VETERINARY PRACTITIONERS REGISTRATION BOARD OF VICTORIA

Board Update May 2016

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President's Message

Dear Colleagues,

I open this Newsletter with a farewell message from members of the 6th Board Ms Janet Cohen, Ms Jenny Wilkins, Mr Alan Gaskell, Dr Michael Doyle, Dr Andrew Gould, and myself. Six new Board members were appointed on 18th March this year and will be introduced in the next edition of the Board Update.

I extend my sincere thanks to ALL past board members and office staff who served through my twelve years on the Board. At risk of leaving others out (I really do appreciate you all enormously) I particularly wish to thank the Registrars Margaret, Sally and Louisa and the Investigation Officers Karen and Danielle who worked during the years I was President. Their support, insight and strength throughout many tough times was absolutely invaluable. Their ability to bounce back and maintain their dignity remains an inspiration.

To the retiring Board – WOW! I don't imagine that it would be possible to be a part of a more highly functional, respectful and cohesive group that was so encouraging and accepting of argument and rigorous debate.

I do not have enough words to express my thanks nor to acknowledge the honour that it was to chair each meeting with you.

I have complete confidence that the 7th Board under the leadership of Assoc. Prof. Peter Mansell with strong support from Deputy President Dr David Beggs & Crown Appointee Dr Tracey Bradley, each of whom served on the 6th Board, will rise to all the challenges and left fielders that will inevitably confront a Board.

In signing off I thank you all for your support and remind you to keep your clinical records complete and to keep your minds open and share your thoughts and concerns with your clients.

I extend my fervent hopes that you never get to meet the Board members in an official capacity.

Warmest regards,

Ros

Appointment to the 7th Veterinary Practitioners Registration Board of Victoria

The Governor in Council under sections 63, 64, 66 and 68 of the *Veterinary Practice Act 1997* has appointed the following persons to the Veterinary Practitioners Registration Board of Victoria from 18 March 2016 to 17 March 2019.

ASSOC. PROF.	PETER	MANSELL	PRESIDENT
DR	DAVID	BEGGS	DEPUTY PRESIDENT
DR	TRACEY	BRADLEY	MEMBER
DR	ANDREW	GIDDY	MEMBER
DR	ALISON	STEWART	MEMBER
DR	RACHEL	PEACOCK	MEMBER
MS	KATHRYN	JOHNS	MEMBER
MS	KERREN	CLARK	MEMBER
MR	OWEN	MAHONEY	MEMBER

The media release regarding the appointment of the 7th Veterinary Practitioners Registration Board of Victoria can be viewed at http://www.premier.vic.gov.au/new-appointments-to-safeguard-animal-welfare/

Registration Renewal 2016

The Registration renewal period will commence on 1 June 2016 and fees are due prior to midnight on 30 June 2016. This renewal period is only applicable to those practitioners who opted for the option of paying for six (6) months registration, rather than the eighteen (18) month option.

Veterinary practitioners are able to renew their registration either online via the *VetConsole* or by downloading the relevant registration renewal application from the website: www.vetboard.vic.gov.au

If, for any reason, you are unable to access the *VetConsole* and complete the online registration renewal, please print out the renewal forms from the website and mail them in.

A late fee will be imposed on any registration renewals that are submitted after 30 June 2016.

Fee Schedule 2016 / 2017

PROVISION	FEE ($)
General Registration	
New General Registration	**470.00**
New General Registration (after 1 January)	**315.00**
Renewal General	**340.00**
Late Renewal General (inc $170 late fee)	**510.00**
Restoration General (< 2 years since registration)	**490.00**
Re-Registration (> 2 years since registration)	**490.00**
Re-Registration (after 1 January)	**325.00**
Other Registration	
Non-Practising Registration	**82.00**
Non-Practising conversion to General Registration	**388.00**
Specific Registration	**470.00**
Specialist Registration	
New Endorsement as a Specialist	**570.00**
New Endorsement as a Specialist under NRVR	**670.00**
Renewal Specialist	**440.00**
Late Renewal Specialist (inc $170 late fee)	**610.00**
Restoration Specialist (< 2 years since previous registration)	**590.00**
Re-Registration (> 2 years since registration)	**590.00**
Re-Registration (after 1 January)	**430.00**
Service Fees	
Fast Track Application Fee	**235.00**
Letters of professional standing	**60.00**
Letters of professional standing (each additional)	**10.00**
Replacement registration certificate	**70.00**
Full copy of Register	**1785.00**
Multiple extracts	**455.00**
Partial copy	**897.50**
Single extracts	**35.00**

AVA Workforce Survey

The AVA veterinary workforce survey is administered every second year to examine the current profile of the veterinary profession and anticipate future trends and changes.

