

# WEST COAST VETERINARIAN

MARCH 2021 | Nº 42

## SHELTER MEDICINE

A COACH APPROACH  
TO LEADERSHIP

OTITIS IN  
SENIOR PETS

PACEMAKERS

SHELTER NOISE  
IMPACTS

LEARNED FEAR  
OF MEDICATION  
ADMINISTRATION

THE VETERINARIAN-  
CLIENT-PATIENT  
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SPRING FLYER  
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**COREY VAN'T HAAFF**  
EDITOR

» **TO THE EDITOR**

Letters from members are welcome. They may be edited for length and clarity. Email us at [wcveditor@gmail.com](mailto:wcveditor@gmail.com).

» **ON THE COVER**

A kitten at the BC SPCA West Kootenay Community Animal Centre in Castlegar. Photo courtesy BC SPCA.



**PLEASE WELCOME NAFONI MODI**

Nafoni Modi has joined Corey Van't Haaff and Adriana Silva on the Chapter's staff to meet the growing needs of members and to further enhance our value to members. Nafoni will rely on her recent experience as a co-op student planning and implementing training for communities focused on mental health and traditional wellness to work on new Chapter projects. She will also assist with our CE sessions and some communications materials. Nafoni is in her final year of a Health Science degree, and she is interested in public health so was drawn to work with the Chapter, where she could make a difference to the lives of people and animals. She is the owner of a five-month-old puppy named Bear. [WCV](#)

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**WCV**  
MARCH 2021

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1. Kirkby Shaw, K, et al. Vet Med Sci. 2016;2:3-9. 2. Rausch-Derra L, et al. Am J Vet Res. 2015;76(10):853-859.

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have had trouble composing this report as there is so much to mention but most of it swirls around a tiny virus that I would like to ignore for now.

I'm sure that like me, you want to get away from hearing or reading the C... 19 word. I am going to focus on an important issue and promise that I will not mention the you-know-what again.

Before I go any further, I want to thank you all for your efforts over the last year to keep providing the care and attention our animals and their guardians need. We have all had to make changes and adaptations, and the mental stress of dealing with work and family issues has taken its toll. I am proud of our profession as we have continued to provide our essential services despite all the hardship. If you are feeling overwhelmed, please seek out help. We are here to do the best we can to assist you. We all need to help each other.

This time, I want to focus on the Western College of Veterinary Medicine. This is our veterinary school. Many practising veterinarians in BC attended WCV. How many of you are aware of its history? Because of restrictions on getting out of our house, my wife started to go through our boxes of books in the attic and came across the book *WCV: The First Decade and More* by Christopher H. Bigland. I had completely forgotten about it but opened the cover to find a history of our profession in Western Canada.

In looking at the history, it was interesting to see that the first discussions for a veterinary school in Western Canada started in 1929, but the Depression quickly took care of that idea. In 1944, the need for more veterinarians started to be discussed by the prairie universities based on livestock numbers. In 1955, the livestock industry started applying pressure to the government, but the universities told them to recruit from OVC. In 1957, university agriculture departments were still telling students to go to OVC. The reason that nobody in the university realm or provincial governments was interested was the cost. By November of 1957, the Canadian Cattlemen's Association and editorials in newspapers were increasing the pressure. The ABVMA lobbied both their provincial government and the federal government and after changes in ministers were able to get some action. By October in 1962, the Western provincial ministers of agriculture had recommended the establishment of a veterinary college only to have Premier Manning of Alberta make a comment that put a damper on the idea. However, by the next year, the new minister of agriculture for the federal government had agreed to pay 25 per cent of the cost of the project, and the department of Agriculture in Saskatchewan gave the University of Saskatchewan one million dollars toward the cost of building a veterinary college, provided the rest of the provinces shared in the operating costs. On August 23, 1963, a committee consisting of deans of agriculture of the four western province universities and chaired by the dean of the

University of Washington Veterinary College decided that the college should be in Saskatoon instead of at the University of Alberta in Edmonton, as they could build a centre that could hold the teaching and hospital facilities in one place and be located near the agriculture facilities as well as being close to the departments of medicine and science. By August 29, the president of the University of Saskatchewan had started the search for faculty.

It was agreed that the government of Saskatchewan with the help of the federal government would cover the capital costs, and the four provinces would divide the operating costs between them. The first estimate by the government of Saskatchewan was \$2,500,000 but this ended at \$8,200,000 for the first phase. Fortunately, the federal government increased their grant from \$625,000 in 1963 to \$3,300,000 to get the first phase completed. In 1973, the second phase became necessary but was not able to get started until 1979 and ended up costing \$12,000,000, an increase of \$5,000,000 over initial expectations.

Why is the history important? In reading about how the college came into being, there are many reminders about the attitudes we are currently dealing with in making sure we maintain our veterinary college and expand its production of veterinarians. Unfortunately, convincing governments to understand our needs is not easy. Politicians are under pressure from a variety of needs. Unfortunately, the operating funds for a veterinary college are the highest of any college or department at any university. As Dr. Bigland's book points out, this is because a veterinary college must maintain extensive facilities for teaching and research, include a large and small animal hospital, an ambulatory clinic, and animal quarters. Veterinary colleges also have a comparatively low student-teacher ratio so that they can teach clinical subjects in specialized areas. This is in contrast to human medicine where the province or other agencies provide the hospital and clinical teaching facilities at little or no cost to the college of medicine.

We are fortunate to have our government sign an interprovincial agreement with Saskatchewan and Manitoba to provide for the continuation of WCV. But the agreement falls short of providing coverage for more seats to BC. To offset the loss of financial support from Alberta, the WCV has had to put the seats formerly allocated to Albertan students up for sale to both Canadian and foreign students. In the class of 2024, 16 BC students opted to pay the substantial extra tuition. Your Board is concerned that finances should not prevent good students from training for our profession. We are concerned about the student debt that will occur after four years of veterinary training over and above the student debt there could be for pre-veterinary university.

We are determined to keep lobbying the government to understand the needs of our province. We are asking for more seats, which would be far less expensive than building a veterinary college in our province (extrapolate the capital costs to current costs based on the Saskatoon costs 40 years ago). We may call on you for your support—please stay tuned.

Thanks for your support of the SBCV. Please take care of yourselves, your fellow workers, and your families. 



*Al Longair, BSc, DVM, graduated from the Western College of Veterinary Medicine in 1977. After graduation, he joined a mixed animal practice in Duncan, focusing on small animal practice from 1981 on. He has been involved with the BC SPCA for over 20 years, serving as the president of his local branch for 12 years and on the provincial management committee for 10 years, with four years as president. In the early 1990s, he served as chair of the CVMA Animal Welfare*

*Committee. He lives on a small acreage with his wife, three horses, three dogs, and two cats and coaches youth soccer in his spare time.*

**A**s your CVMA president, it's my pleasure to provide you with updates on some of the CVMA's initiatives.

#### INTRODUCING SAVI: THE STEWARDSHIP OF ANTIMICROBIALS BY VETERINARIANS INITIATIVE

As animal health and welfare leaders and public health partners, veterinarians must work together to effectively oversee animal antimicrobial use. SAVI, conceived and guided by veterinarians, recognizes that our veterinary community plays a leadership role in antimicrobial use oversight in animals. SAVI provides new knowledge and tools for veterinarians in support of antimicrobial stewardship. The SAVI team invites you to stay connected as the initiative develops over the coming months. Visit [savi.vet](http://savi.vet) to learn more about SAVI, the people involved, and resources available.

