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vetregister

The Newsletter of the Veterinary Surgeons Board of Queensland

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Telephone:
+617 3087 8777

Facsimile:
+617 3087 8144

Email:
vsbqld@daff.qld.gov.au

Website:
www.vsb.qld.gov.au

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Board Membership

Nominated Members:
Dr Robert Cassidy
Chairperson

Professor Glen Coleman
Deputy Chairperson

Dr Edith Hampson
Specialist (Veterinary Ophthalmology)

Ms Ann Barry
Consumer Representative

Elected Members:
Assoc Prof Philip Moses
Specialist (Surgery-Small Animal)

Dr David Lovell
Equine Practitioner

Registry Staff:
Valerie Mustafay, Registrar
Cassie Wright, Deputy Registrar
Lillian Dunn, Project Officer

Have your say...
Veterinary Surgeons Act 1936 to be reviewed

The Minister for Agriculture, Fisheries and Forestry, the Honourable John McVeigh has appointed a steering group, comprising Associate Professor Robert Hedlefs (chair), Dr Robert Cassidy (DAFF), and Associate Professor Phil Moses, Dr David Lovell and Dr Edith Hampson (Veterinary Surgeons Board) to review the *Veterinary Surgeons Act 1936*.

The Terms of Reference include that the review clarify the purpose of the Act; evaluate requirements and restrictions and identify where red tape and regulation can be reduced; review the current system of registration and supervision against other professional registration legislation; review other aspects of the practice of veterinary science; and recommend improvements to the legislation.

The review will include consideration of the prohibition on non-veterinarians practising veterinary science for fee or reward and whether the restriction is justified, its relationship with animal welfare legislation, whether the Act should acknowledge the role of veterinary technologists and nurses, the regulation of allied and complementary animal health service providers (e.g. animal physiotherapists and chiropractors) and current exceptions for specified acts of animal husbandry and dentistry.

All interested parties will have the opportunity to provide input into the review when an issues paper is publicly released in mid 2013. A final report recommending improvements to the legislation is expected to be provided to the Minister by the end of 2013.

If you wish to register your organization's interest in the review to receive further information as it progresses, please subscribe here http://www.vision6.com.au/em/forms/subscribe.php?db=368059&s=91943&a=10433&k=8b85f38

Changes to Board membership

The Board wishes to express its gratitude to **Dr Laurie Dowling, Professor Jonathan Hill** and **Mrs Glenda Whitmore** for their service on the Board.

Dr Dowling served as Chair of the Board for 3 years and was the Board's first female Chairperson. The Board acknowledges Dr Dowling's productive leadership and passion for animal welfare and for the profession.

Prof Hill served for 4 years as Deputy Chair and more recently as Acting Chair of the Board. The Board acknowledges Professor Hill's extensive experience in veterinary science and veterinary education and his valuable contribution to the Board's effectiveness.

Mrs Whitmore served as the consumer representative on the Board for 10 years. The Board appreciates the collegial but firm manner in which Mrs Whitmore presented her arguments and viewpoints and values her contribution to the changes in some of the Board's perceptions and approaches to deliberations.

Left to Right: Prof Jonathan Hill, Deputy Registrar Cassie Wright, Dr David Lovell, Mrs Glenda Whitmore, Dr Edith Hampson, Assoc Prof Philip Moses, Registrar Valerie Mustafay

Welcome to the Board's new Ministerial nominees

The Board welcomes the following members:

Dr Robert Cassidy, Chair
Professor Glen Coleman, Deputy Chair
Ms Ann Barry, Consumer Representative

Triennial Election Results

The triennial election of elective members of the Board was held on **28 June 2013**.

The Board congratulates A/Prof Philip Moses and Dr David Lovell for being re-elected by their peers to represent them on the Board.

A/Prof Moses and Dr Lovell will each serve a 3 year term.

I wish to thank the candidates for nominating and contesting the election and to registrants for voting.

Valerie Mustafay
Returning Officer

Tracheal trauma can result from poor technique or ill fitting tubes.

