

BVA response to RCVS review of ‘under care’ and 24/7 emergency cover

Who we are

- 1) The British Veterinary Association (BVA) is the national representative body for the veterinary profession in the United Kingdom. With over 18,000 members, our primary aim is to represent, support and champion the interests of the United Kingdom’s veterinary profession. We therefore take a keen interest in all issues affecting the profession, including animal health, animal welfare, public health, regulatory issues and employment matters.

Introduction

- 2) We welcome this opportunity to respond to the RCVS review of ‘under care’ and 24/7 emergency cover, which we understand represents the third and final stage of the RCVS consultation process. However, we are extremely disappointed with the scope of the consultation and proposals which represent a missed opportunity to develop guidance which is fit for purpose. The limitations of the online survey have made it impossible to respond adequately through that route as there are key considerations which do not fit within that framework – as such we are submitting a written response.
- 3) In response to ongoing discussions within RCVS relating to under care, telemedicine, and remote prescribing over a number of years, we convened a working group in early 2020 to develop our position. Following a programme of six meetings, and utilising evidence gathered from the professions and other key stakeholders, we published ‘[Under care and the remote provision of veterinary services](#)’, which was shared with RCVS with a view to informing the development of RCVS proposals.
- 4) Our position states that the RCVS interpretation of ‘under care’ should go beyond the act of prescribing, such that it more accurately captures the relationship between vets, clients, and their animals, and the shared responsibilities within this relationship for safeguarding welfare. 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. The VCPR is central to how vets work and internationally recognised^{1,2,3}.
- 5) We consider that a VCPR cannot be established solely by remote means, but once established a VCPR should enable access to remote veterinary service provision, subject to veterinary professional judgement. We are also clear that 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 would otherwise be compromised.

Our position includes 37 recommendations relating to:

- The definition of ‘under care’ and international models
- Shared responsibility for animal health and welfare
- The concept of a vet-client-patient relationship (VCPR)
- Continuity of care
- Limited-service providers

¹ <https://www.avma.org/resources-tools/avma-policies/principles-veterinary-medical-ethics-avma>

² <https://www.canadianveterinarians.net/valid-vcpr>

³ <https://www.ava.com.au/library-resources/other-resources/prescribing-guidelines/client-relationship-and-understanding/>

- Remote veterinary service provision
 - Remote prescribing
 - Animal health telemetry data
 - Technology and innovation, including veterinary leadership, and regulation of technological tools and devices
 - Emergency care
- 6) During 2021 RCVS announced a series of extensions to remote prescribing, which had initially been permitted as a temporary measure in response to the COVID-19 pandemic. Having repeatedly raised concerns with RCVS about these extensions, we grew increasingly concerned that the temporary guidance was being allowed to become part of a new normal and was also creating an expectation amongst clients which would be problematic to pull back from. Our position on under care and the remote provision of veterinary services states:

“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.”

- 7) By autumn 2021, as government restrictions had largely been lifted, we asked for sight of the evidence base on which RCVS was continuing to allow remote prescribing, including the impact on prescribing behaviours, and the proposed exit strategy. At the time, as far as we were aware, RCVS was still assessing the findings from the RAND survey⁴ as part of the under care review, and as those results were yet to be shared it was unclear how the continual extensions to remote prescribing would dovetail with longer term plans and potential changes to the RCVS Code of Professional Conduct.
- 8) The remote prescribing dispensation ended 28 October 2021. It was subsequently reintroduced in December 2021, with additional pressures on practices caused by COVID-19 and the threat of the Omicron variant cited as the rationale, and was finally withdrawn on 14 March 2022. During this time, and subsequently, we have made a number of informal requests for transparency.
- 9) We note that legal advice obtained by RCVS and summarised by Fenella Morris QC, states that the words “clinical assessment” should be interpreted so as to include both in-person and remote clinical assessment, and assume that this underpins the perceived need for change and the resulting proposed changes to the guidance. We would like to better understand the rationale of the College for apparently choosing to amend guidance to fit with this one legal interpretation, instead of going back to first principles by considering what is an appropriate definition of under care. Once the definition is agreed, if necessary, a corresponding amendment to sub-paragraph 4(1) of Schedule 3 of the Veterinary Medicines Regulations (VMRs) 2013 should be sought. Given that the Veterinary Medicines Directorate (VMD) have been clear that a review of the VMRs is underway, we are concerned that this is a missed opportunity to lobby for an amendment which is fit for purpose and recognises the VCPR.

