision trees, flowcharts, drug charts, evidence summaries, and instructional videos.

This care framework became the template for others covering common, high prevalence conditions such as periodontal disease, osteoarthritis, and atopic dermatitis, as well as less common but complex conditions such as mitral valve disease, Cushing's syndrome, and canine and feline diabetes mellitus. Frameworks addressing welfare topics like end-of-life care and behavioural first aid had also been developed, recognising that evidence-based medicine extended beyond diagnostics and drugs to encompass communication and decision-making.

To date, Dr Garde reported, 20 care frameworks had been created through collaborative efforts involving referral clinicians, primary care vets and vet nurses, and client care teams. This diversity ensured each framework was evidence-based, yet practical for use in the reality of 15-minute consultations and busy clinical environments.

Accessibility was a key feature: all frameworks were hosted on the company intranet and accessible from any practice computer, allowing clinicians to consult them before seeing patients. Digital hosting also facilitated rapid updates when new evidence or medications emerged, eliminating the long delays typical of traditional guideline updates.

Feedback from practices had been "overwhelmingly positive", he said. A survey showed 88% of respondents were aware of the frameworks; 71% found them very or extremely useful; 64% agreed or strongly agreed the frameworks had changed their case management; and 64% agreed they had helped reduce antibiotic use. Recent graduates had been especially enthusiastic, saying the frameworks provided confidence, structure, and current evidence in daily practice. They also said they felt more empowered to challenge outdated clinical habits in experienced colleagues.

The care frameworks had become catalysts for team development, too. Practices used them to reflect on cases, identify successes and areas for improvement, and compare their approaches to framework recommendations. This often sparked quality improvement projects tailored to their own data and patient population.

To support such quality improvement initiatives, clinical benchmarking reports had been developed and linked to 13 care frameworks. These used real-world clinical data to help practices identify care gaps and track improvement over time. Dr Garde said that the results had been impressive. For canine otitis externa, within a year, ear swab microscopy increased from 16% to 25%, topical steroid use doubled, and antibiotic prescriptions dropped from 62% to 49%. This translated to 26,000 fewer antibiotic prescriptions and improved care for 17,116 dogs. Similar improvements had been seen in canine periodontal disease and feline renal disease, benefiting hundreds of animals.

"These are real, measurable changes in clinical behaviour and they have happened at scale across hundreds of practices in less than a year of implementation," he said. In fact, thanks to the combined impact of the care frameworks, more than 60,000 patients had received improved care.

He went on to say that, beyond clinical outcomes, the frameworks were redefining continuing professional development (CPD) at IVC Evidensia. Meaningful CPD should improve care by changing clinical practice, he said, rather than focusing on attendance and certificates. IVC Evidensia had aligned its approach with the RCVS's modern definition of CPD as a reflective, continuous cycle involving acquiring knowledge, applying learning in practice, and reviewing

outcomes. This made CPD "more than a tick-box exercise"; it became a learning loop that drove genuine improvement.

Concluding, he reiterated that the care frameworks were created to make evidence-based medicine more accessible, actionable, and engaging for primary care teams. They integrated research, expertise, and clinical data into practical tools that empowered clinicians to make better, more consistent decisions and foster reflective, team-based learning. Most importantly, they had led to measurable enhancements in clinical care and animal welfare.

In discussion, Dr Garde was asked who took responsibility for updating the frameworks and how veterinary teams were made aware of updates. Responding, he said that "quick updates" were done as and when needed. Bigger changes would be reviewed by specialists within IVC on a three-year cycle where possible. The best way of alerting teams to updates was still being decided, but as the number of frameworks increased it would become more important that users were aware of updates to ensure they accessed the most up-to-date versions.

Another delegate asked how the frameworks fitted with contextualised care. If there was a framework for vets to follow, could this affect how care was tailored to an owner's context? For example, using ear cytology in canine otitis externa incurred a cost. Were there alternative pathways or options vets could use when following the frameworks?

"We've definitely stuck with giving recommendations, rather than spelling it out," Dr Garde replied. "Tools not rules is our approach." Most practitioners wanted the best outcomes for their patients and following the recommendations should lead to better outcomes. But if they could not follow the recommendations, they were able to take the best approach with the resources available to them. Contextualised care had been considered when building the frameworks by involving vets and vet nurses who saw cases daily and could advise on factors that needed to be taken into account.

Active learning activities in postgraduate veterinary education: strengthening clinical reasoning, transfer, and engagement

Gemma Coleman, Content Co-ordinator and Editor, Improve Veterinary Education, UK

Traditionally, many veterinary online training programmes relied on lengthy, video-centric lessons that encouraged passive consumption of information and led to poor transfer of learning, said Gemma Coleman MRCVS. In contrast, approaches to education for human healthcare professionals demonstrated that active learning improved achievement, lowered failure rates, and corrected the 'illusion of learning' often created by polished lectures.

She then introduced the ICAP (Interactive, Constructive, Active, Passive) framework, which predicted a graded benefit where learning outcomes improved as engagement shifted from passive to interactive modes. This spectrum of competences aligned closely with the skills veterinary surgeons needed in practice, she said.

The project she was describing had aimed to implement a framework of active learning activities (ALAs) across the education programmes offered by Improve Veterinary Education. The ALAs were designed to move learners beyond watching to doing, thinking, debating, and creating, thereby strengthening their diagnostic reasoning, decision-making under uncertainty, and real-world application, while sustaining motivation in an online format.

"In addition to sound pedagogical foundations, we firmly believe that learning and online learning should be fun," she said. "It should be practical and engaging."

Miss Coleman provided an overview of the ALAs created. Two key activities focused on error management and reverse engineering of clinical cases, emphasising that while errors were inevitable, harm was not. "It's what we do when an error is made, and how we learn and reflect and grow from that that becomes important," she said.

In the error management training ALA, learners worked with cases designed to be ambiguous. They were expected to make mistakes, which were then analysed, and responses and outcomes planned. The reverse engineering ALA presented the final outcome first – good or poor – and asked learners to deconstruct the case by tracing back the clinical reasoning. This helped them identify critical decision points and reflect on improvements for future cases.

Another ALA was a visual synthesis challenge, where learners built concept maps or decision trees from scratch and then compared them to expert gold standards, reflecting on differences and similarities.

Interactive clinical cases formed another ALA, involving branching decisions with consequences that emphasised reassessment loops and replicated real-world outcomes. A further ALA used active checklists – procedural checklists, normally for technical skills – as dynamic practice and assessment tools with targeted feedback.

The 'Human vs AI' ALA invited learners to compare algorithmic outputs with expert judgement, not to guess which was which, but to justify differences and agree on safe, evidence-based plans. She explained that the AI used to provide feedback or generate content had been specifically designed and built for Improve. It was firewalled and protected from

the wider Internet and fed only peer-reviewed, human-validated literature.

The 'consensus and controversies' ALA encouraged appraisal of guidelines and competing protocols, promoting articulation of defensible positions amid uncertainty. A clinical analysis ALA required learners to critically assess multimodal clinical data – imaging, laboratory trends, flow charts, or risk scores – moving from observation through interpretation to action planning, while documenting assumptions and intervention thresholds.

A clinical debate and strategic communication ALA involved moderated debates on management options such as referral timing or client communication strategies, with learners given feedback on clarity, evidence use, and professional conduct.

Finally, a virtual journal club had been created where learners engaged in AI-assisted, faculty-moderated appraisals of recent articles through three perspectives: an experienced clinician who was interested in practical applications; an academic clinician whose focus was on study design and bias; and a statistician who emphasised methods and effect sizes.

All ALAs were supplemented by concise 10 to 15 minute video lessons to support each activity. They were aligned with learning outcomes and there were clear rubrics for their design, which took account of psychologically safe climates:

"If you're asking students to make mistakes and reflect on those mistakes, you have to do that in a supportive environment, which we've worked hard to integrate throughout these courses," Miss Coleman emphasised.

Learners received AI-driven feedback on the ALAs and personalised feedback from the course director mid-way through their programme and at the end. The suite of ALAs had been defined, documented, and standardised so that faculty could implement them consistently.

She explained that learning outcomes following the introduction of the ALAs would be evaluated by tracking performance on applied and clinical tasks, diagnostic accuracy, and awareness of cognitive bias. Measures would also include learner self-efficacy, perceived usefulness of feedback, engagement, retention, adherence to rubrics, the depth and quality of learner-generated materials like decision maps and management plans, and mentoring uptake.

Improve anticipated that the ALA framework would promote stronger knowledge transfer to practice, clearer reasoning under pressure, more durable knowledge retention, and greater professional resilience compared to video-only delivery.

"Replacing basic watch-and-recall formats with a structured ALA framework turns online delivery into coached practice," Miss Coleman said. "Learners must analyse, evaluate, and create and then receive timely feedback."

She concluded by saying that the approach was scalable, faculty-friendly, and closely aligned with the cognitive and non-technical skills demanded in modern veterinary practice.

After the presentation, a suggestion was made that successful cases should be reverse-engineered too, rather than focusing mainly on errors. This would foster a more positive learning environment.

Miss Coleman agreed, noting that Improve had integrated some positive outcomes into the ALA. Vets were often prone to dwelling on mistakes, she said, but it was just as important to reflect on what had been done well: "We should go home and think…I saw 40 cases today and 39 of them are brilliant, my outcomes are great. Maybe I made an error with one of them and I could improve on that in the future."

She explained that Improve had worked with psychologists to develop the ALAs and create a growth climate to support and guide learners, so they could learn and grow from their mistakes in a safe way and felt comfortable participating in a course.

The missing middle: understanding veterinary surgeons' appetite for an intermediate postgraduate award

Dr Aidan B. McAlinden, Academic Director, Improve Veterinary Education, UK

"Is there a missing middle in the veterinary profession?" asked Dr Aidan McAlinden MRCVS as he began his presentation. He reviewed the historical trajectory of veterinary careers, where undergraduate education produced competent veterinary graduates equipped for the realities of practice. Mentorship was largely provided by practice partners and many vets built rewarding careers in general practice. Some advanced their clinical careers by completing postgraduate certificates. He had done this himself, and he showed the audience the letter he had received from the RCVS at the time. This clearly set out what holding a certificate did and did not mean – particularly that it was not a specialist qualification. Having achieved a certificate, a minority of vets then pursued a diploma to become a specialist.

This had created a pyramidal career structure. At the base were the general practitioners who made very significant contributions to the profession. There was a small top tier of specialists, and in the middle were the certificate holders who worked in the intermediate space between specialist practice and general practice.

However, the profession's demographics and expectations had now shifted. Graduates increasingly felt unprepared for practice realities, prompting earlier pursuit of postgraduate certificates to close perceived skills and knowledge gaps. Certificates were completed more quickly, meaning less clinical experience on completion. In addition, with so many providers offering certificate programmes, training and assessment standards could be inconsistent. Dr McAlinden questioned whether this trend was lowering the benchmark for certificates and added that there was a rising demand for career progression beyond certificates, with certificate holders seeking new pathways to distinguish themselves.

Academically, postgraduate certificates led to diplomas and then to professional master's degrees. Dr McAlinden asked whether achievement of a professional master's degree should represent the new middle tier of the veterinary profession. He explained that Improve Veterinary Education had several professional master's pathways that had been validated and accredited, but were not yet launched to learners. Engagement with stakeholders was ongoing and Improve also appreciated that the profession and the public were already confused about the different available qualifications. It did not want to add to this by introducing another career pathway that was not well thought through or aligned with the pending outcomes of the RCVS's Veterinary Clinical Career Pathways project.

He went on to say that Improve had conducted market research to assess the profession's interest in and demand for a master's level qualification, understand vets' motivations for career progression and which postgraduate qualifications they valued, and identify barriers to further professional development. Surveys and focus groups involving Improve students and non-students had been held across the UK,

Germany, and Spain. Most of the vets involved were within six years of graduating, most were aged between 25 and 44, and the largest number of respondents were based in the UK

The work revealed that UK respondents viewed specialist status (European, American, or RCVS) as the most valued postgraduate qualification, followed by postgraduate certificates and RCVS Advanced Practitioner status. In Spain, specialist status was likewise most valued, then an official master's degree and the International School of Veterinary Postgraduate Studies (ISVPS) postgraduate advanced general practice certificates. In Germany, the national specialist qualification (Fachtierarzt) was most respected above other specialist statuses.

Across all countries, the primary motivations for pursuing postgraduate qualifications were enhancing knowledge, skills, and confidence, and improving patient care. Career progression pathways were especially important in the early years after graduation. Focus groups also found that many who wished to go beyond initial certificates preferred obtaining complementary certificates over becoming more advanced in one discipline or specific area.

The main driver for considering a professional master's degree was again enhancing knowledge, skills, and confidence, but salary and obtaining the highest available qualification became more important factors. About half of UK respondents expressed interest in a professional master's degree, while a quarter were unsure, seeking clarity on whether the master's would offer advantages beyond Advanced Practitioner status or contribute towards specialisation. Concerns included the investment of time and money without clear career benefits. Confusion about the hierarchy of postgraduate qualifications and the place of a master's degree was also evident.

In contrast, interest in a professional master's degree was stronger in Spain and Germany, where it seemed to be a more familiar and recognisable vocational qualification.

Finally, Dr McAlinden reported that in the focus groups across all three countries there had been a small cohort of graduates who had pursued a postgraduate certificate in an attempt to access a residency, but had failed to secure a position. This cohort showed much stronger interest in a professional master's pathway.

During discussion, a delegate asked if the profession might be moving towards valuing experience over postnominal letters, especially with technology enabling visual displays of expertise and microcredentials. In this model, a professional master's degree could be a substantial component of a vet's demonstrated experience.

Responding, Dr McAlinden said it was important to move away from the dogma that a master's degree had to be confined to a specific clinical discipline. Improve had conceived a pathway for master's degrees in primary care practice that would allow learners to complete certificates and modules tailored to the needs of their specific practice. He thought this would encourage greater buy-in by employers because they would be able to see the relevance and a return on investment at practice level. He argued that primary care deserved the same recognition as specialised disciplines and deeper discipline expertise.

Parallel sessions (Court Room, afternoon): Postgraduate education (I)

Enhancing wellbeing in veterinary postgraduate training via structured support and programme quality standards

Natasha Hetzel, Head of Education and Career Development, Linnaeus, UK

Setting the scene for her presentation, Natasha Hetzel MRCVS explained that across its 13 specialist-led multidisciplinary referral hospitals and two single-specialty centres, the Linnaeus group was training approximately 85 rotating interns, 30 discipline-specific interns and 90 residents. Additionally, about 80 new graduates were enrolled in its graduate development programme across around 50 primary care sites. These individuals were in diverse settings, with varying cultures, systems, and ways of working.

The literature on veterinary wellbeing, particularly within specialist training pathways, indicated a concerning picture, she said. The average Warwick–Edinburgh Mental Wellbeing Score for vets was 47.5 out of 70, below the national average of 51. It was even lower (46.2) for younger vets, who were likely to be those undertaking training programmes. A study by the American Association of Veterinary Medical Colleges (AAVMC) found that 85% of interns and residents had experienced depressive symptoms within the previous fortnight. Data from the veterinary anaesthesia field indicated a high risk of depression and burnout in 50% of trainees.

There was clearly a need to raise awareness about mental health among postgraduates and ensure supervisors, mentors, and clinical teams were trained to recognise indicators of poor wellbeing and provide appropriate support structures.

So, what could be done to improve wellbeing in the clinical learning environment and what might the impact be? The clinical learning environment, Ms Hetzel explained, was where the postgraduate's place of work overlapped with their learning context, such as the RCVS Veterinary Graduate Development Programme or residency programme. This overlap had an important influence on the quality and safety of patient care, the health and wellbeing of the workforce, and how trainees learnt in their environment.

She said that Gruppen et al. had developed a model bringing together the ideas of personal, social, organisational, physical, and virtual spaces and their interrelation as components of the clinical learning environment. Using this model, Ms Hetzel described interventions made by Linnaeus to embed a culture of wellbeing and support within its postgraduate programmes.

In the personal space, graduates received professional skills training and career development sessions supporting their identity development and growth. Social space interventions included structured mentoring frameworks, with mentors and supervisors being trained in mentoring and coaching skills. Linnaeus had also established a centrally scheduled teaching programme to develop clinical educators.

Regarding physical and virtual spaces, trainees had access to desks, computers, journals, and textbooks away from busy clinical settings. Organisationally, trainees had regular check-ins with central managers, who, alongside the group mental health and wellbeing manager, supervisors, and educators, could detect problems early and direct trainees to appropriate support. Linnaeus also facilitated reasonable adjustments, access to professional mental health support, and mental health first aid training for supervisors and mentors.

Ms Hetzel explained that Linnaeus had formalised these interventions into a structured framework. In conjunction with its internship directors, and drawing on AAVMC guidelines, the NHS's Education Quality Framework, and six years of survey data from internships, it had developed group-wide internship quality standards. These mirrored requirements from the group's graduate development programme, which stipulated what practices must provide to support new graduates.

The internship quality standards covered factors such as cohort size, rotas, rotations, working hours, out-of-hours and rest requirements, education and training, support for research, salary and terms, mentorship, and pastoral support.

Although formalised only recently, the standards had been filtering into internship programmes for some time, she said. Survey data showed that between 2020 and 2024, the proportion of interns self-reporting any degree of mental health problems fell from 39% to 24%. Quality standards for residency programmes were not as advanced, but a decrease from 39% to 33% had been seen. For graduates in the development programme, the percentage needing support dropped from 11% to 5% between the 2021 and 2024 cohorts.

"I think this will always be an ongoing project, but it does seem that if you improve the clinical learning environment, it benefits wellbeing," she concluded.

In discussion, Ms Hetzel was asked about the impact of the COVID-19 pandemic on the percentage of new graduates requiring support. She replied that while the pandemic had had an impact, there was still a general downward trend in support requirement. Intern data were clearer, and they also showed fewer individuals reporting a problem with their mental health but choosing not to say anything about it, and fewer reporting experiencing mental health problems for the first time during their internship.

Asked about neurodiversity among graduates involved in Linnaeus's programmes, she said exact numbers were unknown, but the group was supporting many neurodiverse interns, residents, and graduates – plus other individuals away from the training programmes. It had become clear that reasonable adjustments made to support individuals with neurodiversity, chronic illness, or other issues, brought broader, more universal benefits across the workplace.

A delegate asked how support was being implemented day-to day in a commercial environment. Ms Hetzel explained that support had been designed into Linnaeus's graduate programme from the outset, whereas internships and residencies had been well established in referral hospitals. However, Linnaeus recognised the importance and value of focusing on the wellbeing of its people, she said, and while introducing mental health training may initially be more costly, it offered long-term benefits. Greater focus on culture and support led to better outcomes.

Finally, she was asked about bridging the gap between central teaching on issues such as pastoral care and the reality at practice level. She emphasised the careful selection of practices to avoid setting new graduates up to fail. Many people tried to make life better, she said, but lacked the tools and resources required. In these situations, working for large organisations was beneficial as they could provide central support to help create good clinical work environments.

Mapping veterinary skills needs to training solutions: a systematic framework approach in European agrifood systems

Mark Bowen, Director of Education, European Board of Veterinary Specialisation (EBVS)

Dr Mark Bowen FRCVS considered two projects in his presentation, both funded by the EU's Erasmus+ programme. The first, i-Restart, had involved a consortium of partners in mapping current skills needs in the agrifood sector to support upskilling and reskilling the sector's workforce. "It had to be built around the principles of microcredentials – small bits of learning that anyone could participate in within the agrifood sector," he explained.

The second project, the Agrifood Skills project, was just underway and focused on future skills research and building an observatory so that emerging skills needs could be identified using anticipatory intelligence.

Returning to the i-Restart project, Dr Bowen said it aimed to create a process for identifying skills needs, largely within the agrifood sector, but also across related sectors. It had analysed trends and developed profiles within the European Skills, Competences, Qualifications and Occupations (ESCO) framework. To do so, a modified Delphi approach had been used with focus groups involving European vets, educators, and stakeholders in the agrifood sector to identify skills needs in the areas of digitalisation, sustainability, business and soft skills, One Health, and sector-specific skills. He noted that these were EU priority growth areas. The data gathered then informed Europe-wide surveys to validate the focus groups' outcomes. After thematic analysis, survey results were developed into curricula in each of the skills areas, with associated learning outcomes mapped to levels 6–8 of the ESCO framework.

Content had then been created to populate a learning platform available to educators. This content included training templates containing lecture plans, workshops, assignments, assessments, and multiple choice questions, all of which were microcredential ready, he said. The next phase of the project was to build the microcredential framework.

The focus groups had identified multiple skills needs within the EU priority sectors, and Dr Bowen highlighted some of the key themes to emerge. For example, for digitalisation, skills in data management and interpretation across systems were identified as important, particularly given that agrifood data were increasingly being gathered via sensors and biosensors.

In total, 540 responses to the surveys had been received, including 153 veterinary responses. These had been used to draw up a list of priority skills needs in the various areas, such as skills in preventing antimicrobial and antiparasitic resistance in the One Health arena, and skills around data management in the digitalisation skills arena.

Curricula had then been drawn up for three occupational profiles – a veterinary specialist in data science; a One Health veterinary specialist in medicines and chemicals; and a specialist for veterinary business. Originally, the intention had been to look at a target year of 2050, but a consortium called PIT Food had suggested that the target should actually be 2100. "We

were really trying to think about what's going to happen when people stop eating meat, or when there's no grass in southern Spain – really looking for the future," Dr Bowen commented.

More than 300 hours of content had been created to support these curricula. Subjects covered ranged from biostatistics to One Health and veterinary medicines, to skills for business. Each session had a lesson plan with learning outcomes, instructions for use, and resources including lectures, videos, workbooks, and activities. All content was freely available under a Creative Commons licence.

He went on to explain how the data science module developed, noting that it began with understanding data science, before moving on to discuss how to interpret statistical tests, what tests meant, understanding probability, cleaning data, and how to use Excel to manipulate data. It also asked learners to manipulate a dataset using Python or R. The module culminated with 10 cross-species abstracts of increasing complexity for learners to work through – all had flaws in data presentation and statistics and became progressively more complicated.