Use of endotracheal intubation for general anaesthesia in cats

A contribution from Helen Keates, Lecturer, University of Queensland

Respiratory depression is associated with most of the anaesthetic agents in use. Therefore:

- All anaesthetized patients benefit from supplemental oxygen delivered by appropriately fitted mask by connection via an endotracheal tube to a breathing circuit (eg T-piece, circle absorber). This is one of the reasons that many veterinarians elect to use inhalation agents delivered in a high concentration of oxygen to maintain anaesthesia.
- It is advisable to be prepared to deliver positive pressure ventilation to any anaesthetized patient. For most patients, this means securing the airway by placing an endotracheal tube. Ventilation using a mask is not usually appropriate.

Endotracheal intubation is not without risk, especially in those species prone to laryngospasm, eg domestic cat:

- Attempts at intubation can precipitate laryngospasm and subsequent life-threatening obstruction of the airway.
- Stimulation of the upper airway can result in an elevation of vagal tone and resulting precipitation of cardiac arrest.
- Tracheal trauma can result from poor technique or ill fitting tubes.

To decrease the likelihood of laryngospasm, the veterinarian can administer a short acting muscle paralyzing agent, eg suxamethonium. This is not without risk, apnoea may result and endotracheal intubation then MUST be successful. Suxamethonium causes bradychardia in cats. This method is rarely used.

Commonly, veterinarians use topical local anaesthetic agents (eg lignocaine) sprayed onto the arytenoids coupled with inducing a deeper plane of anaesthesia than would be used for intubation of say, a dog. There are risks associated with these procedures. Firstly, local anaesthetic applied as a spray onto the arytenoids usually cause some reflex constriction of the glottis which can result in total obstruction, ie the spray can precipitate laryngospasm. Secondly, deep anaesthesia is associated with cardiovascular and respiratory depression.

At the University of Queensland Small Animal Teaching Hospital, most cats presented for anaesthesia are intubated. The exception would be cats anaesthetized for very minor procedures such as castration when the risks associated with intubation would be considered to outweigh the risks of having an unprotected airway for the few minutes required for surgery. All cats having abdominal surgery, eg spay, are intubated and anaesthesia is maintained with an inhalation agent delivered in a high concentration of oxygen. As outlined above, the reasons for this are airway protection, facilitation of intermittent positive pressure ventilation (should this be necessary) and provision of a high inspired concentration of oxygen.

In my opinion, a patient undergoing abdominal surgery should be intubated. I would qualify this statement by suggesting that if veterinarians not skilled in intubation of cats were forced to do so, patient morbidity or morality could result. My understanding is that some veterinarians rarely intubate cats and this may suggest lack of the development of this particular skill.

"My understanding is that some veterinarians rarely intubate cats and this may suggest lack of the development of this particular skill."

Case Study

A dog was taken to a practice for desexing. The following day the dog was taken on a lead by a vet nurse to a grassed area outside the practice for toileting. The dog was frightened by something and escaped.

The practice made numerous attempts to find the dog however the dog was not found.

The owner lodged a formal complaint with the Veterinary Surgeons Board.

While the Board found that in this case the veterinarian in charge of the case was not personally negligent under the Act, it warns that safeguards need to be put in place to ensure patients are confined at all times.

Premises standard 33 requires that *exercise facilities are of a size and design adequate for the number and nature of animals that might reasonably be expected to be accommodated.*

Where existing premises do not have a secure area for this purpose, the Board strongly recommends that animals taken outside of the approved premises for exercise or toileting are done so at your risk.

The Board recommends that you seek express approval from an owner prior to taking their animal outside the premises. This requirement can be easily incorporated into the animal's admission form.

Premises standard 7— *Safeguards including self-closing devices on doors to prevent the escape of patients brought into the premises and to ensure the effective confinement of animals at all times.*

QUESTIONS & ANSWERS

REFERRALS

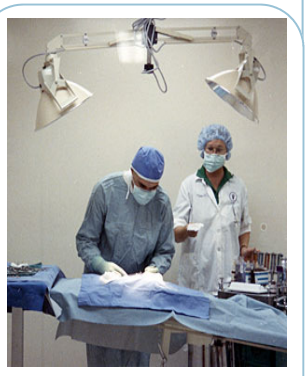
Email from GP: Q: We are updating the general practice protocol about small animal referrals. Does the VSB have a policy statement or similar that defines which patients or conditions should be referred?