Questions on under care

A: Factors that might determine whether a physical examination is required

- 10) Under the proposed guidance, whether or not to carry out a physical examination is a matter for the vet’s judgement, save for some notable exceptions detailed in the consultation. In order to assist vets, the proposed guidance sets out a number of factors that might be relevant in deciding whether a physical examination is required as part of a clinical assessment:

- a) The health condition, or potential health condition, being treated and any associated risks

⁴ <https://www.rcvs.org.uk/document-library/rcvs-under-care-and-247-emergency-care-review--rand-europe-2022/>

- b) The nature of the medication being prescribed, including any possible side effects
 - c) When the animal (or premises in the case of agricultural animals) was last physically examined by a vet
 - d) Whether there is access to the animal's previous clinical history
 - e) The experience and reliability of the animal owner
 - f) Whether the animal is known to the vet and/or whether there is an existing relationship with the client or animal owner
 - g) The practicality of a physical examination for individual animals, particularly when dealing with herds, flocks, or groups of animals
 - h) The health status of the herd, flock, or group of animals
 - i) The overall state of the animal's health
 - j) The impact of any prescription made without physical exam on the ability to gather subsequent diagnostic information
- 11)** We strongly support the principle that whether or not to carry out a physical examination is a matter for the vet's judgement, in the context of an established VCPR. Notable examples of circumstances where a vet may choose not to carry out a physical examination include veterinary inspection of epidemiological units (eg 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 an aggressive dog or zoo animal). However, in these circumstances the vet is present with the animal or animals, is able to observe them, and an assessment is made in the context of their environment and husbandry.
- 12)** We also consider that remote assessment (also known as remote triage) has a valuable role to play in the provision of veterinary services where 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. However, we do not consider that remote assessment constitutes a veterinary clinical examination or veterinary inspection and therefore it should not result in diagnosis or prescription of veterinary medicines.
- 13)** 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.
- 14)** 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 when needed.
- 15)** We are disappointed that the first two sentences of paragraph 4 are not being consulted on (i.e. "*Whether or not a physical examination is necessary is a matter for the veterinary surgeon's judgement. The following factors are relevant in this respect, however veterinary surgeons should note this list is not exhaustive*"). The proposal fails to recognise the existing and emerging range of veterinary business models and current absence of mandatory practice regulation, which in turn could see employee vets under pressure from employers, and potentially clients, to prescribe without physical examination. Further, the scope for misunderstanding, miscommunication and therefore client confusion and complaint will grow exponentially if remote prescribing is conducted outside a VCPR, particularly where clinical notes are not shared between prescribing vets. Leaving the decision on physical examination to the judgement of individual vets is unlikely to be strong enough guidance and will fundamentally change the landscape of the veterinary profession in a way that is a threat to animal health and welfare, and the ability of veterinary professionals to safeguard their work.
- 16)** Factors a-j, drafted by RCVS to support the proposed paragraph 4, assume acceptance of the opinion that the absence of a physical examination would not preclude remote prescribing. There is also no clear

recognition of the role of the VCPR, making it difficult to comment definitively on the appropriateness of the proposed factors. In line with our position, we would strongly support all of the proposed factors a-j as wholly appropriate considerations prior to remote prescribing under an established VCPR, but in the absence of an established VCPR specific concerns include:

- 4a) In many consultations the health conditions or potential health conditions are often not known until physical examination is completed.
- 4b) Again, in many cases it will not be known what medicines should be prescribed until after a physical examination.
- 4c) It should not be left entirely as a matter for the veterinary surgeon's judgement as to whether a physical examination is ever needed at all. However, we do support this paragraph as far as it relates to the establishment of a VCPR.
- 4d) This seems to suggest that it is a matter for a veterinary surgeon's judgement whether or not they should seek an animal's previous history. That appears to be contrary to the intent of RCVS Supporting Guidance 5, Communication between professional colleagues.
- 4e) It is never possible to be entirely sure about the experience and reliability of an owner, but it is far more likely to be achieved in-person than through a remote clinical assessment. This is one of the arguments for considering that a VCPR cannot be established solely by remote means.

