VETERINARY PRACTITIONERS REGISTRATION BOARD OF VICTORIA

GUIDELINES COMMITTEE

Response to Feedback regarding new draft Guidelines 2015

INTRODUCTION

The Veterinary Practitioners Registration Board of Victoria (the Board) is established under the *Veterinary Practitioners Act 1997* (the Act), in order to administer that act.

One of the main purposes of the Act is to protect the public by providing for the registration of veterinary practitioners and investigations into the professional conduct and fitness to practice of veterinary practitioners.

The Act defines unprofessional conduct, and this definition includes "*professional conduct which is of a lesser standard than that which the public might reasonably expect of a registered veterinary practitioner*"; and "*professional conduct which is of a lesser standard than that which might reasonably be expected of a veterinary practitioner by his or her peers*".

The Board consists of a combination of peers and the general public, and when the Board investigates a complaint, it has the authority to determine whether the individual circumstances of a complaint constitute unprofessional conduct.

The Act also provides that one of the powers and functions of the Board is to "*to issue guidelines about appropriate standards of veterinary practice and veterinary facilities*" (S62(1)(e)).

Historically, the Board has issued Guidelines from time to time, often as a result of receiving complaints with a common theme.

The Guidelines reflect the Board's view regarding what might or might not constitute unprofessional conduct under some circumstances, but they are not intended to be a prescriptive list of what registered veterinary practitioners may and may not do.

Indeed, acting in contravention of a Guideline does not of itself necessarily constitute unprofessional conduct. It is not a function of the Board under the Act to seek out and investigate practitioners who may have acted contrary to the Guidelines, but the Guidelines can be used as evidence of what constitutes unprofessional conduct in the investigation of a complaint made under section 21 of the Act.

Whilst the Guidelines are not the only determinant of what constitutes unprofessional conduct, a recent amendment to the Act allows the Board to rely on the Guidelines as evidence of what constitutes unprofessional conduct in a hearing (S47(c)).

The Board initiated a major review of the Guidelines to ensure that they reflect current views of the profession, and so that they explicitly describe what registered veterinary practitioners must and should do or not do.

Feedback is ongoing, but this document describes the Board's response to the first round of feedback which was collected via an online survey in August 2015. There were a total of 97 responses considered.

In responding to feedback from practitioners, the Board makes the following general points:

1. There was considerable feedback regarding issues that respondents had with the Act, rather than the Guidelines (for example, the definition of Unprofessional Conduct in the Act). The Board will take these comments on board, but notes that legislative change requires significant thought and planning, and that while a function of the Board is to advise the Minister on matters related to its functions, the Board does not have the power to change the Act directly.

2. There was feedback regarding functions that respondents thought the Board should undertake that are outside the current powers and functions of the Board under the Act (for example, mandating CPD and inspecting veterinary premises to ensure they comply with Guidelines outside of a complaint investigation). Similarly, these would require legislative change.

The Board values all feedback, and will consider comments that relate to legislative change in due course, but this document will be restricted to considering the wording of the draft guidelines before they are approved by the Board. Stakeholders with views proposing changes to the Act should feel free to make their views known through other channels (for example, the AVA or the Department).

For the purposes of this review, the Board considered each suggestion made and determined whether:

(a) A change to the draft Guideline should be made immediately;

(b) A change may be warranted but this will require more consideration and thought than could be given at the current meeting. In this case, the Board will reconsider the feedback at a future meeting;

(c) No change is required to the Guideline as a result of the feedback.

QUESTION 2 GENERAL COMMENT

Feedback	Response
The name of the Guidelines needs to be changed to reflect their changed status. Minimum acceptable standards?	Would need legislative change – the Act gives the Board the Power to issue “Guidelines”.
How can changing guidelines lead to significant change if no enforcement/monitoring occurs. If Vic Police never checked drivers for alcohol levels would having great guidelines be of value?	Would need legislative change – The Act allows the Board to use the Guidelines as evidence in a hearing as to what constitutes unprofessional conduct, but does not allow for sanctions or other action in the absence of a complaint.

QUESTION 3 - DEFINITIONS

Feedback	Response
Indirect supervision: (a)If the supervising veterinary practitioner is not required to accompany the person being supervised then they cannot be made wholly responsible for that persons work. However, they should be able to show that they have provided sufficient direction. Do you want comments on grammar? In the first sentence of the last para of Unprofessional Conduct there should not be any commas. (b) 'Indirect Supervision means that the supervising practitioner is not required to accompany the supervised person but must be available to provide advice or direction whenever the person being supervised is working. It is expected that the supervising practitioner maintains conscientious oversight of the work that the supervised person performs. The supervising veterinary practitioner accepts responsibility for the standard of care that the person under their supervision provides.' I am not sure yet how this will be used, but it is a bit hard for the supervising veterinary practitioner to accept full responsibility when they are not actually present. "partial responsibility"? (c) Indirect Supervision says supervisor is not required to accompany "the supervised person” - this relates to Large animal practice Should reword as "be present"	The wording has been changed. The supervising veterinary practitioner accepts broad responsibility for the standard of care that the person under their supervision provides. **Indirect Supervision** means that the supervising practitioner **is not required to be present at all times** but must be available to provide advice or direction whenever the person being supervised is working.