#### CVMA COUNCIL APPROVED A REVISED POSITION STATEMENT ON HUMANE SLAUGHTER OF FARM ANIMALS

The CVMA holds that when farmed animals are slaughtered for food, the methods employed must minimize fear, pain, distress, and suffering, and they must result in immediate death or rapid loss of consciousness that persists until the time of death. The CVMA takes the position that effective stunning should always be used before slaughter. The CVMA also holds that all stakeholders have a responsibility to minimize suffering associated with slaughter without stunning. Visit the Policy and Advocacy section of the CVMA website to read the full position statement.

#### AFRICAN SWINE FEVER

African swine fever (ASF) is very contagious and is killing pigs and wild boars in Africa, Asia, and parts of Europe. The CVMA has collaborated with the Canadian Food Inspection Agency (CFIA) and other stakeholders to share information to prevent ASF from infecting the Canadian pig herd. Veterinarians have an important role to play in educating owners about the disease and current disease risks, reviewing clinic and client biosecurity protocols, providing guidance on biosecurity measures to protect swine health, and identifying and reporting suspected cases of ASF. The CFIA, in partnership with the CVMA, developed a webinar series on ASF in three parts: "Part 1: Disease Overview and Recognition," "Part 2: Disease Response," and "Part 3: Prevention and Preparedness." Access the webinars and more information at [canadianveterinarians.net/practice-economics/asf](http://canadianveterinarians.net/practice-economics/asf).

#### MARCH IS NATIONAL TICK AWARENESS MONTH

March is National Tick Awareness Month, a client education initiative introduced in 2016 by the CVMA in partnership with Merck Animal Health. Thanks to the enthusiastic Canadian veterinary community, a growing number of pet owners across the country are now aware of tick exposure risks in early spring and are taking measures to protect their pets and families. The veterinary community may not be able to stop tick expansion, but there is a great deal we can do to help change public perceptions and behaviours when it comes to tick control. The 2021 Tick Awareness Month theme is, "Could ticks be there? Be aware!" Visit the CVMA website before March to access the resources, graphics, and tools you can use to educate your clients, and for information about our March 1 webinar.

#### CVMA'S DEDICATED COVID-19 WEB PAGE

The CVMA continuously works with provincial veterinary medical associations, regulatory bodies, and federal agencies to bring veterinarians up-to-date information to protect their clients, teams, and families. Visit the CVMA's dedicated COVID-19 web page ([canadianveterinarians.net/coronavirus-covid-19](http://canadianveterinarians.net/coronavirus-covid-19)) for information, resources, and webinars. 



*Enid Stiles, BSc, MSc, DVM, completed a BSc in Biology at the University of Ottawa before graduating with her DVM from the Ontario Veterinary College in 2000. Upon graduation and while working as a clinician, she went on to complete a master's in Clinical Sciences (Behaviour Medicine) at the*

*University of Montreal. Dr. Stiles has been fortunate to work with people and animals around the world as a founding member of Veterinarians without Borders Canada. She works closely with Montreal-based cat and dog rescue groups and has been a regular presence in print, television, radio, and social media in recent years, advocating for current national and international animal health issues. Her interest in veterinary behaviour medicine and animal welfare includes ending feline partial digital amputation (declawing) and teaching low-stress handling techniques in clinics. Dr. Stiles runs her own small animal practice, Sherwood Park Animal Hospital, with her husband Yannick Massicotte as co-owner and hospital manager. Dr. Stiles lives in Montreal with three children, a dog, two cats, and her husband. When she's not working, Dr. Stiles likes to go to the gym, ski, travel, and watch her children on the field or rink.*



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Minimally invasive procedures are some of my very favourites, and I think the patients prefer them too!



Sherisse Sakals DVM, DACVS

Following her graduation from Western College of Veterinary Medicine in 2006, Dr. Sherisse Sakals completed a small animal internship in Saskatoon. She then transferred to Colorado where she completed a surgery internship.

In 2013 after completing her surgical residency at the University of Georgia, she became board certified in small animal surgery. Dr. Sakals then returned to Saskatoon, joining the small animal surgery faculty.

Recently, Dr. Sakals has been working as a locum surgeon at various specialty practices in BC and Alberta and at the University of Saskatchewan.

Dr. Sakals has particular interests in minimally invasive surgery for both soft tissue and orthopedic procedures including thoracoscopy, laparoscopy, arthroscopy, and minimally invasive plate osteosynthesis.

Outside of work, Dr. Sakals enjoys travelling, veterinary work abroad, running, and surfing.

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## IN MEMORIAM

**DR. BRIAN CHRISTOPHER DANKS**  
1943–2020

It is with great sadness that we announce the passing of Dr. Brian Christopher Danks.

He was born in Bristol, England, and immigrated to South Africa with his parents while still a baby. He attended elementary school in Johannesburg, South Africa. When he was 12 years old, he moved with his parents to Bulawayo, Rhodesia (Zimbabwe), where he attended high school. Brian was awarded a Rhodesian government scholarship to attend the Royal (Dick) School of Veterinary Studies in Edinburgh, Scotland, from which he graduated with a five-year Bachelor of Veterinary Medicine and Surgery (BVM&S). Brian met his wife Roma at Edinburgh University where she was a student in Education, and they immigrated to Rhodesia in 1967 after completing their studies. Brian initially worked as a government veterinarian in large animal practice, travelling around farms and the Rhodesian bush. After three years, he joined a small animal practice in Salisbury (Harare). Their only daughter, Fiona, was

born in 1974. In 1979 they immigrated to Vancouver, Canada, where Brian was offered a job and sponsored to come to Canada by Dr. Rex Mears (Dunbar Veterinary Clinic, Vancouver). Rex and Bea, his wife, were extraordinarily kind to Brian and his family and made their transition to North America so much easier. Brian worked at Dunbar for three years. In 1982, Brian opened his own small animal practice at Kennedy Heights Animal Hospital where he worked until the early 1990s. After this time, he sold the clinic and worked for a number of years as a locum in the Lower Mainland and beyond.

He was a fixture at both the Dewdney and Newton Animal Hospitals where his warmth, kindness, and expertise made him a centre point to staff and clients alike.

Brian was working almost full time, aged 77, until spring 2020 when due to COVID-19 he had temporarily stopped. He was looking forward to 2021 and resuming the veterinary work and surgery that he so loved. In total, Brian was a dedicated veterinarian and expert surgeon for 53 years; he never stopped learning, applying new knowledge, and wanting to improve his skills.

Brian is survived by his daughter, Fiona (Cambridge, England), and his ex-wife, Roma.

*Provided by Dr. Adrian Walton.*

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# INSIGHTS

## ON REMOTE LEARNING FROM THE VETERINARY STUDENT LEADERSHIP SUMMIT

BY MADISON AUDEAU

This spring marks the end of the most unconventional academic year on record at the veterinary college. Over the last two semesters, students have been completing the majority of the coursework online from the comfort of our own homes. We've also seen a necessary, though unfortunate, reduction in extracurricular labs and other opportunities to practise hands-on skills outside of the college. In a recent international survey of veterinary students, 96.7 per cent of participants believe that the pandemic has affected their academic performance to some degree. The issues students most commonly reported struggling with included lack of effective communication and interaction, lack of application in a clinical setting, loss of motivation and interest, and lack of contact with animals.<sup>1</sup>

A veterinary education includes subjects that are practical by nature and therefore tough to recreate in a virtual setting. The teaching staff has worked hard this year to compensate, and thankfully we did still enjoy blocks of in-person lab time with smaller groups of students. Although there's something to be said for going through the bulk of the material without other students and faculty around, students with social learning styles may miss opportunities to bounce ideas off classmates and ask questions in real time, and kinesthetic learners may struggle to pick up practical skills without active participation and plenty of chances to practice manual tasks.

