BVA British Veterinary Association | Policy statement

BVA policy position on under care and the remote provision of veterinary services

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BVA position on under care and the remote provision of veterinary services

Introduction

1. The term ‘under care’ has been in existence since the introduction of the Medicines Act 1968. An RCVS interpretation of ‘under care’ was introduced shortly after and exists in its current form in the supporting guidance to the RCVS Code of Professional Conduct for Veterinary Surgeons. The term originally related to responsible prescribing, and this remains one aspect of its meaning. However, the practice of veterinary medicine is much more than prescription of medicines.

2. New technologies, novel diagnostic tools and remotely gathered data, should be adopted where they support the practice of veterinary medicine. Vets should adapt their working practices to integrate new technologies and remote provision of veterinary services when they can contribute to improving animal health, animal welfare and public health. It is important that new ways of working support responsible prescribing and prudent use of medicines across all veterinary business models.

Background to the RCVS review

3. In June 2019 RCVS announced plans for a review of the supporting guidance to the RCVS Code of Professional Conduct, including ‘under care’ and 24/7 cover[1]. The announcement followed more than two years of discussions about the future of telemedicine (at this stage an undefined concept). In early 2017, RCVS began a consultation on the use of telemedicine in veterinary clinical practice, to identify potential risks and benefits[2]. The College asked for the views of the veterinary and veterinary nursing professions, animal owners, and stakeholder organisations. In our response to that initial consultation, we recognised that there would be concerns amongst some practitioners about the potential impact of telemedicine on the structure of traditional veterinary practice. However, notwithstanding those concerns, it was important to understand that innovation and the growth of new technologies was inevitable and should, as far as was reasonable, be embraced.

4. At the time we called for any discussion on the way forward for telemedicine to hold animal welfare at its heart and for this to remain the primary consideration when developing any potential changes to the Code or supporting guidance. We also raised concerns that the RCVS consultation survey did not allow for all the varied ways in which there is a relationship between vets, their clients, and their patients. Therefore, we felt further work might be required on the detail of how telemedicine could work in practice. As we understood that the RCVS consultation survey had elicited a very high response rate from the profession, we reserved the right to await those outcomes before developing our position further. We emphasised the need for further full and open consultation if any changes to the Code or supporting guidance were to be proposed.

5. In April 2018 RCVS published a summary of the consultation phase, following a review of the consultation findings by RCVS Standards Committee[3]. That review had identified potential changes to the supporting guidance regarding ‘under care’, which would allow veterinary surgeons to prescribe POM-V medicines based on telemedicine alone.

6. On 1 November 2018 RCVS Council discussed a proposal from RCVS Standards Committee to “conduct a limited and time-bound trial to assess the benefits and risks of allowing remote

[1] https://www.rcvs.org.uk/news-and-views/news/rcvs-council-agrees-wide-ranging-review-of-guidance-on-under/
[2] https://www.rcvs.org.uk/news-and-views/our-consultations/rcvs-review-of-the-use-of-telemedicine-within-veterinary/
[3] https://www.rcvs.org.uk/news-and-views/news/college-publishes-telemedicine-consultation-summary/

prescription of POM-V (excluding opiates, sedatives and potentially also Critically Important Antimicrobials (CIAs)) where there has been no physical examination". The proposal caused some consternation amongst the profession, and, in response to member concerns and in consultation with BVA Policy Committee, we submitted comments to the RCVS President in advance of the RCVS Council meeting. In particular, we:

- queried the main driver for changing the Code of Conduct and supporting guidance to allow remote prescription
- raised concerns over the specific proposals for the trial
- urged further consultation before a decision was made on conducting such a trial, including the option not to go ahead

Following a lengthy debate, RCVS Council voted to refer the trial back to the Standards Committee to consider the issues that had been raised and to carry out further consultation with several key stakeholders, including BVA[4].

7. Concerns from the profession regarding the trial were subsequently repeated at the RCVS Stakeholders Day held on 26 November 2018, attended by then BVA President, Simon Doherty, along with some individual vets from the specialist divisions. Discussions culminated in a call for a further stakeholder meeting devoted solely to the matter of telemedicine, remote prescribing, and the definition of 'under care'.

8. The Chair of Standards Committee at the time, Kate Richards, attended BVA Council on 12 December 2018 to update on RCVS thinking, particularly with regard to a trial of remote prescribing in companion animal practice, and take part in a Q&A with BVA Council members. The session provided an opportunity for BVA Council members to question the drivers for such a trial and challenge the presentation of the RCVS consultation survey data.

9. After further discussion in early 2019, and following a legal opinion, RCVS Standards Committee recognised that so-called 'telemedicine' and remote prescribing could not be reviewed in isolation and that there were broader questions around the appropriateness of some elements of the RCVS guidance, including the interpretation of 'under care'.

10. The original timetable for the wider RCVS review was set to take place during 2020, however, following the arrival of Covid-19 in March 2020, RCVS announced a delay to the schedule. They undertook to explore alternatives to face-to-face focus group meetings before publishing a revised timetable. Concurrently, in response to the Covid-19 pandemic, there was an RCVS Council decision at the end of March 2020 to temporarily permit the remote prescription of veterinary medicines, where appropriate and where compliance with government restrictions left no other available options[5]. The RCVS Council Covid-19 Taskforce subsequently extended the temporary guidance on a number of occasions[6,7,8].

BVA review

11. In September 2019 BVA Policy Committee agreed to prioritise the development of a BVA position on under care, 24/7, telemedicine, and remote prescribing. This was in response to ongoing discussions within RCVS, and in recognition of concerns across the profession. BVA were

[4] https://www.rcvs.org.uk/news-and-views/news/rcvs-council-members-request-further-development-on/
[5] https://www.rcvs.org.uk/news-and-views/news/coronavirus-rcvs-council-temporarily-permits-vets-to-remotely/
[6] https://www.rcvs.org.uk/news-and-views/news/rcvs-covid-19-taskforce-extends-remote-prescribing-guidance/
[7] https://www.rcvs.org.uk/news-and-views/news/rcvs-covid-19-taskforce-further-extends-remote-prescribing/
[8] https://www.rcvs.org.uk/news-and-views/news/rcvs-covid-19-taskforce-further-extends-remote-prescribing/
https://www.rcvs.org.uk/news-and-views/news/council-votes-to-extend-temporary-remote-prescribing-guidance/

concerned about a perceived lack of transparency of RCVS Council discussions[9] and that the term "telemedicine" remained ill defined. The primary aim of this initiative was to inform a response to RCVS.

12. In late 2019, the BVA Under-Our-Care Working Group[10] was convened. It was chaired by former UK CVO Nigel Gibbens, and included representation from BVA Policy Committee, BVA Ethics and Welfare Advisory Panel, the British Small Animal Veterinary Association (BSAVA), the British Cattle Veterinary Association (BCVA), the Society of Practising Veterinary Surgeons (SPVS), the British Veterinary Nursing Association (BVNA), the Veterinary Management Group (VMG), the Veterinary Defence Society (VDS), and individual members with expertise in the role of technology and growth of innovation across different sectors of the profession.

13. Over six meetings, between January and September 2020, the working group considered:

    - the definition and interpretation of 'under care' and the relationship between vets, their clients, and their patients
    - 24-hr emergency first aid and pain relief, and continuity of care out-of-hours.
    - remote consultation and remote prescribing

14. From the outset, the working group committed to absolute transparency, agreeing to publish the minutes of their meetings in full on the BVA website[11], along with an open invitation to the profession to provide input, via a letter from the Chair to Vet Record[12]. That commitment was well received by the profession with a number of individuals getting in touch with their views and approximately 700 joining a webinar held on 17 May 2020, in which Nigel Gibbens outlined the working group's discussions to date[13]. Subsequently over 450 individuals responded to a snapshot survey developed by the working group to investigate approaches and attitudes to remote consulting and remote prescribing in light of Covid-19 and associated government restrictions.

15. The working group also agreed that some elements would be explicitly out of scope, including the provision of remote veterinary services overseas, and a value judgement on the range of veterinary business models in operation.