with the supervised person at all times or similar words	
More detail regarding scripts	
Public expectations: (a) Definitions which rely on "expectation" of the public are not reliable or necessarily reasonable. People may have completely unrealistic expectations. This comment is in relation to the definition of unprofessional conduct. (b) Unprofessional Conduct Unprofessional Conduct, as defined in section 3 of the *Veterinary Practice Act 1997*, includes (but is not limited to) the following points, which have relevance to the issue of guidelines: (a) professional conduct which is of a lesser standard than that which the public might reasonably expect of a registered veterinary practitioner; How is a Veterinarian to know what the mean of public opinion is. This statement will be very difficult to define. I am not sure that this statement can be quantified and should therefore be removed	This is a legislated definition and is outside the scope of a Guidelines review.
Infamous conduct? What does this mean and is it reasonable to expect a veterinary practitioner or member of the public to recognise the context of this word?	This is a legislated definition and is outside the scope of a Guidelines review – this section is directly copied from the Act. The Board would be bound by legislation and/or precedent.
The provision of advice to aid in and/or supply, and/or the administration of performance enhancing drugs to animals in order to achieve competitive advantage over others should perhaps be specifically stated, since it could be argued that done properly, it does not harm the animal. There are other codes of practice including civil and criminal codes that veterinarians must satisfy in order to exhibit professional conduct.	This is a topic for the Rules of Racing for various sports, but is covered to some degree in Guideline 6.
Use of the word Consultant: I am a Professional Interest Practitioner in Surgery. I have been using the phrase 'Consultant Veterinary Practitioner in Surgery', and also the phrase 'Veterinary Surgical Consultant' for a number of years. I believe that the word Consultant does not contravene any Veterinary Board guideline differentiating between Specialists and non-Specialists. The word Consultant does not in any way imply that I am a Specialist. I believe that a Professional Interest Practitioner who see referrals in a particular field but does not hold endorsement as Specialist in his/her chosen field, should also be allowed to use the word Consultant in that field.	The word consultant could lead to a belief that a person is a specialist if it is not made clear to clients at the time that the practitioner is not a specialist. For this reason the board does not recommend this word in the definitions.
Professional Interest Practitioner: (a) Don't know why i bothered getting a Specialist qualification, when I could just put "Professional Interest Practitioner in Equine Surgery" all over my	 These comments are noted.

stationary. Joe Bloggs won't know the difference (b) As a specialist I would like to know - who and what determines that a general practitioner has "demonstrable interest in a particular field" I am also concerned that this title in the eyes of the general public does not make a clear distinction between general veterinarian and specialist. (c) Definition of professional interest practitioner - is any extra training required to hold this title? i.e. memberships?	Veterinary practitioners must not mis-represent their specialist status. There are no particular requirements for non-specialists. See above.
24 hour service is too onerous a definition and the definition should be allowed to state that if alternative arrangements have been made with another veterinary business to provide after-hours services they should still constitute provision of 24hrs service whether done by the practice or another that has an arrangement with the practice. This is especially important in some areas where there may be several small clinics that may share the provision of 24hr service between them. To provide for this the practices should have a written agreement that can be provided to the Board if requested. This will therefore deter one clinic just stating that clients should ring another clinic. A Basic form provided by Vet Board should cover this.	The Board disagrees. Veterinary practitioners should describe accurately the level of service they provide. The Public would likely believe that 24 hour service means that a clinic actually provides 24 hour service. Other words (shared service etc) could be used as appropriate.
Part 1: non-veterinarians may not specifically say that they are registered or qualified vets BUT they often profess to be, or induce the belief, that they are vets and are highly qualified. 'Registration' per se, in these cases is of no immediate consideration by the public, so this aspect should be reconsidered. In this way, there is little direct proof of this claim and this practise the same procedures as a vet. i.e. invasive procedures. They also frequently use drugs under this guise. Of course this is illegal under separate legislation BUT section b) suggests this may be investigated too. These non-veterinarians do make diagnoses and recommend or perform treatments, this should be adequately covered. In conclusion: in the past, the Board has not pursued these issues as they do not relate to registered veterinarians, BUT they should have the ability and appropriate consequences for these lay transgressors.	This response is proposing legislative change, rather than Guideline change.

GUIDELINE 1 - STANDARDS OF VETERINARY PREMISES

Feedback	Response
Must also have the ability to sterilise instruments by the use of a functioning autoclave wherever instruments are used for any procedure	Using sterilised instruments would be expected during surgery, but this might be outsourced and is not a requirement of premises.
What you are perhaps better to say is that if full surgical facilities aren't available, then surgery shouldn't be undertaken. I don't have a problem with a consult room being used for surgery in some circumstances.	This is noted but the Board considers the current Guideline is adequate.

Have appropriate ventilation for operation of anaesthetic machines	This is an OHS matter. The words Safety Standards have been added to (g).
Surely there should be more detail about the minimum standards required?	The Guidelines are not intended to cover every possibility, or to be prescriptive.
Why don't the same Guidelines as in 1.3 apply to 1.2 where they are not stated as such?	They do. The Guideline states that *The general standards, which apply to all veterinary premises, must be met.*
in line 3 of 1.3 substitute "as for" for "or" (Line reads: veterinary practitioners must not use the same room for the purpose of surgical procedures)	This suggestion is accepted.

GUIDELINE 2 - STANDARDS OF HOUSE CALL AND ON-SITE SERVICES

Feedback	Response
Anaesthetics: (a) Specifically, the giving of general anaesthetic agents to induce the unconscious state must only be performed in premises where there are adequate facilities, and especially where the practitioner has the ability to resuscitate and perform critical care if the need arises. Anaesthetic machines and intubation are mandatory in the performance of general surgical procedures in companion animals and desirable in large animal practice (b) 2.2 and 2.3 are too vague. E.g. if a practitioner deems it safe to give a general anaesthetic to a small animal in someone's house this is deemed as complying. However if things go wrong and, for example oxygen is needed, it is not a requirement that this is carried. Why: should not oxygen be available every time an animal is anaesthetised? In other countries oxygen and fluid pumps are a requirement of house call practice. (c) I believe the same applies to the previous Guideline. That is: if full surgical and anaesthetic facilities aren't available (including resuscitation and assistance), then surgical or anaesthetic procedures shouldn't be undertaken. I believe that should apply to sedation as well as general anaesthesia, and particularly any surgery. (d) I do not believe that small animal surgery should be performed during a house call. The animal should be transported to a suitable clinic/hospital. (e) They should offer referral to a vet clinic with a surgery routinely.	Provided the risks are explained and accepted, the Board does not prescribe the methods for anaesthesia and surgery.
Is there a right for a veterinary practitioner to refuse to visit a house? E.g. if the person sounded intoxicated or there was any reason to think it would be unsafe. Common sense suggests avoid the situation but is there any legal protection for vets who do?	Yes – this is covered in Guideline 9.