He then discussed the Agrifood Skills project and the observatory, explaining that he had built a platform to pull in research and grants awarded data emerging over the past five years from OpenAlex (a open version of PubMed), CORDIS (Horizon Europe's database), and NIH RePorter. These data had been entered into range of thematic tools using AI to generate a set of emerging occupational profiles, ranging from veterinary clinical researcher and veterinary clinical educator, to veterinary digital twin specialist and veterinary communications specialist. He invited his audience to scan a QR code to visit a site where they could give feedback on the profiles. Happily, he commented, the process had also come up with the three profiles identified by the i-Restart project.

Concluding, Dr Bowen said these were initial steps. The framework showed how skills mapping could be converted into a structured training programme. The i-Restart portal contained freely accessible data that now needed to be turned into usable learner-facing content.

During questions, he was asked how microcredentials fitted in with what he had described. "The principle of microcredentials fits beautifully with what we've been talking about in terms of modularising the content,' he replied. It was possible to modularise a residency or internship to create components of teaching that 'stacked'. Microcredentials were digital badges that anyone could award. They acted as immutable records of an individual's learning and might include assessments, but could simply reflect learning – for instance, a geotagged QR code could be scanned to register attendance at a relevant symposium. Individuals could create their own portfolios of microcredentials and make them available to anyone anywhere in the world. More importantly, they could be taken to employers to demonstrate learning. Competences could also be included to indicate what an individual could do; this could help businesses find people with the skills they needed.

Perceptions of the impact of the RCVS Certificate in Advanced Veterinary Practice on the careers of its graduates

Evan Holdsworth, Postgraduate Coordinator, University of Liverpool, UK

Presenting research carried out at the University of Liverpool as part of his studies for Fellowship of the Higher Education Academy, Evan Holdsworth MRCVS explained that, at the time, there had been no published research examining the impact of the RCVS Certificate in Advanced Veterinary Practice (CertAVP) on the profession. Given the diverse backgrounds of his audience, he first briefly summarised the CertAVP's history, requirements, and options.

His study of perceptions of the impact of the CertAVP on the careers of those who had completed it began with a literature review. Three key outcomes for further investigation were identified, namely, CertAVP graduates' perceptions of the impact of the qualification on their professional practice, career advancement, and contentment within the industry. Statements linked to these outcomes were developed into a survey circulated to CertAVP holders. He explained that Advanced Practitioners (APs) were asked not to respond because, at the time, the RCVS was conducting its own survey of APs.

The survey collected demographic data before asking respondents to use a Likert scale to rate their agreement with a set of statements within each of the three outcomes. In total, 103 responses had been received. Of these, 89% said that gaining the CertAVP had led to an improvement in their professional practice; 56% felt that it had helped them advance their career; and 55% said it had improved their contentment within the veterinary industry.

Mr Holdsworth commented that the statement most associated with perceptions of improved career outcome was that the CertAVP helped holders work as a mentor for colleagues. "At the time, I was quite naïve of the significance of this," he said, "but after all of the discussion of mentorship today, I think that is quite important."

He went on to consider some of the more negative responses related to the professional practice outcome, noting that responses to a statement about the CertAVP helping a graduate achieve a sustainable work-life balance had been "quite resoundingly negative". Returning to the career advancement outcome, he noted negative responses to statements about gaining pay rises and promotion.

For the industry contentment outcome, he said it was clear the CertAVP had increased intellectual satisfaction and allowed an individual's professional life to more closely match their career expectations.

Concluding, he set out possible future avenues to explore. The omission of APs from the survey altered its validity, as the message was incomplete and thus less useful to prospective students. "A future study that focuses on Advanced Practitioners would be both helpful and interesting," he commented. He also noted that employability had not been included as a key outcome. This had direct relevance to AP status, so he proposed a future survey to investigate perceptions of AP status on employability.

Taking questions, he was asked whether he had captured people's motivations for starting the certificate. This had not been investigated, he said, but he would like to undertake a longitudinal study to explore the reasons people gave for enrolling on the certificate, and whether, after they had completed it, they felt it had been worthwhile and whether their conceptualisation of their reasons for engaging with postgraduate study had changed. Based on his own experience, he said he had enrolled on the British Small Animal Veterinary Association's postgraduate certificate in small animal surgery in 2011/12, because he had felt "fairly directionless" at the time. "I knew I wanted something else, but I didn't know where to find that," he said, adding: "A certificate appealed to me in that sense." Having gained the certificate, he realised the benefits he had drawn from it were greater and different from the reasons why he had enrolled.

Lessons from a case study: the impact of the COVID-19 pandemic on part-time postgraduate veterinary professionals

Emily Chapman-Waterhouse, Associate Head of Department, Principal Lecturer, Harper Adams University, UK

Explaining the driver for her study, Emily Chapman-Waterhouse recalled that in 2020 at the start of the COVID-19 pandemic, sectors operating in socially-oriented settings, including education and healthcare, had adopted emergency protocols so the most critical services could continue while minimising spread of the virus. However, despite a growing body of literature, the pandemic's impact on students in UK land-based or veterinary education appeared to be under-researched.

Her study explored the impacts of COVID-19 on part-time postgraduate students and how student engagement related to success during this time. It aimed to gather information that would be useful to programme managers and teaching and support staff in UK institutions offering postgraduate and/or undergraduate veterinary education programmes.

In 2021, 126 students enrolled on two postgraduate veterinary professional development modules at Harper Adams University had been invited to complete an online questionnaire asking 24 questions about their working situation, current worries and stresses, mental health, and prior study experiences: 14 responses were received. All respondents were working as general practitioners or Advanced Practitioners in the UK. Two subsequently took part in semi-structured interviews, informed by analysis of data gathered by the questionnaire. The interviews considered personal experiences of COVID, indirect experiences and attitudes towards the pandemic, and satisfaction with communication and support during their studies.

Questionnaire data revealed a decline in life satisfaction during the pandemic in 72% of respondents, with only 21% reporting an improvement; 64% reported negative impacts on their health, relationships, and view of where they worked and lived. Seventy-nine per cent said they felt impacted by school, hospitality, or business closures; 79% reported they or other adult members of their household had changed

their routine or location for work; and 79% reported no change in the frequency with which they were expected to be at work during their studies.

Regarding how their views of the economy and natural environment had changed during the pandemic, 36% of respondents reported a negative change, and 43% a positive change. Also, 64% reported negative impacts on their well-being, although 36% reported some positive impacts. No respondents reported using the wellbeing services offered by the university and all said they sometimes or always felt safe in their study space.

Mrs Chapman-Waterhouse noted that the self-reported prevalence of COVID-19 among the respondents' immediate family or colleagues had ranged from low to high, and 86% of respondents said they had been planning to meet friends or family to celebrate a special occasion before the pandemic, but none of these events had gone ahead at the time of data collection.

All 14 respondents felt that online delivery of education suited the pandemic-associated restrictions although only 57% had felt equipped to engage with online study before starting the module.

Thematic analysis was used to evaluate information collected during the interviews, with four themes emerging: social structures, communication, capacity, and coping strategies. She reported two quotes that had stood out: "It turned to chaos..." and "Doing reflective learning stuff made me more aware...".

"Interview responses suggested that veterinary practitioner experience dealing with emotional, stressful, and challenging situations in practice provided them with some comparison for the challenges posed by the pandemic," she said.

Other challenges identified included the loss of non-verbal communication during text-based, online, asynchronous learning, and the loss of the opportunity to sense-check with peers in person in both practice and online settings.

She noted that increased time for studying due to lockdown may have improved performance in modular assessments, highlighting the known conflict between work, life, and study experienced by part-time postgraduate students. Online delivery of both professional development modules suited the pandemic restrictions in place at the time, and more than three-quarters of respondents said they would choose online professional development again in future.

Such information helped programme managers approach future curriculum design, she said, indicating, for example, that greater support was needed to equip students for online learning.

In conclusion, the pandemic had introduced diverse changes, some disruptive, others enabling. She suggested that future research should include larger cohorts and longitudinal engagement to facilitate success analysis.

During discussion, a delegate noted that some pandemic-imposed changes had opened new opportunities. For instance, group-wide and evening meetings in his work setting were "so much easier... and so much more readily subscribed to" than they had been previously thanks to technology introduced to facilitate remote learning and meetings during the pandemic.

In contrast, another delegate said that in her workplace "actually, the pendulum is swinging back". More in-person contact was being reintroduced and "people were really enjoying coming together again".

Mrs Chapman-Waterhouse commented that, at Harper Adams University, some courses were using more face-to-face teaching and people were enjoying the social networking aspects of this. However, it was not happening so much for veterinary postgraduate courses because of the geographical spread of the students and because employers would have to release them from work to attend courses in person.

Day 1 conclusion

With delegates coming together at the end of day 1, Dr Prescott-Clements said she hoped everyone had enjoyed the sessions and that they had stimulated new thoughts, debates, discussions, and ideas. She reminded everyone that the symposium aimed to spark conversations and create a permanent community of practice with its own identity. “That will only happen if the delegates here today continue those conversations,” she said, encouraging everyone present to engage with their organisations to support the concept and express their interest in participating and moving it forwards.

Day 2

Morning plenaries

Latest developments in the use of artificial intelligence in learning

Professor Lambert Schuwirth, Professor of Medical Education, NewMed School, and Director of Healthcare Innovative Learning Solutions (HILS), Australia.

Professor Schuwirth declared a conflict of interest before his presentation, noting that he was co-director of HILS-HPE.com, a for-profit organisation that develops AI for education software.

"If you're not at the table, you'll end up on the menu!" was how Professor Lambert Schuwirth described his approach to artificial intelligence (AI). Speaking remotely from Australia, he acknowledged there were concerns about AI's societal impact, but said the technology was not going away. Therefore, he believed it was important to engage with it.

Setting the scene for his plenary lecture, Professor Schuwirth highlighted the rapid evolution of AI since November 2022 when the large language model (LLM) ChatGPT was released to the public. In just three years, ChatGPT had advanced significantly, other 'frontier models' (highly advanced, large-scale models that push the boundaries of AI) had emerged, and specialised models for tasks such as literature searching and mapping had been developed; all were incredibly strong, powerful, and multilayered.

Against this backdrop, educators needed to prepare students for a disruptive future. AI had initially been used in education as a 'glorified chatbot', but now had multiple applications, including generating a wide variety of assessment questions and giving feedback. However, in all these instances, AI was replacing existing

processes. Now, leading educators were exploring how to integrate AI tools into their curricula and assessments to act as complex, interactive study companions.

Professor Schuwirth illustrated this shift through four widely cited aphorisms about generative AI:

- Every teacher or course that could be replaced by AI, should be replaced by AI.
- You won't be replaced by AI – you'll be replaced by somebody who knows how to use AI.
- In disruptive times, think about your value proposition rather than processes.
- The real moral panic is not that AI can pass our assessments, but that we are still teaching or assessing in ways that AI can pass.

He noted that the first two aphorisms were already being realised. In some disciplines – although not yet medicine or health-related – employers were increasingly valuing self-taught, self-managed candidates with strong portfolios over university graduates. Similarly, organisations were reducing staff numbers because AI enabled fewer people to do the same amount of work.

For those developing and designing education, this raised fundamental questions about the future. Here, the third aphorism applied: during disruption, it was more helpful to think in terms of the value proposition (in education, this would be learning and competence) rather than in terms of processes (such as the process of teaching). "Think in terms of what value am I offering to my students, my clients, my customers, my patients?" he said.

Explaining how LLMs work, Professor Schuwirth warned against viewing them as large document libraries. Instead, they were better understood as "a sea of words and relationships". Models scraped vast amounts of internet data, converted words or word fragments into numerical matrices called tokens, and embedded relationships between those tokens. A typical LLM, he explained, was trained on 18 to 20 trillion words mapped across 30,000–50,000 dimensions.

This had significant implications for education. Traditionally, the content of the curriculum and the knowledge of the teacher were created first, then learners engaged with them. With AI, the process was reversed. Learners had to actively seek knowledge, entering questions or prompts into a LLM to generate a response from the information held in the sea of tokens and relationships. This approach offered flexibility, availability, personalisation, and contextualisation, he said, but also demanded far greater learner agency and effort.

There was general agreement among those at the forefront of AI technology that education should be guided by six key principles. The first was learning about AI tools by using them. Professor Schuwirth emphasised that learning to use AI was not like following an instruction manual; it involved learning to communicate with a rapidly evolving, non-human intelligence. Different models had different strengths, so users needed experience working with multiple tools.

The second principle was human–AI synergy: combining human expertise with AI to produce better outcomes than either could achieve alone. In education, this meant considering how AI could be used in conjunction with human teachers to enhance learning.

Ethical considerations formed the third principle – essentially powerful tools should not be used for harmful purposes. Professor Schuwirth explained there was a pragmatic aspect to this, too: AI was resource-intensive and using it incorrectly, frivolously, or for the wrong purposes, wasted resources. "We are used to wasting energy for trivial things, but with AI it becomes even more important to make sure that when we use this energy-using, water- and resource-using technology that you use it for the right purpose and you use it well," he commented.

The fourth principle was the ability to discern truth. While knowledge had once been expensive, hard to come by, and scarce, information was now cheap, easy to come by, and abundant. But the distinction between information (which might be shallow, biased, mono-perspective, or simply wrong) and knowledge (something that was demonstrably true) had widened. This was not solely due to the emergence of AI, but also to advertising, social media, and political messaging. Learners therefore needed strong skills in critical evaluation.

This led to the fifth principle: the ability to build associative networks – well-organised knowledge networks that could be connected and used to assess information for relevance and plausibility.

The final principle was agency balance – deciding who was in control. Students had to learn which tasks could be appropriately outsourced to AI and which required their own judgement and responsibility.

Professor Schuwirth observed that students were already highly "technology-afforded", as were their future patients. Many patients now conducted their own literature searches, translated technical terms, and arrived at consultations well informed about their conditions. Education therefore had to prepare students to work effectively with such patients.

This needed to be acknowledged when developing, redesigning, and adapting education. It was vital both to keep abreast of technological developments and educational and societal disruptions, and to maintain human input into education. Although AI could generate and mark assignments, provide feedback, and summarise results, a system in which students used AI to complete work and teachers used AI to assess it – with no meaningful learning in between – would lead to educational collapse. Learning, he stressed, remained slow, effortful, and cognitively demanding.

Rather than replacing learning, AI could support it in partnership with teachers. AI could function as a tutor, coach, assessor, role player, and study guide, essentially becoming a study companion to help students adopt an active, multimodal approach to learning. Human educators remained essential, but more as mentors and guides, addressing uncertainties, emotions, tacit knowledge, and lived experience.

At the NewMed school, students were permitted to use generative AI in research projects, but they had to justify their choice of tools, reflect on their experiences, and demonstrate that the combined human–AI outcome was superior to either alone. They also had to explain how they ensured ethical use, managed bias, verified accuracy, and maintained appropriate agency at each stage.

In doing so, students actively applied the six principles: learning with the tools, understanding synergy and ethics, critically evaluating information, building associative knowledge, and remaining in control.

Professor Schuwirth's lecture was warmly received, with delegates describing it as "fantastic", "excellent", and "so interesting". One delegate asked how he saw interactions between doctors and patients changing given his comment about tech-savvy patients. Responding, Professor Schuwirth clarified that he was not referring to patients who used 'Dr Google', but to genuinely well-informed individuals. Medical education was already helping students to develop strategies for these encounters. Doctors had to consider their value to such patients if they were not making a diagnosis or 'calling the shots' on a management plan. The key would be partnership. While patients might bring strong theoretical knowledge, doctors contributed practical expertise and wisdom. There would be a shift from the pure 'cure-oriented' perspective to a more 'care-oriented' perspective.

When asked about data privacy and the risk of graduates entering patient data into chatbots,

Professor Schuwirth was unequivocal: they should not. Preventing misuse, he argued, came through education. Just as students were taught not to disclose confidential information by telephone, they needed clear guidance on appropriate AI use. Ironically, the greatest risk of misuse would arise if students were not taught how to use AI properly during their training.

Rethinking the nature of veterinary competence to serve the education–practice continuum

Professor Olle ten Cate, Emeritus Professor of Medical Education, Utrecht University, The Netherlands

Professor Olle ten Cate began his presentation by inviting delegates to scan a QR code to answer a question: "Have you ever personally signed off for the completion of a programme or a rotation while you were not fully confident the learner had met critical objectives?"

Reviewing the 23 responses, which had been categorised into 'Never', 'Once', 'A few times', 'Regularly', and 'Frequently', he said the distribution was similar to that seen in 18 similar polls he had conducted in recent years. Across these polls, 60% or more of the respondents admitted signing off training despite doubts about whether critical objectives had been met.

He then moved on to discuss competency-based education, which, he explained, aimed to develop a standard level of proficiency among graduates. Traditionally, training had been delivered over a fixed time period, but outcomes varied among trainees. In contrast, competency-based education allowed training to continue for as long as needed for trainees to achieve a fixed outcome.

The core requirements of competency-based education were: a clear description of the standards expected of a 'good health professional'; assessment of all trainees against these standards; and the use of demonstrated competence – rather than time spent in training – as the basis for sign-off. This approach was widely recognised as a way to prevent unprepared trainees from graduating.

However, Professor ten Cate noted that competency frameworks had been criticised for being overly detailed, too vague, or insufficiently connected to real clinical practice. This suggested a need to reconsider how 'competence' and 'competent' should be defined.

He illustrated this by contrasting two models of competence acquisition. In the first, which he described as a "traditional but dysfunctional" view that was widely accepted outside academia and medicine, novice trainees completed a fixed period of education, during which they were not permitted to practise, reaching an 'expert' level of competence at the point of licensure. Subsequently, they had full permission to practise and their competence was accepted to remain at the 'expert' level throughout their career.

In contrast, a 'much more functional' model showed competence developing along a curved pathway. Some development might occur before the formal training period, but there was a timepoint on the curve at which the trainee was judged to have acquired sufficient competence to be ready to practise. After this point, competence continued to grow, with practitioners becoming proficient and ultimately expert over time. Importantly, individuals might reach the threshold for practice earlier or later than the standard training duration.

This same pathway could also reflect readiness for specific activities – a trainee might be ready for one activity before the end of the training period, but take longer than the specified training period to be ready for another activity.

Professor ten Cate then asked his audience to consider what it meant to be "competent". There were two ways to look at this, he suggested. Retrospectively, competence could be judged by mastery of taught content and examination performance – an educational perspective. Prospectively, it could be judged by readiness to assume future professional responsibilities – a healthcare perspective. It was important to both look back and look forwards.

Referring to the plenary lecture given by Professor Martin Cake on the first day of the symposium, Professor ten Cate considered Miller's Pyramid, reminding delegates that it set out approaches to the assessment of learners. He had proposed extending the pyramid with an additional level of 'Trusted', which would reflect a learner's readiness for future demands: could they be trusted to practise healthcare?

So where do trust and entrustment with tasks fit within the conceptualisation of competence? Professor ten Cate invited the audience to accompany him on a "journey to reconceptualise what competence actually is". Competence, he suggested, was a hierarchical, multilayered construct. At its core was 'canonical competence': the context-independent knowledge and skills expected of all professionals. Surrounding this was 'contextual competence': the ability to apply and adapt those skills in specific settings. The outer layer was 'personalised competence', reflecting individuality and the art of professional practice.

Contextual competence, he explained, was closely linked to readiness for entrustment with specific tasks. Drawing on the definition of 'entrust', he introduced the concept of 'entrustable professional activities' (EPAs), defined as units of professional practice (tasks or responsibilities) that could be fully entrusted to a trainee who had demonstrated the required competence to undertake the activity unsupervised. EPAs were designed to operationalise competency-based education by allowing trainees to gain progressive autonomy in clinical practice.

He then returned to the meaning of 'competent', explaining that competence was not a fixed state but a point along a developmental continuum. Operationally, being competent meant having mastered a professional activity at a threshold level that justified being trusted to practise unsupervised. Trainees would vary in how quickly they reached this threshold, both overall and for individual EPAs. Skills could also decline below the threshold if an activity was not practised.

Decisions about entrustment, Professor ten Cate emphasised, should be made by a committee using multiple data sources, including workplace-based assessments and portfolio evidence.

The final layer of his competence construct – personalised competence – represented legitimate differences in the style of patient care, he said. It was what made physicians, and vets, unique in their excellence and turned the science of healthcare into the art of healthcare. Central to this was the concept of '*perezhivanie*', introduced through the work of psychologist Lev Vygotsky. Although difficult to define precisely, *perezhivanie* referred to the unique blend of cognitive and emotional experiences accumulated over a lifetime that shaped how

individuals perceived and acted in the world. In essence, it was what allowed professionals to develop a distinctive personal style while maintaining standards.

Professor ten Cate illustrated this using Picasso as an example. Picasso, he explained, had trained in the foundational, canonical skills of an artist, and in his early career had painted very naturalistic images, before subsequently developing his highly individual style.

Professor ten Cate also referenced Maslow's Hierarchy of Needs, particularly the need for self-actualisation, described by Maslow as a 'desire for self-fulfilment… to become actualised in what [one is] potentially'. Maslow found that self-actualised individuals often displayed a specific form of creativity and were 'relatively unfrightened by the unknown'. Experienced professionals, Professor ten Cate suggested, reached a point where they were comfortable encountering unfamiliar situations because they trusted their accumulated experience.

Canonical, contextual, and personalised competence developed over the educational continuum and into professional practice, but the emphasis changed throughout. While canonical competence was most prominent early on, personalised competence became increasingly important later in a career.

Returning to his curve of competence development, Professor ten Cate highlighted a particularly critical phase: the transition from training to independent practice. Whether this was the transition from undergraduate education to practice, or from postgraduate education to practice, it required careful attention.

First, reaching the competence threshold meant an individual could perform activities safely, but initially this should be with a modified caseload to manage cognitive load. "They can do it," he commented, "but they need to be treated somewhat differently than an experienced veterinarian."

Second, entrustment implied readiness to handle situations not previously encountered, but even when trusted overall, individuals might still require indirect supervision for certain activities. Professor ten Cate likened this to receiving a driver's licence: while judged competent to drive, a new driver might not yet have experienced all conditions, such as severe weather or driving in another country.