16. Central to the working group's discussions was the need to ensure that any recommendations must be appropriate across all sectors of the veterinary profession and must recognise the range of circumstances and business models within which veterinary services are provided. This related to the interpretation of 'under care', the role of remote veterinary services (including but not limited to remote prescribing) and the future of out-of-hours provision. Crucially, any recommended changes should not jeopardise existing good practice or create unintended consequences. They should also reflect specialised sectors such as zoos, or aquaculture and other strands of the food supply chain, where the remote provision of veterinary services is already well established and adds value.

Terminology

17. A complicating factor in the discussions of the working group was the confusion around terminology in the debate on "telemedicine". The term "telemedicine" has been applied to anything from a vet-to-vet telephone conversation about a specific case, through to irresponsible prescribing of Critically Important Antimicrobials to groups of animals which have never been inspected by a vet.

[9] https://www.rcvs.org.uk/news-and-views/news/rcvs-provide-reassurance-over-recent-council-decision-to-review/
[10] See Appendix 1 for working group membership.
[11] https://www.bva.co.uk/about-us/our-structure/working-groups/
[12] https://veterinaryrecord.bmj.com/content/186/9/286.1
[13] https://www.thewebinarvet.com/webinar/covid-19-and-the-veterinary-profession-your-weekly-update-17th-may

18. With this difficulty in mind, the working group chose to avoid the term "telemedicine" entirely and instead set out to agree a number of definitions intended to set the context of the BVA position, ensure clarity, and maintain consistency. There is no expectation that others will adopt these definitions, and they are in no order of importance.

Definitions

For the purposes of this document:

- 'vet' can mean an individual vet, a practice[14] or a business group where there is shared data and detailed clinical notes.
- 'animal' can mean an individual animal or a group[15].

Veterinary clinical assessment

- The assessment of an animal by a vet, RVN, or anther suitable member of the vet-led team, either in person or remotely
- It can be full or partial and may rely on auxiliary aids to gather data

In-person veterinary clinical assessment may include:

Veterinary clinical examination

- The physical examination of an animal by a vet
- It can be full or partial and may be augmented by the use of auxiliary aids to gather data
- Typically performed on an individual animal

Veterinary inspection

- The vet is present with the animal or able to observe the animal from a distance, and an assessment is made without veterinary clinical examination
- Often used on groups, herds, or flocks, sometimes after one or more individuals are examined, or in individual animals when it is not possible to carry out a physical examination for safety reasons (eg aggressive dog or zoo animal)
- Usually occurs in the context of existing knowledge of the animals' environment or husbandry

Remote clinical assessment (interaction by remote means – audio/visual, with or without telemetry data for the purpose of animal health and welfare advice) may include:

Remote assessment (also referred to as remote triage[16])

- Carried out by a vet, RVN or another suitable member of the vet-led team
- Uses phone, video call, or other electronic interaction, to make an initial assessment
- Does not include veterinary clinical examination or veterinary inspection
- Can occur without access to clinical notes
- Does not diagnose or prescribe

[14] we have not attempted to define 'practice', which will have a range of interpretation depending on business model.
[15] The current definition of animals in the VSA excludes certain groups, most notably fish, which are covered by definitions in more recent medicines and welfare legislation. This anomaly should be addressed but meanwhile this policy position has assumed a wider definition of 'animal'.
[16] The term 'triage' is commonly used in veterinary practice to describe the initial assessment of a patient with a view to providing advice on further care needs. Triage can also refer to the prioritisation of a number of acute cases, although this is the less common use of the term in veterinary practice. This ambiguity means that we have avoided the term entirely for the purposes of this position.

- Will often result in referral to a vet, RVN, or appropriately regulated allied professional

Remote veterinary consultation
- Carried out by a vet with access to clinical notes
- May include wider acts of veterinary surgery as defined by the VSA[17]

Remote prescribing
- Prescribing to an individual animal or group/herd/flock without veterinary clinical examination or veterinary inspection, or direct observation at the time of prescribing
- Prescribing where any requisite clinical assessment is made remotely
- May include new or repeat prescriptions

Vet-Client-Patient Relationship (VCPR)
- Where the vet has been given and has accepted responsibility for advising on the health and welfare of an individual animal or group. Such responsibility must be real and not merely nominal
- Where both the vet and the client work together to agree and implement a health and welfare plan appropriate for the animal

Continuity of care
- Out-of-hours veterinary care which goes beyond emergency first-aid and pain relief
- Provided for existing clients/patients
- Occurs with access to clinical notes
- May be provided off-site or by a dedicated OOH provider

Animal health telemetry
- Encompasses telemetry/remotely accessed biometrics for the purposes of assessing the health and welfare of individual/group/flock etc
- Using biometric data gathered from sensors on the animal or in the animal's environment.
- Using technology to enhance or monitor the health status of an animal or group of animals. Examples include remote ECG or blood glucose, activity trackers, cardio monitoring, or records of group behaviour.

Current legislation

19. The veterinary surgeon's right to diagnose[18], prescribe and undertake surgical procedures and medical treatments, is enshrined in the Veterinary Surgeons' Act[19].

20. With these rights comes the responsibility to maintain the five principles of practice as set out by the RCVS Code of Professional Conduct[20]

    - Professional competence
    - Honesty and integrity

[17] https://www.legislation.gov.uk/ukpga/1966/36

[18] By "diagnose", we mean to identify the nature or absence of an illness or other problem, by assessment of the clinical signs and other available data. That assessment will include giving appropriate weighting to the value and relative value of the information available and using clinical judgement to form the best available evaluation.

[19] http://www.legislation.gov.uk/ukpga/1966/36

[20] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/#principles

- Independence and impartiality
- Client confidentiality and trust
- Professional accountability

21. The principle of professional accountability is currently underpinned by the RCVS disciplinary process. The jurisdiction of the RCVS covers both professional conduct and fitness to practise. 'Disgraceful conduct in a professional respect', is more commonly referred to as serious professional misconduct, and being unfit to practise is usually because of a relevant criminal conviction. Going forward the trigger for considering sanctions may change to whether the practitioner's fitness to practise is 'currently impaired', with investigation options outside the DC process made available and options for mandatory remedial action increased.

22. Good prescribing practice and observance of the relevant legislation is core to clinical veterinary activity. A good understanding and appropriate application of the regulations is an essential element of professional competence and is one of the RCVS Day One Competences for newly qualified veterinary surgeons in the 'Personal Leadership – Professionalism' category.[21]

[21] https://www.rcvs.org.uk/document-library/day-one-competences/

Chapter 1: Under Care

Current use of 'under care'

Veterinary Medicines Legislation

1. The term 'under care' in the context of veterinary medicines has been in existence since the introduction of the Medicines Act 1968[22]

2. An RCVS interpretation of 'under care' was introduced shortly after, although at the time it did not include the condition of a physical examination. The condition of a physical examination was introduced with the RCVS Code of Professional Conduct in 2012

3. In August 2000, the Independent Review of Dispensing was carried out as part of the Government's Action Plan for Farming. The resulting Marsh report, published in March 2001, observed that in some EU Member States veterinary medicines were prescribed as part of an overall animal health plan for the farm, and within that plan, medicines could be obtained from appropriate sources without further reference to the vet. It was suggested that this approach represented a more effective use of professional resources by allowing veterinary expertise to be accessed, sometimes at a distance, without necessarily requiring a farm visit. The report further observed that to operate a similar scheme in the UK it might be necessary to redefine the concept of 'animals under their care' which restricted the rights of vets to prescribe[23], acknowledging that there was no definition in either Community or National legislation of the term 'Animals under his/her care'.