The information is intended to help the profession, government, veterinary boards and others to understand how the provision of veterinary services may be affected by various factors, including increasing or decreasing numbers of veterinary graduates, career breaks, part-time working, early retirement and veterinary practitioners choosing to work outside the profession.

There is obvious benefit to the veterinary profession, government and veterinary boards in the data being as representative as possible and we encourage all registered veterinarians to complete the survey, which can be accessed via the following link:

https://www.surveymonkey.com/r/LBD8N98

Introducing Guideline 20 – Obligation to Report

In its last newsletter the Board discussed the drafting of a new guideline to address registered veterinary practitioners obligation to report potential public safety and/or animal welfare issues to the relevant authority.

Following the publication of the draft guideline and as a result of the valuable feedback received from veterinary practitioners, a revised guideline has been adopted by the Board (below).

If a registered veterinary practitioner is of the reasonable belief that there exists, or potentially exists, a serious risk to the health and safety of the public and/or the health and welfare of an animal, the practitioner should to report the matter to the relevant authority. This responsibility takes precedence over the obligation to maintain client confidentiality.

All of the Board's Guidelines are published on the website.

Submission to amend the Veterinary Practice Act 1997

The Board periodically reviews the *Veterinary Practice Act 1997* (the Act) and makes submissions for amendment where deemed necessary.

The Board has recently provided a submission to the Department of Economic Development, Jobs, Transport and Resources (DEDJTR) for its consideration.

As part of the submission process the Board seeks consultation with practitioners as to their support for the proposal. The Board encourages all practitioners to provide comment and suggestion on the submission.

The submission can be viewed and comment provided at:
https://www.surveymonkey.com/r/vpa16

This is a great opportunity for all practitioners to have a say regarding the legislation that governs their registration as a veterinary practitioner in Victoria.

Research Assistance

Dr John Maxwell is requesting your assistance with a research project being conducted at Murdoch University Veterinary School for a DVetMedSi thesis "Australia's Veterinarians and the Frawley Review of 2003."

As part of the thesis, Dr Maxwell has designed a survey questionnaire that he would like you to complete.

The questionnaire has been accepted by the human Ethics research Committee of Murdoch University (2015/28) and has the following attributes:

1. Comprehensive – it involves all veterinarians.

2. Independent – the survey is conducted for research purposes only; the data is not available for any other use.

3. Anonymous – the data collected is anonymous and does not infringe privacy laws.

4. Analysis – survey monkey automatically analyses the date derived from the survey.

The link to the survey is https://www.surveymonkey.com/r/Vet2016

For further details about the project or if you have any questions please email Dr Maxwell directly at berean@westnet.com.au

Case Study – Dr K

A puppy was presented to Dr K with vomiting and diarrhoea. The puppy was hospitalised overnight, and was found to be deceased the following morning. The owners allege that Dr K did not undertake reasonable diagnostic investigation to ascertain the cause of the puppy's condition, and did not initiate reasonable treatment.

After a preliminary investigation, the matter was referred to an informal hearing into the professional conduct of Dr K. It was alleged that:

1. Dr K's clinical management of the puppy was inadequate.
2. Dr K's communication with the puppy's owners was inadequate.

Dr K was found to have engaged in unprofessional conduct, and the Panel determined that Dr K be counselled.

Counselling is one of the determinations that may be made following a finding of unprofessional conduct. It is a formal process during which the veterinary practitioner is informed of how their conduct failed to meet the minimum required standard and how that standard might be met in future. The Panel may counsel in any way it sees fit. The counselling may be oral, written, given immediately or within 28 days of the determination. It becomes a matter of permanent record on the veterinary practitioner's file and may be referred to in any future Hearing or action taken by the Board.