To support the transition to practice, he suggested clearly defining essential EPAs for specific tasks. On their first day, new employees could indicate the level of supervision they felt they needed for each EPA. This would enable open discussion with employers, clarify expectations, and help reduce stress, burnout, and attrition.

Taking questions after his presentation, Professor ten Cate was asked about when competence might decline, and when individuals should no longer be trusted to perform an activity.

Responding, he said he hoped that, in future, individuals would establish a dynamic EPA portfolio throughout their career. If an EPA was not practised over time, entrustment would lapse, but equally new EPAs could be added so that the portfolio reflected an individual's current competence to practise unsupervised. Monitoring this would not be easy, but it began with mindset: professionals needed to ask whether they trusted themselves to perform a task unsupervised. If they could not trust themselves, they should seek supervision.

New ideas and innovations

Integrate non-clinical, humanistic training into all types of postgraduate training and reaccreditation requirements

Petra Agthe, Diagnostic Imager, Southern Counties Veterinary Specialists, UK

Beginning by commenting that she had "more questions than answers", Petra Agthe MRCVS asked: "What do we currently formally evaluate in postgraduate veterinary education?" In postgraduate curricula and CPD, it was predominantly clinical and technical skills, she said. Professional skills were valued but inconsistently included and therefore not equally evaluated.

She proposed shifting educational priorities to reflect all the abilities needed to deliver high-quality, contextualised care. Excellence in the veterinary professions was not founded on clinical skills alone, she said; collaboration and teamwork were essential, too. However, for teamwork and collaboration to flourish, psychological safety was key. Likewise, collaborative and supportive cultures helped mitigate psychosocial hazards in the veterinary workplace.

So, how could psychologically safe environments be created in the veterinary workplace? She believed the answer lay in social and emotional competence – an individual's ability to understand their own needs, emotions, and behaviour and those of other people; their ability to self-regulate, co-regulate and show effective self-leadership and leadership of others; and their ability to create connection and collaboration through communication.

"It is time to revise curricula and CPD requirements to have a more human focus and humanistic approach so that we can all fulfil our true potential as individuals and as teams," she said. Including these elements would send an important message that individuals were valued not only for their technical and clinical expertise but also for their humanity and ability to support growth and learning. This would ultimately result in better patient care and greater career sustainability.

So, her final question to the audience was: "What do you think about this, and what training would you include?"

Discussion

Symposium delegates supported Ms Agthe's proposal. One said training on accepting feedback should be included, as feedback was often viewed as criticism of clinical ability or interactions within the clinic. Training people to give and accept feedback would support communication and teamwork.

Another delegate commented that positive feedback should be normalised as well, to help build trust and psychological capital. Learning how to lead positively helped ensure an empathetic, compassionate approach to difficult conversations.

Ms Agthe agreed that it was automatic to assume feedback would be corrective, although it could be supportive, too. Individuals varied in what they needed from feedback, meaning it was essential to first build relationships to understand

these needs. Feedback could then be delivered and received in a manner that contributed to an individual's learning.

Another delegate commented that academic institutions willingly made reasonable adjustments to support students with different needs, but wondered if this was actually helpful, as they were unlikely to receive the same in the workplace. It was "hugely important" to support students in developing the socioemotional competence to cope with the stressful transition to the workplace and retain them in the profession.

A further delegate said that preparing undergraduates for the real world was frequently discussed, but interns and residents faced similar challenges too. Accommodations to support their training did not necessarily prepare them for the later stages of their careers. There needed to be more awareness of the importance of teaching trainees the skills needed to look after themselves. This delegate commented that engaging recent graduates and interns in this type of education was difficult although residents were more open to it, and primary care vets who had been graduated for a few years were actively asking for it.

Ms Agthe replied that it would always be difficult to foresee the consequences of particular actions. Relying on awareness training alone was not sufficient, and some degree of policy change was also needed so that it did not rely entirely on an individual being motivated to seek it out.

Finally, a delegate commented that giving feedback took time, and in the business of veterinary practice, time costs money. It was important to consider the long-term impact of giving feedback and show the commercial case for it. Ms Agthe replied that literature on psychological safety showed that in the long run it was beneficial.

Beyond the clinic: embedding expeditionary veterinary medicine into postgraduate education

Tom Roffe-Silvester, Managing Director, Veterinary Task Force Ltd, UK

In a dramatic introduction to his proposal to integrate the teaching of expeditionary veterinary medicine (EVM) into postgraduate education, Tom Roffe-Silvester MRCVS began: "Picture this – it's 2 am and you're in sole charge. A critical patient comes in, a fractured limb, in shock, [you have] no blood products, limited kit. What do you do?"

He continued: "You improvise, you lead. You look at your resources; you look at your limitations. You make decisions which are going to be critical to that patient's outcome."

However, the scene he was describing was not in a veterinary clinic. The setting was a glacier in freezing temperatures, and the patient was an injured sled dog. "This," he said, "is expedition veterinary medicine."

EVM, he explained, trained vets to deliver high-quality care in resource-limited and unpredictable environments. The same skills, he argued, saved lives in everyday practice too. Adapting protocols to reality was contextualised care, whether that reality arose on charity or humanitarian missions, military or disaster response deployments, in remote UK locations, or in the veterinary clinic.

However, without the right training, outcomes would be poorer. The training offered by his company, Veterinary Task Force, went beyond theory and was shaped by real-world partnerships and collaborations with working dog units, myriad agencies, and international colleagues. Its underpinning competency framework was based on UK recommendations for pre-hospital emergency medicine (PHEM), human expedition and wilderness medicine literature, and best practice recommendations for pre-hospital veterinary care for cats and dogs, supplemented by the experience of the company's team members. It ensured vet professionals were equipped with measurable skills in the five key pillars of EVM: field readiness and adaptability; the ability to integrate with other teams; preventative care in expeditionary contexts; cross-species competency; and operational medicine principles.

Scenario-based learning, cross-sector collaboration, and immersive field training supported the development of adaptable, resilient veterinary professionals. "These are colleagues who are going to be ready for the demands of modern practice – decision-making under pressure, triage, improvisation, leadership, logistics, personal security," Mr Roffe-Silverster said. "These aren't just niche expeditionary skills, they're universal competencies."

Describing EVM as "the next frontier of veterinary education" he proposed that embedding these skills in postgraduate training as core to veterinary excellence, would create better clinicians by cementing knowledge, skills, attitudes, and behaviours. "Because," he concluded, "when the unexpected happens, whether in a field hospital, outreach project or back in your day clinic, prepared veterinary professionals save lives."

Discussion

During discussion, one delegate suggested that undergraduates should be taught EVM too. They had access to the best equipment and resources during their training, but not in practice. Teaching them to be adaptable and resilient would give them transferrable skills.

Mr Roffe-Silvester agreed that adaptability was key. His company's EVM course had been designed to be relevant to veterinary professionals, but had shown wider benefits, he said. The first course had been attended by a general practitioner doctor from a Caribbean island, who subsequently had to euthanase a horse. He had been taught the principles of euthanasia as part of the course, which gave him the confidence to adapt his skills and knowledge and perform the procedure under telemedicine guidance from a vet on a neighbouring island. The cross-professional attendance at the course had been highly beneficial, with everyone learning from one another.

Another delegate asked whether the EVM course could be adapted for other veterinary team members such as receptionists, who had an element of triage in their job. Although he responded positively, Mr Roffe-Silvester said the course was relatively new, and at present endorsement was being sought to justify it as a CPD option for veterinary staff. However, the course was modular and could be adapted to different environments and contexts.

While endorsing the value of the experiences being offered, another delegate queried whether EVM was the right term to use. Although at an extreme end of the spectrum, EVM was part of contextualised care and perhaps this should be reflected in the terminology. Agreeing that EVM was within the spectrum of contextualised care, Mr Roffe-Silvester said the "ultimate dream" would be to see it regarded as fulfilling some of the canonical competences of veterinary medicine as the skills it taught were "absolutely critical".

A further delegate wondered what the training offered beyond the experience and skills that could gained through volunteering opportunities. And did expeditions have to be veterinary-oriented? Could students not be encouraged to get out into nature, climb mountains, meet people, and learn non-technical skills in this way?

Volunteering opportunities were very valuable, Mr Roffe-Silvester agreed, but there was the question of whether participants were ready to take up these placements. EVM training could give them the skills to make the most of such opportunities. He added that the benefit of getting off-grid was unfathomable, and did not have to be associated with a veterinary opportunity. Such activities should be encouraged at all levels of training in all professions.

A dual-purpose tool: using a modified competency framework to support the continued professional development of primary care emergency vets

Aoife Reid, Head of Edge Programmes and Clinical Career Progression, Vets Now Ltd, UK

To put her proposal in context, Dr Aoife Reid FRCVS began by explaining she worked with early- and mid-career vets (2 to 10 years qualified) in an emergency care setting. They seemed unsure whether they were doing a good job and how they should use their CPD allowance. Their perception, rightly or wrongly, was that they received limited structured feedback and lacked systematic assessment unless they were pursuing a formal qualification. She suggested that supporting these vets to reflect on and plan their development would bring many benefits to the graduates themselves and more widely.

Her idea arose from a project exploring how a modified competency framework could serve as 'both a mirror and a map' for veterinary surgeons in first-opinion emergency care practice. She had adapted an existing framework for emergency care veterinarians, which had four core competency areas: patient care; interpersonal skills and client communication; professionalism; and practice-based learning. Her adapted framework acknowledged the context of primary care emergency vets in the UK and incorporated surgical proficiency and elements of the *RCVS Code of Professional Conduct* relating to emergency veterinary services. She had used entrustable professional activity-style descriptors to help chart progress from 'Have limited experience and can observe only' to 'Can model for less-experienced vets'.

The framework provided a scaffold for self-assessment, helping new starters to identify the areas where they felt they needed to develop, and more experienced vets to chart their development and identify areas of skills decay. Sharing these assessments with mentors could provide valuable data, spark dialogue, and guide support. Ultimately, sharing them with the wider organisation could help identify training needs more broadly and inform strategy.

In an initial evaluation of the framework, more than 100 emergency vets and 75 stakeholders had responded to an anonymous cross-sectional survey. Dr Reid reported that this had collected some "really interesting" insights, including areas where vets felt they were highly skilled but where stakeholders felt there was room for development (and vice versa). She hoped the findings would be used to cultivate alignment rather than to make judgements.

Dr Reid pointed out that, for honest self-reflection, some vulnerability and psychological safety were required, which might limit the use of a competency framework in this way. However, having a defined structure might prompt transparent conversations, strengthening trust between individuals and organisations.

Concluding, she asked delegates to consider the benefits if both vets and mentors aligned around a single structure that was formative and designed for lifelong learning rather than as a gauge or tick-box exercise.

Discussion

During discussion, a delegate asked whether there would be any stratification of the competency framework based on years qualified. Responding, Dr Reid said the aim was for it to apply throughout a career and stratification occurred more in the descriptors used. Where someone was on the continuum of the framework depended on their previous experience; she had found that early-career vets were all at different levels. The framework allowed them to plot where they thought they were, and where they wanted to get to. She hoped findings from ongoing longitudinal evaluation would show how people charted themselves over time.

Another delegate commented that, during their time in equine ambulatory practice, something similar, although more basic, had been done to identify where new vet team members might need support in the field.

The practice receptionists and triage nurses used the information to recognise instances where the vet sent to attend had indicated they needed support with the procedure involved. A senior staff member would be alerted and attend to offer the required support. This delegate felt that having a more detailed structure could be useful and that making it lifelong would help people self-reflect throughout their career and direct their CPD as required.

Dr Reid commented that many organisations were good at identifying where new vets needed support at induction, but not later on in a term of employment. With greater longevity her framework could chart progress – or skills decay – over time. She noted that in emergency practice specifically, certain things were not done very often. While an individual might be competent in a procedure in year 1, they might not be by year 6.

Parallel sessions (Banqueting Hall, morning): Postgraduate education (II)

Error management training and reverse engineering of a clinical case: normalising error and minimising harm in postgraduate veterinary education

Gemma Coleman, Content Coordinator and Editor, Improve Veterinary Education, UK

Building on her presentation from the previous day, in which she had discussed active learning activities (ALAs), Gemma Coleman focused specifically on the error management and reverse engineering of a clinical case ALAs she had introduced. By way of background, she explained that Improve had examined approaches used in other high-stakes industries, such as aviation, where treating error as information rather than something to be avoided had been shown to improve safety culture and performance.

In postgraduate veterinary education, many online learning experiences still relied heavily on passive content and single 'correct answer' cases, which limited learners' ability to transfer knowledge into real-world practice. Throughout its programmes, Improve wanted to emphasise that while error was inevitable, harm was not. The two ALAs being discussed were designed to reshape learners' perceptions of error, showing how it could be used to improve clinical performance and support lifelong learning. They also aimed to help learners feel more comfortable critically examining their own practice, identifying strengths as well as weaknesses, and growing from experience.

Error management training reframed mistakes as opportunities for reflection, metacognition, and resilience, she said. Reverse engineering a clinical case complemented this by working backwards from a final diagnosis, reconstructing the reasoning process that led there. This involved examining how decisions were made, identifying cognitive biases, highlighting the critical information that influenced outcomes, and suggesting alternative pathways for future cases. Together, these approaches created an authentic, non-linear model of clinical reasoning, with the risk contained within a safe learning environment. This was very important for both psychological safety and the safety of patients and their caregivers. As Miss Coleman noted, "There's a reason why pilots train in simulators and not in commercial airliners."

The overall aim was to develop and integrate two scalable, validated learning tools within postgraduate certificate programmes, and to strengthen diagnostic reasoning, error literacy, professional resilience, and real-world transfer, while maintaining learner engagement in online formats. The ALAs were deliberately designed to be visually appealing and interactive.

Explaining the error management training in more detail, Miss Coleman described how learners worked through deliberately ambiguous clinical scenarios in which mistakes were not only expected, but actively encouraged. These errors then became the focus of structured reflection. Each cycle of the training required rapid decision-making under uncertainty followed by immediate reflection on what happened and why. Learners examined the consequences and developed concrete strategies for improvement.

The facilitators of these sessions provided clear, interpretable feedback that was specific, actionable and referenced to defined criteria. The training explicitly targeted emotional self-regulation and built tolerance of uncertainty. It helped identify personal and cognitive biases, and promoted higher-order learning. Learners were required to analyse decisions, evaluate trade-offs, and design improved approaches for future cases.

Authentic cases were used in the reverse engineering ALA, Miss Coleman continued. Learners were given the final diagnosis and outcome and asked to reconstruct the reasoning that could have led to that outcome. They identified pivotal data, explored decision pathways that may not have been taken, examined discarded differentials, and considered potential errors. The aim was to develop strategic vision, retrospective clinical judgement, and awareness of bias. By modelling how clinicians actually thought, this approach aligned closely with real practice and sharpened clinical intuition through reflective reconstruction.

Both ALAs were threaded through Improve's postgraduate certificate programmes in small animal medicine, surgery, and orthopaedics, she said. Each was supported by concise guidance for facilitators and rubrics for consistent feedback. Faculty were trained to deliver the ALAs, with emphasis on psychological safety, positive framing of error, and the use of brief video feedback to maintain learner engagement and momentum.

As the ALAs had only recently been introduced, outcome data were not yet available. Planned evaluation measures included engagement metrics such as timely completion of activities, analysis of the quality of learner submissions, and evaluation of performance in applied assessments and case-based scenarios. Learner questionnaires would capture details of self-efficacy and the perceived usefulness of the feedback, while programme-level indicators such as overall completion rates would also be reviewed.

"We expect to see an increase in short-term training-phase errors," Miss Coleman said. "But we expect this to be offset by a stronger long-term transfer of knowledge and skills, more robust clinical judgement under pressure, improved resilience, and greater transparency around mistakes." These outcomes would align with evidence from similar approaches used in other high-stakes professions, including aviation and human medicine. Improve planned to collect comparative data from cohorts exposed to the new approach and those taught using traditional methods.

She concluded by noting that artificial intelligence (AI) had been integrated into the feedback models, making the approach scalable and practically deliverable. However, she pointed out that the AI had been designed specifically for Improve and had been validated by human reviewers; it was also isolated from the wider internet. Its performance was being closely monitored and she looked forward to sharing the results in future.

During discussion, a delegate commented that Improve's approach required psychological skills that veterinary clinical educators might not have. Agreeing that this was a fair observation, Miss Coleman explained that Improve had worked with psychologists when designing the activities and associated feedback element to ensure psychological safely. Subject matter experts had also been involved to validate the content of the material.

A programme for newly qualified nurses to transition into referral practice

Natasha Hetzel, Head of Education and Career Development, Linnaeus, UK

Natasha Hetzel began her presentation by explaining that, in the UK, only one educational institution currently ensured that student veterinary nurses were exposed to multidisciplinary referral practice during their training. Consequently, many veterinary nurses had little prior experience of referral practice if they entered it early in their careers. This lack of exposure could make referral practice a challenging environment, leading some nurses to leave their role or even the profession entirely.

Linnaeus had established a post-registration programme (PRP) for veterinary nurses in 2020, Ms Hetzel said. Based on preceptorship models used in human healthcare, the programme aimed to provide practical and clinical support during the transition from student to confident, highly skilled referral veterinary nurse.

The year-long PRP began with a four-week induction period, during which the vet nurses learned about the environment of the hospital, its standard operating procedures (SOPs), and how to function effectively in that hospital. This was followed by six-week rotations in wards, diagnostics, and theatre, helping them embed into the team. During the wards rotation, the nurses focused on patient care and client communication; in the diagnostics rotation, the focus was on medicine and imaging; and in the theatre rotation, they were involved in anaesthesia and surgical nursing. There was also an optional rotation, tailored to the services offered by the specific hospital, such as dentistry or neurology.

Throughout the rotations, nurses completed a skills matrix to assess their competence. This included discussing clinical cases and the underlying pathophysiology, demonstrating set-up for procedures, and showing practical nursing skills.

Ms Hetzel explained that PRP nurses received multilayered support. Each was assigned a preceptor – an experienced clinical nurse – who supported clinical skills' development and provided pastoral support, helping nurses integrate into the practice and develop through the programme. Nurses met with their preceptor weekly during the first six weeks and then fortnightly thereafter. Ms Hetzel noted that because preceptors often worked in a specific area of nursing and might not be able to support all aspects of skills development, clinical skills supervisors were also available. These supervisors focused on technical skill development rather than pastoral support.

Additional support came from Linnaeus's central team. A PRP manager in the central education team ran professional development days, with each nurse attending three per year – two online and one in person. The central team also provided wider support, for example when placements were not working well, or when nurses experienced mental or physical health challenges. Preceptors and clinical skills supervisors were also supported by the central team.

Peer support was encouraged too. Each practice hosted a minimum of two, and up to eight, PRP

nurses at any one time. Because the programme ran on a rolling basis, nurses started at different times, allowing more experienced PRP nurses to support those earlier in the programme.

Alongside the in-practice clinical training, the PRP delivered non-clinical training, mainly during the professional development days. Topics included career development, CPD planning, reflective practice, wellbeing, communication skills, and effective handovers. Nurses were also given introductory clinical educator training as they would be supporting student veterinary nurses and patient care assistants. The intention was to ensure the nurses had the best start to their careers in referral practice.

The PRP also aimed to embed the importance of evidence-based veterinary medicine. Nurses were given protected time to undertake a research project, which could take several forms. One option was a nursing care analysis – a case report examining patient care from admission to discharge and critiquing it against existing literature. Alternatively, the nurses could examine the literature to review an existing SOP or create a new one. These SOPs were checked and modified, if necessary, before being shared across hospitals.

At the end of the PRP, nurses were required to present a clinical audit, either individually or in groups, selecting from predetermined topics. This enabled Linnaeus to continuously collect data, audit key areas of practice, and feed findings into hospital quality improvement programmes.

Discussing the impact of the PRP, Ms Hetzel reported that, by 2024, 102 nurses had completed the PRP. These had been compared with a control group of nurses who had joined Linnaeus within one year of qualifying but had not undertaken the PRP. PRP nurses were retained for an average of seven months longer than those in the control group. Retention rates were also higher, with 76% of PRP nurses remaining with Linnaeus compared with 61% of control nurses.

Career progression was faster among PRP nurses, with 29% reaching the 'experienced registered veterinary nurse (RVN)' level compared with 16% of the control group. PRP nurses were also more likely to engage with central support systems, which Ms Hetzel described as important both for communication around education and quality improvement and for providing access to career development opportunities.

While no control data were available, Ms Hetzel said there was a general impression that nurses did not relocate very often. However, 22% of PRP nurses had relocated either to undertake the PRP or afterwards to join a referral hospital. This suggested the programme was valued, that nurses were willing to move for the support it offered, and that referral hospitals actively sought nurses who had completed the PRP.

The PRP was designed as an induction into referral practice, and Ms Hetzel said it had been encouraging to see participants go on to become preceptors and mentors themselves. Others had progressed into leadership or management roles within and beyond Linnaeus, moved into lecturing or education, published research, or undertaken postgraduate qualifications such as a master's degree or Veterinary Technician Specialist qualifications.

In the discussion that followed, Ms Hetzel was asked how the PRP functioned within the time pressures of clinical practice and whether nurses taking on educator roles received additional remuneration.

Addressing the first question, she explained that PRP nurses were additional members of the hospital team and became effective contributors quickly. Unlike students requiring dedicated teaching time, PRP nurses provided immediate value to practices. In some respects, she said, the programme was easier to accommodate than veterinary surgeon development programmes that required protected teaching time. Nursing

culture was already well suited to in-clinic teaching, with experienced nurses accustomed to teaching alongside routine clinical work. For example, preceptors or clinical skills supervisors might work alongside PRP nurses on wards, allowing competencies to be signed off during real clinical cases.

On remuneration, Ms Hetzel said she was unsure of the specifics but noted that preceptor and clinical skills supervisor responsibilities were likely linked to salary bandings or tiers and could contribute to progression into higher pay bands.

Another delegate welcomed the programme's focus on non-technical elements and described the retention information as interesting. Their own experience suggested that referral nurses were paid less than those in first-opinion practice, making non-financial benefits important. Practices benefited from having established teams, while constant team rotation reduced psychological safety and was financially costly due to the continuous need to recruit new team members.