The approach to exams has changed too. Our cohort of students has spent our whole academic careers writing closed-book exams with HB pencils in hushed lecture theatres. This year, we were thrown into a world where exams are conducted at home, and many have been open book. With adjustments made to study regimens to reflect that, concerns have bubbled up that information may not be sinking in the same way. It's been a totally different mode of learning. Will we remember all of this once we enter practice? How confident will we feel as new grads? How confident will our employers be in us? Are we still going to be good veterinarians? Among my friends anyway, impostor syndrome has run rampant.

As this unique academic year winds down, I thought I'd use my space here to reiterate some insights from speakers at last fall's inaugural Veterinary Student Leadership Summit (VLS). The conference was largely focused on entrepreneurship, though many speakers had smart advice for

navigating some of these pandemic-related concerns as students and new grads alike.

Author and media personality Dr. Andy Roark offered reassurance to students who may feel uneasy about their knowledge base after completing a large portion of veterinary school online. "The self-awareness of not knowing all the things is a good thing. The scary ones are the people who think they do know everything. Being realistic in your assessment of yourself will make you a good veterinarian."

In response to a student question about speaking to clients on topics you may not feel well versed in, Dr. Roark encouraged students to "Position yourself as being on the same team as the owner in solving the problem instead of presenting yourself as an expert. Don't try to convince people you're a genius. That doesn't service anyone." He encouraged new grads to have reasons at the ready, even if it's just to look at something under *better lighting* in the back, to excuse yourself and thumb through a textbook quickly if you feel like you need to. We needn't be too hard on ourselves, especially now.

Having a solid theoretical foundation is undoubtedly part of what makes a good veterinarian, but Dr. Roark stressed to students that it's also about people skills. "Some of the smartest vets I know are way less effective than the veterinarians that are not that smart but are good with people. They listen to people and they care, so getting the right answer is not the most important part of being a veterinarian . . . You can look up the answers to questions, but you can't look up how to get clients to trust you."

Similarly, Dr. Peter Weinstein, executive director for the Southern California Veterinary Medical Association, encouraged new grads to lean on the expertise of those around them. "Don't try to be



**"VET SCHOOL ISN'T A SPRINT; IT'S A MARATHON. IT'S PROBABLY A TRIATHLON..."**

everything to everybody. I hated surgery, so I hired an associate that really likes surgery. You don't have to be a jack of all trades," he reminded everyone. "Play to your strengths and become great at something. Surround yourself with a successful team and learn good communication skills . . . Your network determines your net worth."

It's been a chaotic year of online classes, but Dr. Weinstein insists that the light is bright at the end of the tunnel. "Vet school isn't a sprint; it's a marathon. It's probably a triathlon, and you're dealing with it in a current viral pandemic. You might feel that the road in front of you is pretty rocky, but you've got to start to envision the road and see where you're trying to head. Keep focused and keep your eye on the prize." However, Dr. Roark encouraged us not to put off enjoying our veterinary careers until graduation. "The true meaning of life is enjoying the work itself, and that can start now. Try to enjoy learning. Enjoy the work as you do it." He suggested letting yourself enjoy the challenges instead of just trying to get through to the end of the day. The same is also true for practice. "If a day goes by so quickly that you don't realize it's lunchtime—that's a good thing! Lots of people wish they had that level of engagement at their jobs."

Last year, as first-year students, many of my classmates and I dipped our toes into virtual learning, using things like 3D modelling programs to help wrap our heads around anatomy. There is certainly evidence that such tools enhance student learning in the medical sciences.<sup>2</sup> Then, all at once, the COVID-19 pandemic pushed us into the deep end of virtual education. Some insist that not only is the water fine, but they're also excited about what these new technologies mean for the future of our veterinary colleges and the profession.

Dr. James Lloyd, former dean of the University of Florida College of Veterinary Medicine, offered inspiring words on how seeing ourselves through this period

will shape us into the kind of veterinarians that the future will need. "There's all kinds of anxiety out there about what this [pandemic] has brought. There have been challenges I'm certain for everyone personally and professionally . . . It has pushed us as educators to leverage technology like we should have been doing years ago. It's pushing us into the future. The methods of learning and the technologies that you're using in the classroom are going to benefit you and put you ahead of the curve, not only now as veterinary students, but in the future as lifelong learners." He is hopeful that the technological advancements we're seeing in the classroom now will improve both veterinary curricula and the profession generally as telemedicine use expands. "We're going to learn about ourselves, about education, about veterinary medicine . . . It's necessity that's the mother of invention, and the creativity and innovation that we're all experiencing today are just going to lead us to unforeseen benefits in the future. I think it's a great time to be a veterinarian. There's never been a greater time."

There's been so much going on in the world this school year that has pulled focus from studies and created a lot of anxiety among students. The transition to remote learning has presented challenges, but it's true that at the end of the day, our future employers will be more concerned with what we know than how we learned it. The overarching message from the VLS to veterinary students this year is that it's going to be OK. The future is bright. Stay the course. [WCV](#)

<sup>1</sup>M. A. A. Mahdy, "The Impact of COVID-19 Pandemic on the Academic Performance of Veterinary Medical Students," *Frontiers in Veterinary Science* 7 (2020).

<sup>2</sup>L. Lochner, H. Wieser, S. Waldboth, and M. Mischo-Kelling, "Combining Traditional Anatomy Lectures with e-Learning Activities: How Do Students Perceive Their Learning Experience?" *International Journal of Medical Education* 7 (2016): 69–74.



Madison Audeau, WCVM class of 2023, is from Nanaimo, BC. She completed three years of a BSc in microbial biology at Vancouver Island University before coming to the WCVM and looks forward to returning to the BC coast as a small animal clinician after graduation.

West Coast Veterinarian's "A Year in the Life" is a four-part column written by one veterinary specialist about one topic that has four distinct life phases. Through the course of the year, each instalment highlights how this topic affects animals at a certain life stage and what veterinarians should know about how to treat it. This year's focus is dermatology.

# OTITIS IN SENIOR ANIMALS

BY JANGI BAJWA, BVSc & AH, Dipl. ACVD

In a pet's older years, new ear problems may develop due to complications of pre-existing ear disease, or as a novel primary condition affecting one or both ears. In addition, subclinical or clinically less relevant conditions may progress to become significant with age. As with most other organs, neoplasms become a strong differential diagnosis for ear problems in senior and geriatric pets, especially in cases of unilateral ear disease or when a clinician encounters therapy-resistant otitis.

Progressive pathologic changes in the ears are typical for recurrent or unresolved ear disease. Senior pets may often be well known to the veterinarian, due to chronic ear disease, including the involved progressive pathologic changes. Such case presentations may include chronically managed otitis that needs ongoing monitoring and care, or recurrent otitis episodes due to an unrecognized or partially managed primary condition affecting the ears. An acute insult to the ear may also trigger persistent

inflammatory changes in the ear.

Progressive pathologic changes include epidermal hyperplasia, dermal edema, fibrosis, ceruminous gland hyperplasia and dilation, hair follicle hypertrophy, and an increase in the number of sebaceous glands. Such progressive changes cause a thickening of the skin, which eventually extends to both sides of the auricular cartilage, resulting in stenosis of the canal lumen. Calcification occurs in the connective tissue outside the auricular or annular cartilage.

