

## A Blend of Science and Art

### What every shelter should know about shelter medicine

BY LILA MILLER, D.V.M.

A colleague recently provided me with an article describing a shelter parvo outbreak that led to the euthanasia of several cats and dogs and the closure of the shelter's adoption program for several days. Those quoted in the piece included a veterinarian who criticized the decision and suggested that the shelter could have exercised better options.

The article then described how another shelter in the same community had dealt with a disease outbreak very differently, with no euthanasia and only a short cessation of adoptions.

A close read, however, revealed that the first shelter, an overcrowded open-admission facility, had minimal resources and had already filled its small isolation ward. Furthermore, private veterinarians had advised the shelter to euthanize to prevent the spread of disease into the community.

The second shelter, on the other hand, had sufficient resources to send some of the exposed animals to foster care and to isolate and treat the remaining ones.

It would seem that the revelation of the differing circumstances would mitigate the damage to the reputation of the overburdened shelter, but in such situations, this is seldom the case. Not everyone reads the news with attention to detail and nuance. Too often, the shelter stands condemned.

Should it? Maybe. But maybe not. I imagine some shelters have never dealt with full-blown disease outbreaks, but I'm guessing that most shelter workers have had to at some point. They can be real heartbreakers, filled with second-guessing, guilt, and recriminations. I was working in the ASPCA shelter when canine parvovirus first surfaced in the late '70s. While it was difficult to euthanize the animals who already had diarrhea without knowing whether they had parvo or not, it

was devastating when we finally decided to euthanize the exposed and in-contact (but not yet sick) animals to try to save as many lives as possible.

Many shelters these days are dealing with canine influenza and other new or unfamiliar problems. Shelters with different resources will have different responses, and we should be careful not to pass judgment without all the facts. When faced with actual scenarios like the ones I've described, how do we offer an effective and constructive analysis rather than condemnation and rebuke? Each one of these situations should be taken as an opportunity to learn rather than just criticize.

Let's look at several points. They may seem obvious to some, but I think they bear repetition because failure to appreciate these concepts leads to ill will and misunderstandings that undermine the effectiveness of the overall program.

#### **Shelter medicine is still a new field, with more questions than answers.**

Enormous strides have been made in shelter medicine in the last 10 years, but it is still a young specialty. There are still many unanswered questions about the elements of a comprehensive disease control program; we do not yet know everything we need to about disease transmission, shelter design, the impact of stress, sanitation protocols, nutrition, and so on. Our knowledge is growing so quickly that some of the recommendations I made fairly recently are no longer valid.

Shelter medicine, like most fields of medicine, is a blend of science and art. Innovative research gives us new information, old research sometimes gives us forgotten but valid data, new diseases appear, and old diseases yield some new surprises. I know now from research that the quaternary ammonium products commonly used to disinfect shel-



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ters don't inactivate parvovirus or the *Microsporium canis* spores that spread ringworm. It came as a surprise to discover that the old calicivirus that causes a common "kitty cold" is more resistant to routine disinfection than originally believed, and it can also result in a new sudden death syndrome in cats who've been previously vaccinated. Coccidia is more prevalent than previously believed, *tritrichomonas fetus* is a relatively new pathogen responsible for diarrhea in kittens, and many of our traditional therapies are no longer as effective as they once were. I shudder to think about how many cats are euthanized unnecessarily for feline infectious peritonitis (FIP) because of erroneous information or faulty test interpretation.

Just keeping up with all the information that affects the practice of veterinary medicine in shelters, let alone finding time to implement the changes the information warrants, can be a full-time job. Science gives us the necessary information, but



way is to exclude the shelter veterinarian from the process and simply present her with the decision after the fact.

**But remember that even the experts disagree!** Most of us believe (or at least hope) that when experts evaluate the same set of data, they will reach the same conclusion. Unfortunately, that is not always the case, particularly with shelter medicine. Here are a couple of examples.

In my reading of several respected textbooks, I found three different opinions regarding the length of time that parvovirus could be shed from the body after infection. This is important data because recommendations for quarantine and isolation periods will vary depending on this timeframe.

Disagreements over the effect of vaccination on parvo testing also linger, and although we seem to be finally reaching a consensus, many veterinarians are still debating over how often to vaccinate companion animals. And protocols developed for the private practitioner are often not effective in shelters.

Disagreements over recommended protocols may be due to a lack of evidence or any number of other reasons, including philosophical differences, conflicting study results, varied interpretations of the same results, and failure to consider all the circumstances. Regardless of the final outcome, all parties should be treated with respect when good-faith recommendations based on the latest data are made. There are only a few experts in shelter medicine as yet, but the field has grown substantially: Large institutions such as Cornell University, Colorado State University, Ohio State University, the University of California at Davis, the University of Illinois, the University of Pennsylvania, and the University of Wisconsin have shelter medicine programs or residencies or employ infectious disease experts willing to help shelters.

Turning to a column on shelter medicine, many of you would probably prefer to read about parvovirus or canine influenza, and may think this was an overly simplistic or unnecessary discussion of management or communication concerns

rather than shelter medicine issues. But shelter medicine cannot be separated from shelter management. Every shelter veterinarian I approached for feedback on this topic felt there was an urgent need for this column.

Here is a typical letter from a shelter veterinarian: "I am new in shelter medicine and have had my own treatment protocols undermined by the staff and volunteers. They have been used to the shelter manager running things and making decisions about medication or not medicating. Then I came along and change is involved. That change is hard for staff, ergo, a lot of back-talk, resistance, and confusion is happening as we speak. I am going to have a meeting with the manager and really try to open the channel of communication. It is definitely a communication issue for this shelter."

When I talk to shelter veterinarians about their dissatisfaction and their reasons for contemplating leaving the field, the most common complaint I hear is not the low salary, the high euthanasia rate, or the lack of resources. It is lack of respect from shelter staff. Shelter veterinarians complain that their expertise is ignored in favor of measures proposed by less qualified veterinarians, long-term employees, board members, and volunteers. Of course, there are two sides to every story. Shelter workers complain that veterinarians give bad advice, don't appreciate the years of experience of the workers, or don't understand their particular situation or mission.

This all has the potential to undermine the effort to promote shelter medicine as a rewarding and viable career option, an outcome that would in turn threaten future progress in advancing the medical and behavioral care of shelter animals. I hope every shelter struggling with its shelter medicine program or veterinarian will make an honest assessment of programs and attitudes and see if any of the points made here apply. I also hope every veterinarian working with a shelter will do the same. We must find better ways to work together, respect each other's expertise, and understand the limitations we all face. Failure to do so will only hurt the animals in the long run, and that would be a tragedy. AS

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