Ms Hetzel agreed, noting that retention was influenced by many factors. While it might be possible to say that a poor programme resulted in poor retention, it was harder to say that a good programme was the only reason why people stayed.

In further questions, Ms Hetzel was asked whether the PRP was mandatory for nurses joining Linnaeus referral practices and whether competency frameworks existed for referral nursing skills in the different disciplines.

Addressing the second question first, she explained that the skills matrix had been developed alongside the PRP in collaboration with nursing leads from referral hospitals. It outlined competencies by discipline and focused particularly on skills that differed from those required in primary care. For instance, looking after intravenous access in referral practice was often quite different from doing so in primary care practice. Induction competencies were also included, to help nurses understand how things were done in each hospital and integrate into the hospital's culture.

Participation in the PRP was encouraged but not mandatory, she continued. Hospitals had to budget for PRP spaces and nurses were recruited into those roles by the central support team. While hospitals could recruit newly qualified nurses outside the PRP, this was generally discouraged as outcomes were felt to be better when nurses completed the programme. This differed from Linnaeus's veterinary graduate development programme, where practices could not recruit graduates with less than two years' experience outside of the graduate programme.

Ms Hetzel also noted some resistance from RVNs who had trained in referral practices as students and felt they already had the skills required. While they were generally happy to complete the skills matrix, they often resisted the project work. She suggested this reflected limited experience in scientific writing, research, and critical review – areas where the PRP added particular value by supporting development of these skills.

Simulation-enhanced echocardiography training to address skills gaps in primary care practice

Stuart Garde, Head of Clinical Development, IVC Evidensia

About one in 20 dogs presenting to primary care practice in the UK will have a cardiac condition, said Dr Stuart Garde, noting that this figure came from a paper by O'Neill and colleagues (doi: 10.1186/s12917-021-02775-3). Myxomatous mitral valve disease was the most commonly encountered cardiac condition, he continued, affecting as many as one in three dogs over the age of 13 years. These cases were therefore encountered frequently in primary care practice, with IVC Evidensia practices caring for more than 5,000 cardiac cases each month.

In 2016, Boswood and colleagues had published findings from the EPIC study (doi: 10.1111/jvim.14586) evaluating the effect of pimobendan in dogs with cardiomegaly. They demonstrated that dogs with preclinical mitral valve disease treated with pimobendan experienced a 15-month delay in the onset of clinical signs of congestive heart failure, cardiac-related death, or euthanasia when compared with dogs receiving a placebo.

To be included in the study, dogs had to be six years of age or older, weigh between 4 and 15 kg, and have a moderate- to high-intensity heart murmur. In addition, they required echocardiographic evidence of left atrial and left ventricular dilatation.

Dr Garde noted that the first three inclusion criteria could be assessed with a simple history and clinical examination. However, confirming atrial and ventricular enlargement required specific echocardiographic measurements and IVC Evidensia had identified a considerable skills gap in this area among its primary care vets. A proficiency mapping survey across its small animal primary care practice network revealed that, among 1,756 veterinary surgeon respondents, 84% reported no or only basic echo skills, while 16% described their skills as intermediate or advanced.

This raised concerns about missed diagnoses, delays in referral, reduced confidence in cardiac case management, and the ability to provide appropriate contextualised care within primary care practice. It also highlighted an over-reliance on a small number of cardiologists for relatively simple cases.

IVC Evidensia set out to address this gap through the development of echocardiography training designed specifically for primary care practitioners. The aim was to deliver highly practical, clinically relevant training that would build competence and confidence in a low-stress environment for both learners and patients. To ensure relevance, the cardiology section of the group's clinical competency framework for general practitioners was used to define the core knowledge and skills expected of all small animal primary care vets.

For echocardiography, these skills included appropriate case selection, patient positioning, transducer selection and manipulation, optimisation of ultrasound machine settings, and acquisition of the views required to assess

EPIC criteria measurements. As view acquisition and measurement are highly practical skills that cannot be effectively developed through theory alone, IVC Evidensia aimed to maximise the time delegates spent with a transducer "in hand actually performing scans", Dr Garde said.

Historically, achieving this had required either prolonged restraint of live patients or access to large numbers of suitable dogs so patients could be rotated to reduce stress. However, the pool of healthy, well-behaved dogs whose owners were willing to volunteer them was limited, and increasing restraint time conflicted with the aim of maintaining a low-stress learning environment.

IVC Evidensia had therefore looked for an alternative solution, which led it to Deepscope simulators. These provide a three-dimensional, anatomically accurate simulation of a live patient, including a beating heart. A replica transducer was connected to a laptop computer and used to scan a 'patient' either in virtual reality through the use of a headset and computer app, or using a replica physical patient (a stuffed toy).

For its training, IVC opted to use the replica physical patient, as the laptop screen and controls more closely simulated a real ultrasound machine, and the model better reflected the experience of scanning a patient restrained on a table. The laptop-based system also allowed trainers and observers to view the scan in real time and intervene to offer a physical demonstration if needed; this would have been impossible with the virtual reality system.

Dr Garde explained that the simulator was extremely sensitive to transducer movements and provided realistic, real-time feedback. Users could freeze images and perform measurements in the same way as on a clinical ultrasound machine. In addition to the two-dimensional (2D) ultrasound representation, the Deepscope simulator provided a three-dimensional (3D) view that could be sectioned according to the transducer position, helping learners translate between 2D images and 3D anatomy.

"These simulators therefore allow us to realistically simulate performing echos on patients and allow the delegates to build basic confidence in a controlled and repeatable environment without the need for a restrained live patient," he said. This reduced delegate stress and allowed learners to progress to live patients once basic skills had been established. As a result, the benefits of using live patients were realised during the training but without compromising the welfare of the dogs involved.

To maximise learning outcomes, the training was divided into a morning simulator session and an afternoon live patient session. During the morning, delegates were taught transducer manipulation and systematic view acquisition using the Deepscope simulators. They were given ample time to develop muscle memory and visual pattern recognition skills in a low-pressure setting. Once competent, they practised acquiring the EPIC measurements of the left atrium and ventricle on both normal and pathological simulations to demonstrate the subjective and objective differences that could be identified on a scan.

In the afternoon, delegates rotated around stations equipped with ultrasound machines and live patients of varying sizes and conformations. They applied the skills acquired in the morning, learned to optimise the ultrasound images obtained, and compared images produced by curvilinear and phased array transducers. This was particularly important given the variability in equipment, transducer availability, and patient conformation encountered in primary care practice.

Dr Garde said this approach had resulted in a highly effective learning experience. Delegate feedback consistently highlighted the practical format, clinical relevance, and value of simulation-based learning as key strengths of the course. Confidence scores improved by 87%, rising from an average of 2.4 out of 5 before the course to 4.5 out of 5 afterwards.

Delegates reported feeling better equipped to identify cases requiring echocardiography, perform and interpret key measurements, and communicate findings to both clients and referral cardiologists. Cardiologists delivering the training independently noted accelerated skills acquisition compared with courses that did not use simulation.

The simulators also enabled exposure to pathological cases that would otherwise be unavailable for training, while significantly reducing the time live patients spent restrained on the scanning table. This improved both animal welfare and the overall learning environment.

By integrating simulation technology, many of the traditional barriers associated with live animal echocardiography training – particularly patient availability and welfare concerns –were reduced. This allowed more consistent and repeatable practice and enabled courses to be delivered more frequently, reaching a larger number of clinicians.

IVC planned to repeat the proficiency scoring annually and track skills development across its practice network. An impact report was also in development to link course participation with real-world changes in clinical behaviour.

Concluding, Dr Garde said the introduction of simulator-enhanced echocardiography training had enabled primary care practitioners to develop essential cardiac imaging skills in a low-stress, ethically sound and highly practical environment. By combining simulation with live patient experience, IVC had created a sustainable training model that supported professional development and patient welfare, helping bridge the gap between clinical research, diagnostic capability, and everyday primary care practice.

He had brought a simulator and model with him, saying he was "really keen" to demonstrate them as they were "the coolest thing ever". Although the images could not be displayed on the large screen in the Banqueting Hall, he asked the session's chair, Dr Linda Prescott-Clements, to hold up the laptop for delegates to see. "Stuffed dog – beating heart!" he remarked as he showed the system's ability to display multiple cardiac views.

During questions after the demonstration, a veterinary cardiologist asked Dr Garde if learners could practice at home to build their skills further, as it took "more than a morning" to master them. They also asked how 'tweakable' the system was with regard to accommodating different chest wall sizes and shapes – for example, could it simulate a bulldog or a setter?

Dr Garde explained that learners with their own virtual reality headsets could download the app and practice at home. However, learners with no basic skills could not train on their own. They needed initial instruction to learn how to hold and move the transducer. Based on IVC's experience, these foundational skills could be acquired in a single morning using simulators, after which learners could undertake extensive independent practice in virtual reality.

Addressing the second question, he said IVC had found the system to be "very tweakable", with requested modifications typically implemented within two weeks. "We can get all sorts of cool stuff... from them [the system's developers]," he said.

Teaching non-technical skills in postgraduate veterinary education

Bethan Ellwood, Masters Programme Coordinator, University of Edinburgh, UK

Explaining that she was the coordinator of Edinburgh's online veterinary anaesthesia and analgesia (VAA) programme, Dr Bethan Ellwood MRCVS began by defining non-technical skills (NTS). These, she said, were "the cognitive, social, and personal resource skills that complement technical skills and contribute to safe and efficient task performance". They encompassed cognitive skills such as task management, situational awareness, and decision-making; social skills such as communication and teamwork; and personal resource skills such as stress management and resilience.

The importance of NTS was widely recognised in safety-critical industries such as aviation, and also in healthcare, with effects on patient safety and staff wellbeing. In healthcare settings, there was often a particular focus on anaesthesia, but Dr Ellwood emphasised that NTS were relevant across a wide range of roles and areas.

Despite this recognition, there was no clear consensus on the optimal approach to teaching NTS. A growing body of literature explored NTS teaching in medical education, and veterinary undergraduate curricula were increasingly including elements such as communication, recognising the importance of these skills for practice and employability. However, the teaching of NTS to veterinary professionals at postgraduate level, particularly in distance learning contexts, was poorly described.

She went on to explain that Edinburgh's VAA programme was an online, taught postgraduate programme offering qualifications at postgraduate certificate, diploma, or master's levels. Students studied part-time, typically alongside clinical work, for one-to-two years for the certificate and three-six years for the MSc. The programme was positioned at Level 11 of the Scottish Credit and Qualifications Framework (SCQF), equivalent to master's degree level. Alongside two compulsory courses, students chose from a range of elective taught courses.

NTS had been part of the VAA curriculum since 2017, previously offered as an elective titled 'Problem solving and non-technical skills in veterinary anaesthesia'. This had been updated to create a new course for the 2024/25 academic year – 'Non-technical skills for safer veterinary care' – supported by updated learning outcomes and course content. One of the motivations for the update had been to emphasise the relevance of NTS to the entire veterinary team, beyond anaesthesia.

The new elective was available to diploma-level students enrolled on the VAA programme. It carried 10 SCQF credits and was studied over six weeks. Dr Ellwood explained that the learning outcomes had been mapped to SCQF Level 11 descriptors and focused on students demonstrating knowledge and critical understanding of NTS in different contexts. This included the ability to critically review specialist literature and consolidate and extend their knowledge.

As there was no veterinary-specific terminology for NTS, course content had been informed by organisers' expertise and evidence from other

healthcare systems, she said. New content was released weekly, beginning with an introduction to human factors and NTS before focusing on specific topics, including communication, situation awareness, problem-solving, and decision-making. The final week was a reading week, allowing students time to consolidate their learning and prepare for their assessments.

Students were expected to spend approximately 20 hours per week on the course, equating to around 100 hours in total, although weekly time commitment varied due to the course's asynchronous format. There were no 'live' teaching sessions, she explained, giving students flexibility to balance study with personal and professional commitments.

Teaching was delivered by the Learn Ultra virtual learning platform. Students received weekly notifications of new content, alongside information such as assessment deadline reminders. A mixed-media approach to teaching was used, including recorded lectures, recommended reading, and online resources. Online discussion boards were a central component of the course, with topics posted weekly, usually by tutors. Students were encouraged to comment and engage with each other and with tutors to facilitate deeper discussion of the course material and foster an online learning community.

Assessment comprised two coursework-based components. The first was a reflective diary, in which students reflected on their learning in relation to their current practice. The second was an essay, with students choosing one of two questions to demonstrate their understanding of NTS and explore relevant literature. Each assessment contributed 50% of the final mark. Although both were submitted at the end of the course, students were encouraged to work on their reflective diary throughout the teaching period and received formative feedback on their early entries.

Dr Ellwood showed an example of how the course content appeared within the virtual learning environment, explaining that students could work through the material at their own pace and in an order of their own choosing. There was also flexibility in how students could access and use the content.

The course had run for the first time in May 2025, she said. The asynchronous online format had enabled participation from an international cohort of students from varied professional backgrounds, demonstrating the role of distance learning in widening access to postgraduate education. However, the format also posed challenges, particularly in maintaining engagement and facilitating interactive learning and practical application of NTS, especially as many students were balancing study with clinical work. The initial cohort had been relatively small, with around 10 students.

Participation in discussion boards had not been compulsory, she continued, but engagement had been encouraged through signposting and regular announcements. However, the VAA programme was now moving away from traditional discussion formats and exploring alternatives, such as online interactive whiteboards, to improve engagement and interaction. In the upcoming academic year there were plans for activities designed to prompt reflection on factors affecting clinical decision-making.

Although veterinary-specific evidence on postgraduate NTS teaching remained limited, Dr Ellwood noted that a growing number of tools existed to support both teaching and the implementation of NTS in clinical practice. Competency frameworks from human healthcare could inform curriculum design but without a veterinary-specific NTS taxonomy, Edinburgh had relied on 'a somewhat arbitrary' division of topics. A veterinary-specific framework for NTS would support future curriculum development and consistency in NTS teaching across programmes and organisations.

Looking ahead, she highlighted the potential of innovative digital education approaches, including interactive, scenario-based learning and simulation, to support NTS training in an online, asynchronous context. In medical education, in-person and high-fidelity simulation were well established in NTS teaching, she said, and emerging evidence suggested that virtual simulation may also be effective.

She also noted the value of reviewing student outcomes in greater depth, not only in terms of assessment performance and achievement of learning outcomes, but also in understanding how NTS teaching influenced students' behaviour and effectiveness in clinical practice.

Concluding, Dr Ellwood said Edinburgh's experience demonstrated the viability of asynchronous online delivery for introducing NTS in postgraduate veterinary education. As the course developed, it was hoped that the use of additional digital tools would enhance NTS teaching and provide insight into the impact of NTS education on clinical practice.

During discussion, the session chair, Dr Linda Prescott-Clements, asked about the plans for using virtual simulation. Dr Ellwood explained that several approaches were under consideration. One was a platform called Storyline, which presented students with a clinical case and a series of decisions in an interactive, click-through format. The team was also working closely with Edinburgh's education unit to develop more advanced simulations, such as a virtual anaesthesia environment that students could explore and interact with on screen.

A delegate asked whether artificial intelligence (AI) might support simulation-based training, particularly for communication skills. Dr Ellwood confirmed that this had been discussed informally and suggested that AI could be particularly effective for simulating conversations with clients. She noted, however, that its application to complex anaesthetic scenarios involving multiple team members and interactions might be more challenging, especially using general AI tools not specifically designed for such purposes.

Mapping the structure, support, and outcomes of rotating veterinary internships across Europe: findings from a multinational survey

Julie Rosser, CEO, European Board of Veterinary Specialisation (EBVS), Austria

Introducing her talk as "less of a presentation and more of an invitation", Dr Julie Rosser explained that the European Board of Veterinary Specialisation (EBVS) had conducted a survey on internships across Europe in 2024. "Spoiler alert – the UK provided the most responses," she said. Some of the data had already been presented at the 2025 EBVS Congress in Belgrade, with further discussion expected at the 2026 EBVS Congress in Krakow. She hoped her presentation at the PGVE symposium would act as a 'teaser', encouraging wider engagement in conversations about data collection, future planning, and the evolution of veterinary internships in Europe and the UK.

Highlighting reasons for examining internships, Dr Rosser pointed to quality assurance, standardisation, and long-term sustainability of the veterinary workforce. For this presentation, however, her focus was on providing clarity for individuals considering internships and for employers offering them. Another motivation was ensuring that internships could be embedded within a broader vision for the future of the veterinary profession across Europe and beyond.

She described herself as part of a group of people who valued "hard data and numbers" and who sometimes did not feel that survey responses qualified as such. However, without data, "we don't know where we're at", she said, before pointing out that the first question a phone navigation app would ask when a user wanted directions was where were they starting from? Survey data, therefore, offered a starting point, giving an understanding of what was currently valued, where gaps existed, and what possible destinations might be.

Responses to the EBVS survey had been received from more than 100 institutions across Europe and the UK offering internships, representing almost 700 intern positions. The majority of these internships (63%) covered companion animals, while equine internships were the second most common. Over half the equine internships were UK-based, whereas companion animal programmes were more widely distributed throughout Europe.

Addressing the question of whether new graduates could secure internships, Dr Rosser said the answer was "yes, but it is not a guarantee in companion animal practice". According to the survey, 97% of new graduates seeking equine internships were successful, as were 90% of those applying for 'other' internships such as farm animal, fish, or laboratory animal. In contrast, only 57% of applicants for companion animal internships secured a position. Many companion animal internships required at least one year of prior experience, with 10% requiring more than two years.

Looking specifically at small animal rotating internships, she said the data broke down "as expected", with 48% of rotating internships being offered by corporate veterinary groups, 45% by universities and 6% by private clinics. She noted that 40% of EBVS diplomates worked in academia and 34% in private practice, although this varied by specialty. For equine internships, 10% were offered by corporate veterinary groups, 59% by universities and 31% by private practices.

"I was a little bit surprised by these numbers, I expected them to be closer," she said, but the insight was still valuable.

Turning to internship structure, Dr Rosser noted that some survey findings raised concerns – one was the continued existence of unpaid internships in Europe. There was also wide variation in the number of disciplines interns rotated through. Companion animal internships often included up to 10 disciplines, while equine internships typically involved six or seven. The most common rotations were medicine and surgery, anaesthesia, emergency (out-of-hours), imaging, emergency (day), and critical care. Other less common rotations were more dependent on species and internship provider. These included disciplines such as cardiology, dermatology, oncology, and ophthalmology, as well as areas such as sports medicine and dentistry. Some internships, particularly equine, extended beyond 12 months in duration.

Survey findings on workload and support were also significant. Some internships still exceeded a 48-hour working week for clinical duties, with study time expected in addition. Wellbeing and support structures varied, and some interns reported having no access to external conflict mediation, although many programmes did offer some wellbeing resources.

Briefly discussing internship outcomes, Dr Rosser noted that formal recognition of completion was most commonly associated with internships offered by universities or academic institutions. Case logs were consistently required only for internships associated with university degree programmes.

She highlighted some "very exciting" results relating to career progression following an internship, reporting that the number of interns who moved on to residency was "relatively strong".

Dr Rosser also addressed remuneration, drawing on data from a Federation of Veterinarians of Europe (FVE) survey. The key question was whether interns saw a financial return on their investment of time. Survey data showed that the answer was "not necessarily", she said. In many countries, interns were paid the same as new graduates, but sometimes they were paid less. She described this as concerning, but cautioned that the data were not sufficient for firm conclusions to be drawn and said the issue warranted further investigation. She also emphasised the need to consider the value of internships to host institutions, noting that the financial and resource investment made by practices and universities in training interns was often overlooked.

In response to these findings, the EBVS had formed a working group tasked initially with developing a standardised definition of a rotating internship for veterinarians. Membership of the group included national veterinary chambers, the Union of European Veterinary Practitioners, FVE, and multiple EBVS specialty colleges. While its remit might appear limited, Dr Rosser noted that reaching consensus among such diverse stakeholders was "surprisingly difficult". The definition was seen as a first step, with broader discussions needed on how to improve internships and position Europe as a leader in veterinary postgraduate training.

Dr Rosser concluded by inviting delegates to engage with her during the PGVE symposium and to participate in discussions at the 2026 EBVS Congress. She said the working group was likely to continue after it had agreed its definition of an internship and the EBVS wanted wide stakeholder involvement in shaping future developments.

During questions, one delegate raised the issue of unpaid internships, suggesting this could reflect cultural and economic differences between countries. In France, for example, government funding for training was limited, and institutions incurred costs when training interns. The delegate asked whether, rather than penalising providers, the EBVS had plans to introduce recognition or certification to encourage them to pay their interns.

Dr Rosser described this as a delicate issue, noting that some institutions already advertised internships as 'EBVS-recognised', despite EBVS not formally recognising any programmes. She said EBVS lacked both the resources and desire to act as an enforcement body and instead aimed to empower stakeholders. Developing a shared definition of a rotating internship was the starting point, and while she did not rule out future recognition or certification schemes, these were unlikely in the near term.

Another delegate asked about intern mobility across Europe, including where interns trained and where institutions recruited from. Dr Rosser said there was limited data on this, as most survey responses had come from institutions rather than individuals. However, she highlighted the importance of mobility, particularly given EBVS discussions with the European Commission's Directorate-General for Internal Market, Industry, Entrepreneurship and SMEs (DG GROW).

A further delegate emphasised the value of tracking the movement of interns and residents, noting that some organisations already held such data. When recruiting interns, there was often a focus on immediate workforce needs – what was needed in a veterinary clinic at a particular moment in time – rather than longer-term career trajectories. They noted that relocating people after training could be challenging, because "lives happen and people don't tend to move".

Dr Rosser agreed, adding that there may be cultural and language barriers to mobility, especially in client-facing roles. She suggested it would be valuable to identify where veterinary professionals were most needed and what factors might attract them to underserved areas. "Can we find the variables that induce people to move?" she asked. Understanding how to attract talent to regions requiring advanced veterinary care was, she concluded, was a key question to address.