Permanent changes in the

micro-anatomy and physiology of the ear canal may result. These changes favour the proliferation of bacteria and yeast within the ear. Fibrosis and calcification complicate management by contributing to stenosis of the ear canal and by inhibiting the effective treatment of deep infections.

While otic masses can appear in association with ongoing inflammation, primary neoplasms may also develop, irrespective of the presence of previous otic disease. In dogs, ear masses are typically benign, whereas in cats, they are more likely to exhibit malignant characteristics. Clinical signs of otic neoplasms in the ear canal may not be very different from signs associated with non-neoplastic ear disease. These include pruritus

(including head-shaking and ear-scratching), malodour, otic discharge, hemorrhage, and secondary yeast and/or bacterial infection. Middle ear tumours often result in chronic ear disease, including signs related to otitis externa or those related to the vestibular system.

Diagnosis of ear neoplasms is usually obtained with a combination of signalment, history, and clinical signs along with otoscopic assessment. Otoscopic visualization of neoplasms in the external ear canal is diagnostic, although secondary otic changes may be significant enough to limit this form of assessment. Patient compliance, including the use of sedation to perform otoscopic assessment, is often vital for adequate assessment of the deep ear canal and tympanum. If imaging is needed, CT or MRI testing is considered superior to conventional radiography for ear disease.



Squamous cell carcinoma in a white cat affecting pinna tips and nasal planum.

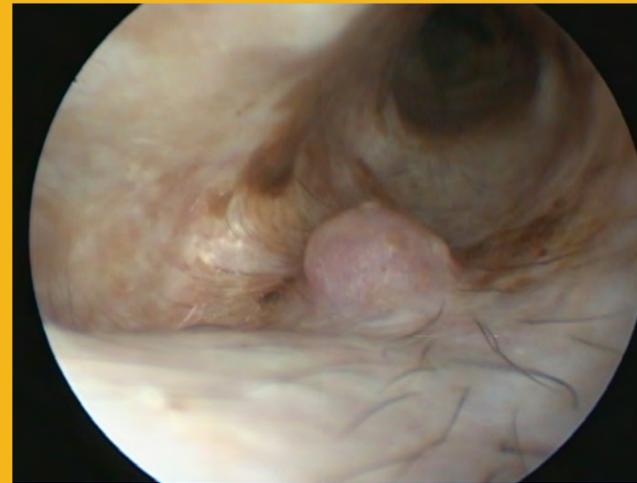


Ceruminous cystomatosis in a cat (similar masses were also present within the ear canal along with otitis externa).

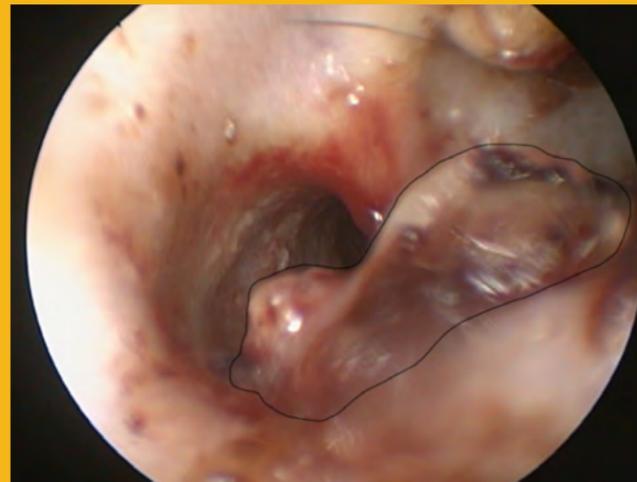
Some neoplastic and non-neoplastic conditions noted in ears of senior pets include:

1. **Ceruminous gland tumours** account for most neoplasms arising from the external ear canal, including ceruminous gland adenomas and adenocarcinomas. Malignant adenocarcinomas are more common than benign adenomas in dogs and cats, with most ceruminous gland tumours possessing regionally invasive properties.
2. **Feline ear pinna squamous cell carcinoma (SCC)** affects the dorsal ear tips and lightly haired pre-auricular areas of cats. It is associated with chronic ultraviolet light exposure, and white cats have a much greater risk of developing this condition and other lesions associated with ultraviolet light than coloured cats. SCCs in cats typically present as bilateral lesions that progress in severity over time. Occasionally, pinna SCC is seen in dogs. These neoplasms are slow to metastasize, but recurrence is common.
3. **Ear canal squamous cell carcinoma** is more commonly reported in dogs than in cats. With chronic otitis, damaged skin and continuous exposure to carcinogenic ceruminous discharge within the ear canal may be a predisposing factor for SCC development. Although rarely seen in the canine and feline middle ears, SCC is considered the most common neoplasm of the middle ear.
4. **Sebaceous gland neoplasms** are uncommonly seen in the ear canals. In dogs, sebaceous tumours may be noted on the pinna, including nodular sebaceous hyperplasia, sebaceous adenomas, sebaceous epitheliomas, and sebaceous adenocarcinomas.
5. **Cutaneous lymphoma** in dogs typically presents as scaly, alopecic patches and non-healing ulcers or nodules on the skin. Involvement of the ear may be seen as part of generalized lesions. Cutaneous lymphoma may mimic eosinophilic plaques in cats, SCC, or any other ulcerated, inflammatory mass of the pinna.
6. **Cholesteatomas** are benign masses located in the tympanic bulla of dogs, composed of a matrix of keratinizing stratified squamous epithelium, inflammatory cells, and keratin debris. Such masses are most likely formed due to chronic otitis media. While surgical procedures have been historically used for treatment, video-otoscopic removal of these masses followed by medical management is another less invasive yet generally successful treatment option.
7. **Feline ceruminous cystomatosis** is a syndrome that affects the concave pinna, external orifice, and occasionally ear canal of cats. Lesions are striking and generally multiple, often coalescing papules, vesicles, nodules, or plaques that are bluish to black in colour. The lesions obstruct normal self-cleaning of the ear, leading to otic discomfort and secondary infection. Progression usually occurs over months to years, and may eventually become severe enough to cause obstruction of the ear canal opening in some patients, in addition to recurrent otitis episodes. Laser ablation of these lesions helps minimize otitis and patient discomfort.
8. **Primary allergic ear disease** due to environmental and/or food factors remains a potential cause of ear disease at all ages. Atopy usually affects pets earlier in life and may progress in senior years, whereas novel food allergies may develop in old age.

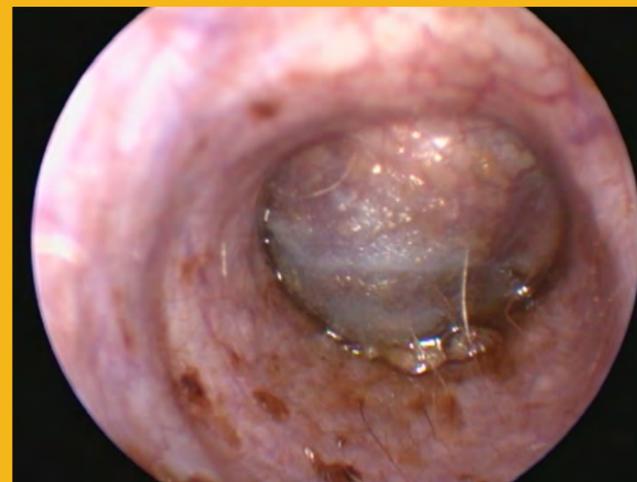
The veterinarian's otoscopic and cytological assessment of the ears as part of frequent patient monitoring and assessment remains the cornerstone of successful ear disease management through all life stages. [WCV](#)



Ceruminous adenoma in the ear canal of a dog.