GUIDELINE 3 - STANDARDS OF MOBILE VETERINARY CLINICS

Feedback	Response
Nowhere in any of the above Guidelines are any requirements for suitable housing for animals while at a veterinary premises.	Provided the risks are explained and accepted, the Board does not prescribe the facilities for housing.
Informed consent must include written consent	This is covered in Guideline 8.
Assistance: (a) Trained assistance changed to suitable assistance. Farmers are unlikely to meet a definition of trained but are called upon for cattle crush side surgery's. (b) How many vets in the field have an assistant if an animal is anaesthetised? We do, but I know most other vets in area don't. These need to be way more precise, both in interpretation and action. (c) Does that mean an equine practitioner electing to do a short general anaesthetic to remove a tumour from the body/leg of a horse is no longer able to do so under 'Board wisdom' unless 'a trained assistant is present to monitor the anaesthetic?	The wording has been updated to have appropriate assistance during sterile procedures for the purposes of anaesthetic monitoring and to assist in maintaining sterility.
Resuscitation: (a) Provision of resuscitation for large animals in the field would be difficult and possibly be over-servicing. Perhaps prior offering a referral to such a facilities may be more appropriate. (b) Where general anaesthetics are administered, provide facilities for resuscitation of patients. That's the end of field castration of horses, then. Which is good, because the criterion below has increased the cost by 100-200%? Supervise all animals that have been anaesthetised until they are ambulatory. (c) For routine equine practice, geldings are routinely performed under general anaesthesia without an assistant present. The same case could be made for some stitch-ups - performed in the field under GA without an assistant. Resuscitation of equine patients is not straight forward and, apart from administration of adrenaline, is not practical for field anaesthesia.	Agreed. This requirement has been removed. Provided the risks are explained and accepted, the Board does not prescribe methods of anaesthesia; resuscitation facilities; or anaesthetic/recovery monitoring. This Guideline refers to mobile clinics, not farm animal practice. This has been made clearer in the definition of Mobile Clinic.
Should the guidelines mention anything about ensuring roadworthiness of the vehicle being used?	The Board believes that in general the Guidelines do not need to state that individual laws need to be observed as the general public would expect vets to obey the law.

GUIDELINE 4 - AFTER-HOURS HOSPITALISATION

Feedback	Response
Progress reports: 4.4: Communication should be on a daily basis. At the end of 4.4, I think it is important to state that "and the relevant details be recorded on the patients hospital sheet/records" e.g. time of communication, discussion of costs, summary of phone call. In this way, there can be no argument that this protocol was not followed.	The Board considers that arrangements can be tailored to individual circumstances.
Are vets obliged to provide an alternative clinic for after-hours hospitalisation if they don't provide their own?	No. Veterinary Practitioners must accurately describe the services they do provide.
Minimal Supervision: (a) For rural practices where it is not reasonable/safe nor practical to move critical patients to 24hr care this would say we need to offer something that is obviously not logistically possible then document this fact within the clinical record? I agree with advising the client of the degree of OOH monitoring and care however where the options are extremely limited (e.g. my practice is >3hrs by car from the nearest emergency centre) it is exceedingly rare that any emergency patient is referred for overnight care so that would mean we need to document this every time? (b) 4.2 (c) could include remote monitoring of patients (good IP cameras available for this). (c) 4.2 Minimal supervision - our clinic checks patients' morning and night, schedules further visits as requires by patient condition and during subsequent call outs - this should meet the definition for min supervision. (d) In 4.2(c) remove space between "the" and "hospitalisation"	Veterinary Practitioners must accurately describe the services they do provide. This is adequately covered in the Guidelines. The Board does not prescribe what services must be provided. Refer to the Communication Guideline for further details. Fixed.
Nothing here holds the veterinarian responsible for educating the client as to what may be the most beneficial course for their pet. It is based around what level that clinic offers and cost to client, not necessarily what is needed.	This is covered by the communication Guideline (8) rather than the Hospitalisation Guideline.
Documented informed consent sounds like overkill!!! Any practitioner at all interested in maintaining their good reputation would be well aware of the risks of leaving unattended patients overnight, and would be sure to inform the owners of the risks, the options and costs. What happens if the owner doesn't have access to a fax or scanner and doesn't want to have to return to the practice?? Decisions about hospitalisation are often made at or around closing time over the phone. A number of country and even some outer urban practices don't have access to AFTER HOURS FACILITIES, so documented informed consent would be UNNECCESSARY RED TAPE for them. The way things	Documented simply means recorded in the History – it does not imply that the client needs to sign anything. Informed consent can be verbal. See the communication Guideline (8).

are going, pet owners are going to be lucky to get after hours care in the country with demographic changes and mooted IR changes, so why make it more difficult for the vets who do offer this very important service.	