Parallel sessions (Court Room, morning): Postgraduate education (II)

Unifying standards, empowering progress: Veterinary Continuing Education in Europe (VETCEE) and the future of European CPD accreditation

Lidewij Wiersma, Chief Executive Officer, VETCEE, Belgium

"I feel like I've found my people... [people who] are thinking about the same things that I am thinking about." This was how Dr Lidewij Wiersma opened her presentation introducing Veterinary Continuing Education in Europe (VETCEE), an international non-profit accreditation body for postgraduate veterinary training. She explained that VETCEE had been established in 2014 by the European Board of Veterinary Specialisation (EBVS), European Association of Establishments for Veterinary Education (EAEVE), Union of European Veterinary Practitioners (UEVP), and the Federation of Veterinarians of Europe (FVE). These organisations had identified a gap in the market for a unified accreditation of postgraduate education.

Initially, a "very structured, specific, and constraining model" for accreditation had been developed, she said, but most postgraduate education programmes had not been eligible. However, in 2021, a survey found overwhelming support for VETCEE to accredit all types of CPD, so the strategy changed. FVE and UEVP had stepped away from membership of VETCEE in 2024 and had become clients, with VETCEE now accrediting a programme they offered.

The new membership structure allowed national veterinary competent authorities to join VETCEE, giving them a defining role in structuring CPD at a European level. The number of accredited postgraduate programmes was rising, even without active outreach. "People are interested, they want this," Dr Wiersma said, adding that, in a major development, VETCEE was preparing to accredit the entire postgraduate education portfolio of a European university. VETCEE's experience suggested that once it accredited one programme offered by an institution, it was then asked to accredit more.

She explained that VETCEE's mission was to provide accreditation of national and international CPD programmes across Europe and beyond: "Obviously, we're a European organisation but it doesn't mean that we're limited to just European programmes," she said. VETCEE aimed to set standards, create transparent quality assurance mechanisms, and facilitate recognition of CPD across Europe so CPD completed in one country was recognised in another. As a non-profit organisation, it tried to ensure accreditation costs were accessible.

To help learners identify high-quality programmes, VETCEE was creating a portal where clicking on a European country would display the accredited CPD programmes available there. Having unified standards across Europe would increase veterinarians' mobility and it might be possible to automatically convert accreditations from existing national systems, such as the *Akademie für tierärztliche Fortbildung* (ATF), which accredited high-quality veterinary CPD in Germany.

Programmes accredited by VETCEE were detailed on its website (vetcee.eu), Dr Wiersma said, explaining that all programmes had to provide high-quality, evidence-based scientific content, be free from bias, adhere to established minimum standards, and use appropriate educational approaches. VETCEE would accredit any type of continuing education that fulfilled its quality requirements.

The new portal would also allow providers to build and submit courses for accreditation. The content and approach of submitted courses would be assessed by two or three paid reviewers and Dr Wiersma encouraged members of the audience interested in becoming reviewers to sign up on the VETCEE website.

She concluded by noting that VETCEE also offered microcredentials – portable, stackable badges that contributed directly to EBVS recognised postgraduate pathways.

During discussion, a delegate pointed out that CPD provision was a lucrative market and that quality varied. It was hard to prove a provider had the right intentions. How did VETCEE ensure its accreditation was taken seriously?

Responding, Dr Wiersma said it was important to be serious enough to be taken seriously but not so serious as to make accreditation impossible to achieve. The development of accreditation was an iterative process that could be adjusted over time. VETCEE would also be gathering feedback from participants to ensure accredited courses were meeting expectations.

Empowering veterinary professionals as educators

Louise Dingley, Lecturer in Veterinary Primary Care Education and Leadership, University of Lancashire

As educators, veterinary practitioners made an enormous impact on a daily basis, began Dr Louise Dingley MRCVS, but while this was perhaps known intuitively, it was under-recognised formally. Some of the most authentic learning happened in the workplace, including learning that contributed to professional identity formation. Students learned how to perform tasks themselves and how clinicians performed tasks. They also learned how clinicians prioritised, responded to stress, and treated one another.

This was the hidden curriculum – the unwritten, unofficial, unintended lessons that students learned. "Much of the hidden curriculum in the workplace is made up of the little, unspoken, unnoticed moments that just happen," she said. Such moments shaped students' behaviours and values.

However, given that the theme of the symposium was postgraduate education, she explained she would be focusing on how postgraduate development could help practitioners recognise their influence and use it more intentionally. This could make a big difference to the students learning with them.

But there were challenges: practice was stretched and practitioners felt underprepared and uncertain

about their role as educators, or that they were not qualified to teach. Some feared giving feedback, or dreaded conflict, or felt they had less to offer because they were not academics. "We also know that the profession is grappling with stress and retention issues, and in some places a lack of psychological safety," she said. People should not be asked to take on the role of educators without equipping them with the right tools to do so.

The University of Lancashire offered two postgraduate programmes to support the development of educators: a postgraduate certificate in veterinary education, coaching, and leadership, and a postgraduate diploma or master's degree in veterinary primary care and clinical leadership. Both included a compulsory 'education in veterinary clinical practice' module, offered accessible, part-time, online learning, and were flexible and asynchronous to fit around practice life. On completion, learners could join the Academy of Medical Educators. "This is an important point to raise, because it reinforces the fact that they are medical educators," Dr Dingley commented.

The courses did not aim to turn clinicians into academics, she said. Rather, they helped clinicians understand that small, everyday interactions with students and colleagues mattered.

She reported that, after running the courses for a year, feedback from learners had been very encouraging. Some had redesigned their practice induction programmes, others had delivered interactive CPD to colleagues, or had implemented structured debriefs. While the findings were anecdotal, they reflected "small, positive shifts in practice".

Summarising, she reiterated that teaching already happened in veterinary practice. Offering clinicians an opportunity to undertake postgraduate development in education would help them teach in a more intentional, effective, and competent way. Gaining skills in coaching, delivering feedback, debriefing, and ensuring psychological safety, helped change practice culture, bringing benefits to the whole team. She hoped the narrative would "gently shift" so more vets and vet nurses saw themselves as educators, thus supporting better workplace learning.

During discussion, a delegate commented that both courses would also be relevant to specialists, to improve the teaching of residents. However, the focus on primary care in their titles did not suggest this; if this could be addressed it could open the courses to a wider audience and encourage greater buy-in.

Welcoming this comment, Dr Dingley agreed that the emphasis on primary care could potentially be a barrier to participation.

Another delegate asked what was known about the backgrounds of course participants and their career trajectories after completion.

Responding, Dr Dingley said it was early days for both courses. Most participants in the first year had been vets, with one registered veterinary nurse (RVN). In the second year, total numbers had tripled, with many more RVNs participating. One potential barrier to entry was that some RVNs did not have the required Level 6-equivalent degree; however, to widen participation, the course was now open to participants who met Level 6-equivalent standards.

In terms of post-course career trajectory, she noted many students were already in leadership positions or were seeking to move into such positions. They were particularly interested in the leadership modules, but were finding the education and coaching elements impactful too.

A further delegate noted that the University of Lancashire used a distributed model of delivery for its veterinary degree, and asked if clinicians supporting students in the associated practices undertook the courses on offer.

Dr Dingley replied that some were enrolled, but the university offered specific training for clinical tutors in practices that were part of the education model.

A breath of fresh AIR: harnessing AI review to enhance question quality in specialist examinations

Mark Bowen, Director of Education, European Board of Veterinary Specialisation (EBVS)

To illustrate his opening remark that writing good-quality, discriminatory multiple choice examination questions was hard, Dr Mark Bowen FRCVS presented a clinical scenario for the audience to consider. It described a horse with acute-onset watery diarrhoea, gave details of clinical and laboratory findings, and asked which of four interventions should be prioritised. Highlighting flaws in the example presented, he explained that when questions were reviewed, the clinical vignette was often what was focused on. However, the testing point usually arose from the options on offer. Reviewers wasted time "polishing" the vignette while overlooking the testing point.

He showed how the scenario presented could ultimately be reduced to a very straightforward statement and answer.

He asked whether artificial intelligence (AI) could save time and ultimately replace academics in this area before noting that, while AI could write 100 questions in a matter of minutes, it could not deliver nuance or higher-order testing skills. "Academics in the room, your Yoda-like skills are well protected because you bring that nuance to question writing," he commented.

Nonetheless, AI could still be helpful, particularly for question review.

He described a preliminary study he had carried out to evaluate whether AI review could improve question writing for specialist examinations. No comparative data were available to identify the best AI review model, so the study had aimed to see whether AI review was possible and what safety concerns may be associated with it.

He had examined three AI review platforms. The first was SAQUET, an open-source, freely accessible platform that applied 19 parameters in order to review questions. The second model was AL-BERT, the Automated Learning-Based Exam Review Tool, a custom GPT he had developed himself. It had been built with 41 parameters against which to review questions, looking for cues, at the language, and assessing how plausible the options were. The final platform was ItemCrTQ, a commercial platform built with 175 parameters looking at more diverse sets of questions.

SAQUET worked very quickly, Dr Bowen reported, but with just 19 rules it offered only surface level review and its utility was limited. When first built, AL-BERT had used GPT3.5 and had "worked OK", he said, but at the time of the study, he had moved to GPT4.0 and AL-BERT "performed horribly badly, kept missing things, and was skimming". Following an upgrade to GPT5.1, AL-BERT's performance improved. He showed the platform's review of the scenario presented earlier and how it had highlighted the good and bad elements. A problem with "complexity drift" remained, and AL-BERT continued to miss things.

With 175 rules to guide its review, ItemCrTQ performed much better than the other two platforms. It produced reports on numeric

functionality and identified all the flaws in the question. It also tried to identify "not just the testing point that you wrote, but the testing point that you thought you wrote", he said.

However, AI review came with risks. The biggest risk, Dr Bowen said, was memorisation – when an AI model stored and recalled training data. Memorisation was clearly an issue when using public-facing AI tools, but most question review tools were custom-built, bespoke models that did not put data into the public forum. Nonetheless, it was plausible that a situation would arise where one individual recalled a question that another individual had entered.

Following his presentation, Dr Bowen was asked if he had evaluated question types other than multiple choice questions. He explained that the three platforms evaluated were all designed to assess multiple choice-type questions.

He was also asked if he had used a training data set for the models and, if so, whether he had refined the data. He replied that, in developing AL-BERT, he had not used a training data set but had refined the prompts within it "many, many times" until it became functional. He assumed that there was a large training data set associated with the commercial platform, but he did not have access to this.

Another delegate asked what the outcome might have been if the original question had been written by AI and then reviewed by AI. Responding, Dr Bowen explained that AI review would still review the question and identify its flaws – which were often associated with a lack of depth of knowledge and the complexity of the cognitive skills being tested. Using AI to generate questions could be useful in student-based learning, he said, helping students create questions to test their basic knowledge. However, AI-driven question generation was not yet good enough for high-stakes examinations.

Finally, a delegate asked whether AI review could determine competence. Dr Bowen replied that both AL-BERT and ItemCrTQ tried to model this. He had worked with the company behind ItemCrTQ to try to define the minimum competency required by a new diplomate, an advanced practitioner, and a general practitioner so the model could consider this. The model also generated a predictive cut score for questions, indicating what percentage of exam candidates would get it right, reflecting a question's ability to help discriminate between candidates.

Training veterinary leaders to advocate for sustainability

Sharon Boyd, Deputy Director of Postgraduate Teaching, Royal (Dick) School of Veterinary Studies, University of Edinburgh, UK (presenting on behalf of Vet Sustain)

Training veterinary leaders to advocate for sustainability encompassed the competencies, skills, knowledge, emotional aspects, and ability to use diverse skills to tackle "super complex problems", such as the climate and nature emergencies, and biodiversity loss, Dr Sharon Boyd explained. At the University of Edinburgh, One Health was used as a framework to bring together all the skills and competencies needed to make a better future for all – individuals, practice, the professions, and the planet.

She noted that Kramer et al. had investigated whether vets in the USA thought support and training to help them deal with climate change would be of value (doi: 10.3389/fvets.2020.613620). The response had been yes, she said. As professionals, vets thought it important they were involved in climate change advocacy; however, they felt they lacked the knowledge to do this, with many reporting no educational opportunities during their undergraduate studies and a lack of continuing education (CE) in this area.

She then introduced Vet Sustain, a UK-based non-profit organisation established by vet Laura Higham in 2018, which now offered a range of resources and CE/CPD training.

Referring to questions relating to CPD choice and impact posed in a recently published research paper by Prescott-Clements et al. (doi: 10.3138/jvme-2025-0030), Dr Boyd highlighted factors that vets considered when choosing professional development, ranging from how the training was delivered, to the cost and time involved, to the CE/CPD that would have the greatest impact, whether that was on the individual or the practice, community, or planet.

She then introduced the 'whole professions approach' to integrating sustainability into the postgraduate veterinary curriculum being used at the University of Edinburgh, explaining that the university's curriculum working group included vets, vet nurses, and allied professionals. The approach had been adapted from the "whole institution approach" to integrating sustainability set out by Cross and Congreve in a review for AdvanceHE (www.advance-he.ac.uk/news-and-views/sustainable-institutions-evidence-informed-review-good-practice). It considered education, monitoring (including impact), the importance of lifelong learning, integrating into practice and the local community, and how the professions could both influence and learn from higher education institutions, businesses, and other partners and stakeholders.

In their review, Cross and Congreve had highlighted challenges that could be encountered, including engagement – was there a value in taking the learning that was being presented? They also talked about politics and how this might influence willingness to have conversations about a topic, and the need for support to do so.

Vet Sustain, she continued, supported veterinary professionals to become leading forces for sustainability. It had three pillars – learn, connect, and lead – together with "the six Ws of veterinary sustainability": wellbeing, welfare, waste, water,

warming, and wildlife. These 'six Ws' helped to break down the United Nations' Sustainable Development Goals into six areas that could be focused on.

She concluded by extending an invitation to delegates to join one of Vet Sustain's working groups or to attend one of its roundtables, which brought regulators, industry, and businesses together to make a change for the veterinary professions. There were also courses and webinars available, she said, all designed to fit around busy work/life schedules.

Following Dr Boyd's presentation, the previous speaker, Dr Mark Bowen, said there would be value in examining sustainability in the use of artificial intelligence (AI), pointing out that AI was increasingly being used in practice.

Another delegate asked if there was a hierarchy in "what sustainability is prioritised in the face of global collapse". Responding, Dr Boyd said people often felt overwhelmed by the enormity of the challenge, so connection and community were particular priorities given their impact on wellbeing. Vet Sustain relied on people coming together, she said, and when facing "super complex problems", the key was to break them down, find people with the talents to deal with them, and know you were supported in doing so.

From systems to skills: modular, active and personalised postgraduate training in small animal internal medicine (SAM) and soft tissue surgery (SASTS)

Gemma Coleman, Content Co-ordinator and Editor, Improve Veterinary Education, UK

For the final presentation of the morning parallel sessions, Gemma Coleman focused on two postgraduate courses offered by Improve Veterinary Education that had recently been revamped "to work in a new way". Her aim was to highlight the shift in mindset behind the redesign and how course development had changed.

She began by noting that while some of the newer veterinary schools had already integrated problem-based learning into their undergraduate curricula, at postgraduate level it was less well established. Traditionally, Improve's courses had been delivered in organ- or system-based blocks through lengthy lectures that created an illusion of learning but transferred poorly to the consulting room. The revised approach instead considered what clinicians actually needed in practice. "We've moved from teaching topics, to training competencies," she explained, focusing on modularity, active learning, and high-quality feedback to make learning more coherent, applicable, human, and practical.

Explaining the rationale for change, Miss Coleman said traditional postgraduate education often followed a systems logic that did not reflect how vets thought in real clinical situations. Cases rarely presented as textbook examples, meaning lectures did not always equip learners with the practical decision-making skills needed when faced with real patients.

In the revamped courses, methodology was prioritised before content. This methodology was built on three pillars:

- modularity and granularity – small, concise learning units delivered as video lessons;
- active learning activities (ALAs) – centred on doing, deciding, and defending;
- personalised feedback and mentoring – provided through video feedback from subject matter experts, and 'ask-it-now' webinars at the end of each module, allowing learners to raise concerns or ask questions anonymously.

The aim was to develop clearer decision-making, sturdier reasoning, and consistent quality at scale.

Elaborating on the modularity and granularity pillar, Miss Coleman explained that video lessons were delivered in short, 10 to 15 minute units, each answering a specific question linked to a learning objective. These could be associated with the ALAs pillar to encourage engagement. However, she acknowledged that while multiple small pieces of learning could be helpful in many respects, they could be difficult to map. To address this, Improve was developing a 'living atlas' to bridge and tag across concepts and link them.

In Improve's Small Animal Medicine (SAM) course, she said, the emphasis had moved from the traditional organ blocks approach towards clinical presentation pathways, such as vomiting, polyuria/polydipsia, or cough/dyspnoea. Theoretical content was supplemented by "top tips" and "most common errors" presentations from specialists to ensure relevance for day-to-day clinical practice. A suite of ALAs had been developed to increase engagement and performance, shifting learning from a passive activity to something active, constructive, and interactive.

She went on to explain that the feedback and mentoring pillar aimed not only to evaluate performance but to elevate feedback into a meaningful learning tool. Feedback was delivered using the 'STATIC' framework: Specific, Thoughtful, Actionable, Timely, Individualised and Criterion-referenced. Learners could also access a dashboard and upload short reflective videos, which course directors used to inform feedback. Expectations were set high to encourage student performance and positive thinking.

Miss Coleman presented a SAM case example designed to mirror real clinical decision-making under uncertainty. It incorporated elements such as taking a focused history, determining thresholds for decision-making, prioritising tests, and recognising when reassessment was needed. Such cases could be integrated into ALAs, starting with the final diagnosis and reconstructing the clinical pathway in reverse.

She noted that, in the Small Animal Soft Tissue Surgery (SASTS) course, observable progression in technical skill was required alongside the accumulation of theoretical learning. To support this, rubrics inspired by human medicine had been introduced, enabling structured, performance-based feedback throughout the course. One-to-one observable mentoring was also provided on practical days. The aim was to help learners feel "a true sense of growth from the beginning to the end of the postgraduate experience".

The expectation was that the revamped approach would lead to better engagement, improved clinical safety, and higher performance than the previous lecture-centric model.

In summary, she said, Improve was creating micro-units of learning and linking them into a living atlas, supported by ALAs that translated knowledge into real-world practice. These repeatable elements allowed learners to practise in a psychologically safe environment. Faculty were being trained to deliver feedback that was specific, measurable, and positively framed. The ultimate goal was to develop a scalable, human-centric framework that shaped how vets thought, decided, and acted when time was limited and patients needed care.

During the discussion, one delegate highlighted the difficulty of accurate self-assessment and the tendency to focus on negative feedback. How, they asked, was the "human condition" being addressed? Miss Coleman agreed these challenges were significant, noting that negative bias was common among vets in light of their high expectations and desire for perfection. While Improve learners would be encouraged to self-reflect throughout their course, there would also be structured touchpoints with external reviewers midway through and at the end of the course.

These external reviewers would help realign learners' reflections with reality, and give them direction and support for further focus.

Another delegate asked whether branching scenarios were included in the ALAs. Miss Coleman confirmed that they were and described them as "really fun to do". Some scenarios had multiple correct pathways, allowing learners to explore different outcomes depending on context, available equipment, or testing options.

Afternoon plenaries

Assessing doctors for UK practice: from medical school to specialty training and revalidation

Professor Suzanne Chamberlain, General Medical Council, UK

Professor Suzanne Chamberlain began her plenary lecture by outlining the statutory role of the General Medical Council (GMC), as set out in the Medical Act 1983. The GMC's purpose, she said, was to protect, promote, and maintain the health, safety, and wellbeing of the public; promote and maintain public confidence in the medical profession; and promote and maintain proper professional standards and conduct.

Its work centred on the standards it set for the medical profession. It was responsible for undergraduate and postgraduate training and assessment, maintaining the medical register, and overseeing revalidation and fitness-to-practise processes.

To illustrate the scale of the GMC's remit, Professor Chamberlain noted that more than 300,000 doctors currently held a licence to practise in the UK. For the first time, women now formed the majority of this workforce.

In addition, almost 80,000 trainee doctors were on the register, and around 42% of all registered doctors had qualified outside the UK – a figure that had increased markedly in recent years.

She then posed the question: what did it mean to be a doctor, and what influenced satisfaction or dissatisfaction with the role? In 2018, prompted by annual survey data showing unease within the profession, the GMC had undertaken research into why doctors were leaving practice, taking extended breaks, or stepping out of training. The findings showed that satisfaction correlated strongly with factors that she suggested would be familiar to veterinary professionals, including working hours, time spent with patients, multidisciplinary teamwork, locum work, opportunities to suggest innovation, levels of autonomy, and the burden of administrative work.

As an aside, Professor Chamberlain commented that while medicine had "aimed very high" in terms of the tasks artificial intelligence might support – such as diagnosis or treatment planning – one of the most valuable contributions it could make was in reducing administrative workload. The administrative burden, she emphasised, had a major impact on job satisfaction.

She then described the typical career journey of a doctor. After four–six years at medical school, graduates entered the GMC's provisional register, allowing them to progress to foundational training, during which they rotated around clinical specialties and gained real-world experience. After a year, doctors joined the full medical register, allowing them to practise unsupervised. On completing a second year of foundational training, they either entered non-training posts or progressed to specialty training. The duration of specialty training varied, but on completion doctors received a certificate of completion of training and could take on a range of roles within the NHS.

Assessment took place throughout this journey. Although assessment methods rose and fell in popularity over time, Professor Chamberlain observed that "big-bang, high-stakes assessments" had remained largely consistent: knowledge assessment using multiple examination formats, assessment of clinical and professional capabilities, and assessment of practical skills.

She noted a shift away from purely standardised assessment towards greater reliance on professional clinical judgement to form holistic decisions about readiness to practise, rather than depending solely on quantitative data.

The GMC played multiple roles in assessment, Professor Chamberlain explained, but she focused on the Medical Licensing Assessment (MLA). There were two versions of the MLA, one for UK medical students and one for doctors who had qualified overseas who wished to register in the UK (this was known as the Professional and Linguistic Assessments Board [PLAB] test).