Ulcerated and bleeding ceruminous adenocarcinoma at distal ear canal of a cat (outline of mass drawn in image).



Cholesteatoma in the deep canine ear canal.

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# “JEEPERS, CREEPERS. YOU WANT TO PUT WHAT IN MY PEEPERS?”

## ADDRESSING LEARNED FEAR OF EYE MEDICATION ADMINISTRATION IN A CHIHUAHUA

BY LAUREN FRASER, MSc, CHBC

“MUCH LIKE SOME PHYSICAL INJURIES, BEHAVIOURAL INJURIES OFTEN DO NOT SELF-RESOLVE IF LEFT UNTREATED. WITHOUT INTERVENTION, MANY EVEN WORSEN.”

**A**version to husbandry or veterinary procedures is a common issue for companion animals. Animals may display escape or avoidance behaviours, attempting to flee, freezing, hiding, or struggling against restraint. If escape is thwarted, animals may resort to displays of aggression—growling, snapping, clawing, or biting—in an effort to escape.

Such fear-based behaviours may result from inadequate training to accept the event or may occur from prior behavioural injuries in similar contexts. Much like physical injuries, behavioural injuries are acquired when trauma to the animal results in measurable, unwanted changes to the animal's behaviour.

Injuries, whether physical or behavioural, frequently need targeted care post-injury to help return the animal to their prior level of health. While the pool of professionals who specialize in addressing these behavioural injuries is currently small, distance from such professionals is no longer a barrier for veterinarians looking for help for the patients.

### MAKING ASSOCIATIONS: “THIS PREDICTS THAT”

Learned fears of specific stimuli can develop in as few as one experience that causes an animal to feel fear. While rapidly created, these fears can be time-consuming to change. Fuzzy memories of a distant Psychology 101 course may cause the term “classical conditioning” to ring a bell for you. Classical conditioning, the process by which these fears are created, is the formation of an association between two stimuli: one which previously had no “meaning” to the animal, and one which, without prior learning, has “meaning” to the animal. For example, a naive young dog enters an exam room. A veterinarian enters, the owner restrains the dog, and in the process of trimming the dog's nails, the veterinarian cuts the quick. The pain elicits an immediate, involuntary response from the dog, triggering fear and escape behaviours. In a matter of seconds, an association has been created in the dog's

brain—veterinarians predict pain and fear to come. A month later, when the client brings the dog in for vaccines, the dog is triggered simply by seeing the veterinarian enter the room, and a cycle of fear-based escape and avoidance behaviours begins.

Much like some physical injuries, behavioural injuries often do not self-resolve if left untreated. Without intervention, many even worsen. Fear is generally an adaptive emotion that helps animals stay safe when faced with stimuli perceived to be threatening. However, when fear becomes associated with procedures meant to enhance the animal's health or welfare, it can become problematic. Behavioural injuries related to husbandry or veterinary procedures are a perfect example of this phenomenon. Without intervention, the dog who rapidly learned to fear the veterinarian will likely always fear the veterinarian. This may result in the owner avoiding routine health care procedures to ease their own discomfort with seeing their animal in this state. Often, the dog creates additional associations regarding other stimuli associated with the veterinarian and will become frightened sooner. We are all familiar with the patient who puts on the brakes outside the clinic door, trembling and cowering before even seeing the veterinarian. Clearly, this is a welfare issue. Fortunately, even in these strange, physically distanced days of the pandemic, help is available for these animals.

### CASE STUDY

**History:** Ella, a 10-to-12-year-old spayed female Chihuahua, was acquired from a rescue organization in California in January 2018. The rescue stated that she was picked up as a stray. Upon intake, Ella weighed three pounds and had a heart murmur, dental disease, and a large, partially healed wound on her face. It was reported that the shelter staff could not touch or handle Ella due to her “fractious” behaviour.

Ella's adopters report that she was averse to human touch upon adoption. While this has improved with handling by her adopters, she is still reactive when touched by others. Ella is currently on Fortekor and Vetmedin. Any medications must be hidden in food or be given, under duress, when she is restrained. Ella also has other medical issues that make it even more critical that she not experience fear, anxiety, or stress during treatment.

Recently, Ella was diagnosed with conjunctivitis, necessitating eye medications multiple times a day. After several attempts to medicate her eyes, Ella's compliance worsened, and her owner contacted me to help address the issue.

**Primary complaint:** Learned fear of medication administration

**Summary of assessment and initial consult:** After taking a history, I met with Ella's owner via online video conferencing. At this consultation, I visually obtained baseline behavioural measurements necessary to devise a behaviour change plan for Ella and her owner. I considered factors such as Ella's tolerance of various low-stress restraint or positioning procedures, the “threshold,” or distance at which Ella would show signs of apprehension regarding various relevant stimuli, and Ella's owner's restraint and medication administration skills.



Ella gets ready to fight the application of her eye medicine.

When animals have learned to fear an event like husbandry or medical care, there are two approaches I like to use: co-operative care training or approaches that decrease the negative response. With co-operative care training, we can train the animal to accept future occurrences of the event by teaching the animal they can give consent to all aspects of the event, from beginning to end. This approach progressively teaches desired behaviours that build toward an end goal behaviour that facilitates the husbandry or medical procedure. These end goal behaviours can be active or passive. Active behaviours occur when the animal actively engages in its own husbandry. Passive behaviours occur when animals voluntarily “station,” assuming a still position that facilitates the procedure. One example of an active end goal behaviour is teaching a dog to trim their own nails—front and back—by scratching a sandpaper-covered “scratch board.” Passive end goal behaviour includes teaching an unrestrained cat to voluntarily target their nose to a tongue depressor held above their head, while eye drops are easily instilled, or teaching a dog to perform a chin rest on a person's lap while their ears are medicated.

Whether active or passive, at any point the animal may effectively remove their consent to co-operate by engaging in a safe, non-aggressive behaviour. For example, the cat may remove their nose from the tongue depressor target, or the dog may lift their head off the person's lap. This is a two-way signal, given by the animal to communicate to the person to stop the procedure. At first glance, this approach seems counterintuitive—giving an animal the ability to say no surely must result in the animal refusing to participate. But in fact, the opposite is true: animals trained using co-operative care techniques willingly participate in unpleasant events. You have likely personally experienced this very effect, when by raising your hand during a dental procedure, you can ask your dentist to temporarily stop drilling to ascertain your needs in that moment. Once these needs are addressed, drilling can then resume with your consent.

While co-operative care is a wonderful way to train animals to accept what may be mildly unpleasant events, it does have one downfall: this training takes time, and thus is usually not the best choice when dealing with pressing medical conditions that require immediate intervention.

Thankfully, there is another option available to help animals who need treatments right away. We can use techniques such as systematic desensitization, counter-conditioning, and differential reinforcement. Systematic desensitization involves progressively exposing the animal to the feared stimulus in “doses” small enough not to trigger stress or fear. Counter-conditioning is a form of classical conditioning, changing the animal's emotional response to stimuli they have learned to fear. Differential reinforcement teaches the animal what behaviour they can do instead of trying to escape the situation. Using such techniques, the “this predicts that” effect is changed for the animal, and all aspects of the formerly scary event now predict good things.