GUIDELINE 5 - CERTIFICATION

Feedback	Response
Vets Registration Number: (a) It is not currently commonplace (I have never seen it used) for a vet to use their reg board number on certification. (b) Good, especially having the veterinarians registration number	This has been recommended for quite some time and is not a change!
Batch Numbers/Level of detail: (a) Not sure I agree that we need to record vaccine batch numbers on animal clinical record. Agree they should be on vax card but having to include them on individual record seems unnecessarily onerous. (b) I think the degree of documentation for a vaccination record is excessive. The above asks for not only all batch numbers to be provided with the certificate but then also separately recorded in the medical record. Secondly it would be necessary to make are all practitioners are properly advised of these requirement changes if they are considered necessary. (c) Again sounds like overkill. Making some of these records mandatory on a vaccination certificate will add unnecessary complexity for vets; the end result being vets will be less inclined to give out vaccination certificates where they haven't been requested. Putting the name of the temporary owner on a vax certificate is a nuisance; the new owner then will have to cross it out, or get a new card, losing the initial record. Sometimes the Vaccine sticker is damaged or lost so shouldn't be mandatory for it to appear either. A lot of clients don't request or require vaccination certificates, it should be up the practitioner as to what level of information they think is appropriate. (d) I don't think it is necessary to record batch numbers on vaccination certificates that are issued to the client, as long as it is recorded in the animal's clinical record - it is difficult to organize the software to perform this task on computer generated vaccination certificates (impossible on my clinic's software), and difficult to attach the stickers from the vaccine vial on the majority of pre-printed vaccination cards (as they physically do not fit onto the card). (e) The microchip number should be preferred but not essential. This covers cases where it is not recorded on the clinical record and a chip reader is not available or functional. (f) Under 5.1 (c) include microchip no.	Batch Numbers are covered by the current Guideline as it states it is recommended (should), not required (must). Reasonable efforts must be made to record microchip numbers.

(g) In 5.1(c) include reference to microchip no's (if the animal is microchipped).	
Certificates must be prepared in a contemporaneous time frame.	The Board has no objection to practitioners making certificates based on practice records at a later date.
Production Animals: (a) Has the Board considered production animals/ if so how does an ear tag ensure that certificates clearly and accurately identify any animal(s) that is the subject of the certificate, so that there can be no doubt to which animal(s) the certificate applies ?	Yes. The Board understands the issues associated with herd management/identification. The wording has been changed: 1. ensure that certificates clearly and accurately identify, to the extent that it is possible, the animal(s) to which the certificate applies;

GUIDELINE 6 - SUPPLY & USE OF DRUGS & VETERINARY MEDICATIONS

Feedback	Response
Time Frame: (a) I agree with this guideline, especially as it defines a bona fide client to a time frame of 12 months. This area is the most contentious amongst vets, but 12 months is a reasonable timeframe in Victoria (b) I like the specific time frame of 12 months. We have a lot of complaints from farmers when we refuse to provide medication if we haven't seen the stock for more than a year, it is very helpful to be able to show them in writing the guidelines we must follow. (c) I think 12 months for recheck is too long, I think medications should be supplied for up to 6 months and then a check-up is required, this will tie in with the prescribing rules of doctors (d) 6.3.1 putting a 12 month time line on (a) & (b) does not in my opinion satisfy every situation we deal with in mixed practice. Happy with it for equine, companion animals and dairy herds. I think it is unrealistic with beef herds in our area. For e.g. we have numerous beef herds that do not breed. We may only visit them every 3-4 years. They are bona fide clients. They don't use any other vet. They have a history of using us over several decades. They just do not have a high requirement for vets. Under these guidelines if they wanted some orbenin eye ointment to treat a pink eye outbreak in their young stock we would need to visit their property to supply it if they had not had a visit in the last 12 months. These experienced beef farmers would think this is ludicrous and I would tend to agree with them. They can diagnose	The Board agrees that 12 months is a reasonable time frame in Victoria for practitioners to attend herds or flocks. This Guideline is intended to address feedback from practitioners that it is unreasonable to prescribe medications from long distances simply because the farm had been visited at some time in the past. The Board accepts that there may be circumstances where more than 12 months would be reasonable but this would not be the norm. The wording has been changed to: While some conditions will require more regular review, veterinary practitioners cannot **generally** establish therapeutic need if the animal or herd has not been examined by a veterinary practitioner within the previous 12 months.

pink eye. We are aware when outbreaks are occurring in the area so can assess the likelihood that their diagnosis is correct without a visit. There are other examples-minor wire wounds requiring penicillin for example. If we denied access to medications many of these farmers would fail to treat as they will not be able to justify the economics of a veterinary visit. At the vet board roadshow, Mirboo Nth on 22/10/14, the vet board members present acknowledged that bona fide clients may include clients such as the beef clients above that have not had a veterinary visit in the last 12 months. (e) Bona Fide client definition of 12 months is too long and should be shortened. If client has not been seen in 12 months a lot may have changed and as a result I feel that a 6 month period would be more suitable. (f) In relation to establishing a Bona Fide client and Therapeutic Need every 12 months is too infrequent. Should be 6 months. (g) 'The veterinary practitioner has attended the animal(s) within the last 12 months; and 'the particular animals? Or the flock/herd? (h) I believe 12 months is too long, esp with respect to dermatological drugs. Corticosteroids can have serious side effects and continual resupply over 12 months can compromise animal welfare. Clients often request resupply of otic medications when the ears really need evaluation, potential cleaning, cytology+/- culture and a possible medication change. I urge that a bona fide client means seen in last 6 months	
Quantity Supplied: (a) Quantity supplied- it is commonplace and reasonable for vets to supply agricultural businesses with drugs to treat their herd for conditions not always individually prescribed for by a vet. i.e. a client may take a box of intra-mammary antibiotics in anticipation of cows with mastitis. The above states a client may not have drugs on a 'just in case basis'. I feel this part of the document is unclear and implies that the example I have provided would not be appropriate? I feel this needs to be clarified within the document as it would impact large animal practitioners that cannot reasonably visit every individual animal for every condition where there is large herds. A second example might be the provision of anti-anxiety drugs for animals. i.e.: a vet may prescribe valium for dogs with severe storm phobias for the owner to have on hand. It would not be reasonable to expect a client to be able to predict, make an appointment and come in 30 minutes prior to every storm event. The TPS standards state is the amount "reasonable" this is a more useful	Medication cannot be supplied on a “just in case” basis, but can be supplied for ongoing treatment of an “outbreak” or recurring condition. It is a fine line and practitioners should act reasonably. The Board considers the Guideline is sufficient.