The Panel made this finding based upon the following reasons.

The puppy was purchased from a pet shop. The owners reported that he seemed subdued when they collected him, which was in contrast to his demeanour when viewed a few days prior to purchase. Upon arrival at their home the owners reported that the puppy developed diarrhoea, which continued over the following day. The puppy was presented to a local veterinary clinic. A clinical examination did not reveal any abnormalities. The puppy was wormed and it was recommended that he be fed bland food until the diarrhoea resolved.

The puppy was re-presented to the clinic later that afternoon as he had begun vomiting and passing bloody diarrhoea. A repeat clinical examination revealed the puppy to be depressed (in comparison to his presentation earlier in the day), with a slightly increased capillary refill time (in comparison to earlier) and tacky mucous membranes. Abdominal palpation elicited severe pain. His body temperature was marginally increased and bloody faeces were evident on the thermometer. A parvovirus test was undertaken; the result of which was negative.

It was recommended that the puppy be hospitalised for intravenous fluid and antibiotic therapy, analgesia, and supportive care. Diagnostic investigation was recommended to determine the cause of the puppy's symptoms, including (but not limited to) faecal analysis to test for parasites (hookworm, etc.), coccidia, giardia, salmonella, campylobacter, coronavirus, etc., and blood testing to check packed cell volume and total protein levels.

Subsequently, the owners phoned the pet shop to advise of the puppy's condition, and the veterinary practitioner's findings and recommendations. The pet shop owner advised the owners that for the pet shop to cover the costs of any veterinary treatment the puppy would need to be treated by their nominated veterinary practitioner, Dr K. Therefore, the puppy was taken directly to Dr K's clinic by his owners. Prior to leaving the local veterinary clinic the puppy was given an injection of Temgesic® to relieve his pain.

Upon presentation at Dr K's clinic the puppy was admitted to hospital. The clinical examination recorded by Dr K did not reveal any abnormalities apart from a depressed demeanour and smelly brown diarrhoea with mucous. According to the clinical record Solvasol®, Onsior® and Cerenia® were administered upon admission. The puppy was checked overnight by Dr K; at 11.00pm when no abnormalities, besides depression, were noted and no treatment was administered. At 3.00am, 20ml of subcutaneous fluid was administered and glucose was rubbed onto his gums. The puppy was found deceased later that morning.

<u>Allegation 1</u>
The Panel had several concerns about the management of the puppy's condition.

Dr K informed the Panel that in his/her opinion the puppy did not seem particularly unwell. According to Dr K he/she did not observe any haemorrhagic diarrhoea or abdominal pain, either at presentation or during the time the puppy was under observation. Dr K reported that he/she was advised by both the puppy's owners and the owner of the pet shop that the puppy was suffering from diarrhoea, and based upon that advice and the results of clinical examination he/she treated the puppy accordingly.

The puppy's owners stated that they informed Dr K that the puppy had been vomiting and suffering from haemorrhagic diarrhoea. The owners say a faecal sample collected at the local clinic was presented to Dr K and the owners claim that this sample was maroon in

colour due to the presence of blood. They also report that at the time of presentation the puppy's bedding and hind legs were soiled with bloody diarrhoea. Dr K denied any knowledge of either a faecal sample or the soiled bedding. The Panel was concerned that Dr K did not seem to take into account the recent history of haemorrhagic diarrhoea and rapid deterioration in the puppy's condition in his/her management of the puppy's care. Even if the puppy was not currently exhibiting signs of haemorrhagic diarrhoea, the Panel considered that the fact that he had been suffering from it only a short time prior to his presentation to Dr K was relevant and should have been a consideration in the management of his condition. The Panel found no evidence to suggest that Dr K was not made aware of the fact that the puppy had been suffering from haemorrhagic diarrhoea and/or the resulting recommendations made for care by the local veterinary clinic. In his/her response to the Board, Dr K states that he/she asked the owners to confirm that "*your vet said he was quite sick*", and when the owners responded in the affirmative he/she replied "*let's keep our fingers crossed that it's not that bad*". The Panel was of the opinion that this conversation supported the owners' claim that they informed Dr K of the history, findings, and recommendations from the original veterinary practitioner.