For many animals, this approach can rapidly result in enhanced compliance with the procedure. However, some animals may have a baseline level of fear that prohibits quick acceptance of the procedure. In such instances, veterinarians can prescribe anxiolytic medications to facilitate treatment tolerance. Attempts to address the issue or treat these animals without such medications can result in a worsening of the existing behavioural injury, or create new ones.

Given Ella's assessment findings and the timely need for eye medications, option two was determined to be the best course of action. Using my naive young dog, during video conferencing I demonstrated how to implement these techniques, and coached Ella's owner as she learned how to apply them to her dog. With my adult dog, who is titled in co-operative care, I was able to demonstrate what a reasonable end goal behaviour for Ella might look like. We made accommodations for Ella's small size and her owner's lack of an assistant. At the end of the first session, I gave the client homework and explained that I could provide support by text and email.

By day two of training, Ella's owner was able to administer the eye medications as prescribed without Ella experiencing fear, anxiety, or stress. As behavioural injuries such as Ella's are prone to relapse given certain conditions, it is important for clients to understand the ongoing need to take steps to minimize fear, anxiety, and stress during future husbandry or veterinary procedures.



After training, Ella allows the application of her eye drops while remaining calm and friendly.

### REMOTE TELEHEALTH SERVICES: NOT JUST FOR PEOPLE, OR PANDEMICS

Telehealth services, using telecommunication platforms to assess clients and provide them with health-related information, are commonly used across all human health specialties. A 2020 literature review found that the use of telehealth services by veterinarians is increasing. This format can offer valid ways for veterinarians or veterinary specialists to provide clients with high-quality, effective care—particularly when an in-person appointment is not a viable option.

The telehealth approach can also benefit other professionals who work with animals, particularly in areas where in-person access to a service is limited. For example, since the pandemic began, many dog trainers have started to offer remote training services. Prior research has also demonstrated that the remote format is suitable for addressing even serious animal behaviour problems, such as owner-directed aggression and separation anxiety. Additionally, this format offers advantages over in-person services for certain issues. For example, a shy cat experiencing behaviour problems who hides in the presence of visitors is difficult, if not impossible, to assess by a behaviour consultant in person. That same cat, however, can be readily observed and assessed during a remote consultation.

As certain behaviour problems may result from underlying medical or physical conditions, an exam by the client's veterinarian or a veterinary behaviourist prior to the appointment is always advised. Psychopharmacological medications can also enhance the results of behaviour modification retraining programs for certain issues.

### REFERRAL TO THE RIGHT PROFESSIONAL

Referral to the right professional for remote behaviour or training services is imperative. As the animal training industry in Canada is currently unregulated, before referring a client, veterinarians should have at least a basic understanding of the techniques used to address behaviour problems in animals and of the categories of professionals who offer services.

Dog trainers, in general, teach dogs new, wanted behaviours. As a profession, they are analogous to teachers or sport-specific coaches. As with their human counterparts, dog trainers often specialize in teaching a particular subset of learners. Agility competitors, pet dog owners, and detection dog handlers are all best served by working with the appropriate trainer for their needs. Regardless of the skills required to be taught, the Canadian Veterinary Medical Association position statement on humane training methods for dogs advises the use of positive-reinforcement-based training techniques when teaching dogs new, wanted behaviours. These techniques use food, toys, and praise to reinforce desired behaviours, while ignoring (not punishing) unwanted behaviours.

Dog behaviour consultants, applied and/or clinical animal behaviourists (possessing an MSc or PhD in animal behaviour), and veterinary behaviourists generally address unwanted behaviours in animals. Loosely analogous to human counsellors, psychologists, or psychiatrists (depending on academic qualifications and accreditations), these professionals work primarily with behaviours that are accompanied by negative emotional states. The evidence-based, low-stress techniques they use to address issues include counter-conditioning and systematic desensitization, and positive reinforcement to teach alternate behaviours. As with dog trainers, accreditation for dog behaviour consultants and animal behaviourists is currently voluntary. Unlike the term “veterinary behaviourist,” “behaviour consultant” and “behaviourist” are not legally protected. Referring veterinarians should therefore inquire as to the professional's qualifications prior to any referral. [WCV](#)



Teaching a stationing behaviour of a chin rest allows for co-operative care during many procedures.



Training co-operative care behaviours when an animal is young can enhance their welfare.



Targeting objects with a body part can be taught to any species to facilitate co-operative care.

**“THE TELEHEALTH APPROACH CAN ALSO BENEFIT OTHER PROFESSIONALS WHO WORK WITH ANIMALS, PARTICULARLY IN AREAS WHERE IN-PERSON ACCESS TO A SERVICE IS LIMITED.”**

PHOTOS COURTESY LAUREN FRASER

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# SHELTER MEDICINE:

## A GROWING COLLABORATIVE FIELD, CHANGED BY COVID-19

BY EMILIA WONG GORDON, DVM, Dipl. ABVP (Shelter Medicine)

**P**ablo entered BC SPCA care at the Prince Rupert branch as a stray kitten. At intake, he received an FVRCP vaccine and parasite control according to shelter medicine protocols. There are more animal intakes than adopters at many Northern shelter locations, so he was transferred south. During his stay at the Vancouver branch, he became sick, with vomiting and diarrhea. A large outbreak of feline enteric illness was identified, control measures were implemented, and the outbreak was investigated as part of a research collaboration. A novel virus, fechavirus, was discovered. Despite Pablo's brush with an emerging infectious disease, he recovered fully and was placed in an adoptive home.

Athena also joined the legion of animals calling a shelter their home. Athena is a senior dog surrendered to the BC SPCA Vancouver branch because her owner could no longer afford her care and was facing other challenges. Soon after intake, Athena became ill and was diagnosed with pyometra. Surgery was successful, but Athena was in the shelter for a long time because she was also diagnosed with ringworm. During her stay, staff worked with her to do behaviour modification to help reduce her fear of handling and enable co-operative veterinary care. Athena recovered fully and was adopted.

For many animals, shelters are their only hope at life; and for a life beyond the shelter.

Shelter medicine is defined as "veterinary medicine aimed at improving the health and well-being of animals in shelters." Shelter veterinarians provide a range of individual and population-level care, including medical, surgical, dental, and emergency care (similar to private practice) as well as care that is more specific to populations of confined animals. The latter includes a strong focus on infectious disease prevention and management, population management, behavioural health, veterinary forensics, and community medicine, including outreach and spay/neuter programs to support vulnerable human-animal families and keep animals out of shelters.

One major difference between shelter medicine and general practice is that shelter veterinarians are generally supporting the care of unowned animals. Instead of working with and managing clients, shelter veterinarians must speak for the needs of sheltered animals with a variety of stakeholders. These include the board, staff, and management teams of shelters and other non-profit groups, as well as municipalities, rescue groups, and animal advocates.

Shelter medicine is a rapidly growing field and the newest AVMA-recognized veterinary specialty, with 30 board-certified diplomates. Canadian students are strongly interested in shelter medicine and other closely related forms of non-profit community medicine that support public health and the human-animal bond. Yet, most Canadian veterinary colleges offer little or no formal shelter medicine instruction.

British Columbia presents a very unusual animal sheltering context. Most animal shelters in BC are small by North American standards (admitting anywhere from a few hundred to about 2,000 animals per year). At this time, there are no shelters in BC that have their own full-time on-site shelter veterinarian providing care exclusively to shelter animals. This is in contrast to many shelters across Canada and the US that employ multiple veterinarians in large buildings housing dozens to hundreds of animals at any given time.