statement and more applicable to extensive enterprise. (b) A challenging section for mixed rural practices, but I think this is fairly well covered in this draft. There are going to be times where the rules may be "relaxed" slightly, but ultimately it is the dispensing veterinarian who has to be held accountable for the medications prescribed and the quantity supplied. One area of concern is the supply of sedatives to clients for the purpose of shearing rams. There are vets who are supplying these drugs to contract shearers, and there is no veterinary input after that time to ensure there are no complications associated with the procedure. If the guidelines were strictly adhered to, then the issue of "bona fide" clients should eliminate this situation.	
There should be specific reference to the supply and use of drugs with the potential for performance modification of animals engaged in sporting events.	This is covered in the Rules for various sporting codes and 6.3.10.
Follow up: (a) Could there be further clarification on an "appropriate system for follow up on outcomes"? Does this imply each case needs verbal/phone/consult follow up? (b) In all my years of attending medical doctors I can't recall ever having received follow up to my outcome. Does the Board in all common sense expect it is valid for a vet to follow up every case? If they expect that and doctors are not required why is the Board holding vets up to higher standard? If so how many Board members truly follow up after prescribing and administering a vaccine to a small animal to check that the desired outcome has been achieved? How many cattle practitioners does the Board truly expect to only sell intra-mammarys for only one animal as opposed to a 'box full'? Does the Board really believe there is a high rate of practitioners 'following up' on every animal that an intra-mmamry or 'penicillin for foot rot' is OTC dispensed for? (c) I strongly disagree with mandatory recording of Outcome of treatment/Follow up, although it's not clear if this is being proposed. This would put a considerable extra burden on practitioners to have to chase up owners. It's hard enough to contact owners to report pathology results that they've paid for, yet alone getting them to respond to messages that you've left asking them to respond to response to treatment questions. Good practices see more revisits, which are effectively follow ups, and whilst this is highly desirable and strongly recommended, a lot of owners won't comply.	The Guideline was not intended to require every case to be followed up. The Guideline has been reworded to clarify the Board's intent: There must be an appropriate method for the client to access follow-up care or advice in the event that the expected progress or outcome is not achieved.
In relation to drug storage does the Board truly expect every LA vet to empty their vehicles of all restricted	Yes. The Board expects that restricted drugs would be in locked containers that are not

drugs when the vehicle goes into a garage for servicing particularly equine vets who rarely if ever have separate lockable storage so that the storage guild lines are truly adhered to or is it acceptable that the mechanic has access to restricted drugs?	accessible to unauthorised people.
Online/Pharmacy (a)There needs to be a guideline or clarification around the burgeoning industry of "online" pharmacies and compounding pharmacies. When clients seek prescriptions because of a perceived or real cost saving or because the drug is not available in as a registered veterinary medicine then who is responsible for all the above guidelines including the quality and safety of the drug itself? Is it the prescribing veterinarian or the online pharmacy/compounding pharmacy? (b)How does the above apply to on line veterinary pharmacies selling cheap drugs to my patients? (c) How are online vet pharmacies allowed to operate based on the above - and sell cheaply to my clients?	This is a complex issue of which the Board is aware. The Board will consider this in due course.
Another point needed: - I have established that I am allowed to dispense the drug or medication for this particular use in this particular species. There have been cases where practitioners have dispensed drugs that are fine in companion animals for livestock species and been charged under AVC(CU)A.	Veterinary practitioners must comply with all legislation. This does not require a change to the Guideline.
I think that the 'bona fide client' provisions need to be looked at: at a first glance it looks like a veterinarian cannot vaccinate a dog because it is brought in by the client's mother (who is not responsible for the day to day husbandry) - or cannot treat an animal in an emergency as it is brought in by a friend or stranger?	The Board has changed the wording: Before supplying, prescribing and administering medications, veterinary practitioners must satisfy themselves of the following: (a) the client is a bona fide client; **or the agent of a bona fide client**
6.2 1st paragraph "infection" more appropriate than "infestation" 6.3.5 last paragraph (3), (6) or (7) years????? 6.3.8 replace "properly" with correctly In opening paragraph replace "But" with "However", 6.2 "infection" is more common/appropriate than "infestation" 6.3.5 Is it 3, 6 or 7 years?? 6.3.8 Replace "properly" with "correctly"	Infestation is the word in the AVPMA regulations.

GUIDELINE 7 - EMPLOYMENT OF REGISTERED VETERINARY PRACTITIONERS

Feedback	Response
1. The contents table refers to "Employer/Employee Relations and the Employment of Inexperienced Registered Veterinary Practitioners" and the title of the guideline is "Employment of Registered Veterinary Practitioners". However, the guideline preamble deals	Noted.

exclusively with the relationship between recent graduates and employers, and only indirect mention is made of inexperienced practitioners other than recent graduates elsewhere in the text. The Board may consider making the descriptions of the guideline more consistent with its contents and choose a description relating to supervision of recent graduates. The preamble could mention that the guideline refers equally to other inexperienced practitioners.	
2. With regard to the supervision and support of recent graduates, I suggest that the Guideline makes reference to the Accreditation Standards of the Australian Veterinary Boards Council (AVBC) of February 2015 upon which the VPRBV presumably relies to accredit veterinary schools. The clear implication from the Standards is that the profession is expected to assist recent graduates to achieve competency. This is more than a matter of the employer recognizing the importance of supporting recent graduates as the preamble states. I believe it should be spelled out that it is an obligation of employers to supervise and support recent graduates	Noted.
The problem with Guideline 7 in that context is that nowadays many veterinary practitioners are employed by corporations rather than by Registered Veterinary Practitioners. I would like to be proved incorrect in this interpretation, but it appears to me that the only power the Board has in relation to corporate employers lies in Section 58(A) of the Act – "inciting unprofessional conduct" - and that a corporation cannot be found guilty of engaging in unprofessional practice. An implication of this seems to be that before the Board could take any action against a corporation under 58(A), it would have to determine that the incited conduct in question was in fact unprofessional.	This is covered by legislation – the Guidelines can only refer to vets.
A veterinary graduate should not be registered as a full veterinarian...... they do not have the skills. These have significantly decreased over the last 10 years. As they are fully registered they are eligible to even set up a practice if they wish. How stupid a system is this? Surely you don't believe they are arrogant enough to think that can do most things. They have been led to believe this, but don't have the experience.	This would require legislative change. Vets should only undertake procedures which they have assessed themselves as competent to undertake.
There should be more detail in the above paragraphs relating to the type of support/guidance that should be provided to inexperienced veterinary practitioners e.g. relating to being the sole vet in the practice, afterhours requirements etc.	The Guidelines are not intended to be prescriptive.
How is this to be assessed? By complaints from the employed vet practitioner? Very likely to quit rather than complain and be unable to get a reference etc. Do you conduct audits to determine the state of this guideline?	This is not within the jurisdiction of the Board under current legislation.
7.2 'telephoning the relevant Board's office'. If the Vet is practising in Vic, shouldn't he/she be registered in Vic?	No – under NRVR a different Board may be