The MLA had taken around 10 years to develop – although Professor Chamberlain noted that the first proposal for a national licensing assessment dated back as far as 1859. Several factors had driven its introduction: growing numbers of medical students and medical schools in the UK (currently 44, with more planned); a sharp increase in international doctors seeking UK registration (from around 2,500–3,500 candidates in 2014 to a peak of approximately 22,000 in 2024); variation in assessment methods and outcomes across medical schools; and the need to better understand and address award gaps.

The central, consistent aim of the MLA was to ensure that all doctors seeking a UK licence to practise met a common threshold for safe practice appropriate to their point of entry to the medical register.

Designing and implementing the MLA had been challenging, involving many stakeholders with differing perspectives and expertise within a complex educational landscape. "Where we started was not where we ended up," she said. In the final model, all candidates sat assessments that met the same requirements and drew on the same content, although they did not sit identical tests.

She went on to explain that all UK medical students undertook a knowledge test comprising two multiple choice papers of 200 questions set and coordinated centrally by the Medical Schools Council and quality assured by the GMC. Clinical and professional skills assessments were designed and delivered by individual medical schools but had to meet GMC standards. The MLA formed part of the medical degree, and passing it was required for graduation.

International medical graduates continued to take the two-part PLAB examination, but this was now aligned with the same requirements as the MLA and led to full UK registration.

Now the MLA was established, the GMC had begun a two-phase evaluation over a 10-year period. The first phase, running over 12 months in 2025/26, focused on early benefit realisation, examining the impact of the MLA on students and educators. This involved gathering feedback from a wide range of stakeholders about their experiences and perceptions.

She then turned to revalidation, another national initiative introduced by the GMC within the past two decades. The primary aim of revalidation was patient safety, she said, ensuring that doctors remained up to date and fit to practise. Revalidation was underpinned by the GMC's principles of good medical practice and helped ensure that all doctors had access to appraisal and development opportunities, which had not previously been universal.

Revalidation was introduced in 2012, and by 2017 most doctors had completed the process once. It operated on a five-year cycle, based on annual appraisals conducted in the workplace. Evidence for revalidation included quality improvement activities, continuing professional development, feedback from patients and colleagues,

significant events, descriptions of roles held, personal development plans, and probity and health statements. Professor Chamberlain described it as “a really big portfolio of evidence gathered over five years”.

She concluded by discussing work undertaken since 2019 to better understand and address disadvantage and discrimination, with the GMC setting an ambitious target to eliminate it by 2031. A comprehensive strategy supported this goal, including improved data collection and analysis, targeted support initiatives shown to improve outcomes for underperforming cohorts, and networking and educational events to raise awareness.

Practical actions had included enhanced training for trainers, fair and unbiased recruitment processes, improved feedback quality, and the use of representative images in examination materials.

During questions following the lecture, a delegate asked whether MLA pass rates varied between medical schools. Professor Chamberlain explained that the first full year of the MLA had only just been completed, and results remained provisional. However, very little variation had been observed. The MLA was designed to assess safe practice rather than excellence. Nonetheless, the GMC would monitor pass rates and work with any schools showing lower performance to understand and address underlying issues.

Asked about revalidation of doctors who were not seeing patients, such as those in senior management positions, she replied that any doctor wishing to retain a licence must still undergo annual appraisal and revalidation. While this would not be based on clinical evidence, it remained important to gather evidence from colleagues with whom they worked closely.

Limited licensure assessment in Canada

Lindsay Sproule, Director, Regulatory Programs Performance, College of Veterinarians of Ontario, Canada

For her plenary lecture, Lindsay Sproule shared an overview of the College of Veterinarians of Ontario’s (CVO’s) recently completed project to develop a modern licensure pathway for veterinarians educated outside of Canada. The CVO, she said, had strong organisational values that fostered an environment where creativity and new approaches were encouraged.

She began by explaining that veterinary medicine in Canada was regulated at the provincial and territorial level. The registrars of each provincial regulatory body were members of the Canadian Council of Veterinary Registrars (CCVR), which collaborated on issues of national importance in veterinary regulation. Provincial regulatory organisations had a mandate to protect the public interest, which they did by licensing qualified veterinarians; investigating complaints and concerns and holding disciplinary hearings when necessary; inspecting and accrediting veterinary facilities; and promoting quality assurance.

To practise veterinary medicine in Canada, individuals must hold a veterinary degree, complete a national competency examination, meet language proficiency requirements where

applicable, and undergo a review of past conduct and any fitness-to-practise concerns. Assessments were provided a National Examining Board (NEB) through the Canadian Veterinary Medical Association (CVMA).

Providing context for the project, she explained that there were approximately 5.700 licensed veterinarians in Ontario, with a total of about 16,000 across Canada as a whole. Most Ontario veterinarians had qualified in the province, but around 1.700 had been educated outside of North America, and had undertaken the traditional licensing examination.

Ontario had one veterinary school, she continued, and for the first time in 35 years, its class size had recently increased from 105 to 125 domestic students. At the same time, applications for registration from internationally educated veterinarians had risen significantly, placing pressure on the existing examination system.

The traditional licensure pathway differed depending on where a veterinarian was educated. Graduates of schools accredited by the American Veterinary Medical Association's Council on Education were required to pass the North American Veterinary Licensing Examination (NAVLE) to apply for licensure. Graduates of unaccredited schools had to complete a basic and clinical sciences examination, the NAVLE, a preliminary surgical assessment, and a clinical proficiency examination.

Ms Sproule explained that the basic and clinical sciences examination and the NAVLE were computer-based and could be taken at proctored exam centres. However, the availability of the preliminary surgical assessment and clinical proficiency examinations was more limited. Candidates wishing to take these examinations in English could currently do so only in Saskatchewan, while those wishing to take them in French had to attend the University of Montreal. The clinical proficiency examination cost approximately CAN$10,000 to sit.

Although precise data were unavailable, it was understood anecdotally that completing all four examinations typically took between two and five years, Ms Sproule said, adding that candidates were often new to Canada, navigating settlement, working in other jobs, and supporting families while progressing through the process.

She pointed out that the traditional examinations were based on a general licensure model, meaning successful candidates were licensed to practise across all species and scopes of practice. These assessments did not take account of candidates' prior experience or areas of specialisation. Some candidates potentially had significant experience with a particular species or practice area in which they wished to continue working in Canada. However, all candidates were required to demonstrate broad competency across all areas.

This traditional system had been developed when there had been far fewer candidates. While it had served its purpose, it had not always worked well for international candidates with narrower educational backgrounds, or for more experienced veterinarians who had restricted their scope of practice and then struggled to demonstrate the breadth of competency required.

Ms Sproule went on to explain that it had long been considered reasonable to issue licences limited to a veterinarian's demonstrated competence. However, suitable competency assessment tools had not existed. Publication of the North American Essential Competency Profile for Veterinary Medicine in 2022 had provided the foundation for developing such tools.

Although Ontario's veterinary legislation was outdated, it did allow individuals to apply for a restricted licence, she continued. These licences were granted by the CVO's registration committee, and set terms, limits, and conditions on an individual's practice. Applications were considered on a case-by-case basis and the committee had to be satisfied that granting the licence was in the public interest. Most

applications for restricted licences came from internationally educated veterinarians seeking full or partial exemption from national board examinations.

Challenges with the existing system led the CVO to consider rethinking the general licensure model and whether it might be possible to find a middle ground that allowed individuals to demonstrate competence in specific area and obtain a licence limited to that area.

Therefore, in recent years, the CVO had collaborated with the CCVR to develop a modern competency-based licensure pathway for internationally educated veterinarians with a more limited scope of practice. The project had received financial support from the CVMA and had relied heavily on the Essential Competency Profile as its foundation.

The CCVR first undertook work to identify appropriate tools to assess the competence of experienced veterinarians within a limited scope of practice. Two tools were selected: a portfolio assessment and a supervised practice assessment. Experts in regulation, assessment, and psychometrics were engaged to build the new pathway and ensure that assessment used reliable, validated, and legally defensible tools. Three streams were developed – companion animal, production animal, and equine – and both clinical and non-clinical competencies were assessed. Subject matter experts helped define which skills should be assessed and how they should be scored.

Ms Sproule noted that these assessments differed significantly from standardised examinations, as candidates were evaluated in real practice settings, which added complexity to the process.

To enter the first step of the new pathway – the portfolio – candidates must have completed their veterinary education, have at least five years' experience, and meet language requirements if applicable. She explained that the online portfolio required candidates to upload evidence of their proficiency in a series of competencies. This evidence could include videos demonstrating practical skills, records of completed courses, or research papers and other publications. Each portfolio was evaluated by two assessors practising in the same area as the candidate. It acted as a screening tool to determine whether candidates met the required competencies before they moved on to the supervised clinical practice assessment.

This assessment took place in a veterinary facility and lasted up to five weeks. Candidates practised under supervision and were assessed by both an on-site supervisor and a remote assessor. The dual-assessor model was intentional, Ms Sproule said, because the on-site supervisor may also be the candidate's current or prospective employer. Assessment was based on the Essential Competency Profile, using scoring rubrics that evaluated both knowledge and its application to determine competence.

The pathway had been piloted in 2024, with 22 candidates from Ontario and Alberta. She pointed out that, although there was national support for the project, only Ontario and Alberta currently had legislative authority to grant restricted licences. Other provinces had expressed interest in amending their legislation to be able to issue restricted licences.

Of the 22 candidates, 15 completed and passed the portfolio. This stage provided valuable insights into the eligibility criteria, and it had become clear that candidates further removed from clinical practice, or those who had not practised for some time, struggled to show the required evidence of competence. Ultimately, 12 candidates then successfully completed the supervised practice assessment and received their limited licences to practise in Ontario and Alberta.

A final project report received by the CVO in February 2025 confirmed that the assessment tools were reliable and valid for limited licensure. The report also identified lessons to improve

implementation, including addressing cost issues and refining policies and procedures.

Looking ahead, Ms Sproule said the report had been shared with all Canadian provinces, with provincial councils reviewing and approving it. Ontario's council had approved the report in June 2025, and the NEB had agreed to assist with national implementation. While significant work remained, a test launch was mooted for the first half of 2026, with full implementation later that year.

She concluded by noting that there had been strong interest in the project and that the response to it had been "overwhelmingly positive".

In the discussion that followed, Ms Sproule was asked whether a similar limited licensure pathway might be developed for domestic graduates. She said this had been considered and that the assessment tools were designed with the flexibility to apply to both international and domestic veterinarians. While not formally proposed, she said, "It's on the table." When asked about the broader veterinary community's response, she noted that awareness among licensed veterinarians was currently limited and would need to be addressed as policies and procedures were further refined.

PAVE and evaluated clinical experience

Amy Farmer, American Association of Veterinary State Boards, USA

Providing background for her lecture, Dr Amy Farmer began by explaining that the American Association of Veterinary State Boards (AAVSB) comprised the 63 licensing boards in the USA, Canada, and associated provinces.

It operated the Program for the Assessment of Veterinary Education Equivalence (PAVE) to allow internationally educated veterinarians to become licensed to practise in North America.

She noted that similar veterinary workforce pressures were being experienced across North America and Europe: rising pet ownership, growing demand for urgent and specialty care, and chronic shortages of veterinary professionals in rural and production animal sectors. Internationally trained veterinarians were one of the most promising sources of talent to meet these demands, she said.

The PAVE was accepted by most US states and provided a standardised, rigorous way to evaluate whether graduates of veterinary schools not accredited by the American Veterinary Medical Association's Council on Education (CoE) had the educational foundation needed to practise in the USA and Canada. Veterinary regulators relied on the PAVE because it was "defensible, consistent, and grounded in both psychometrics and professional standards", she said.

For candidates, the PAVE meant increased mobility, for regulators it meant competence, and for employers it meant a broader talent pool.

To enter the pathway, candidates had to verify their veterinary degrees and their English language proficiency, and provide credential evaluation materials. This established that their background aligned with the standard expectations of CoE-accredited schools, Dr Farmer explained.

Eligible candidates then sat the Qualifying Science Exam (QSE), a 220-minute computer-based examination with 225 questions assessing foundational science knowledge covered in the first three years of veterinary school. She explained that the QSE was offered three times a year at testing centres as well as via live remote proctoring. Questions were developed and reviewed by veterinarians and psychometric experts and covered six major domains from anatomy and physiology to therapeutic and public health. There was a strict retake policy to ensure exam integrity.

Candidates also had to demonstrate their clinical competency through a rotation or fourth year at a CoE-accredited veterinary college or teaching hospital. This showed they could translate theory into practice and exposed them to North American standards of care, communication expectations, and clinical reasoning.

Candidates successfully completing the QSE and the evaluated clinical experience (ECE), received a PAVE certificate. This was not a licence to practise, she explained, but entitled candidates to sit the North American Veterinary Licensing Examination and go on to meet any jurisdiction-specific requirements. The PAVE strengthened the veterinary workforce by increasing the availability of qualified veterinarians to fill roles in underserved communities. It also provided a fair, accessible, and rigorous route for international veterinarians to gain licensure in North America, and helped regulators ensure public and animal safety by evaluating competency.

However, the veterinary workforce crisis required immediate and scalable solutions, Dr Farmer continued, and although PAVE-certified candidates could enter the workforce within two years of beginning the programme, demand for veterinarians continued to rise much faster than supply. A single programme could not solve all the challenges. Although the PAVE was rigorous, its scalability was limited, with capacity to provide the ECE a particular issue.

Consequently, developing alternatives to the PAVE programme would be a priority for the AASVB in 2026/27. A taskforce was being challenged to think “outside of the box” and ideas included encouraging all CoE-accredited veterinary schools globally to accept PAVE students for the fourth-year rotation. This was already happening, Dr Farmer said, with Seoul National University set to accept PAVE students in 2026. The use of distributed models allowing candidates to undertake the ECE outside of teaching hospitals was also underway.

More complex proposals included performance assessments to identify candidates’ competency gaps so they completed additional testing only in specific areas. Virtual reality and simulation-based exams were also improving and becoming more feasible for programmes such as the PAVE, she explained.

In summary, she described the PAVE as an essential pathway that expanded access to qualified veterinarians, strengthened the workforce, and protected the public.

Panel discussion

The plenary lectures were followed by a panel discussion addressing key issues raised earlier. The panel comprised Professor John Norcini, who had delivered the opening plenary lecture of the symposium, alongside Professor Chamberlain, Ms Sproule, Dr Farmer and Dr Linda Prescott-Clements, RCVS Director of Education.

Dr Prescott-Clements opened the discussion by noting the rising numbers of international graduates and asking how performance assessment could be scaled up to accommodate them without compromising the robustness of the decision-making. She invited Professor Chamberlain to respond first, observing that, while no animals were involved, the human medical field faced similar challenges but at much greater scale.

Professor Chamberlain replied that the absence of animals probably made the task easier in medicine. The General Medical Council's assessments were scalable, but were also resource-intense and expensive to run. The clinical and professional skills assessment for international medical graduates used simulated patients (actors), who were easier to recruit, train, and manage than real patients. Real patients could be assessed only a limited number of times, and had complex, variable conditions and circumstances. Simulated patients, by contrast, allowed assessments to be standardised, with actors repeating scenarios multiple times for different candidates throughout the day.

Professor Norcini added that international medical graduates were critically important in the USA, making up about a quarter of trainees and a substantial proportion of practising doctors. Before the COVID-19 pandemic, all graduates – domestic and international – were required to pass the same examinations, including a clinical skills assessment that tested around 15,000 candidates annually across five centres using standardised patients. During the pandemic this had not been possible, so the Educational Commission for Foreign Medical Graduates adopted an alternative approach based on recognising accrediting bodies worldwide. The World Federation for Medical Education had developed a system to accredit organisations that accredit medical schools as a substitute for the need to test international graduates' clinical skills. Going forward, Professor Norcini said, accrediting the accreditors might be a way to scale assessment, although candidates would still need credential reviews, written examinations, and language proficiency testing.

Turning to veterinary medicine, Dr Prescott-Clements asked whether recognising other veterinary school accreditation systems might be a way forward. Ms Sproule said this could be a starting point. Currently, Canada recognised only the American Veterinary Medical Association Council on Education accreditation system, but recognising other established systems could reduce the number of candidates required to sit licensing examinations. However, she stressed that there would be no single solution and that all options needed to be explored.

Dr Farmer agreed in principle but said such change was unlikely in the near term in the USA, as reopening all state Practice Acts would be extremely challenging.

Dr Prescott-Clements then raised the issue of recognition of higher learning, noting that currently, there was no formal system in place and asking whether this might be a way forward.

Ms Sproule responded that this was beginning to emerge through limited licensure pathways and could be looked at in more detail. Other professions had systems in place to evaluate higher learning and prior experience, and veterinary medicine might learn from these. She also emphasised ethical considerations around international migration, noting the importance of ensuring that recruiting countries were not contributing to a skills drain from others.

Asked by Dr Prescott-Clements how regulators could monitor and manage this, Ms Sproule said that regulatory bodies could not be fully responsible, as immigration lay outside their remit. However, they needed to remain aware of these issues and consider them in policy decisions.

Professor Chamberlain described similar concerns in the UK when international medical graduate numbers rose sharply. While applications had recently declined, the reasons were unclear. She stressed the importance of robust data systems to track where graduates came from, their motivations, and their plans. Research had shown that some candidates passed the Professional and Linguistic Assessments Board (PLAB) examination but did not then apply for their UK licence. It was possible these graduates used the status associated with passing the PLAB examination in their home countries.

Dr Prescott-Clements then asked whether streamlining performance assessments could help address the challenge of the increasing numbers of international candidates for licensure. Dr Farmer noted that many UK graduates could move quickly into US practice due to similarities in training, yet faced the same barriers as those with less comparable education. There was therefore currently a strong focus on working out how to more rapidly assess who was truly ready to practise.

Ms Sproule added that greater collaboration and dialogue between assessment providers could help streamline existing systems over time.

Noting that Dr Farmer had mentioned virtual reality and simulation-based exams in her lecture, Dr Prescott-Clements asked whether these technologies were being actively explored. Dr Farmer replied that a new role – the veterinary professional associate (VPA) – had been created in Colorado and the American Association of Veterinary State Boards had been awarded the contract to design the VPA examination and act as the credentialling body. It was exploring virtual reality and simulation-based assessments to move candidates through the process more efficiently. Virtual reality technology had advanced significantly, she said, and was now far more affordable than in the past.

Dr Prescott-Clements then commented that licensing decisions were ultra-high-stakes and needed to be legally defensible, which might be why regulators favoured highly standardised assessments. She asked whether, given evidence that workplace-based and programmatic assessment could be equally valid and reliable, alternatives to standardised examinations might eventually be acceptable.

To laughter from the audience, Professor Norcini immediately replied “No!” He said that equating standards across training programmes would be extremely difficult. Programmes varied widely, and all had inherent conflicts of interest because they both educated and assessed candidates. While workplace-based assessment was valuable educationally, he did not believe it could ever provide the rigour required for high-stakes licensing examinations.

Professor Chamberlain took a more optimistic view. She felt workplace-based assessment was the missing element of the Medical Licensing Assessment. While objective structured clinical examinations were useful, they were simulations that were controlled and formulaic. True competence, she argued, was best observed in real-world practice. She anticipated serious debate over the next five–10 years about how competence could be assured in the workplace.

Returning to the issue of draining skills and knowledge from countries, a delegate asked whether the RCVS was considering opening up residency training to make it easier for overseas veterinarians to undertake supervised training in the UK, and then return home with enhanced skills. At present, this was difficult, partly because of visa restrictions, but also because the RCVS would not consider residents and interns for temporary registration.

Dr Prescott-Clements replied that discussions were underway, but currently she could not provide further details.

Ms Sproule added that in Canada it was known that some individuals registered for licensing examinations but did not remain in the country. Many moved on to the USA, but it was unclear how many returned to their home countries. Tracking the movement of veterinarians across their careers would give insight into what they were doing, and where they were working, she suggested.

The final question challenged whether the discussion itself was misplaced. The focus had been on scaling registration to bring more international veterinarians into the UK, yet the UK faced a longstanding productivity problem. Why, the delegate asked, was more attention not being paid to improving productivity, for example through better leadership of teams or better use of technology?

Dr Prescott-Clements agreed this was a valid point but argued it should be considered alongside, rather than instead of, discussions about international graduates. Workforce gaps still needed to be addressed. The UK was producing more domestic graduates and the outlook was improving, but that was not to say that productivity was not important.

Ms Sproule concluded by noting that in Ontario veterinary technicians were not currently licensed and certification was optional. New legislation, expected within a year, would introduce licensing for veterinary technicians, enabling better use of team-based care and fuller recognition of their role.

Parallel sessions (Banqueting Hall, afternoon): Postgraduate education (III) – licensing and revalidation

From knowledge to creation: using Webb's Depth of Knowledge to define the veterinary specialist

Mark Bowen, Director of Education, European Board of Veterinary Specialisation (EBVS)

Dr Mark Bowen opened his presentation by asking, "Who thinks they can define a veterinary specialist?" Despite the presence of several specialists in the audience, no one raised their hand. "It's a real challenge," he said.

He examined the RCVS requirements for veterinary specialist status, noting that it was not easily achieved. RCVS specialists must hold at least a diploma (a Level 7 qualification below a master's degree) and demonstrate active contribution to their specialty. However, Dr Bowen did not believe this constituted a useful definition of what a specialist actually was.

He then turned to the European Board of Veterinary Specialisation's (EBVS's) definition, which described a specialist as someone who had completed rigorous training, who maintained their specialist status by demonstrating their proficiency every five years, and who was dedicated to serving the public. "Again, not helpful at all," he said.

Evidence suggested that public understanding of veterinary specialists was extremely limited. Dr Bowen noted that one survey-based study found only a single respondent who knew what a veterinary specialist was. Similar findings had been reported in other professions, and debates about what constituted a specialist dated back as far as 1937.

The EBVS therefore wanted to develop a clearer, more meaningful definition of a specialist and had received Erasmus+ funding from the EU under the Pact for Skills. It recognised that the growing range of qualifications risked 'qualifications fragmentation' and that without a unifying language, the result would be confusion rather than clarity. The EBVS wanted to clarify for both the public and the profession what was meant by the 'veterinary specialist'. It also wanted to move away from the concept of a "middle tier", Dr Bowen said, arguing that the term "tiers" was dismissive when applied to advanced practitioners, who were highly experienced professionals.