4. The Veterinary Medicines Regulations were introduced in 2005. They were written to implement the reviewed EU law, disapply the Medicines Act 1968 in respect of veterinary medicines and implement recommendations from the Marsh report and subsequently the Competition Commission. In doing so some 50 amending statutory instruments (SIs) were revoked, and the consolidation of existing regulations relating to veterinary medicines produced a single set of regulations which are in theory reviewed annually. The regulations were subsequently revoked and remade in 2006, 2007, 2008, 2009, 2011 and most recently in 2013. In each iteration the reference to 'under care' has not changed, appearing in Schedule 3, Part 1 of the Veterinary Medicines Regulations 2013 as:

   Prescriptions by a veterinary surgeon

   > *4.—(1) A veterinary surgeon who prescribes a veterinary medicinal product classified as POM-V must first carry out a clinical assessment of the animal, and the animal must be under that veterinary surgeon's care.*
   >
   > *(2) This does not apply in relation to the administration of such a product to a wild animal where the administration is authorised by the Secretary of State.*[24]

RCVS interpretation

5. There is no definition of, "under that veterinary surgeon's care" in the VMR 2013 and in the

[22] http://www.legislation.gov.uk/ukpga/1968/67/section/9/enacted
[23] https://www.yumpu.com/en/document/read/29945065/the-marsh-report-veterinary-medicines-directorate
[24] http://www.legislation.gov.uk/uksi/2013/2033/schedule/3/part/1/made

supporting guidance to the RCVS Code of Professional Conduct for Veterinary Surgeons "under care" is interpreted as follows:

> ***Under his care***
>
> *4.9 The Veterinary Medicines Regulations do not define the phrase 'under his care'[25] and the RCVS has interpreted this as meaning that:*
>
> *a) the veterinary surgeon must have been given the responsibility for the health of the animal or herd by the owner or the owner's agent*
> *b) that responsibility must be real and not nominal*
> *c) the animal or herd must have been seen immediately before prescription or,*
> *d) recently enough or often enough for the veterinary surgeon to have personal knowledge of the condition of the animal or current health status of the herd or flock to make a diagnosis and prescribe*
> *e) the veterinary surgeon must maintain clinical records of that herd/flock/individual*
>
> *4.10 What amounts to 'recent enough' must be a matter for the professional judgement of the veterinary surgeon in the individual case.*
>
> *4.11 A veterinary surgeon cannot usually have an animal under his or her care if there has been no physical examination; consequently, a veterinary surgeon should not treat an animal or prescribe POM-V medicines via the Internet alone.*[26]

6. The existing RCVS interpretation is widely understood and accepted, and 88% of respondents to the BVA Voice Survey in autumn 2019 indicated broad support for the interpretation as detailed at clause 4.9. However, the interpretation has been developed within the context of access to medicines and limits the concept of 'under care' to a temporal relationship to the act of prescribing. Although this is understandable given the origins of the term 'under care', and responsible prescribing and prudent use of medicines remain essential outcomes, the practice of veterinary medicine is much more than examining and prescribing. Vets across all sectors play an integral role in preventive healthcare, health management plans, welfare outcomes, and end of life care, where medical intervention is only one element of a much more complex and holistic concept of 'under care'.

7. Under the Animal Welfare Act, owners have a responsibility to take reasonable steps to make sure their animal's welfare needs are met. There is an obligation on the owner to facilitate the work of the vet by providing truthful and accurate information (within the confines of their own ability to recognise and communicate potential signs), to facilitate inspection or examination of the animal or herd, to collaborate with the vet on decision-making around the appropriate course of action, and to cooperate with any joint decision by complying with the instructions provided by the vet. A revised interpretation could benefit from the introduction of the principle of the owner's responsibility to collaborate with the vet and support a jointly owned patient management plan, which is regularly reviewed.

- **Recommendation 1: The RCVS interpretation of 'under care' should go beyond the temporal relationship to the act of prescribing, such that it more accurately captures the relationship between vets, clients, and their animals, and the shared responsibilities for safeguarding welfare. It should be appropriate for all species and situations, including**

[25] NOTE: a this is a direct quote the terminology is not gender-neutral

[26] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/veterinary-medicines/

food, companion, equine, zoo, laboratory animals, and British wildlife. It should be equally relevant to groups of animals and individuals.

- **Recommendation 2: Any revised definition of 'under care' should be supported by RCVS guidance.**

International models

8. The concept of 'under care' is far from new, although other countries do not necessarily use the same terminology as the UK or the same interpretation as RCVS. Attempts to define what is meant by having responsibility for the care of an animal or animals has led to several veterinary associations and councils adopting the term Vet-Client-Patient Relationship (VCPR) as a more effective descriptor for the 'under care' principle.
9. The American Veterinary Medical Association Principle of Veterinary Medical Ethics sets out conditions which must be satisfied in order to establish a VCPR:
    - *The licensed veterinarian has assumed the responsibility for making medical judgments regarding the health of the patient(s) and the need for medical therapy and has instructed the client on a course of therapy appropriate to the circumstance*
    - *There is sufficient knowledge of the patient(s) by the veterinarian to initiate at least a general or preliminary diagnosis of the medical condition(s) of the patient(s)*
    - *The client has agreed to follow the licensed veterinarian's recommendations*
    - *The licensed veterinarian is readily available for follow up evaluation or has arranged for:*

      Emergency or urgent care coverage, or

      Continuing care and treatment has been designated by the veterinarian with the prior relationship to a licensed veterinarian who has access to the patient's medical records and/or who can provide reasonable and appropriate medical care
    - *The veterinarian provides oversight of treatment*
    - *Such a relationship can exist only when the veterinarian has performed a timely physical examination of the patient(s) or is personally acquainted with the keeping and care of the patient(s) by virtue of medically appropriate and timely visits to the operation where the patient(s) is(are) kept, or both*
    - *Patient records are maintained*[27]

10. Similar conditions, with minor variations in wording, have been adopted by the Canadian Veterinary Medical Association[28] and the Australian Veterinary Association[29], and all three, to a greater or lesser extent, position the VCPR within the context of prescribing.
11. We consider that the approach taken by the AVMA and others provides a potentially useful model which could be drawn on in reviewing and updating the existing RCVS definition of 'under care'. In particular, the AVMA allowance for the vet to visit the "operation where the patient is managed" rather than specifically carrying out a physical examination is a better reflection of the realities of veterinary services in the food animal sector and wild animal or zoological settings. However, it should of course also be recognised that differences in legislation, the veterinary landscape, and business models overseas mean that a direct application of any one international definition will not necessarily be appropriate for the UK.

[27] https://www.avma.org/resources-tools/avma-policies/principles-veterinary-medical-ethics-avma
[28] https://www.canadianveterinarians.net/valid-vcpr
[29] https://www.ava.com.au/library-resources/other-resources/prescribing-guidelines/client-relationship-and-understanding/

- **Recommendation 3: RCVS should look to existing international definitions or descriptions of the relationship between vets, their clients, and their patients, for pragmatic alternatives to the existing requirement for a physical examination.**

Shared responsibility for animal health and welfare

12. The RCVS Code of Professional Conduct for Veterinary Surgeons requires veterinary surgeons to make animal health and welfare their first consideration when attending to animals[30]. The supporting guidance further requires the decisions on treatment regimes to be based first and foremost on animal health and welfare considerations, but also the needs and circumstances of the client[31]. This suggests that the principle of a jointly owned vet-client approach to patient management is accepted and understood as a key element to the provision of veterinary care, if not explicit in the guidance.
13. As already alluded to, owners have responsibilities under the Animal Welfare Act, and this should be understood by clients. They should collaborate with their vet on an approach to patient care which prioritises animal welfare whilst also taking into account client circumstances, wishes, and financial considerations. Ultimately the animal owner has overall responsibility for the health and welfare of their animals, with the veterinary responsibility limited to the duration of the relationship with the client or even the context within which the client seeks access to specific veterinary services. There is also an owner responsibility to inform themselves of the limitations of access to veterinary care. Whilst vets must take steps to provide emergency first aid and pain relief, it is contingent on animal owners to consider their individual circumstances, particularly in relation to out-of-hours access to veterinary services, and take steps to mitigate against issues which could reasonably be foreseen. For veterinary businesses with clients in geographically remote areas of the UK, a shared understanding of roles and responsibilities is particularly important.
14. The shared responsibility also extends beyond the direct relationship between the vet and the client. Vets are responsible for facilitating an appropriate level of communication and coordination with the wider vet-led team in relation to the care of an individual animal or group of animals. The client has a responsibility to enable effective communication amongst the vet-led team by informing the vet or practice of services procured elsewhere, and vets should discuss this with clients. Understanding of shared responsibility by all stakeholders supports the vet to work effectively, provide oversight of care, and optimise animal health and welfare outcomes.