The clinical examination of the puppy did not take place until after the owners had left. Dr K indicated that his examination did not reveal any abnormalities, apart from a depressed demeanour, which he/she attributed to the recent administration of Temgesic® and some smelly brown diarrhoea with mucous. Based on these signs, Dr K treated the puppy's illness as a simple case of diarrhoea. The puppy was administered antibiotic, antiemetic, and anti-inflammatory injections upon admission. No further treatment was provided until 3.00am the following morning when 20ml of subcutaneous fluid was administered and glucose rubbed onto the gums.

The Panel considered that Dr K's preliminary assessment of the puppy's condition was inadequate. While the owners stated that they discussed the puppy's condition with Dr K, the clinical record states "*no history provided…*" The history is an important and relevant part of any clinical assessment. Without an adequate history the practitioner's assessment will be entirely based upon physical examination; the results of which are specific to a moment in time and may not reflect the clinical picture in its entirety. While Dr K assessed the puppy's condition to be stable, he/she was aware that the puppy had been assessed by another veterinary practitioner only a short time before, and that their assessment was that the puppy's condition was potentially very serious (as evidenced by his/her question to the owners that "*your vet said he was quite sick*"). The Panel considered that knowledge of the recent assessment by another practitioner, which differed quite significantly from his/her own, should have raised questions regarding the puppy's prior history and clinical status, and resulted in Dr K taking measures to obtain a complete clinical history (whether from the owners and/or the other practitioner). This is not to say that a practitioner must treat an animal based upon another's assessment or judgement, only that a thorough history contributes to the clinical management of a case. In this case, the Panel found that Dr K had proceeded without obtaining all possible information with which to make a clinical assessment. Had all possible information been obtained and considered by Dr K, the clinical management and outcome of this case may have been different.

A puppy with diarrhoea (especially haemorrhagic diarrhoea) can deteriorate extremely quickly and death is not an uncommon occurrence in such cases. The Panel considered that Dr K should have been aware of this fact and managed the puppy's case accordingly. The Panel considered that the signs displayed by the puppy (and communicated to Dr K by the owners) indicated a more severe systemic illness than a simple case of diarrhoea, which is

generally self-limiting, and that as such a more proactive diagnostic and therapeutic intervention was warranted. The Panel was unable to reconcile Dr K's assessment of the puppy as being stable and not particularly unwell, with that of the veterinary practitioner who examined the puppy only a short time earlier (<1 hour) to his presentation at Dr K's clinic.

No diagnostic investigation was undertaken by Dr K in an attempt to ascertain the cause of the puppy's symptoms and/or assess the severity of his condition. Dr K notes that external laboratories were shut for the evening; precluding much diagnostic testing. While acknowledging this fact, the Panel considered that given the lack of any signs of improvement in the puppy's condition, some basic in-house testing may have been beneficial to assess the puppy's condition; the results of which may have identified that a change to the management plan was indicated.

While Dr K expressed surprise at the puppy's death, the Panel considered that in such a young animal with limited physiological reserve death was a potential consequence, and it is due to this possibility that the clinical management undertaken in such cases should actively support physiological maintenance and recovery.

Dr K informed the Panel that as a result of this incident he/she no longer admitted pet shop animals to hospital without conducting a clinical examination with the owners present.

Allegation 2

The Panel found that Dr K did not take reasonable steps to obtain a thorough history of the puppy's symptoms and prior clinical assessment, and that (as documented above) this resulted in a clinical management plan which was formulated without all available and relevant information.

As Dr K did not perform a clinical examination on the puppy until after the owners had left the clinic, the examination findings, options for treatment, and recommendations were not communicated to them. Dr K stated that it was his/her opinion that in leaving the animal in the care of the clinic, the owners were consenting to whatever treatment he/she deemed necessary.