The EBVS had explored whether suitable language could be found in the European Qualifications Framework. However, although a useful guide, its discussion of Level 7 qualifications referred to 'highly specialised knowledge' while Level 8 described 'most advanced' knowledge. "It's the complete opposite to the language we use everywhere else," he said.

Educational frameworks commonly used in undergraduate curricula were also considered. Bloom's taxonomy, while useful for designing individual sessions, "collapsed" when applied to occupational profiling.

Seeking an alternative, the EBVS explored different frameworks. Drawing on his background in assessment, Dr Bowen proposed Webb's Depth of Knowledge framework as a more effective way of differentiating advanced

practitioners from specialists, for example. The model comprised four levels – recall and reproduction (applies); skills and concepts (resolves); strategic thinking (anticipates); and extended thinking (redesigns) – which could be readily translated into professional practice. For example, while Bloom's taxonomy might describe a specialist as someone who could 'evaluate and create', Webb's framework would describe a specialist as someone who operated in contexts requiring sustained synthesis across multiple domains with tolerance for ambiguity.

The EBVS mapped specialist competencies against Webb's framework. It became clear that the key inflection point between advanced practitioner and specialist lay between level 2 (resolves) and level 3 (anticipates). Advanced practitioners largely operated at level 2, with some level 3 activity. They worked reactively within their competence, solved complex problems, and were highly skilled. Some advanced practitioners would move into "proactive mastery" at level 3, he said, and would be integrating across demands, creating new knowledge, and tolerating ambiguity. However, the EBVS felt that the dividing line between advanced practitioner and specialist sat between levels 2 and 3.

These concepts were then mapped to career stages: novice (level 1), proficient (level 2), advanced (levels 2–3), and specialist (levels 2–4). Each level was associated with different competencies. Advanced practitioners should be able to integrate advanced diagnostics and work confidently with uncertainty, while still recognising their boundaries and relying on literature and guidelines. Specialists, by contrast, synthesised evidence, created new understanding, developed novel solutions, and thrived in ambiguity, uncertainty, and change. Specialists would be the professionals who created new frameworks and reshaped understanding.

These competencies were subsequently aligned with the competency-based veterinary education framework to generate words and phrases to describe new graduates, experienced practitioners, advanced practitioners, and specialists. For example, new graduates primarily followed established guidelines. Experienced practitioners applied knowledge through multistep reasoning, largely within familiar contexts. Advanced practitioners used strategic thinking within established frameworks in narrower contexts. Specialists used extended thinking across multiple domains.

Dr Bowen stressed that this work was a starting point for discussion. He illustrated how the definitions might be used to differentiate levels of practice. In a case of diabetic ketoacidosis, for example, a level 2 (proficient) practitioner might request repeat electrolytes, discuss the anion gap, and define fluid therapy needs based on advanced diagnostics. A level 3 (advanced) practitioner would anticipate electrolyte and glucose derangements and adjust interventions such as insulin before a crisis occurred. A level 4 (specialist) practitioner would develop stratification guidelines and teach others about complex disease management.

Using a surgical example, tibial plateau levelling osteotomy (TPLO), he explained that both level 2 and level 3 practitioners needed to predict change, risk, and uncertainty. A level 4 practitioner, however, would design cranial cruciate disease registries and develop protocols to change practice.

He gave further examples showing how the framework could be applied to managing a cat with a diaphragmatic hernia and a horse with atrial fibrillation.

He then presented the definitions of an advanced practitioner and a specialist that had been developed. An advanced practitioner was defined as a vet with additional training and experience who bridged everyday practice and specialist care, managed challenging cases confidently, recognised emerging complexity, and guided early intervention before problems became critical.

A veterinary specialist was defined as a vet with deep expertise who worked where cases were most complex or uncertain, brought insight, foresight, and direction when the path forward was unclear, and integrated advanced diagnostics, evidence, and teamwork to guide treatment.

Dr Bowen emphasised that the goal had been to find shared language, not perfect wording. The concepts mattered more than the exact phrasing. He highlighted key differences, such as "managing challenging cases confidently" and "guiding early intervention" for advanced practitioners versus "bringing insight, foresight, and direction" for specialists. He acknowledged overlap between the roles, noting that some advanced practitioners might meet specialist descriptors and vice versa. He asked delegates not to be offended if they felt miscategorised, stressing that the framework was intended as a useful tool rather than a rigid classification.

He argued that the framework was needed to help the profession communicate clearly to the public what a veterinary specialist was, update publicly available information, and value practitioners for what they contributed rather than the qualifications they held. He challenged delegates to ask to be introduced at conferences by the value they brought, rather than by their achievements.

Concluding, he said the EBVS had established a starting point for development. The framework was not definitive, but it aimed to move away from purely metrics-based definitions and inconsistent national interpretations of specialist status, towards a shared understanding of what a veterinary specialist is.

When asked who had developed the framework, Dr Bowen said the work had been carried out by the EBVS executive board. As a small team, it was able to work dynamically, and the intention was to present ideas and invite feedback.

The session's chair, Dr Linda Prescott-Clements, noted that the RCVS was addressing a similar issue through its clinical careers pathway work but was approaching it from a different direction. The RCVS was developing definitions of a GP vet, an advanced practitioner, and a specialist but these definitions were likely to be more high level than the EBVS ones. She highlighted the difficulty of drawing a clear boundary between advanced practitioner and specialist and the risk that advanced practitioners could fall within specialist descriptors. She also questioned the EBVS's use of "creating new understanding" in the definition of a specialist, pointing out that under the European Qualifications Framework, the Level 8 (specialist) descriptor was of someone who created new knowledge rather than new understanding. She associated the creation of new knowledge with research. If specialists were not doing this in the veterinary field, who was? Was there a reason why the EBVS had used "understanding" rather than "knowledge".

Dr Bowen replied that the EBVS was not dismissing research, noting that a scholarship framework existed within the competency-based model. However, he questioned whether research alone still differentiated specialists, as many master's-level programmes now produced high-quality research. The difference between an advanced practitioner and a specialist lay in how they went about managing and leading research. A rigid tier system did not reflect reality; overlap was inevitable. He argued that the focus should be on impact rather than publication, though he acknowledged the challenge of measuring this.

Julie Rosser, CEO of the EBVS interjected at this point, noting that the choice between using "creates new knowledge" and "brings more understanding" depended on the intended audience. While "creates new knowledge" might resonate within the profession, it might not be meaningful to consumers. Dr Bowen agreed, reiterating that the emphasis should be on the value and impact of research, rather than research as an end in itself.

Distributed clinical teaching: how do residencies fit into this undergraduate community-based model?

Jessica Reynolds, Clinical Assistant Professor in Farm Animal Practice, School of Veterinary Medicine and Science, University of Nottingham, UK

Explaining that she was a bovine specialist, Dr Jessica Reynolds MRCVS said she was approaching her presentation from the perspective of someone who had completed a residency within a distributed community model. She also supervised residents and sat on the education and residency board of the European College of Bovine Health Management (ECBHM), which was working to set standards for its residency programmes.

She began by briefly describing the distributed community model for any delegates unfamiliar with it. The University of Nottingham offered a standard five-year undergraduate veterinary programme with dual intakes in April and September. It followed a spiral curriculum, introducing clinical systems in years 1 to 3 before moving to species-based teaching in year 4. The distributed community model was most prominent in year 5, when students undertook external rotations, moving between the veterinary school and clinical associate practices in the community. Final examinations took place mid-year, after which students returned to practices to focus on areas of particular interest.

Clinical associate practices were central to this model and ranged from first opinion to referral level, giving students a "nested understanding" of UK veterinary practice. The university partnered with small animal, equine, farm, exotics, and charity practices. In most cases, a University of Nottingham clinician was embedded within the practice, contributing to caseload management and student teaching. Some practices also hosted clinical residents. She directed delegates to a paper by Cobb et al. (doi: 10.3138/jvme-2024-0039) for further detail.

Turning to residencies, Dr Reynolds noted that the evidence-base associated with these programmes had been discussed extensively during the PGVE symposium. It was clear there was significant variation between residency programmes and little evidence to determine what worked best in terms of structure, content, and assessment. There had been drift over time in both American and European residences, with insufficient focus on measuring outcomes.

While undergraduate education had moved firmly towards competency-based curricula, residencies often remained focused on minimum caseload requirements. The prevailing mindset was that if residents completed sufficient surgical or population health cases, for example, and passed their final examinations, their competency was assumed. However, she questioned whether this was appropriate, noting that some American surgeons in human medicine had commented that there was little value in requiring minimum case volumes if operative competency was not directly assessed. They had observed that reduced caseloads during the COVID-19 pandemic had clearly affected resident competency, yet assessment systems continued to measure volume rather than ability.

Focusing on European veterinary residencies, Dr Reynolds explained that around 27 colleges were accredited across various disciplines. Her presentation centred on the ECBHM residency and its integration into Nottingham's community-based teaching model. The residency requirements were broad, with a practical element comprising case logs for individual animals and population health, a research component requiring at least two publications during the residency, and a theoretical element that complemented clinical work. Externships and pathology placements were also required. Once these elements were completed, residents were eligible to sit their certifying examinations.

Although these components were mandatory, there was significant flexibility in how residencies were structured, and approaches varied widely between institutions. Nottingham's model, which had been running successfully for nearly 15 years, was distinctive, she said. Residencies typically took three–four years. Residents spent three months of each rotation at the veterinary school, working with a large group of ECBHM diplomates known for their population health expertise. During this time, they completed the foundation work for the research element of their residency.

As Nottingham did not have a teaching hospital, residents then spent three months in community-based associate practices. These placements focused on clinical work and encompassed first opinion to referral-level cases. Residents also used the specialist population health skills acquired at the vet school out in the field on associate farms. She explained that Nottingham had partnerships with 40 to 50 farms either directly, or through its clinical associates.

Maintaining contact with residents while they were off campus was critical. Dr Reynolds stressed the importance of monitoring both wellbeing and caseload to ensure residents remained on track. This had been one of the main challenges of the model, she said.

Taking account of what had worked and what had not worked with this approach, the vet school had developed best practice guidelines to try to optimise the residents' experience and help them maintain positive relationships with associate practices and contribute to undergraduate teaching.

Some of the "dos" in the guidelines were obvious, she continued. These included maintaining a clear structure and awareness of the syllabus content to ensure each three-month block was used effectively and to prevent drift over the course of the residency.

However, clarifying expectations was the single most important factor. Resident attrition had been observed when individuals entered the programme without fully understanding its direction. Nottingham's strengths lay in population health, and without a teaching hospital, residents relied on externships to gain sufficient referral-level individual animal caseload. It was essential that residents understood this before they started.

Also important was ensuring associate practice staff understood the purpose of the residency and the role of a specialist. Dr Reynolds acknowledged that specialist status in bovine practice was not well understood within the profession, with some practitioners questioning its value. Gaining buy-in from practice teams was therefore crucial.

In addition, regular check-ins were essential to maintain communication and ensure residents were contributing positively to their associate practices. Many Nottingham residents entered the programme without completing an internship, but were six–eight years qualified and experienced farm vets. They could add value to practices through mentoring early-career colleagues, running journal clubs, and providing consultancy-level input.

Another key principle was simply "saying thank you", a point she noted applied equally in undergraduate education.

There were also clear "do nots" in the guidelines. Some activities, particularly repetitive TB testing, offered poor learning experiences. While limited testing was acceptable, being assigned large-scale routine testing was inappropriate and would quickly be flagged as such. Placing a resident in a practice without agreement from the whole team was another major concern. The most serious issue, however, was assuming that the caseload would meet the resident's learning objectives.

Comparing Nottingham's model with traditional hospital-based residencies, Dr Reynolds noted that hospital settings offered more intensive diagnostic workups and the opportunity to follow cases through to postmortem examination. There could also be strong relationships with a smaller number of farms to enable population health work. On-site hospitals were often multispecies, offering enriched learning experiences.

However, surgery exposure could be highly variable, and many farm animal hospitals were not commercially driven. Cases might be worked up for teaching purposes but not taken to surgery. Population health was often less emphasised, and hospitals tended to have fewer relationships with external farms. Additionally, the lack of a clear farm animal referral model in the UK meant hospital-based residencies could be disconnected from real-world clinical practice. Being away from practice for three–four years could be a significant disadvantage for diplomates returning to senior clinical roles.

In terms of outcomes, graduates of Nottingham's programme commonly entered academia, returned to practice in senior roles, or pursued careers in research or consultancy. Some established their own companies. These varied pathways led back to a central unresolved question: what is the role of a bovine specialist? Dr Reynolds felt this required broader professional discussion.

She went on to say that feedback from former residents had been largely positive, particularly regarding time spent with key opinion leaders and the opportunity to apply population health skills on real farms. Challenges identified included a lack of clarity around the residents' roles in first-opinion practice, and the risk of being directed towards lower-quality learning experiences. Interestingly, associate practices reported very positive experiences, suggesting some mismatch in perception.

Practices also highlighted residents' value as mentors for early-career staff and their ability to provide referral-level services and training support.

In the discussion that followed, a delegate asked Dr Reynolds to confirm that ECBHM diplomates were embedded in all the associate practices to help supervise residents. This was the case, Dr Reynolds said, although it could be cyclical. For example, she might spend two days a week in one practice, with another diplomate present for the remainder of the week.

International School of Veterinary Postgraduate Studies (ISVPS): innovating global veterinary postgraduate assessment

Dr Charlotte French, ISVPS Academic Manager, ISVPS

Putting her presentation in context, Dr Charlotte French MRCVS explained that the International School of Veterinary Postgraduate Studies (ISVPS) was a global awarding body delivering accredited postgraduate veterinary qualifications. It offered several qualifications in association with Harper Adams University, including the ISVPS General Practitioner (GP) certificate. The assessment she was describing was associated with this certificate, although she wanted to open a wider discussion about what effective assessment should look like at veterinary postgraduate level and how to ensure genuine assessment utility.

Many factors influenced the usefulness of an assessment, and balancing them was challenging, she continued. Key among these factors were reliability, validity, and educational impact (the effect of an assessment on student behaviour). Also vital were the acceptability of an assessment to candidates, examiners, awarding bodies, and other stakeholders, and its feasibility (such as the cost of running it).

She went on to explain that an online, remotely proctored, case-based scenario (CBS) examination was among the assessments used for the GP certificate. Historically, only one case had been included and the exam had been composed solely of UK Quality Assurance Agency Level 7 essay-style, examiner-marked questions. Candidates entered their answers into a text box and examiners marked to a standardised mark sheet or rubric.

Although this was felt to be a valid assessment, feedback from UK-based candidates for whom English was a second language had indicated that the essay-style exam was less acceptable to them. She noted that the aim of the assessment was to evaluate how a candidate would manage a case in practice rather than to examine their English language competency. Similar issues had been raised by candidates with specific learning differences, such as dyslexia.

Other drivers to refine the approach to this assessment included ISVPS's recent investment in an exam delivery platform that allowed inclusion of auto-marked questions other than traditional multiple choice questions (MCQs). ISVPS felt these would be valuable for achieving Level 7 requirements for synthesis, analysis, and evaluation. Also, although ISVPS taught globally in nine languages, the CBS examination was mostly delivered in English in the UK. ISVPS felt that the exam was useful, and wanted to scale it up.

Therefore, the aim had been to develop and pilot a new examination format that increased acceptability to UK candidates and examiners and streamlined processes, particularly related to examiner marking, while maintaining assessment validity, reliability, and educational impact.

The new format was developed in association with Harper Adams University. To begin with, it focused on endoscopy and endosurgery and comprised two cases, allowing assessment of a broader range of learning outcomes and giving

candidates the chance to show management of two clinical cases rather than one. Rather than solely comprising essay-style, examiner-marked questions, 60% of the marks in the new assessment came from such questions, and 40% from computer-marked, carefully crafted, Level 7 questions such as MCQs, extended matching, hotspot interactions, or selections from a list.

The new-style assessment had been piloted with 15 vets, five of whom had previously sat the old-style CBS exam in endoscopy and endosurgery; six had sat a CBS in a different discipline; and four had never previously seen a CBS exam. Two participants spoke English as a second language. Feedback indicated that the new-style exam was universally acceptable. Of the vets who had previously sat a CBS exam, only one said they preferred the old style because they thought it was more challenging. All participants believed the new-style exam was a good mix of computer-marked and examiner-marked questions.

Overall, ISVPS felt that the new format was more acceptable, while remaining a valid and reliable assessment. It was also more efficient, reducing examiner marking time, which could lead to reduced costs in the long term.

Dr French said that the new CBS format had been implemented in some disciplines in 2025 and initial feedback from candidates and examiners had been positive. Evaluation was ongoing but early indications supported ISVPS's confidence in the new assessment, which was felt to be aligned with its goals of delivering rigorous, valid, and feasible assessments globally.

She concluded by saying she was keen to know how other providers balanced the utility equation, acknowledging there would be ongoing challenges in assessment amid rapid developments in artificial intelligence technology.

There were no questions following this presentation.

Task clarification and wellbeing in emergency veterinary care practice. Reframing work through Entrustable Professional Activities with desired supervision levels: an observational survey study

Robert Favier, Director of Education for Professionals, Faculty of Veterinary Medicine, Utrecht University, The Netherlands

Giving the final presentation of the session, Dr Robert Favier began by remarking that his head was "rather stuffed after two days with all kinds of ideas and challenges". However, he wanted to share some preliminary data from a study on task clarification and wellbeing in veterinary emergency care. The study had begun three or four years earlier and focused on veterinary professionals with zero–three years of postgraduation experience who were beginning to deliver emergency and critical care (ECC).

The research was motivated by widespread recognition that the transition to unsupervised practice was stressful, particularly when newly qualified professionals faced critical workloads requiring high levels of expertise. For veterinary graduates, this could lead to uncertainty, feelings of incompetence, and reduced job satisfaction, potentially contributing to attrition from the profession. Dr Favier and his colleagues were therefore looking for ways to alleviate stress among veterinary graduates, with a particular focus on ECC. This was especially relevant in the Netherlands, where there was a shortage of veterinarians willing to work in ECC settings.

One potential solution explored was the use of entrustable professional activities (EPAs) to create greater task clarity in early practice, with the aim of balancing autonomy, patient safety, learning, and professional wellbeing.

Referring to an earlier plenary lecture by Professor Ollie ten Cate, Dr Favier reminded delegates that EPAs were units of professional practice representing day-to-day tasks that could be entrusted to a trainee once they demonstrated sufficient competence. However, competence related to individuals, while EPAs related to tasks, raising the question of how the two could be aligned. Because EPAs focused on progression towards autonomy and unsupervised practice, the research team hypothesised that they could be a useful tool for task clarification.

They formulated two research questions asking whether use of a framework of EPAs, each linked to an appropriate level of supervision, would improve task clarity for early-career ECC veterinarians, and whether improved task clarity, through the use of EPAs, would reduce stress, increase job satisfaction, and foster motivation in this group.

Dr Favier's presentation focused on the first question.

Seven referral hospitals with ECC departments across the Netherlands participated in the study. The intervention group consisted of veterinarians with zero–three years of postgraduation experience who were starting to deliver emergency care. Some had up to two years' experience in first-opinion practice but had not previously undertaken ECC shifts. The control group comprised veterinarians one–four years postgraduation who had already been delivering emergency care for approximately one year.

Participants were given a list of 23 tasks, formulated as EPAs. For each task, they provided a self-assessed estimate of the level of supervision they believed they required, using a scale from 1 (observe but not perform the EPA) to 5 (able to supervise junior learners). This assessment was completed before participants began their ECC shifts and repeated at three months and 12 months. At the same time points, participants completed online questionnaires assessing task clarity, motivation, wellbeing, and job satisfaction.

There were 24 participants in the intervention group, with an average age of around 27 years, approximately one year younger than the 20 participants in the control group. Participants were also categorised according to whether they worked primarily as ECC veterinarians or as first-opinion practitioners who undertook ECC duties out of hours. Dr Favier expressed concern about this latter group, noting that emergency care was increasingly concentrated in referral hospitals and that caseloads were growing and becoming more complex, raising questions about the sustainability of ECC as an additional responsibility alongside routine practice.

He presented a graph showing self-reported scores for supervision requirements for the 23 EPAs across the three time points, with a score of 4 indicating readiness for unsupervised practice. For many EPAs, even after one year of ECC work, participants did not feel able to perform the tasks unsupervised. While this was not necessarily surprising, he noted that the data made the issue more concrete and visible. However, participants

indicated they could perform two EPAs – epilepsy management and euthanasia – unsupervised from the outset. He reported that there had been concerns about undergraduate preparation to perform euthanasia in the Netherlands, but these findings suggested new graduates felt confident once in practice.

Analysis of mode scores at 12 months highlighted areas where supervision was still commonly required, particularly ophthalmology and surgery.

Dr Favier then discussed data on the perceived usefulness of the EPA framework. Participants rated EPAs as more useful at three months than at 12 months, suggesting that the learning and clarification effects were strongest in the early months of ECC work.

When asked after 12 months whether their work was clear, both intervention and control groups gave a mean score of 4 ('agree'). This was unsurprising, Dr Favier said, as after a year most veterinarians would understand how ECC operated in their workplace regardless of EPA use. Similar results were seen when participants were asked whether they knew what was expected of them. Responses regarding whether they performed tasks they had not yet fully mastered aligned with the EPA data, indicating that some activities still required supervision after one year in both groups.

He shared some quotes from study participants before noting that perceptions of support within the clinic had also been explored. The control group reported experiencing less support than the intervention group, while those using EPAs felt more supported by colleagues.

Overall, the findings suggested that EPA self-assessments helped provide task clarity in the first months of ECC employment and could function as a supported autonomy tool. The effect appeared less pronounced after one year. Importantly, EPA supervision ratings were most effective when used as part of an active dialogue between veterinarians and their supervisors; however, not all supervisors consistently engaged in these discussions.