As of 2019, there were 36 BC SPCA sheltering branches and 203 other shelters and rescue organizations in BC with the number growing every year. Many of these organizations also operate community programs that help low-income pet guardians with spaying/neutering and other veterinary care. Nearly all of these rely solely on general practice veterinarians for veterinary care. This means that many veterinarians in BC may be practicing shelter medicine some of the time. Even in the face of the severe veterinarian shortage, veterinarians in BC have remained willing to do the often difficult

work of caring for the most vulnerable animals in our province. Words cannot express the gratitude of the shelter and rescue community for this incredible gift.

The COVID-19 pandemic has changed the animal sheltering world, in some cases accelerating existing trends and inspiring (or forcing) new practices. Near the start of the pandemic, animal sheltering, like veterinary medicine, was deemed an essential service. Animal shelters in BC looked to guidelines from the AVMA, CDC, and CVMA for information on how to modify operations to protect human and animal health. Not only do shelters bring people together (staff, volunteers, and the public), but they present a relatively unprotected human-animal interface with confined animals from multiple origins. Information confirming that companion animals can become infected with (and rarely, become sickened by) SARS-CoV-2 emerged early.

In response to provincial public health and veterinary regulatory guidance and interim shelter-specific guidelines from the AVMA/CDC, shelters significantly curtailed their operations. Common changes included admitting the public by appointment only, reducing acceptance of non-emergency strays and owner surrenders, reducing on-site staff and reducing or eliminating volunteers, increasing virtual offerings (such as adoptions), and implementing standard COVID-19 precautions. At the BC SPCA, in accordance with AVMA/CDC "abundance of caution" guidance, animals entering shelters from homes with positive COVID-19 tests were tracked, handled with PPE, and segregated from other animals for the recommended period of 14 days. To date, the BC SPCA has taken in 20 animals from such homes and managed another 20 animals exposed to staff who were infected through community transmission.

Shelters and rescues participated in collaborative efforts to support public health and preserve PPE and supplies for frontline health care workers, including suspending pre-adoption spay/neuter requirements and postponing elective procedures. The BC SPCA donated a large quantity of PPE to Vancouver Island and Lower Mainland human health care providers and purchased washable fabric PPE for sustainable future use.

In a matter of days in March, BC SPCA shelters were nearly emptied of animals; quick action was necessary due to uncertainty over whether shelters would receive an essential services designation and be allowed to keep operating. Community members stepped up to adopt and foster animals in large numbers. From March to December, the BC SPCA fostered 4,495 animals to 731 foster families (representing a 46 per cent increase in the number of newly recruited fosterers compared to 2019); at any given time between March and July, up to 75 per cent of the total in-care animal population was in foster care as opposed to being housed in the shelters. Many organizations reported that interest in fostering and adoption was much higher than normal as British Columbians stuck close to home.

Many brick-and-mortar shelters (both private

BACKGROUND PHOTO: ATHENA RECEIVING BEHAVIOUR MODIFICATION TRAINING FROM BC SPCA STAFF MEMBER JENNIFER. PHOTO COURTESY BC SPCA.



Elizabeth and Panda.

and municipal) had to reduce operations and on-site personnel. Many organizations experienced budget cuts due to decreased municipal funds and/or reduced donations. This, combined with additional births resulting from spaying/neutering being unavailable in the province for several months, meant that rescue organizations that relied on fostering took on an extra burden of care. These organizations report increased requests to surrender animals and increased workload, particularly relating to community cats. For example, Kitty Cat P.A.L.S. on Vancouver Island received 700 cats—approximately 50 per cent more cats than expected—in 2020, including a 100 per cent increase in owner surrenders.

There are at least 21 organizations in BC supporting families to access veterinary care, helping over 1,500 animals in 2020. Many of these organizations report a significant increase in requests for help, including the provincial Better Together program operated by Paws for Hope Animal Foundation, which has seen an uptick in requests since COVID-19 began and ultimately helped 339 owned animals with emergent veterinary care in 2020. Organizations that provide free wellness care in both urban and rural and remote areas had to cancel clinics due to COVID-19 precautions and travel restrictions. There is evidence that economic hardships, such as loss of employment income associated with COVID-19, have disproportionately affected people who were already vulnerable. The lack of access to wellness care, combined with an increase in people in crisis and the existing veterinary shortage, has led to what multiple organizations supporting owned animals describe as an overwhelming amount of need, particularly in Northern BC.

COVID-19 also led to an increase in the need for compassionate boarding

(free temporary boarding or fostering of owned animals whose families are in crisis due to domestic violence, loss of housing, or hospitalization). Pandemic precautions (specifically, staying at home) have been associated with multiple known risk factors for domestic violence, and one domestic violence organization in Vancouver reported a 300 per cent increase in calls during the first wave of the pandemic. Paws for Hope Animal Foundation launched a crisis boarding program as part of Better Together in April 2020, helping 40 people and animals to date through temporary foster care. This enabled 80 per cent of pets entering crisis care due to domestic violence to be reunited with their owners, with only 20 per cent being surrendered for rehoming. The BC SPCA also provides shelter-based compassionate boarding; this previously informal program was formalized in 2020 in response to the crisis, helping 269 animals in 2020 (representing 2.5 per cent of total shelter intakes, up from 1.5 per cent in 2019).

Many shelters and rescues also operate pet food bank programs, with some reporting growth in need during 2020 and others experiencing reduced programming due to COVID-19 precautions. Due to increased need, the BC SPCA formalized a provincial food bank program that had previously existed only in specific locations, providing over 66,000 kg of dry food and 42,500 cans of wet food (representing a week's worth of food for over 30,000 animals). Research shows that human-related reasons relating to housing and life circumstances are often more prevalent than animal-related reasons for shelter relinquishment. Programs that help with food, temporary housing, and veterinary care can be the difference between a family staying together during hard times or being separated by circumstance.

The trend toward supporting companion animals in existing homes and engaging local communities through foster care and other programs began before COVID-19 and has a name: community-supported animal sheltering. According to Humane Canada, many Canadian shelters called on communities for support during COVID-19 and found positive outcomes, inspiring the sector to make some of the changes permanent through “maintaining and enhancing the gains made during the pandemic and rethinking animal welfare and sheltering in a post-COVID world.”

Some community-supported animal sheltering principles may surprise people. For example, there is a growing body of research evidence that reducing barriers to fostering and adoption saves lives and improves animal welfare by reducing the length of stay in the shelter. Longer shelter length of stay has been identified as a risk factor for upper respiratory infection in cats and canine infectious respiratory disease complex in dogs, and higher shelter intake is correlated with higher euthanasia rates, particularly for cats. Yet, historically, shelters and rescue groups have used a “pass-fail” application process for adoptions, often accompanied by multiple levels of time-consuming reference and rental-related checks.

This barrier-heavy approach can deter or eliminate



Hailey, Kerry, and Dr. Tatjana Mirkovic work on a dog, while a client and patient wait.

## “RESEARCH ON SHELTERED ANIMALS IS EXPLODING, WITH STUDIES UNDERWAY ON EVERYTHING FROM ADOPTION AND FUNDRAISING PRACTICES TO EMERGING INFECTIOUS DISEASES.”

excellent adopters, particularly if they do not own their own homes or have not had an animal before. It can also inadvertently promote bias and discrimination against people whose life experiences are different from those of the staff and volunteers processing the adoptions (who are often demographically homogeneous). Research shows that a more open conversation-based approach, where the animal's needs (as opposed to the adopter's history) are the central consideration in making the best match, can result in equivalent or better outcomes with less load on shelter resources.