A. This is not straightforward and requires consideration of a broad variety of factors that require detailed consultation with the client. The Board has been presented with cases where the primary veterinarian clearly misinterpreted an animal's condition whilst in the veterinarian's care. The veterinarians in these cases failed to recognise clinical signs (e.g. vomiting, tachychardia, elevated body temperature, high PCV, extended CRT) as being representative of an acutely ill animal and in some cases left the animal unattended with only basic supportive care.

The veterinarians in these cases failed to initiate appropriate diagnostic process such as blood testing, x-rays, ultrasound, **or referral** to determine an appropriate course of treatment.

The Board recommends that a referral option always be given in complex medical or surgical cases, and that the offer given, if declined, should be noted in the case records.

A vet should also never undertake unsupervised surgery without previous proven experience in the procedure. The requisite competency to conduct a procedure or manage a medical case is arguably more essential than having state of the art range of equipment.



Surgical procedures should not be undertaken unless competency is achieved through previous experience or if performed under supervision.

MEDICATIONS CONTINUED AFTER REFERRAL

Email from specialist: Q. If a patient is referred to us and we see and treat the patient then is the referring vet able to dispense medication for that dog on our advice? Referring vets have said that they cannot dispense a drug despite the animal being seen by them recently.

A. The policy invoked is that a veterinary surgeon may not repeatedly dispense scheduled medication for an animal under the vets care without examining the animal on at least 6 monthly intervals. The interval between examinations can extend to 12 months for production animals, where it is sufficient to have a personal knowledge of the health status of the herd/group.

If an animal is treated at a specialist practice and is discharged under continuing medication, nothing prevents the referring GP from dispensing a scheduled drug on the advice of the treating specialist. The rule of thumb however still applies, ie the animal must be examined either by the specialist or the GP at a minimum of 6 month intervals whilst continuing medical treatment for that specific ailment.

Small animals must be examined at 6 month intervals for dispensing repeat medications and 12 months for large animals

CATHETERISATION

Email from GP: Q. I am writing to the Board with a query re the Board's stance on the shaving or otherwise of dog and cat legs before catheterisation for intravenous fluids and injections. I would like to know where we stand if a client requests that we do not shave a leg before IV fluids.

Would the Board see this as a negligent act if an infection occurred in the leg?

A. The Board's opinion is that the merits of catheterisation would vary for each and every individual case and any owner request that the area not be shaved should be assessed on its own merits.

The clinical protocol in any practice should be to shave the area of catheterisation and any request not to do so should be met with a full explanation to the client of the potential for adverse consequences. Signed client consent should be sought in all cases where the client wishes to proceed against the recommendation of the clinician.

SCHEDULE 8 DRUGS

Q. Does the Schedule 8 register have to be signed at the time the Schedule 8 medication is used?

A. Yes and it has to be the veterinarian who initials the entry.

Q. Can a veterinary nurse administer Schedule 8 medications under a veterinary surgeon's supervision?

A. A veterinary nurse must not administer a S8 medication in any situation. A veterinary surgeon may place a S8 medication in an intravenous drip bag to allow medication for an extended period when the veterinary surgeon is absent.

Q. If I take a Schedule 8 medication on a farm visit do I need a safe bolted into my vehicle?

A. No. You can keep the S8 medication in a doctor's bag or on your person and return it to the safe on your return to the practice.

Are you about to employ a vet?

Have you checked whether they are currently registered to practice? You can conduct a search on the VSB website: http://www.vsb.qld.gov.au/search.html or call the Registry on 07 3087 8777 during business hours.