Therefore, telephone the VPRBV?	appropriate

GUIDELINE 8 - COMMUNICATION WITH CLIENTS

Feedback	Response
Necropsy: (a) Clients must be provided with the option of accessing an independent Necropsy service, where this is reasonably practical. (b) In the event of an unexplained / unexpected death of an animal while under the care of a veterinary practitioner, the practitioner must advise the owner that a necropsy can be performed. Although I agree in principle in cases of extreme grief this often feels inappropriate in the circumstances. "Must advise" is strong terminology and states that not offering is a breach of professional conduct. This seems difficult to implement in every case. Proper guidance and training on how to implement this would be helpful. (c) In the event that a necropsy is required, an independent veterinary practitioner should carry out the necropsy procedure only if they have the facilities and appropriate skills to do so. Inadequate post mortem investigations are commonplace under these circumstances, where investigations are commonly constrained through limited time, resources and expertise. Often the documentation of the necropsy is exceedingly poor. A guideline for the minimum standards expected for a necropsy done in a practice setting would be useful.	The Board feels the Guideline is satisfactory.
Cultural, ethical, financial options: (a) I personally feel that all clients should be made aware of the option of referral to a specialist for the same procedure or a procedure considered to be of a higher standard or performed with better equipment. Pet owners have the right to be aware of their options and too many general practitioners put their own financial interests in front of what is best for the pet. (b) What does this mean? How does one show consideration of ethical and cultural circumstances? The above implies it is a veterinarian's responsibility to try and factor these into treatments options? I think this is an unnecessary addition to the document. it should be the responsibility of the vet to supply the full range of possible options and ensure the client makes as informed decision but a vet cannot make assumptions about a person's financial, cultural or ethical requirements. (c) Cultural sensitivities should not interfere with primary welfare considerations of the animal.	The option of referral to a specialist is not necessary in all cases. This requires professional judgment. Cultural has been removed.

Production Animals: When a cattle vet sutures a lacerated teat does the Board honestly believe vets are documenting all the options discussed? Risks, costs etc.? I often can't help wonder whether the Board is failing to fully recognise the broad spread of the profession and the variation in an animal's economic/social worth compared to a more homogenous population within the medical profession????? Is the Board too small animal focussed/experienced? Does the Board really expect a vet gelding a pony to go through the full range of surgical options including referral to a specialist centre which has anaesthetic disaster recovery skill/equipment that is not available in the field when called out to a gelding procedure?	No. The Board does not require this documentation (the word should rather than must), and the Guideline states that individual circumstances should be taken into account. Consent can be verbal. The Board acknowledges that the Guidelines do tend to focus on small animal matters, as the Guidelines are generated in response to complaints, and the vast majority of complaints are regarding small animal cases.
8.1 Insert "Many of" 8.1 Insert after Many "of the" (8.1 reads: Many complaints the Board receives arise because of a breakdown in communication)	

GUIDELINE 9 - OBLIGATION TO PROVIDE TREATMENT

Feedback	Response
I believe that "emergency treatment" should be defined in the guidelines as the provision of immediate pain relief which may or may not also include euthanasia.	The Guidelines reflect the wording in POCTA.
I am pleased to see that we have some ability to refuse to perform euthanasia on healthy animals and to refer such requests elsewhere. I think this is important for the mental health of vets and nurses. WE should not be forced to perform euthanasia where other options exist.	Noted.
Currently there is confusion about whether a veterinarian is able to contact an owner of a stray animal or whether they are instead required to contact the local council animal welfare officer. Often this means an animal waits for definitive care rather than emergency care and is transferred to a pound when it still requires ongoing veterinary care. A veterinarian should be able to contact the owner on admission of a stray so that optimal care can be given. Recently the clinic I work in had an owner contact us as their diabetic pet had strayed. We had already sent the animal to the pound as this is the policy the local council is insisting must occur. This is far from an ideal situation which seems to be slanted towards making sure pounds collect fees from the owners of stray animals. This policy is contradicted by the requirement that we are required to contact the owner if we think euthanasia is required.	This is a matter for local laws and legislation rather than these Guidelines.
9.7 is an unreasonable request as a lot of clinics will not have medications on hand to treat a species outside their area of expertise. E.G. An Equine clinic examining	The Guideline states that "Reasonable" measures are required, which covers this situation.

an injured dog or cat cannot nor should not be expected to carry drugs that would alleviate pain in a dog or cat. And indeed it should be written that if outside the normal services of the practice and that the administration of an inappropriate medication from one species to another would constitute negligence then the veterinary surgeon should be required to facilitate the transfer of the injured animal to a practitioner who has the drugs at their disposal to treat the species presented.	
I think the issue here that is not mentioned is the conflict between occupational health and safety and prevention of cruelty to animals' obligations. Increasingly with Hendra in horses and ABLV in bats some vets are refusing to treat horses and bats respectively for the risk of these diseases. Is this issue being looked at? The guideline says a vet can't refuse to provide emergency treatment - if this issue has been considered and this is the outcome then that is fine, but I just wanted to check. Employers are responsible for providing a safe workplace for their vets and staff and this can be challenging with these diseases and others around.	OHS is always a consideration. This Guidelines states that "reasonable efforts" need to be made, and being unsafe is clearly not acceptable.
9.8 'Must make suitable provision' not sure what this means. Notify client of an alternative vet premises? 'Place of business' maybe replace with 'veterinary premises' as 'place of business' has not been referred to before.	Wording changed: All veterinary practitioners, who provide a direct veterinary service to the public, must make suitable provision for their clients to obtain veterinary services when they are unavailable.