The Panel considered that there were several treatment options available to address the puppy's condition, and these options should have been presented to the owners with details of the associated prognosis, potential complications, and consequences in order for them to make an informed decision in regards to the puppy's ongoing care. The Panel further considered that options for overnight hospitalisation should also have been communicated to the owners. There is no evidence to suggest that the owners were made aware of the level of overnight supervision which would be provided by Dr K, or of other options for overnight care if they were not agreeable to the level of supervision offered at Dr K's clinic, such as referral to a 24-hour clinic (for which the owners would have borne the cost).

In conclusion, the Panel was of the opinion that an animal presented to the clinic under the pet shop warranty should not be treated any differently to that of a normal, client-owned patient. The same obligations for clinical assessment, communication of findings with options for care and standard of clinical management exist regardless of the fact that veterinary service is being provided subject to warranty.

Specialist Endorsement

Congratulations to the following veterinary practitioners who have recently received specialist endorsement.

V4926	DR	LEAH	BRADBURY	VETERINARY ANAESTHESIOLOGY
V8143	DR	ELIZABETH	BROWNE	VETERINARY ANATOMICAL PATHOLOGY
V4387	DR	PHILIPPA	MCLAREN	VETERINARY CLINICAL PATHOLOGY
V4949	DR	GARETH	TROPE	VETERINARY SURGERY EQUINE
V8554	DR	ANDREW	WORTH	VETERINARY SURGERY SMALL ANIMAL
V6018	DR	CLINTON	YUDELMAN	VETERINARY MEDICINE SMALL ANIMAL

Celebrating 50 years veterinary registration in Victoria

Congratulations to the following veterinary practitioners who have held 50 years of veterinary registration in Victoria.

V500	DR	JOHN	BRYDEN
V501	DR	PETER	CARBONELL
V502	DR	ROGER	CLARKE
V510	DR	ALAN	HART
V525	DR	LYNDAL	SCOTT
V498	DR	GORDON	STEWART
V506	DR	BARBARA	WELLINGTON
V532	DR	RONALD	WELLS

Removal from the Register

Please note that the following veterinary practitioners have been removed from the register in accordance with section 12(3) of the *Veterinary Practice Act 1997*.

V5637	DR	VERITY	AMBLER
V8372	DR	JASPREET	ASSI
V5272	DR	LINDA	BRADBURY
V8303	DR	ALLIE	BROWN
V8038	DR	BIDINA	CHOO
V5356	DR	LEIGH	DE CLIFFORD
V5402	DR	NOEL	DONG
V1023	DR	JANE	FORDYCE
V8206	DR	SAMUEL	IVES
V8131	DR	LAURIE	JOHNSON
V8111	DR	LAY HONG	KEK
V2082	DR	ANTHONY	NELLIGAN
V6222	DR	NICOLAAS	PRETORIUS
V8387	DR	SUSAN	SALTER
V1279	DR	GRAEME	SMITH
V6349	DR	BIKRAM	SOHI
V8357	DR	KEEWOONG	SOHN
V8339	DR	MATTHEW	SWARBRICK
V6280	DR	THOMAS	THORNTON
V8402	DR	KAREN	VON DOLLEN

From the Department of Economic Development, Jobs, Transport And Resources (DEDJTR).

Bairnsdale Ulcer

Possums with skin ulcers and scabs can have *Mycobacterium ulcerans* (Bairnsdale or Buruli Ulcer) infections. These can occur in Melbourne including the Bellarine and Mornington peninsulas and the bacteria can cause skin lesions and disease in people.

Differential diagnoses include: traumatic skin ulcers, other mycobacterial and infectious skin ulcers, mites, etc.

Please consider potential zoonotic risks and wildlife animal welfare (duration of treatment required) if you suspect Bairnsdale ulcer. There may be risks of treated animals developing antibiotic resistant Mycobacterium infections (this is only a suggestion, there is possibly no data to support this) which could have public health consequences.

PCR and biopsy/histopathology are probably the best way to make a clinical diagnosis, but these take time (and money).

This infection is an example of why it is important that wildlife are only released in the area they were found.