- **Recommendation 4: Veterinary businesses should maximise opportunities to discuss with their clients the responsibilities of owners under the Animal Welfare Act, including the responsibility of ensuring access to care that is appropriate to their animals' needs, and the use of multiple care providers.**

- **Recommendation 5: RCVS, BVA, specialist divisions and other stakeholders should play a role in supporting the profession to communicate responsibilities to animal owners.**

[30] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/#animals
[31] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/veterinary-care/

The Vet-Client-Patient Relationship

15. A definition of the VCPR that could be applied across all sectors of the profession has the potential to provide a pragmatic alternative to the existing RCVS interpretation of 'under care'. Furthermore, it offers a means of encompassing the ethical and professional responsibilities of the vet, beyond prescribing, as well as capturing the principle of shared responsibility with a client for a jointly owned patient management plan.
16. A VCPR should be recognised, defined, and understood by all stakeholders:
    - for the protection of animal health and welfare
    - to facilitate the provision of appropriate and timely veterinary care
    - to protect and promote the responsible use of medicines.

    As such, the practical detail of a VCPR will need to be agreed at a practice or business level, although the overarching conditions under which a VCPR is established remain the remit of the RCVS.

17. We consider that it is reasonable for a VCPR to be adopted for a particular condition or treatment, or for it to refer to all relevant veterinary care for an individual animal or group of animals. In either scenario, the scope of the relationship must be clear to both vet and client, and potentially other stakeholders where such stakeholders exist.

18. Although a VCPR does not necessarily need to be formalised through the signing of a dedicated contract (which in many cases would be not only impractical but also potentially off-putting for a client), there should be some means of establishing and communicating the terms of the VCPR. Veterinary businesses should, as good practice, establish their terms of business and make those terms of business available to clients. Terms of business represent a form of contract between the practice and its clients for the supply of goods or services and whilst they can use general broad language to cover a range of situations, such terms will also routinely cover specific areas such as pricing structures, payment terms, limitations of liability, and approaches to dispute resolution. The terms of a VCPR can reasonably be incorporated into the terms of business such that they are available to clients and established without an additional administrative burden for the veterinary business. Time should be taken to explain the VCPR, and the vet and client responsibilities under it, at this point.
19. Consideration should be given to the inclusion of a 'longstop' within the terms of a VCPR. The 'longstop' represents the period of time after which the VCPR expires. This is when there has been no ongoing engagement, such that the vet no longer has sufficient knowledge of the animal and its circumstances to continue to provide care or prescribe responsibly. The expiration of the 'longstop' would not mean that the client was no longer registered with the practice, but a further visit or physical examination would be required before further services, other than emergency care, could be provided. The 'longstop' should not be confused with the frequency of visit and does not represent a recommended industry standard for the frequency of visit.
20. The appropriate 'longstop' would be different dependent on species and would be linked to the production cycle in food animal veterinary work. For example, most pigs bred for meat are slaughtered within six months, so in pig veterinary work six months might represent the appropriate longstop. In poultry work, the life cycle of layer hens is very different to broiler chickens so the appropriate longstop would also be different. In sheep a longstop of twelve months will usually be appropriate. In companion animal work, including equine, where annual health checks and vaccinations are a routine part of preventive healthcare, twelve months would

often be an appropriate longstop. In veterinary work with fish, which crosses aquaculture (fish farming), laboratory fish, aquaria, and ornamental, there would be an even greater variety of appropriate interpretations of 'longstop'.

21. In all species, the appropriate 'longstop' should be defined based on clinical judgement. For multiple species sites, the 'longstop' would apply to each species at the site rather than simply the premises in its broadest sense. Similarly, for multiple sites the VCPR would need to define whether the 'longstop' applies to each individual site or all sites as a grouping, based on veterinary professional judgement.
22. Some degree of flexibility must be built into the principle of the 'longstop', allowing for professional judgement to extend the 'longstop' where otherwise there might be unacceptable animal health and welfare or public health compromises. Such flexibility might be required when the physical limitations or the remoteness of the client or animal require it, or when government introduces restrictions on movement, such as those imposed in response to Covid-19.
23. We consider that a VCPR cannot be established solely by electronic means or remote interaction. In order to prescribe responsibly and foster prudent use of medicines, the relationship with the client must be established by seeing the patient and understanding the operation within which the patient is managed. Although remote interaction can reasonably form a significant proportion of subsequent interaction once a VCPR has been established, we consider that in-person interaction is necessary to establish the terms of the VCPR – in effect, the levels of trust. Without the level of trust established the risk of the interaction leading to compromised animal health and welfare or public health is increased, and in some cases could result in misuse or abuse of POM-Vs.
24. As already discussed, the AVMA allowance for the vet to visit the "operation where the patient is managed" rather than specifically carrying out a physical examination is a better reflection of the provision of veterinary services to the food animal sector. We consider that this approach is sufficient, subject to veterinary judgement, when establishing a VCPR with food-producing animals, regardless of species.

- **Recommendation 6: The RCVS should formally adopt the concept of the vet-client-patient relationship (VCPR) and define it in a way that is fit for purpose now and in the future.**
- **Recommendation 7: The RCVS should provide guidance on the overarching conditions under which a VCPR is established, definitively enough that it is not open to abuse, but sufficiently flexibly that it is appropriate to all species and allows for the terms to be defined at a practice or business level.**
- **Recommendation 8: The RCVS should provide guidance on the appropriate 'longstop' in consultation with BVA specialist divisions.**
- **Recommendation 9: Veterinary businesses should set out their terms of business and within those terms include the principle of a VCPR and the local conditions under which it is established, taking the time to explain it to the client.**
- **Recommendation 10: Veterinary businesses should ensure that their terms of business are made available to clients.**
- **Recommendation 11: All animal owners should seek to establish a VCPR with a veterinary practice as a means of fulfilling some of their responsibilities under the Animal Welfare Act.**
- **Recommendation 12: A VCPR cannot be established solely by remote means.**

The Vet-Client-Patient Relationship as an enabler of additional services

25. Once a VCPR has been established, it allows the vet to apply professional judgement based on the level of trust in the vet-client relationship as well as clinical judgement based on knowledge of the health status of the animal. The trust levels within an established VCPR allow the client to gain access to additional services, which enhance the veterinary provision and support animal health and welfare.

26. The extent to which additional services are enabled by an established VCPR will depend on several factors, including the competence of the client and their understanding of their animal's health picture, their reliability, their compliance with any previously given advice, and the extent to which they have demonstrated commitment to joint responsibility for patient care.

27. Access to additional services, enabled by an established VCPR, should be set out in the terms of business and the benefits of the added value should be communicated to clients.

- **Recommendation 13: An established VCPR should enable access to remote veterinary service provision, subject to veterinary professional judgement.**

- **Recommendation 14: Veterinary businesses should seek to communicate the value that can be added by an established VCPR.**

Chapter 2: Continuity of Care

1. There is a professional responsibility, and an expectation from clients, that there will be some degree of veterinary care available at times when the practice would not normally be open. This is often referred to as out of hours (OOH). Such veterinary care goes beyond emergency first-aid and pain relief and is more accurately described as continuity of care[32]. "Continuity of care" does not imply that the care provided OOH is the same as that provided during the day, and the level of provision is usually decided at a practice level.

2. The approach to continuity of care should be understood by all stakeholders, and it should be absolutely clear whether the care is provided on-site by practice staff or outsourced. Written information on associated costs, whether inpatients are left unsupervised at night or moved between premises, and which services provided during normal opening hours are not available overnight should be clearly communicated and readily available to the client, or potential client.