New Specialist Training Programs

Are now included on the list of recognised specialist training programs: http://www.avbc.asn.au/Media/Default/Website%20Documents/Documents/ACRVS%20InfoBooklet%20Jan%202013%20-%20AUS.pdf

Equine Medicine—Diplomate of the European College of Equine Internal Medicine (ECEIM); and

Veterinary Ophthalmology—Diplomate of the European College of Veterinary Ophthalmologists (ECVO)

Have you provided/updated your emergency contact detail for disease alert?

89.5% of registrants have recorded their emergency contact details on the Register of Veterinary Surgeons. You can record or update your details by:

providing this detail on the Notification of Details Form enclosed with your registration renewal notice;

completing the Change of Particulars Form on the Board website http://www.vsb.qld.gov.au/forms/Change-of-particulars-on-register-form.pdf

Email – vsbqld@daff.qld.gov.au; or

Telephone – +617 3087 8777

New diseases do occur

You may be looking at the first case

EXOTIC DISEASE WATCH HOTLINE

89.5%

USEFUL LINKS

Exotic disease bulletin http://www.daff.gov.au/animal-plant-health/pests-diseases-weeds/animal/ead-bulletin

Re-vaccination intervals—cats and dogs www.apvma.gov.au/use_safely/vaccination.php

AVA Code of practice for Management of Hygiene and Infection control for Veterinarians www.avacms.eseries.hengesystems.com.au

AVA Workforce Survey 2013 http://ava.informz.net/survistapro/s.asp?id=2134

Hendra Virus Personal Protective Equipment (PPE) Rebate Scheme The Queensland Government has allocated $1 million over four years to help frontline veterinarians in their fight against Hendra virus through the Hendra virus Personal Protective Equipment (PPE) Rebate Scheme. The rebate promotes the use of PPE and minimise the risk of exposure to Hendra virus by offsetting the purchase price of PPE.

Two separate rebates are available for eligible equine veterinarians:

(a) Start-up rebate—rebate for initial purchase of prescribed PPE for an eligible veterinary surgeon ($250). An applicant can receive only one Start-up rebate. The applicant must have purchased PPE on or after 24 March 2012 and provide proof of purchase.

(b) Replenishment rebate—rebate for purchase of prescribed PPE payable after an approved test of a suspected Hendra virus infection sample has been submitted by the veterinarian ($250 for each test completed). Only one Replenishment rebate can be paid in relation to an approved test.

To apply for the rebate, download an application form from the QRAA website www.qraa.qld.gov.au or call 1800 623 946

Case Study—Leaving an animal unattended

A dog was presented to a practice after the owner was concerned as the dog was coughing blood.

The treating veterinarian determined the dog was in a critical state noting the dog's condition in the patient history records as being cyanotic.

The veterinarian's differential diagnosis was pulmonary embolism and unidentified toxicity. The vet advised the owner that the prognosis was poor and that the dog could die if stressed from further handling. The veterinarian recommended the dog be hospitalised and monitored. The vet administered Dexamethasone.

After several hours the owner was concerned about the management of the case and decided to transfer the dog to an emergency centre.

On arrival at the emergency centre, the dog was examined and diagnostic tests confirmed the dog had been bitten by a brown snake. The dog was treated accordingly and survived.

The initial treating vet was found guilty of professional misconduct in that he/she was negligent in the practice of his/her profession.

During the misconduct hearing the vet advised the Board that he didn't expect the dog to survive. He did not undertaken diagnostics as he believe this would stress the dog and expedite it's demise.

The Board found that the vet did not conduct a diagnostic workup of the dog or initiate referral; nor did the vet provide the basic necessary first aid for the dog's condition including administering fluid therapy or pack cell volume and total protein.

The Board also found that the vet failed to keep adequate records of treatment including vital signs and monitoring.

The Board advises that a veterinary surgeon is required to keep a full and complete record for each animal treated as prescribed in Section 25 of the Veterinary Surgeons Regulation 2002.

As an extension of the Regulation, the Board has nominated the components of model clinical records. These were published in the September 2011 newsletter http://www.vsb.qld.gov.au/VetRegister/2011-September-newsletter.pdf