17) We support the inclusion of paragraph 5 of the proposed guidance which states that the more complex or unusual the health needs of the animal, or where a differential diagnosis includes serious conditions not yet ruled out, the more likely a physical examination will be necessary.

B: Exceptions to the rule

18) We support the inclusion of paragraph 6 of the proposed guidance which states that a physical examination is required where a notifiable disease is suspected or part of a differential diagnosis.

19) We cannot support the inclusion of paragraph 7 (a) of the proposed guidance which states that a physical examination is required in all but exceptional circumstances where a veterinary surgeon prescribes antimicrobials for an individual animal or group of animals that are not agricultural animals, as it is unclear whether this means in the context of an established VCPR. 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.

20) We support the proposed paragraph 7(b) to the extent that it states that when prescribing antimicrobials for agricultural animals, veterinary surgeons should ensure they have an in-depth knowledge of the premises, including its production systems, the environment, disease challenges and the general health status of the herd or flock. We agree that this can only have been achieved by a veterinary surgeon attending the premises and physically examining at least one animal per epidemiological unit immediately prior to prescribing or, where this is not possible, recently enough to ensure they have adequate information and knowledge to prescribe responsibly. It is unclear whether the remainder of the proposed paragraph (*Veterinary surgeons should be prepared to justify their decision in cases where antimicrobials are prescribed without conducting a physical examination and record this justification in the clinical notes*) means in the context of an established VCPR, which we consider represents the only opportunity for remote prescribing.

21) We cannot support the proposed paragraph 8 which requires a physical examination in all but exceptional circumstances when prescribing controlled drugs. As already stated, some categories of POM-Vs should

never be prescribed remotely even in the presence of a VCPR, including some Schedule 2 and 3 controlled drugs. Safeguarding responsible prescribing of parasiticides should also be a key consideration.

C: 24/7 follow up service

- 22)** We cannot support the proposal that where a physical examination is not carried out immediately prior to prescribing, vets should ensure that a 24/7 follow-up service is available as it is not clear whether this means that prescribing is taking place within an established VCPR. In the context of a VCPR we could support this proposal, where the follow-up service is contracted.
- 23)** 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. “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. 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. 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.

D: General obligations

- 24)** 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. 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”.
- 25)** 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.

E: Limited-service providers

- 26)** We broadly support the proposed guidance on limited-service providers, which recognises other types of limited-service providers and imposes a general obligation to provide out-of-hours emergency care that is proportionate to the service offered. However, it should be recognised that all types of practice are in some way ‘limited’ (eg by species or by discipline) and the obligation to provide proportionate out-of-hours emergency care already applies to all – in that respect singling out certain types of practice as ‘limited’ may not be helpful or necessary.
- 27)** 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. 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.

F: Advice only services

28) We support the proposal to retain the current guidance that vets offering advice-only services are not obliged to provide 24-hour emergency cover, providing that advice is limited to generic information only, does not diagnose or prescribe, and makes an onward referral to physical veterinary services as required.

G: Referral practice

29) We support the proposal to retain the current guidance for vets working in referral practices that they should provide 24-hour emergency availability in all of their disciplines, or by prior arrangement direct referring vets to an alternative source of appropriate assistance. We also support the proposal not to change the guidance which requires referral practices to make arrangements to provide advice to the referring vet on a 24-hour basis and that appropriate post-operative or inpatient care should be provided.

Conclusion

30) In conclusion, we consider that the RCVS proposals represent a missed opportunity to develop guidance which is fit for purpose, safeguards and benefits animal health and welfare and public health, and recognises and defines the concept of the VCPR. In particular, we cannot support the RCVS proposals in Section A (Factors that might determine whether a physical examination is required) and Section B (Exceptions to the rule) as they seem to be underpinned by a single legal interpretation, instead of going back to first principles by considering what is an appropriate definition of under care.

31) We consider that the proposal to leave the need for physical assessment to the judgement of the vet fails to recognise different and emerging business models, fails to adequately protect employee vets, and will inevitably lead to confusion, complaints, and animal welfare harms, which could exacerbate the recruitment and retention issues which already exist.

32) We urge RCVS to reconsider the proposals and take this opportunity to recognise and define the VCPR, which represents the only appropriate opportunity for remote prescribing of POM-Vs and POM-VPSs.