3. The provision of good quality continuity of care forms a key element of the overall care package and is an essential part of the VCPR. As such, veterinary businesses should not only communicate it clearly as part of the terms of business but should also promote the offering to potential clients. Practices that are part of the RCVS Practice Standards Scheme can demonstrate their commitment to good quality continuity of care through additional in-patient modules and awards.

- **Recommendations 15: Practice arrangements for continuity of care provision should be set out in the terms of business and form part of the established VCPR.**

- **Recommendation 16: Practices should promote high-quality continuity of care provision.**

Outsourced continuity of care provision

4. Where continuity of care provision is shared with another practice or outsourced to a dedicated provider, all parties have a professional responsibility to ensure that provision is appropriate. The outsourced provider must be capable of serving the conditions and species which could reasonably be expected to be entrusted to their care. Both parties have a shared responsibility to regularly review and assess that capability against evolving requirements and make risk-based adjustments to the arrangements as needed. This shared responsibility should be real and not nominal and in the form of a written agreement, such that any shortfall which could reasonably have been anticipated does not generally occur.

5. Shared data is a facilitator for good continuity of care, supporting animal health and welfare. The approach to data sharing, in compliance with relevant legislation, should form part of the contract with an outsourced provider and the client and kept under review with the aim of continual improvement.

- **Recommendation 17: Outsourced continuity of care should be contractual, appropriate, and reviewed regularly.**

- **Recommendation 18: The approach to two-way data sharing should form part of the contract and should be sufficient to enable continuity of care.**

[32] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/veterinary-care/

Owner responsibility

6. Owners also have their part to play and are responsible for ensuring access to a level of continuity of care appropriate to their animals' existing or anticipated needs. This is particularly important in the context of chronic conditions which may require ongoing management, or post-operatively when the need to access veterinary care outside of normal hours might reasonably be expected.

7. This shared responsibility should be communicated as part of the VCPR and forms part of a mutual understanding between vet and client such that shortfalls which could reasonably have been anticipated by vet or client do not generally occur.

- **Recommendation 19: The responsibility of owners to ensure that they can access the continuity of care provision appropriate to their needs should be communicated by practices as part of their terms of business.**

Limited-service providers

8. RCVS currently requires that limited-service providers comply with the RCVS Code of Professional Conduct and supporting guidance, and specifically that:

   3.50 Veterinary surgeons working in neutering clinics must make provision for 24-hour emergency cover for the entire post-operative period during which complications arising from the surgery may develop.

   3.51 Veterinary surgeons working in vaccination clinics must make provision for 24-hour emergency cover for the period in which adverse reactions might arise.[33]

9. Limited-service providers who offer specific healthcare services, however limited, have a duty of care to the client and patient, effectively entering a VCPR within the context of the specific provision. As already discussed, there is a professional responsibility, and a reasonable expectation from clients, that in the context of an established VCPR there will be some degree of veterinary care available overnight and on other out-of-hours occasions. Limited-service providers, and those offering peripatetic veterinary services, are not considered exempt from this responsibility and should take steps to provide an appropriate degree of continuity of care relevant to the services rendered.

10. As with other veterinary businesses, there is no obligation to provide that care themselves, and the provision can reasonably be outsourced. However, such outsourcing must be appropriate, contractual, sufficiently clear to all stakeholders, and regularly reviewed.

- **Recommendation 20: Limited-service providers, and providers of peripatetic veterinary services, should provide continuity of care appropriate to the services rendered. The arrangements should be set out in the terms of business and form part of the VCPR.**

[33] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/24-hour-emergency-first-aid-and-pain-relief/

Chapter 3: Remote veterinary service provision

1. The provision of veterinary services through remote means has operated informally for many years, with most veterinary businesses offering telephone advice to registered and unregistered clients, on an ad hoc basis and, more often than not, free of charge. More recently, the remote gathering of data to enhance, support and complement veterinary clinical assessment has become increasingly common across the food animal production sectors. Photos and videos from mobile phones have become increasingly important in all areas of practice.
2. On 12 March 2020, the World Health Organisation declared the Covid-19 outbreak as a pandemic, and on 16 March everyone in the UK was advised against "non-essential" travel and contact with others, as well as to work from home if possible. This resulted in veterinary practices restricting work to that directly connected with the maintenance of the food supply chain[34] and emergency veterinary care.
3. This forced a step change for many veterinary businesses, in particular companion animal practice where remote clinical assessment became the first-line response and remote veterinary advice became the norm in non-emergency cases. Our snapshot survey of members during Covid-19 restrictions showed that over 90% of respondents were using remote consulting as part of their veterinary services offering. The changes also highlighted the issue of charging for professional time, with, anecdotally, many practices reporting difficulties with clients who did not recognise remotely provided services as chargeable. This change was accompanied by an RCVS Council decision at the end of March 2020 to temporarily permit the remote prescription of veterinary medicines where appropriate and where compliance with government restrictions left no other available options[35]. The RCVS Council Covid-19 Taskforce subsequently extended the temporary guidance on a number of occasions[36] [37] [38].

Remote veterinary service provision within an established VCPR

4. The remote provision of veterinary services has and can be a valuable adjunct within the existing models of veterinary practice. Under an established VCPR, remotely provided services can add value to the client/patient care package, supporting animal health and welfare, public health, and good biosecurity. Where remote provision is done well and forms a credible part of a veterinary business, it may also ensure more effective and efficient use of veterinary time, benefitting both vets and their clients.
5. An established VCPR can reasonably be extended to include referrals to a specialist[39], providing the specialist is working as part of the vet-led team, with the primary vet retaining control of and responsibility for the case. In these circumstances, a remote consultation between specialist and client or specialist and primary care vet, including advice on likely diagnosis and appropriate treatment, operates within the framework of the existing VCPR. In situations where the primary care of the patient needs to transfer to the specialist, then a new VCPR should be established by physical interaction rather than remote consultation.

6. A wide variety of tools, platforms, and approaches are available to facilitate the provision of remote veterinary services, with their integration into veterinary businesses hastened and

[34] https://www.bva.co.uk/news-and-blog/news-article/veterinary-practices-to-remain-open-only-for-emergency-care-and-to-maintain-food-supply-chain/
[35] https://www.rcvs.org.uk/news-and-views/news/coronavirus-rcvs-council-temporarily-permits-vets-to-remotely/
[36] https://www.rcvs.org.uk/news-and-views/news/rcvs-covid-19-taskforce-extends-remote-prescribing-guidance/
[37] https://www.rcvs.org.uk/news-and-views/news/rcvs-covid-19-taskforce-further-extends-remote-prescribing/
[38] https://www.rcvs.org.uk/news-and-views/news/council-votes-to-extend-temporary-remote-prescribing-guidance/
[39] NOTE: this may mean an RCVS Specialist, Advanced Practitioner or other vet with particular experience or expertise

necessitated by government restrictions relating to Covid-19. A range of options should be available, so that factors such as internet bandwidth and owner familiarity with or access to technology can be accommodated. This is essential for remote veterinary services to function effectively, efficiently, and genuinely add value.

- **Recommendation 21: Under an established VCPR, veterinary businesses should consider integrating the provision of remote veterinary services to expand and complement the care package. Veterinary businesses should promote the added value of the remote services offered and justify and make clear where these are chargeable.**
- **Recommendation 22: Veterinary businesses should proactively review approaches to remote consultation and establish ways of working which are practical, accessible, reliable, and valued by clients.**
- **Recommendation 23: RCVS, BVA and other stakeholders should share examples of good practice to support and guide the veterinary profession in integrating the provision of remote veterinary services into existing veterinary services.**

Remote veterinary service provision without an established VCPR

7. In the absence of a VCPR, the animal, their management and the animal owner are unknown. There is no access to clinical notes and levels of trust have not been established. In these instances, remote veterinary service provision, whether by a dedicated provider or a veterinary practice, should be limited to offering generic information and advice only and making an onward referral to physical veterinary services.
8. Once a specific animal or group of animals is being discussed, and where that discussion includes specific advice on treatment, then it can be considered an act of veterinary surgery, or at least a route towards it, and vets and RVNs who offer such advice need to be mindful of this aspect. Lay people should not offer anything other than general information and can only provide a very limited service.
9. The limitations of the advice offered must be clearly communicated to the animal owner, as should their role in providing full and truthful information within the confines of their own ability to recognise potential signs or assess pain. Onward referral to a vet with which the owner already has a VCPR will be appropriate in most cases. In the absence of an existing VCPR, onward referral should be made to a vet who can establish a VCPR with the owner via physical interaction.
10. Remote engagement between animal owners and dedicated remote providers, charities, specialists, or other supplementary veterinary services, regardless of frequency, does not establish a VCPR. Such providers must operate within the legislative framework which protects and promotes responsible prescribing and prudent use of medicines, animal health and welfare, and public health. In consequence, the value-added services which are potentially enabled by an established VCPR should not be available in this context.