There is information on the Victorian Department of Health and Human Services website:

https://www2.health.vic.gov.au/about/news-and-events/healthalerts/mycobacterium-ulcerans-Bairnsdale-or-Buruli-Ulcer-18-March-2015

https://www.betterhealth.vic.gov.au/health/healthyliving/bairnsdale-ulcer

The method of transmission to people is not known, but probably involves skin damage. The bacteria are also found in animal feces.

There is also information on the Wildlife Health Australia fact sheet website:

https://wildlifehealthaustralia.com.au/Portals/0/Documents/FactSheets/Mycobacterium%20ulcerans%2029%20Dec%202010%20(2.0).pdf

Please contact Pam Whiteley, Wildlife Health Surveillance Victoria, Faculty of Veterinary and Agricultural Sciences, The University of Melbourne, Werribee, pamw@unimelb.edu.au 0400 119 301 if you wish to discuss this. We are very keen to investigate suspect cases in euthanased animals including pathology and PCR to test for M.ulcerans infections.

Rabbit Haemorrhagic Disease

Veterinary practitioners who consult on rabbits (intensive farms and pets) may be interested in recent developments with Rabbit Haemorrhagic Disease virus (RHDV) as a rabbit bio-control agent. While this is not a risk to human health and is not a notifiable livestock disease, there is potential for the proposed release of RHDV(K5) and the new presence of RHDV2 to impact on pet rabbits and/or the rabbit meat industry in Victoria. It is uncertain how RHDV2 arrived into the Australian environment, and its release has not been sanctioned by either State or Federal Governments. RHDV2 was originally evaluated as a

potential agent for release in Australia but was considered less attractive due to the potential of the the virus to infect non-target species (European Hares in Australia).

During November 2015 wild rabbits from Kerang and Kilmore tested positive for RHDV2, a pet rabbit from the Wangaratta and small rabbit farm at Manangatang. The current vaccine (Cylap RCD Vaccine for Rabbits, Zoetis Australia Pty Ltd) for calcivirus is not fully protective against disease caused by RHDV2. Veterinary practitioners are directed to the Invasive Animals PestSmart website for further information and advice on vaccination.

http://www.pestsmart.org.au/the-arrival-of-rhdv2-in-australia-and-implications-for-current-rabbit-biocontrol-initiatives/

Australian Bat Lyssavirus

Victorian practitioners should note the recent confirmation in NSW of Australian Bat Lyssavirus (ABLV) in one adult and three juvenile grey-headed flying foxes rescued from a Central Coast flying fox roost on 9 November 2015. The bats were found amongst numerous dead juvenile flying foxes under the roost. The adult was showing neurological signs that were initially assumed to be related to a head injury, and it died the next day. The three juveniles were estimated to be 3 to 4 weeks old and ate well and grew until around 23 November when they began to show nervous system signs. One died and one was euthanased on 26 November and the third died on 27 November. The NSW Health Department through local Public Health Units have assessed over 100 people who may have had contact with the infected bats. To date, nineteen people, some with significant exposures, have been provided with post exposure treatment.

ABLV can occur in Victoria, and has been confirmed on 10 occasions in bats since 1995. We have grey flying foxes here in abundance and other Victorian bats are susceptible. More detail is available from the Wildlife Health Australia website.
https://www.wildlifehealthaustralia.com.au/Portals/0/Documents/ProgramProjects/ABLV%20BATSTATS%20Jun%202015.pdf

The following lessons have been identified from the NSW experience:

1. Always use Personal Protective Equipment1 when handling bats even if they appear healthy (Refer to the AVA Guidelines for veterinary personal biosecurity)
2. Any person handling bats should be vaccinated against rabies.
3. **DO NOT** allow bats of any age, whether healthy or sick to be handled or touched by children or other people who do not have a current rabies vaccination.
4. Beware of the exposure of pets to bats.

Wildlife Victoria will coordinate the response to reports of sick, injured or orphaned bats by experienced volunteers (ph 1300 094 535), the Department of Health and Human Services Communicable Diseases Unit can advise on human exposure (ph 1300 651 160) and my office will manage outbreaks where animals are affected on land managed by DEDJTR and provide technical information and support for disease investigations comes from this department (**DEDJTR Customer Service Centre** Phone: 136 186 or **Emergency Animal Disease Hotline:** 1800 675 888).