Looking ahead, Dr Favier said the team was continuing to analyse data on job satisfaction, mental wellbeing, and motivation. They were also investigating why participants in the EPA group appeared to experience greater workplace support than those in the control group.

Following his presentation, Dr Favier was asked if the number of EPAs in the list affected their perceived usefulness. This was an interesting point, he said, and in human medicine, training trajectories often used 13–15 EPAs. However, veterinary medicine posed additional challenges due to its multispecies nature, although developing too many EPAs risked turning the exercise into a tick-box activity. The list used in this study was "not the Holy Grail", he said, "but it helps."

He was also asked whether the researchers had measured how often participants performed each EPA and how many repetitions were needed before they felt confident to work unsupervised. These data were available, Dr Favier replied. For five EPAs, including euthanasia, diarrhoea, and anaemia, frequency of performance correlated with perceived readiness. Supervisors had also been asked to estimate how long it should take graduates to achieve unsupervised practice for each EPA. Responses varied widely, ranging from two weeks to 12 months for the same task

Finally, the session's chair, Dr Linda Prescott-Clements, observed that the decline in perceived usefulness of EPAs after 12 months mirrored findings from the RCVS Veterinary Graduate Development Programme, even though EPAs were used very differently in that programme. Dr Favier confirmed that this issue was being actively explored.

Parallel sessions (Court Room, afternoon): Postgraduate education (III) – licensing and revalidation

Multifaceted education development to support commercial oral healthcare strategy

Natasha Hetzel, Head of Education and Career Development, Linnaeus, UK

Giving some background to Linnaeus's dental strategy project, Ms Hetzel explained that the veterinary literature showed dental disease was the most common cause of disease in dogs and cats, but was frequently unrecognised by owners. In response, Linnaeus launched a strategy in 2023 to improve preventive and reactive oral healthcare across its primary care practices, driven by a desire to improve the quality of dentistry care.

To develop the strategy, Linnaeus had sought the perspective of multiple teams. Ms Hetzel had provided an education-focused input, first identifying knowledge and skills gaps before introducing an education strategy to empower clinical teams and improve access to high-quality dentistry.

An initial questionnaire, completed by 400 respondents, had been used to understand the challenges. Patient care assistants (PCAs) reported low confidence in their role in dentistry; they said they were rarely involved in procedures, and wanted training "in everything". However, they "really enjoyed" dentistry when involved. Veterinary nurses, both student and registered, were least confident with periodontal therapy and nerve blocks and faced challenges with radiography. They identified a need for further training, particularly in radiography, charting, and nerve blocks. Vets were least confident with nerve blocks and radiography and highlighted training needs in extractions, radiographic technique and interpretation, nerve blocks, and feline dentistry.

Free text responses identified time pressures, scheduling, and fatigue as major challenges. Respondents expressed a desire for shadowing by more experienced colleagues and for more practical training. While a majority of respondents said they enjoyed dentistry, Ms Hetzel noted hat this included dental certificate holders; fewer than half of vets who were two to five years qualified said they enjoyed it.

The questionnaire also explored how dental procedures functioned within practices. Only 9% of respondents felt dentistry was always well planned and managed. While 90% believed that charting, scaling and polishing, and radiography should be delegated to veterinary nurses, only 3% said this happened consistently.

Overall, the findings indicated that dentistry was not working optimally in clinics, leading to frustration when procedures were delayed or did not take place. Increasing nurse involvement and responsibility appeared to be a solution, but both vets and nurses required additional training. PCAs were also likely to have a role.

"We really wanted everyone to enjoy dentistry more and make the whole procedure work a bit better," Ms Hetzel said.

The first step to achieving this had been the development of online training for vets, vet nurses, PCAs, and client care teams. Created by veterinary dental specialists and certificate holders, experienced dentistry nurses, and dentistry nursing certificate holders, the content was closely aligned across professional groups. The training was designed to be accessible, and allowed users to "dip in and out". It had been accessed by 700 individuals to date, she reported.

Alongside this, Linnaeus produced a guide outlining the roles and responsibilities of different team members, clarifying what each "could and should be doing" in dental procedures. One of the biggest successes was the creation of around 60 short technique videos covering topics such as nerve blocks, extractions, and radiographic views. These proved popular and posters had been placed in treatment rooms with QR codes linking directly to relevant videos.

Two levels of practical dentistry training were also introduced: foundation and intermediate. Recently, the foundation level training had become a truly interprofessional programme for both vets and nurses, which had proved very beneficial. The programme included multiple cycles of debriefing, feedback, and continuous improvement, and a feline dentistry course was being added. So far, 200 vets and vet nurses had completed the practical training.

Ms Hetzel noted that another key component had been the introduction of a "dental champions" programme, appointing a vet and a vet nurse champion in each practice or small group of practices. Their role was to support high-quality dentistry delivery, including equipment maintenance and set-up, skills development, and support with complex cases. A Microsoft Teams group brought together Linnaeus's dental specialists and certificate holders, dental champions, and other interested staff, developing into a strong community of practice used regularly for advice and information sharing. Monthly webinars had been trialled but proved less effective and were being replaced by a monthly case discussion forum.

She went on to explain that, in response to vets' requests for shadowing by more experienced colleagues, a "dental leads" programme had been piloted in one of Linnaeus's regions. This had involved an experienced vet or vet nurse spending one day a week supporting practices. Although highly valued and popular, the programme was financially unsustainable, and the practice dental champions were now being asked to take on this role.

Outcomes showed clear improvements in the quality of dentistry being offered, with increased use of radiography and nerve blocks. "We're improving patient care, we're improving patient safety, and we're improving access," Ms Hetzel said.

Concluding, she identified the interprofessional training and the ability to demonstrate impact at an organisational level as the programme's "biggest wins". At an individual level, participants reported improved knowledge and increased confidence.

During discussion, a delegate noted that dental CPD was in high demand but that access to cadavers for training was challenging, asking whether this had been a barrier. Ms Hetzel confirmed that cadaver access was a significant issue and explained that Linnaeus had addressed it by arranging training in Dublin and Italy using ethically sourced cadavers. The use of fox cadavers had been considered but Linnaeus had decided that it did not feel comfortable with this.

Another delegate asked whether delegation from vets to vet nurses had increased following the training. Ms Hetzel said attempts had been made to measure this using tracking codes in practice management systems. While there was clear willingness from both vets and nurses to increase nurse involvement, and some data suggested increased nurse-led procedures, the results were difficult to interpret because codes were not linked to charges and relied on staff recording procedures manually.

Leveraging the Pygmalion Effect with personalised video feedback in online postgraduate veterinary education

Gemma Coleman, Content Co-ordinator and Editor, Improve Veterinary Education, UK

For those unfamiliar with the Pygmalion Effect, Miss Coleman began by explaining that in Greek myth, Pygmalion carved a statue so exquisite that he fell in love with it. His devotion was rewarded when the statue came to life. The metaphor from this myth, she said, was that "what we truly attend to and invest in and believe in tends to come to life".

In education, this belief was communicated through expectations, attention, and opportunities given to students. A classic experiment had shown that when teachers believed certain students would bloom, those students improved more. Expectations had shaped the classroom climate, the richness of input, opportunities to respond, and the quality of feedback.

"The lesson here is that expectations are not just thoughts... our beliefs influence our actions, which influence the actions of others and their actions towards us," she said.

There had been debate about the validity and extent of teacher expectations and their impact on learners. However, Miss Coleman argued that it could not be denied that feeling part of a positive learning environment enhanced the student experience.

The bridge from belief to results, she said, was behaviour. To support this, Improve made its standards explicit by setting out expectations and commitments at the start of courses, clarifying the learning environment students were entering.

She added that online courses scaled well but risked becoming impersonal, lacking the dialogue that built clinical competence. Improve had therefore aimed to make courses more personal and raise performance by introducing personalised video feedback. Feedback quality was standardised using the STATIC framework: Specific, Thoughtful, Actionable, Timely, Individualised and Criterion-referenced, making it simple to deliver, fast, and effective.

Miss Coleman explained that a dashboard captured learner engagement with course content and progress with active learning activities. Learners also submitted a video discussing their reflections, needs, and perceptions of progress made. Course directors reviewed this and then provided short, personalised video feedback addressing each learner's experiences. Feedback was delivered twice, mid-course and at the end, and the tone was intentionally warm, positive, and demanding.

Improve also focused on training faculty to deliver strong feedback in the required style, providing guides and exemplars. While structure, clarity, and tone were standardised, individual educators could deliver feedback in their own style, something that she described as fundamental to creating the human element that made courses successful.

These feedback moments formed part of a wider learning ecosystem that included monthly webinars, allowing learners to raise uncertainties anonymously with content experts. "Reflecting on my own learning journey, this would have

definitely opened up my own ability to ask questions where I might have been fearful of judgement in the past," Miss Coleman said.

Student engagement, motivation, achievement, self-efficacy, and specific skills development were all measured and feedback was used to encourage targeted actions, moving learners from vague intentions to explicit thresholds for improvement. Giving clarity on required actions was intended to build confidence. "We recognise that you can't improve everything in one communication with somebody," she said, "but what we're trying to do is focus on the things that will matter most to that particular individual."

At the time of the PGVE symposium, a small cohort was using the new pathway and feedback was being gathered on its effectiveness.

Concluding, Miss Coleman said: "Personalised, asynchronous video feedback, delivered with STATIC quality and a Pygmalion mindset, offers a pragmatic upgrade to our online veterinary postgraduate training. It restores the educator-learner relationship, raises expectations transparently, and provides actionable guidance at scale. We should hopefully improve clinical learning while retaining flexibility for online delivery."

During questions, one delegate asked how much time course directors were given to evaluate learners and provide feedback. Miss Coleman said ideally feedback should be delivered within a week of learners submitting their reflection videos. Feedback was not intended to be immediate, allowing directors time for rigorous evaluation. As the programme scaled, additional subject matter experts would help maintain this timeframe.

Another delegate asked how long feedback videos took to produce compared with live half-hour conversations and what the advantage was. Miss Coleman replied that the advantage lay in the asynchronous nature of the feedback. Improve had students all over the world, she explained, and finding mutually acceptable times to have conversations could be difficult. Improve supported course directors to produce the feedback videos by doing the "heavy lifting" of data collection and summarising each learner's progress alongside the learner's own video.

A final question asked whether the video feedback was superior to written feedback. This was being assessed, she said, but the hope was the video feedback would feel more human, allowing tone, warmth, and body language to be conveyed. Written feedback, she noted, could more easily be misinterpreted as critical rather than supportive.

The Evidence-Based Veterinary Medicine (EBVM) Academy: developing a course to meet practitioners' needs in evidence-based veterinary medicine

Jenny Stavisky, Clinical Research Manager, VetPartners, UK

"This is very much a reflection on a work in progress," was how Dr Jenny Stavisky MRCVS described her presentation. The project under discussion was not yet complete and she did not have "sexy graphs or results". Instead, she aimed to share some of the learning gained so far.

As a member of the Clinical Board Support Team that supported knowledge and evidence across the VetPartners group, she specifically focused on clinical research, and supporting and informing clinicians. Evidence-based veterinary medicine (EBVM), she explained, was a set of tools and methods that could be applied in many ways across different areas. EBVM was now often introduced during undergraduate education, but it remained a relatively novel concept for older generations and levels of understanding varied.

VetPartners was a corporate veterinary group with approximately 12,000 colleagues across the UK and several European countries. Within the group were a series of species boards (equine, small animal, and farm animal) and clinical interest groups, which any colleague could nominate themselves to join. These existed to support decision-making, produce guidance and resources, and act as a sounding board. VetPartners did not operate with central protocols or dictate practice, but it did produce evidence-based guidance.

It had been felt that colleagues on these boards would benefit from having EBVM skills to guide their work. The boards met in person several times a year and, she said, "We thought that if we're going to develop a piece of teaching [on EBVM skills], let's do it with people who are really enthusiastic and available."

Members of the Clinical Board Support Team had substantial experience of teaching EBVM, mostly at undergraduate level but some at postgraduate level. "So, we thought we kind of knew what we were doing and how to do it," she said. However, while that was partly true in terms of EBVM knowledge, the team had learned "some really new stuff" about how to teach it during the project.

She then showed a slide with a picture of a "turducken roast" (turkey, duck, and chicken), which, she commented, looked "grim" but represented the team's first attempt to design its EBVM teaching. "We all sat down and thought about what the learners needed and how we would design a coherent course, and we rammed it and we stuffed it and we came up with this wholly indigestible thing because we are all very passionate about what we do," she explained. Everyone wanted their interests included, resulting in a bloated proposal that missed the mark. While the subject areas were "probably reasonable", the team had approached the design from a very academic perspective, and many of the learning outcomes were overly applied.

Over the following year, the team reflected on the outline, discussed ideas, and tested approaches. It realised that the values underpinning the programme needed to focus less on knowledge acquisition and more on doing and being: building communities, collaboration,

and safe spaces where people could express ideas, voice uncertainty, and grow.

The team also considered how practitioners working in practice environments differed from undergraduate or full-time postgraduate learners. While undergraduates and full-time postgraduate students might have quite busy lives, learning was their primary job, Dr Stavisky pointed out. Practitioners, in contrast, were in full- or part-time employment, with limited time and energy for learning. "Your brain is full of other stuff, and that often comes first, so we really need learning to be compressed, we really need it to be digestible," she said.

There were further differences, too. Undergraduates often lacked an understanding of the context in which EBVM would be applied, while practitioners had a clearer sense of how EBVM could be useful. EBVM was also "not a sexy subject" for final-year students, who wanted to learn practical clinical skills rather to conduct a literature review or critical appraisal. However, once in practice and confident with clinical tasks, many vets recognised EBVM as a valuable tool.

There was also a philosophical shift. Students often believed there was a right answer, whereas experienced practitioners accepted uncertainty and became more comfortable with decision-making. As a result, they were more receptive to frameworks and rules that helped manage uncertainty and, overall, practitioners were often more open to EBVM teaching.

Another difference was assessment. Undergraduates were frequently concerned about being examined, which shaped teaching and had influenced many of the initial learning outcomes devised by the Clinical Board Support Team for its EBVM teaching. "It was quite liberating not to be assessment-focused," Dr Stavisky commented.

Having settled on an approach, the team had now delivered three in-person sessions to the equine, small animal, and production animal clinical boards, with a fourth planned. Feedback had been very positive, although it was too early to say whether the teaching would drive lasting change. The team was still testing and refining elements of its approach.

The experience of stripping back content, learning together, accepting imperfections, and moving forward collectively had been valuable, Dr Stavisky said. The team had learned that practitioners were not the same as dedicated students, and that differentiation remained challenging. People had varying levels of knowledge, and it was essential to be able to engage and encourage across the spectrum within the same session.

There were ambitions to roll the training out more widely, and discussions were ongoing about format and scope. However, the emphasis on community and psychological safety could be harder to maintain at scale.

The mutuality aspect had also been interesting, and it was not just the participants who had learned. The team itself had learned and grown from the process too, she concluded.

During discussion after the presentation, one delegate remarked that the team had "tapped into the motivation" of learners. Dr Rachel Dean, VetPartners' Director of Clinical Research and Excellence in Practice, who was in the audience, noted that clinical board members could only serve for up to six years, yet many asked if they could continue the training afterwards. "People are getting something," she said. "It's definitely not a qualification and it's not a letter after their name, and many of the people on our board... are not after structured, formal learning – but they come again."

Another delegate asked whether more topic-specific training, such as journal clubs, could be developed. Dr Stavisky said the team already supported topic-based journal clubs and helped clinicians run them. While there was room for specific topics, the team's focus was not on driving clinical content but on equipping learners with the tools to do this themselves.

Evaluating the utility of a quantitative skills-based audit as the basis for self-reflection and future professional development in veterinary surgeons

Stephanie Richardson, Clinical Assistant Professor in Veterinary Education, University of Nottingham, UK

The final presentation in The Court Room was given by Dr Stephanie Richardson MRCVS, who explained that a significant part of her role involved working on the University of Nottingham's Certificate in Advanced Veterinary Practice (CertAVP) teaching provision. Her presentation focused on an educational inquiry project undertaken as part of her Postgraduate Certificate in Higher Education. The project evaluated a "skills audit and reflection" element within the CertAVP C module in small animal clinical practice to determine whether it was a useful and effective form of assessment.

In an asynchronous distance-learning environment, she said, it was difficult to assess how students' practical skills developed. To address this, at the start of the 16-week module students were asked to self-select five skills they wanted to develop. They scored themselves on a scale of 1 to 5 to indicate their current level of expertise, before setting a target to achieve by the end of the module. They then established personal learning objectives and devised a plan for achieving the desired level, as well as outlining how they would use learning from the module to improve their skills.

Her research sought to answer two key questions: how veterinary surgeons used the self-scoring element as a basis for written self-reflection at the end of the module, and whether this was useful for planning future development beyond the module; and how this scaffold might be developed to support reflection more broadly within CPD across the profession.

An underlying pedagogy of the project focused on the idea of assessment for learning: "I believe that this assessment has learning-orientated assessment tasks – the skills had to relate to learning on the module – and it was thinking about practical skills that were required in day-to-day practice," she said. The intention was for learners to use their self-assigned scores as a scaffold for reflection, allowing them to judge whether scores improved and whether they were achieving their aims.

Using a mixed methods approach, Dr Richardson had found that 365 skills in total had been assessed by the students evaluated. The average self-scored skill level had improved from 2.08 to 3.87. While acknowledging that the numbers were abstract, she suggested they indicated that those delivering the course "were doing something right", as learners perceived improvements in their practical skills despite the distance-learning format.

She had hoped that thematic analysis of the written reflections would clarify whether students found the numbered framework helpful for reflection. Unfortunately, this was not evident from the comments made. However, what was clear was that where skills had not improved as hoped, this prompted learners to reflect on why they had fallen short of their targets.

Of the 365 skills assessed, only four showed no improvement. In one case, the learner had selected a highly specific skill but there had been no opportunity in their practice to perform

the relevant procedure during the module. Other learners cited a lack of suitable cases or time pressures. One learner mentioned a lack of motivation, which Dr Richardson found interesting, noting that the individual had chosen to undertake a postgraduate distance-learning module yet still struggled with motivation.

The thematic analysis had been complemented by structured focus group discussions. These revealed that although the learners were scoring themselves, they experienced positive emotions when their scores improved. Participants valued having an objective measure and found that setting a personal learning outcome at the start of the module helped them focus their time. One learner commented: "The ones where I hadn't improved so much, I think those were the ones I got the most out of because that prompted me to think why."

Dr Richardson then explored whether the assessment approach could align with the RCVS 'plan, do, reflect' framework for CPD more broadly. She asked learners whether they would consider using the method independently outside their current course. "They all basically said no," she said, even though some had used the framework across four separate modules. However, they did not view the idea negatively and felt it could be useful in providing structure. Barriers cited included lack of time, motivation, and enforcement. One learner suggested it would be useful if it was required as part of the 1CPD framework. "I'm certainly not saying everyone should be ranking themselves from 1 to 5," Dr Richardson said, "but maybe there is something we could look at more broadly about how people are structuring their CPD reflection."

In summary, she concluded that the scoring system was an effective framework for guiding reflection, particularly when learners failed to meet their targets. It may be especially helpful for veterinary surgeons new to reflective practice. Barriers included limited case exposure and the challenge of self-critique. Looking ahead, she suggested it would be interesting to explore whether a similar framework could support undergraduate skills development, or be adapted more widely for vets in practice. The current scoring system might be too simplistic and could potentially be contextualised within entrustable professional activities. Further work could also examine how vets planned their development and which planning approaches were most effective.

She also acknowledged several limitations, including the small size of the focus group, the lack of consideration of career stage, and the "overwhelming" nature of the thematic analysis involved for a small sample size.

In the questions that followed, delegates raised the issue of learner motivation. One asked whether motivation always had to come solely from the learner, or whether teachers and coaches shared responsibility.

Motivation was interesting, Dr Richardson replied. She felt that some level of intrinsic motivation was needed to embark on postgraduate study. She wondered if vets reaching the end of the new graduate phase sometimes asked "What now?" and enrolled on a certificate to fill a perceived gap. However, postgraduate education might not suit everyone.

Another delegate commented that when formative opportunities were presented to people, engagement was often low. Had Dr Richardson seen any language in her qualitative analysis to suggest that while a learner might say they lacked motivation, they actually meant they lacked the momentum needed to change their habits?

Dr Richardson said she had not analysed the data at that level of nuance, but her instinct was that a lack of motivation to commit the time was a key factor. She acknowledged, however, that motivation and momentum were intrinsically linked, and if someone wanted to develop a skill within a 16-week module, they had to be motivated to do so.

Concluding remarks

Bringing proceedings to a close, Dr Linda Prescott-Clements extended her thanks to the Ironmongers' Hall team, sponsors, and the RCVS's events team for organising and supporting the symposium. She also thanked the speakers for being so generous with their time. She felt that the presence of so many international speakers from across the health professions had made a real difference to the event. "It's clear that we're all facing the same issues and challenges, and I've found it incredibly useful to hear from colleagues around the world," she said.

She then invited Professor Harold Bok, Professor Martin Cake, and Ms Julie Dugmore, the RCVS's Director of Veterinary Nursing, to offer their final reflections on the symposium.

Professor Bok described the two days as "amazing", filled with excellent presentations and discussion. The numbers attending demonstrated the need for the symposium, he said, and he hoped it would be repeated in 2026 to continue to build an evidence base to inform postgraduate education. He thanked Dr Prescott-Clements and the RCVS team for their hard work.

Professor Cake said it had been notable that many of the presentations had looked to the future as well as at the present. He commended the high level of scholarship demonstrated, saying there was a call to action to develop the evidence base and validate competence.

Ms Dugmore echoed the comments made by both professors, adding that she had been pleased to see veterinary nurses involved and presentations focusing on veterinary nursing. Moving forward, she wanted more nurses to share their research.

Concluding, Dr Prescott-Clements said there was clearly a wish to develop an international community of practice for postgraduate veterinary education. The RCVS had been proud to promote it in 2025, but the community needed its own identity and continued support. Several international colleagues had expressed interest in hosting the next symposium, she said, encouraging all delegates to stay engaged, share their feedback, and indicate their interest in attending a similar event in future.

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