- **Recommendation 24: Providers of remote advice operating outside an established VCPR should only offer generic information and advice, ensure that the limitations of their offering are communicated to any animal owner choosing to use their service.**
- **Recommendation 25: Providers of remote advice operating outside an established VCPR should, in most cases, and subject to owner consent, make an onward referral to a vet with which the owner already has a VCPR. In the absence of an existing VCPR, onward referral should be made to a vet who can establish a VCPR with the owner via physical interaction.**

Remote prescribing

11. Currently, to prescribe a veterinary medicine, vets must first carry out a clinical assessment of the animal and establish the animal as being under their care[40]. As already discussed, the current RCVS interpretation implies that the concept of 'under care' is limited to a close temporal relationship to the act of prescribing, given the requirement for a physical examination. We are recommending a revision that holds to the intent of the Code and goes beyond that to capture the modern-day relationship between vets, clients, and their animals. Animal health and welfare must be central to the development of a revised and modernised interpretation, and as such, the principle that responsible prescribing requires knowledge of the animal/group of animals that is provided by a physical examination or an established VCPR must be maintained.
12. Responsible prescribing of all veterinary medicines must always be ensured, including when clinical assessment is by remote means. An established VCPR supports responsible prescribing and represents the only appropriate opportunity for remote prescribing of POM-Vs and POM-VPSs. Remote prescribing should only be available when a VCPR has been established and, in the professional judgement of the vet, the trust levels are sufficient that remote prescribing represents an enhanced service, which is necessary for animal health and welfare and promotes responsible prescribing and use of medicines.
13. In line with legislation and in the interests of wider public health, some categories of POM-Vs should never be prescribed remotely even in the presence of a VCPR. These could include some Schedule 2 and 3 controlled drugs, or Highest Priority Critically Important Antimicrobials[41].
14. The temporary measure put in place by RCVS in March 2020, permitting remote prescribing, represented a pragmatic solution during government restrictions relating to Covid-19 and has created an opportunity to assess the impact on responsible prescribing and explore lessons learned. It must not lead to a longer-term change without full consultation with the profession and total transparency in relation to impacts on prescribing behaviours. Our snapshot survey of remote consulting and prescribing behaviours during Covid-19 restrictions showed that 54% of respondents were prescribing remotely for new conditions in existing patients, and 15% were prescribing remotely for animals not under the care of their practice.

- **Recommendation 26: POM-Vs should only be prescribed remotely in the presence of an established VCPR and where, in the professional judgement of the vet, animal health and welfare will benefit.**
- **Recommendation 27: Consideration should be given, by the regulator, to which POM-Vs should never be prescribed remotely.**

Animal health telemetry data

15. As technological advances are increasingly providing opportunities for the provision of remote veterinary services, the proliferation of tools which enable the remote gathering of data represent further opportunities to enhance and complement veterinary assessment, diagnosis, and advice in the context of an established VCPR.
16. The value of remotely gathered animal health data is already well recognised in many parts of the farm animal sector, with vets using such data to give early predictions of potential health and welfare issues. This can allow appropriate interventions to be made before major problems occur[42].

[40] http://www.legislation.gov.uk/uksi/2013/2033/schedule/3/part/1/made
[41] https://www.who.int/foodsafety/cia/en/
[42] https://www.bva.co.uk/media/1181/bva-position-on-uk-sustainable-animal-agriculture-full.pdf

17. In the companion animal sector, the role of remotely gathered health data is less well established, and challenges can arise in relation to the value of data gathered by technological tools, complicated by the vast array and variable quality of unregulated devices available. There are roles for veterinary professionals to help owners navigate and understand the wealth of information available, as well as identifying and discarding incorrect and misleading information, which may compromise animal health and welfare. It is important to educate owners to use technology effectively by properly explaining how it can supplement veterinary advice. The value added by veterinary interpretation of remotely gathered data should be more widely recognised and communicated by the profession, such that it is understood and valued by clients and forms a credible component of the veterinary care package. This complements the vet's role as a knowledge interpreter rather than a knowledge provider.
18. Clients may seek greater autonomy in relation to the care of their animals, in parallel to the human healthcare sector, where technology is a tool for empowering the patient who has healthcare choices. However, for animal care, vets must remain guardians of animal health and welfare, with ultimate responsibility to the animal under their care. Treatment choices must be made in consultation and with the agreement of the client, with veterinary advice enabling and directing the client to the best course of action to protect the welfare of their animal.

- **Recommendation 28: Animal health telemetry data, and the added value of veterinary interpretation of that data, should be communicated by the profession and form part of the modern provision of veterinary services.**

Chapter 4: Technology and innovation

1. Evidence-based technology and innovation have always been at the heart of veterinary science. This will increasingly be the case as the potential of technological advances is harnessed across many sectors of veterinary work. The profession embraces and drives innovation that improves animal health and welfare and the delivery of services to clients whilst maintaining professional standards.

2. Technological advances are, and should be, supported and fostered where they make a positive contribution to animal health and welfare and support the veterinary profession in protecting public health. Supplementary benefits may include (in no particular order):

    - Supporting the relationship between owners and their animals, particularly in the companion animal sector
    - Improving client and public education on animal health and welfare
    - Improving the efficiency of animal keeping across all sectors, but in particular food animals and competition animals where economic returns are critical
    - Facilitating early recognition and intervention on a range of potential health and welfare issues, and assessment of response to changes. In doing so, health and welfare impacts can be reduced and conditions which support production prevail, enabling responsible use of medicines
    - Sharing of prevalence data of relation to diseases
    - Reducing damage to the environment and supporting sustainable animal agriculture
    - Facilitating the verification of animal health and welfare standards, particularly for farm assurance purposes
    - Supporting the certification of exports of live animals and products of animal origin

Veterinary leadership

3. New animal health monitoring tools are often driven by client need and perceived market opportunity. There is currently a large amount of investment from non-veterinary sources in the development and commercialisation of technology relating to animal health. Veterinary engagement at an early stage is essential to ensure the products are providing robust data. Vets have a key role to play in helping clients navigate the market. They should be discerning in their choice of tools to support their professional activities so that animal health and welfare benefits are realised.

4. The veterinary profession achieves this by being critically forward-looking and should continue to inform itself as to the relative value of the range of technology available, showing leadership in adoption where there is demonstrable value to animal health and welfare. Animal health information provided by newly emerging technological solutions is, in principle, no different to data provided by other more widely established diagnostic tools. There is a professional responsibility to assess the validity of the outputs of new technologies before deciding on their application. This is similar to understanding the sensitivity and specificity of a diagnostic test before using it as an aid to veterinary clinical assessment and recommending it to a client. Vet schools should adopt new technologies, and the veterinary undergraduate degree programmes should teach critical assessment of new technologies as part of the syllabus.

5. As well as new technologies aimed at improving the health and welfare of individual animals, there are opportunities for innovation in agricultural systems. This can be through higher animal welfare, increased productivity, and improved sustainability. The veterinary profession has a key role to play in advancing the roles and status of animals within the sustainability debate and

ensuring that the highest standards of health and welfare for production animals are maintained and recognised as a key sustainability objective. The profession achieves this by communicating the holistic overview of One Health and sustainability as well as demonstrating leadership in the application of technological advances for the benefit of wider society[43].