GUIDELINE 10 - EUTHANASIA OF ANIMALS

Feedback	Response
Ownership: (a) I would also like to see a definition added that the client is the "legal owner or legal owner's representative" (b)If a dog is presented with a broken leg and the person requested euthanasia does the Board expect the person to go away and come back with a piece of paper to 'prove' ownership? How is the vet expected to know ownership is current? (c) 10.5-there could be a long discussion regarding the definition of "reasonable steps". Some sort of definition would help. Is asking the presenting "owner" whether they are the owner sufficient? Does consent from spouse/parents/children need to be sought in addition (I could tell you about the jilted wife who presented us with her 2 dogs for euthanasia which we performed and then received a phone call from the distraught husband who confirmed she only did it to get back at him!) perhaps for euthanasia our consent forms need multiple persons consent-not just 1? I would think that a consent form should always be completed for euthanasia, not only if the vet has doubts as to the presenting owner's authority. I think if the vet has doubts then they need to do more than get a consent form signed. (unless the euthanasia is required immediately to relieve pain &	Wording changed: Veterinary practitioners may euthanase animals upon a client's request, having satisfied themselves that the client has the authority to make such a request. Asking a client to sign a consent form would suffice in most circumstances.

suffering)	
What are acceptable methods of euthanasia?	The Board does not wish to be prescriptive.

GUIDELINE 11 - VETERINARY MEDICAL RECORDS

Feedback	Response
Provision of records: (a) I believe 11.3 should have an additional clause, that "veterinarians are able to charge the client a reasonable fee for the production of such records", as a request to produce computer medical records , say some 5 years plus after the date, incurs large amounts of administrative time. (b) Are Vets legally required to provide copies of clinical records to the Stewards of HRV or RVL?	This is not in the scope of the Guidelines. This will vary. Vets should comply with legislation.
Quality of records: (a) If a cattle vet is called out to six lame cows in the middle of winter does it truly expect the vet to have recorded ID details for each animal? If so what percentage of vets does the Board believe do so? If a sheep vet examines 20 sheep with foot rot does the Board honestly expect it is valid that the vet record ID details for each animal? If so has the Board become too small animal centric in their perspectives? If a cattle vet attends 10 cows with retained foetal membranes, which can be a serious life threatening disorder, does the Board truly expect cattle vets are recording IDs for each animal? (b) I'm not sure there is a perfect way to prevent human error. WE always try to have detailed records but there are occasions where a record may not be completed at the time due to an emergency etc. I think if the vet has been shown to reasonably record records 99% of the time this should be sufficient. It is just not possible to do it perfectly every time in a bust practice. (c) Medical records should be made contemporaneously. (d) When records are provided, they should be legible - I am still receiving handwritten illegible histories from practitioners when requested. (e) 11.1.3 (f) Provisional and final diagnosis. Sometimes a final diagnosis may not be possible. Better to word 'provisional diagnosis and final diagnosis when/if decided' or words along…	No. The Board expects records to be "reasonable". Again, the words used are should, not must. The Board acknowledges that the Guidelines do tend to focus on small animal matters, as the Guidelines are generated in response to complaints, and the vast majority of complaints are regarding small animal cases. The Guidelines do not cover every possible situation.

GUIDELINE 12 - CAESAREAN SECTIONS

Feedback	Response
All feedback was positive.	

GUIDELINE 13 - CONTINUING PROFESSIONAL DEVELOPMENT

Feedback	Response
CPD should be mandatory/Monitored more, Policed, etc.	This would require legislative change. The general principle is that veterinary practitioners should keep themselves up to date in the area in which they practice, and failing to do this would constitute unprofessional practice in the event of a complaint.
Classification of structured/unstructured: (a) If a denture technician is electronically checked in and out of attending a conference so as to ensure CPD, why has the Board failed to put in place a system that has some degree of credibility? (b) With more corporatisation of the veterinary industry more "in-practice training and instruction" is being delivered. This often takes the form of journal club, morbidity and mortality rounds, practical classes using manikins, and webinars. Presumably webinars would be considered distances learning, however would the other delivery methods classify as structured? Within our organisation they are being run by specialists. I guess some clarity around what constitutes in-practice vs structured under such arrangements would be useful. I think that what we deliver to our employees is world-class training and should not be considered unstructured. (Or is it considered "other professional presentations"?) (c) Is this adequate? Does it cover all veterinarians i.e. those in Government service (award rescinds all other awards) There is a requirement under the award for veterinarians to be given 1 week's study leave / yr but this does not require that it needs to be used for study - either structured or unstructured. 20 hours / year including courses / conferences etc. is, I would say, manifestly inadequate from the public's view of a profession and does nothing to increase the standing of our profession in their eyes. My person view is that it should be 15hrs conference and 45hrs other per year, not triennium. (d) Supervision/training of students.... 2 hours one unit??	This is complex. The Board will consider this in due course.
13.3 Change "claimed" to "undertaken"	

GUIDELINE 14 - REGISTERED SPECIALISTS: SPECIALIST PRACTICE STANDARDS

Feedback	Response
Specialist and referral practices should provide an information board within the public area, which lists all veterinary practitioners working at or from the premises and clearly states their registered status and specialty domain. This seems over the top. All veterinary practitioners who are not registered specialists, who	Non-specialists must ensure that the public are not misled regarding their status. The Board is not prescriptive about this. Note the use of "Should" rather than "Must" in this instance.