6. There is also a need to consider the role of artificial intelligence and apps which may augment or have greater accuracy than human interpretation. The profession will need to consider how it can assess and adopt such technology when the underlying algorithms are not readily accessible or assessable. Such technology will be at its most valuable as an auxiliary aid within the context of a VCPR.
7. It is important to assess the value of available and emerging technologies, devices, and software systems. Efficacy claims should be supported by data. The evaluation of new applications that are evidence-based, robust and ideally peer-reviewed, should be encouraged and readily available. There could also be a role for RCVS Knowledge and veterinary publications, such as *In Practice,* to assess emerging technology and make evidence accessible. There may also be potential for veterinary associations and other stakeholders to offer CPD and signpost to appropriate resources to support the integration of technology across the range of veterinary business models. The requirement for regular audits of the evidence behind the data sources a practice uses could be incorporated into schemes such as the RCVS Practice Standards Scheme.
8. Veterinary businesses also have challenges relating to their obligations and duties when agreeing to receive, store and process data on behalf of their clients. They should be aware of and ensure compliance with relevant legislation. It is critical that the profession's understanding of cybersecurity keeps pace with change.

- **Recommendation 29: The veterinary profession should show leadership in adoption by being forward-looking and informed as to the value of the range of technology available.**
- **Recommendation 30: Vet schools should adopt new technologies, and the veterinary undergraduate degree programmes should teach critical assessment of new technologies as part of the syllabus.**
- **Recommendation 31: Data to support the efficacy claims of new technology should be published.**
- **Recommendation 32: RCVS Knowledge, BVA, and other stakeholders should consider how best to provide guidance on emerging technology and showcase best practice.**
- **Recommendation 33: Guidance should be provided for the profession about the risks associated with the processing, storage, and security of animal health data.**

Regulation of technological tools and devices

9. As technology advances, there may be greater reliance on devices to aid diagnosis. This may necessitate supporting guidance within the RCVS Codes of Conduct for the veterinary professions, setting of standards, and support for individual vets through timely advice and leadership on evolving best practice.
10. The ultimate responsibility for diagnosis should always rest with vets. However, as reliance on diagnostic devices increases, the need for regulation of performance standards and claims of

[43] https://www.bva.co.uk/media/1181/bva-position-on-uk-sustainable-animal-agriculture-full.pdf

medical relevance of new diagnostic tools should be considered because of the potential impact on animal welfare. Medical Devices legislation currently only relates to medical devices for the field of human healthcare, but with rapid growth in the animal health monitoring field, there may be opportunities to regulate such devices with regard to safety and efficacy. Opportunities to set standards for production might also need to be considered.

- **Recommendation 34: The potential need to regulate veterinary medical devices in relation to safety and efficacy should be kept under review.**

Chapter 5: Emergency care

1. The Veterinary Surgeons' Act 1966 makes no mention of a requirement to provide 24-hour emergency first aid or pain relief. However, the RCVS Code of Professional Conduct states:

   1.4 Veterinary surgeons in practice must take steps to provide 24-hour emergency first aid and pain relief to animals according to their skills and the specific situation.

   Part 1 of the RCVS supporting guidance sets out the key professional and legal responsibilities for veterinary surgeons in relation to emergency care, and also states that the responsibility for the welfare of an animal ultimately rests with the owner, keeper, or carer, with owners being responsible for transporting their animals to a veterinary practice, including in emergency situations[44].

2. We consider that the existing RCVS requirement and guidance on emergency first aid and pain relief is clear, appropriate, and reflects the ethical responsibility of individual vets[45]. Such responsibility should apply regardless of the existence of an established VCPR, and in principle should encompass all animals, owned and unowned, regardless of the ability of the owner or finder to pay. We support the existing wording in the RCVS guidance which requires that "all veterinary surgeons on duty should not unreasonably refuse to provide first aid and pain relief for any animal of a species treated by the practice during normal working hours, or for all other species until such time as a more appropriate emergency veterinary service accepts responsibility for the animal"[46].
3. Although the responsibility to *administer* first aid and pain relief can only reasonably apply to vets in clinical practice with access to the necessary resources to provide such care, we also strongly support the RCVS caveat of "according to their specific skills and experience". However, vets not working in clinical practice, or presented with a situation or species not covered by their skills and experience, still have a moral duty to 'take steps' – which may be limited to intervening by directing to the nearest suitable practice. As such, we support the existing RCVS guidance, which is clear that veterinary surgeons do not need to personally provide the service[47].

4. In the event of being called upon to work outside their specific experience, and where it is practicable, a vet with access to the necessary drugs or equipment could reasonably be expected to seek technical knowledge from other sources in order to take action in an emergency.

5. In all cases, action should not unduly risk compromising animal welfare, or the health and safety of the vet, their colleagues, other professionals, or the wider public.

[44] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/24-hour-emergency-first-aid-and-pain-relief/
[45] BVA Voice of the Veterinary Profession survey panel autumn 2019 showed that 75% of respondents agreed RCVS Code requirements in relation to emergency care were clear, and 80% agreed they were appropriate.
[46] https://www.rcvs.org.uk/setting-standards/advice-and-guidance/code-of-professional-conduct-for-veterinary-surgeons/supporting-guidance/24-hour-emergency-first-aid-and-pain-relief/
[47] Ibid

Supporting the profession to provide emergency care

6. Historically there has been concern amongst the profession with regard to the capacity of the profession to meet public expectations in relation to the provision of emergency care, particularly out of hours. In 2014 the guidance was amended, placing greater emphasis on owners' legal responsibilities for their animals, and clarifying situations where delaying or declining attendance to an animal may be appropriate[48]. The changes were intended to assist and empower vets to decline to attend an animal away from practice when they feel it is unnecessary or unsafe, and make it clear that vets are not obliged to carry out substantive treatment for which the owner cannot pay. At the time, we welcomed the RCVS commitment to providing clarity on responsibilities, stating that:

   "The willingness of veterinary surgeons to provide 24/7 emergency care is one of the main reasons that the public places its trust in our profession. But BVA has argued that the delivery of that obligation has to be realistic and public expectation must be managed. We therefore welcome the College's commitment to highlight owners' responsibilities alongside those of veterinary surgeons…"[49]

7. However, although the requirements of the RCVS in relation to first-aid and pain relief are largely supported and understood by the profession, there remains a notable shortfall in application, with only 65% of respondents to our Voice of the Veterinary Profession survey panel agreeing that the responsibilities were followed through in practice.

8. In line with the advice already provided in human healthcare, and the Social Action, Responsibility and Heroism Act 2015, vets should be provided with reassurance that in an emergency situation and in the absence of a VCPR, it is acceptable and entirely adequate to do the best you can under the circumstances and with the resources available, working within the limits of your competence. Such guidance could include:

   - Carefully consider your own competence and expertise, particularly if you are retired, not in a clinical role, and/or no longer registered with RCVS
   - Consider whether anyone else is better placed to assist, such as a current MRCVS
   - If retired, or not in practice, make this clear to the owner/finder
   - Take a full history and carry out a full examination, as far as the situation and available equipment allows, in order to make an informed assessment
   - Make contemporaneous notes
   - Suggest options for managing the situation (balance benefits and risks of treatment)
   - Work within the confines of your expertise and training, except in a critical emergency (eg where death or life-changing injuries would be the likely outcome of inaction)
   - Delegate and communicate appropriately

9. We consider that there is also more work to be done to improve public understanding of the extent of veterinary responsibility in an emergency outside an established VCPR. Animal owners need a better understanding of their responsibilities under the Animal Welfare Act, including the importance of being registered with a vet and planning for emergencies. The RCVS has a role to play in educating the public on when it is appropriate to seek emergency care.

10. The role of euthanasia as an acceptable treatment choice for owned animals, with or without a VCPR, and where poor quality of life or inability to pay are factors, also needs to be better

[48] https://www.rcvs.org.uk/news-and-views/news/new-guidance-on-247-emergency-cover-published/
[49] https://www.politicshome.com/members/article/bva-welcomes-rcvs-decisions-on-247-emergency-care-and-postgraduate-postnominals

understood by the public. Individual veterinary surgeons, RCVS, BVA, charities, and other stakeholders should all play their part in challenging the perception of euthanasia as a welfare harm, or an option that is only considered when all other treatment options have been exhausted.

11. In relation to British wildlife casualties, vets in practice should be willing and able to make an initial veterinary clinical assessment regarding the potential suitability of the animal for eventual return to the wild, with reference to the expertise of veterinary colleagues and wildlife rehabilitators where appropriate. In many instances, euthanasia may be the preferred or only option and there is a need for the acceptability of euthanasia as a treatment choice to be better communicated to the public. The longer-term prospects of successful rehabilitation and release, and the welfare of the wild animal, should form part of that communication. Where animals can be treated, appropriate first aid, including pain relief, should be provided. For ongoing treatment, rehabilitation and eventual release, the services of a wildlife rehabilitation centre, experienced in the care of that particular species, will normally be required.

- **Recommendation 35: Fear of liability and accountability when providing emergency care outside an established VCPR should not paralyse action that supports animal health and welfare. RCVS and professional indemnity insurers should provide appropriate reassurance for the profession.**
- **Recommendation 36: Stakeholders should better communicate the role of euthanasia as an acceptable treatment choice where poor quality of life or inability to pay are factors.**
- **Recommendation 37: All vets on duty in clinical practice should be willing and able to make an initial veterinary clinical assessment of British wildlife casualties and provide appropriate first aid, including pain relief, or euthanasia where necessary.**

Appendix 1

BVA Under Our Care Working Group Members

Nigel Gibbens (Chair)

Nigel qualified as a veterinary surgeon from London University in 1981 and spent three years in mixed practice before gaining a Masters degree in Tropical Veterinary Medicine at Edinburgh University. Nigel worked in Government veterinary services in Belize and Yemen before returning to join the UK state veterinary service as a field veterinary officer in 1990. He moved to the UK central animal health policy group in 1996 and worked on international trade for 8 years, followed by BSE control policy, animal welfare policy and agriculture international relations before becoming the UK Chief Veterinary Officer in May 2008. Retiring from the UK CVO role in February 2018, Nigel is now providing consultancy services on veterinary public health.

Madeleine Campbell – Ethics and Welfare Advisory Panel

Madeleine is a lecturer in Human/Animal Interactions and Ethics at The Royal Veterinary College and sole partner for Hobgoblins Equine Reproduction. With extensive committee experience for BEVA, RVC, Defra, RCVS, and as member and chair of BVA's Ethics and Welfare Group (2010-2016), Madeleine is also a peer reviewer for the Journal of Applied Animal Welfare Science and holds an MA from Keele University in Medical Ethics and Law (Distinction).

Daniella Dos Santos - BVA President

Daniella obtained a BSc (hons) in Molecular Genetics from Kings College London in 2007, before going to study veterinary medicine at the RVC, qualifying in 2012. Since then, she has been in first opinion small animal and exotic animal practice and is currently working towards her CertAVP zoological medicine. She became a member of the BVA Ethics and Welfare Advisory Panel in 2015, and became Chair in 2017. She also became a Trustee of the Animal Welfare Foundation in 2016.

Phil Elkins - British Cattle Veterinary Association

Phil graduated in 2005 from Edinburgh and spent 14 years in clinical practice, primarily in the livestock sector. This includes both independent and corporate practice. Following a short stint working for an AgTech start-up, Phil is now an independent consultant. He provides health, welfare, and productivity consultancy to dairy units, and advises a number of agricultural service providers.

Fiona Fell - BVA member

Fiona is Deputy Chair of the Centre for Innovation Excellence in Livestock and a Trustee of the BVA Animal Welfare Foundation. She was previously a Non-Executive Board member of AHDB (Agriculture and Horticulture Development Board) and of the Moredun. She moved into NED roles in the area of veterinary/agricultural innovation and knowledge exchange, having started out as a mixed practice vet in the Northeast of England.

David Green - Veterinary Defence Society

David qualified from Bristol in 1987 and after some years as a mixed, large, and equine vet he joined the Veterinary Defence Society as a claims consultant. Now VDS Technical Director and Board Member David has also held professional appointments as Chair of the Association of Racecourse Veterinary Surgeons, President of the Yorkshire Veterinary Society, FEI Official Veterinary Surgeon, and Official Racecourse Veterinary Surgeon. David lives on a small holding with his family, rare breed sheep, and horses.

Ruth Layton - Ethics and Welfare Advisory Panel

Ruth co-founded Benchmark in 2000 to drive greater sustainability in the food chain, after gaining 17 years' experience in veterinary practice. In 2017, Ruth was awarded the BVA Chiron Award in recognition of her contributions and achievements driving progress in farm animal welfare within the supply chains of some of the world's largest food brands.

Sheldon Middleton - British Small Animal Veterinary Association

Sheldon graduated from Cambridge University and joined Acorn House Veterinary Surgery, a mixed practice in Bedford. He became Senior Vet and ultimately a Partner in the practice. Over the years the practice sold the farm side and became a Veterinary Hospital for small animals. The practice was sold in 2018 to the Royal Veterinary College (held in an arm's length company) as a flagship primary care teaching hospital. Sheldon remains as the Managing Director of the company. He has had a parallel volunteering career, mainly with the BSAVA where he has held regional, committee and Board level positions. He was recently Honorary Treasurer of the association and is now on the Presidential ladder as Vice President.

Alice Moore - Policy Committee

Alice is a small animal veterinary surgeon at Garston Veterinary Group in Somerset. During her time in practice she has become increasingly interested in wider policy matters and the problems facing the veterinary community, in particular responsible pet ownership and breeding. Alice is also an enthusiastic advocate of mental wellbeing and sustainability.

Adrian Nelson-Pratt - BVA member

Adrian graduated from Bristol in 1995. He has a varied background, having spent 6 years in small animal practice followed by a fourteen-year career at Hill's Pet Nutrition where he was Customer Development Director for the UK and Irish vet channels. More recently he has been running his own business consultancy and building the EMERGE Veterinary project, a coaching and personal development product aimed at improving veterinary wellbeing and performance.

Hannah Perrin - Veterinary Management Group

Hannah originally qualified as a pharmacologist, subsequently becoming Practice Manager of a busy four-site practice in Kent. Following an MA in Health Services Research, she completed her PhD in 2015 on the socialisation processes of veterinary training and EMS. She taught on the MA in Veterinary Education at RVC for several years, and her consultancy work now includes veterinary leadership, management, and education.

Jack Pye - British Veterinary Nursing Association

Jack began his career in first opinion practice. After qualifying in 2018 he decided to pursue new challenges at a small animal hospital in Norfolk, where he is currently employed solely in emergency and critical care. Jack is passionate about supporting other veterinary nurses to grow and enhance their skill sets. His specialist interests are ultrasonography, emergency & critical care, anaesthesia, and exotics, and he regularly shares his experiences by engaging with others on social media platforms with the hope of encouraging and supporting others professional development. He is enthusiastically involved with the BVNA after being elected to BVNA Council and is committed to driving the veterinary nursing profession forward.

Iain Richards - Policy Committee

Iain was a mixed practice vet for over thirty years. Having studied for a Masters in Conservation Medicine he is currently developing a speciality in the problems of disease and welfare that exist at the wildlife-livestock interface. With considerable committee experience within BVA territorial and specialist divisions, he has also been a valuable contributor to BVA working groups on bTB and the vet-led team, and currently chairs Policy Committee.

Kathleen Robertson - Society of Practising Veterinary Surgeons

Kathleen Robertson graduated from Glasgow University in 1995 and has had a varied career including mixed practice, academia, and veterinary investigation officer. She is currently in practice support roles in the North of Scotland. She lives near Inverness and understands rural and remote issues. She holds an RCVS certificate in Veterinary Anaesthesia and has recently completed a Glasgow Vet School microcredential - Veterinary Practitioner and Food Security. She also is the Secretary of Vet Trust and current President of BVA's Scottish Branch.