accept referral work within any practice, must make it clear to clients or potential clients and referring practitioners that they are not registered specialists. By doing what, specifically?	
Non-referral practitioners: (a) I believe that a referral veterinary practitioner should also be allowed to use the word Consultant to describe themselves. For example, 'Veterinary Consultant in Surgery' or 'Veterinary Surgical Consultant'. The word Consultant does not at all imply the word Specialist, in my opinion (b) As a non-specialist referral practitioner, this section is important to me. Yes, agree on obligation to inform clients that you are not a registered specialist. I do this at every initial consultation and mark record with the letters NSSD, indicating that my non specialist status discussed. Do not agree with title Professional Interest Practitioner. This has a broad implication of hobby or sideline and fails to define many non-specialist referral practitioner who hold externally examined post graduate qualifications but are not eligible for specialist registration. The RCVS (UK) has created "Advanced Practitioner" as a registered status for those non-specialist referral practitioners with approved examined credentials and clinical expertise. I would respectfully submit that non-specialist referral practitioners be permitted to use a title of either - Referral Practitioner (non-specialist) in Veterinary xxxxx - Advanced Practitioner (non-specialist) in Veterinary xxxx.	See previous comments.

GUIDELINE 15 FEEDBACK – RESCINDED GUIDELINE INTER-PRACTITIONER COMMUNICATION

Feedback	Response
All feedback was positive	

GUIDELINE 16 - CONFLICT OF INTEREST FOR REGISTERED VETERINARY PRACTITIONERS

Feedback	Response
Delete 16.2 (c)	This is a standard definition of a conflict, and the Board is of the opinion it should remain.
"To prevent potential conflict of interest, an independent veterinary practitioner should carry out the necropsy." This is an extraordinarily difficult thing to do in equine practice. I think the wording should be less strong.	The use of the word "should" implies that there may well be situations where this is not appropriate. No change required.

GUIDELINE 17 - PROVISION OF SERVICES ACROSS BORDERS AND TO REMOTE CLIENTS

Feedback	Response
This should be replaced by a guideline about online provision of services. Presumably the elements of Total Professional Service cannot be reasonably met, but it should be spelt out clearly.	This is complex. The Board will consider this in due course.
NRVR: (a) Is National Registration in existence, or still works in progress? (b) National recognition of registration should be fast tracked so that it is automatic Australia-wide.	There is no National Registration however, there is some National Recognition. Victoria has enacted legislation so that veterinary practitioners who reside in other states and who are registered there are deemed registered in Victoria. No changes needed for the Guideline.

GUIDELINE 18 - STANDARDS OF BIOSECURITY FOR PROPERTY VISITS

Feedback	Response
Could 18.3 have "other people" defined a little more expansive, as "employees, clients, and other members of the public including vet students and/or work experience students who may be present"	Noted – but “Other People” includes everyone rather than a restricted list.
This seems a little light on given the increasing importance of biosecurity and the important roles vets play in not spreading disease and other biosecurity risks between properties.	Noted Other legislation and agencies regulate biosecurity. (E.g. Livestock Disease Control Act).
Link to the list of notifiable diseases for Victoria.	This is in Legislation, not a Guideline.

GUIDELINE 19 - DIRECTION OR INCITEMENT OF A REGISTERED VETERINARY PRACTITIONER TO COMMIT UNPROFESSIONAL CONDUCT

Feedback	Response
I believe that veterinary employers must provide employees the basic standards and conditions as set out by Fair Work Australia. To not do so, must be regarded as unprofessional conduct. This point should be spelt out to minimise the unfair peer pressure that an employer is able to exert over an employee.	This is covered in other legislation.

OTHER GUIDELINES

Feedback	Response
Online veterinary services: (a) I would like the board to consider a guideline as to the conduct of online veterinary advice services such as www.vetchat.com.au. How do we deal with providers such as this as a profession? Will they be able to prescribe medications without a thorough examination of	This is a complex matter. The Board will consider it in detail in due course.

the animal? Will the disclaimers on their website preclude them from action from the Vetboard, and in what jurisdiction? Where will the consultation be deemed to have taken place? (b) Guidelines for clients requesting scripts for veterinary medications so can buy online. Also clear guidelines for clients wanting scripts for non- vet meds.	
Guidelines applying to corporate entities as well as veterinarians (a) These guidelines set out minimum standards for an individual vet. But an individual vet is rarely responsible for the (for example) equipment in a facility. Traditionally, this presumably would have reflected on the senior vet who is also an owner, and would have been their responsibility to ensure that the quality of the services being offered is satisfactory (eg, laboratory equipment does the job; x-ray and US facilities are fit for purpose, etc.). With increasing numbers of clinics being owned by corporates, who is then responsible for this? If I work at a clinic that offers in-house lab, x-rays, US, etc., but I do not believe the equipment is fit for purpose, who then is responsible if the lab results are inaccurate, or the quality of the radiographs is poor because the radiation source is no longer potent? If a vet has tried to have these things rectified, but due to "budget", cannot get practice owners to buy suitable equipment, who is then responsible? Should such vets just not offer these services to clients until the problems are rectified (and then miss a diagnoses, be forced to refer elsewhere?)? Can be hard in a referral emergency practice! Maybe there is a clear answer that I am not seeing, but perhaps there needs to be some guidelines that practice owners are accountable to (and not an individual practitioner). As an employee (and specialist) within a corporate, I have virtually no say over the equipment with which I am made to practice with - it has all been selected based on profit margin, and against the advice of myself and other specialists within the group. The guidelines do not seem to cover this scenario where the standards of premises and whether equipment is "fit for purpose" should be the responsibility of practice owners (not individual vets). I hope this makes sense (sorry for my long winded comment!	The Guidelines, by their nature, can only apply to veterinary practitioners. There are sections of the Act that apply to corporate entities (eg inciting unprofessional conduct) that are appropriate for this.