During COVID-19, animals were quickly placed in foster and adoptive homes, and some members of the public have raised concerns about these animals being returned as “normal life” resumes. It is important to note that, so far, this has not occurred. The BC SPCA has seen no increase in returns during the latter part of 2020. This is an area of active research, with one published study so far confirming that despite high demand for adoptive homes, shelter dogs adopted during the “lockdown” phase of the



The Cuffley family and Jake.

PAGE 26: PHOTO COURTESY KIM MONTEITH, BC SPCA; PAGE 27 (TOP): PHOTO COURTESY COMMUNITY VETERINARY OUTREACH; PAGE 27 (BOTTOM): PHOTO COURTESY DOMINIC CHAN



Kelly, Oreo, and Dr. Doris Leung.



Dotty and Cecil, Downtown Eastside.

pandemic in Israel were not returned in greater numbers during reopening.

Shelter medicine is evidence based. There are published standards of care for Canadian shelters and for animal rescues in BC. Research on sheltered animals is exploding, with studies underway on everything from adoption and fundraising practices to emerging infectious diseases. Another area of active research is incremental care (intuitive, tiered diagnostic plans and preventive care), which is integral to shelter medicine due to resource constraints and is considered key to solving the growing crisis in access to veterinary care. As the sector moves into the future, there will likely be many changes made during COVID-19 that persist and undergo research to assess their effectiveness. There is no doubt that community-supported animal sheltering principles will receive a heavy emphasis.

Private practice veterinarians are a crucial part of the BC sheltering community. Whether providing care to animals in shelters and rescue groups, providing post-adoption examinations, or supporting community spay/neuter initiatives and growing efforts to keep families together despite hardship, veterinarians in BC are impressively engaged and give generously of their time and resources. Shelter medicine in BC is thus a uniquely collaborative endeavour—one that benefits vulnerable people and animals alike.

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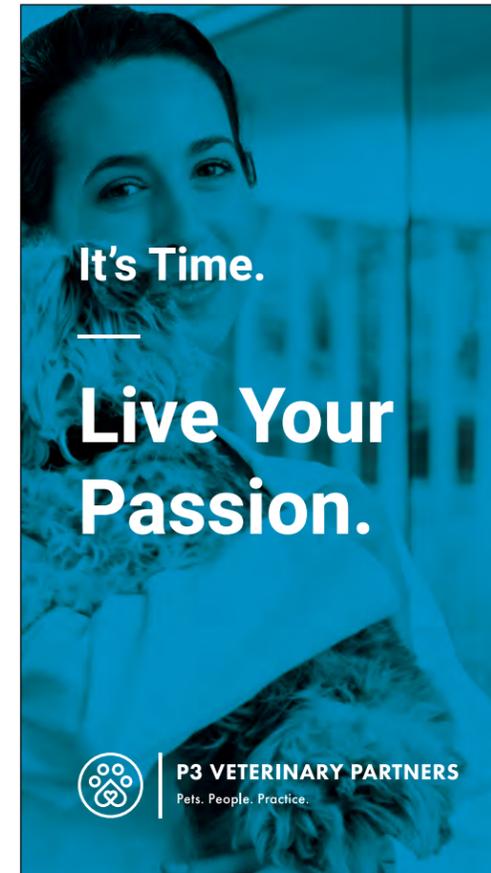
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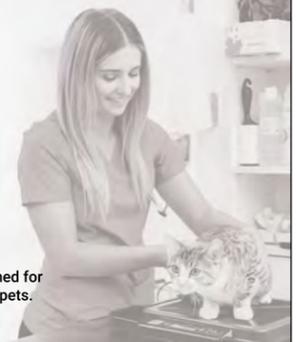
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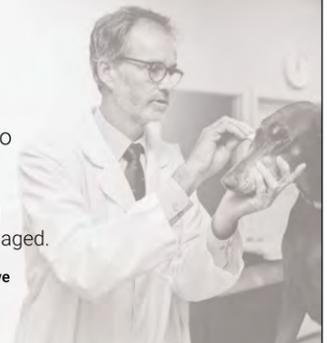
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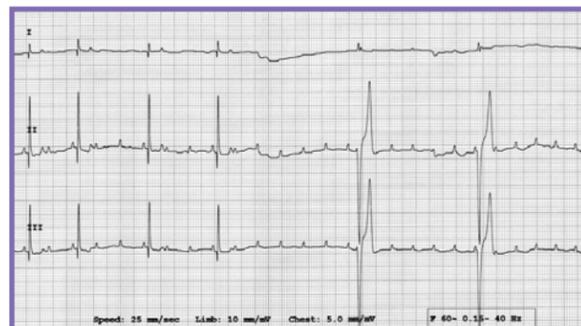
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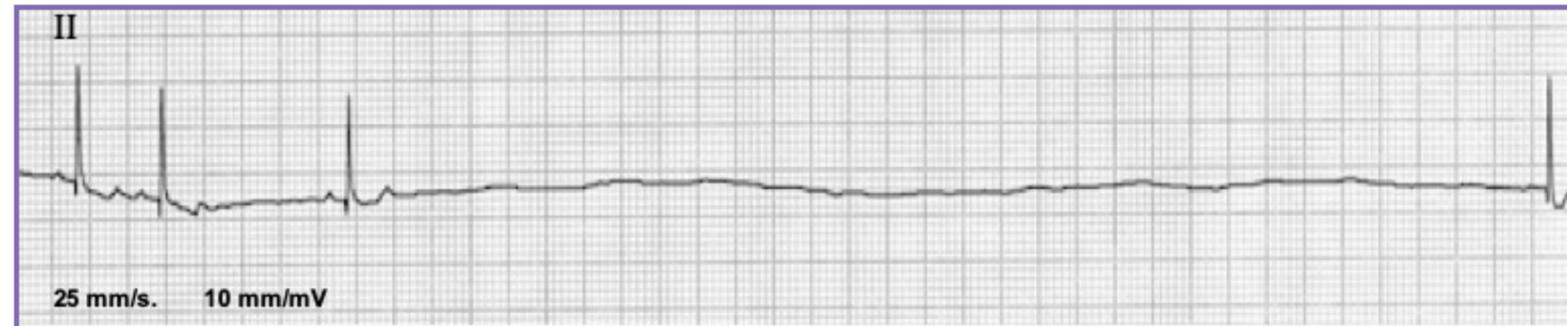
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This specialist column on interventional cardiac therapies is broken into two parts. The previous instalment in the winter 2020 issue discussed surgical interventions for some of the more common congenital conditions. This instalment focuses on pacemakers.



**FIGURE 1:** ECG from a patient exhibiting AV block; simultaneous leads I-III. On the left side, there are two to three P waves present before a QRS complex arises. The final P wave prior to the QRS maintains a set relationship with the QRS, and the QRS is narrow indicating rapid conduction through the ventricles. This is consistent with a high-grade second-degree AV block. On the right side, there is a significant slowing of the ventricular rate (to approximately 34 beats/min) with widening of the QRS complexes indicating emergence of a ventricular escape rhythm. Additionally, the relationship between P waves and QRS complexes is lost, indicating a complete (third-degree) AV block.



**FIGURE 2:** Lead II ECG tracing in a patient with sick sinus syndrome. The first three complexes are normal in appearance. This is followed by a prolonged period of sinus arrest lasting approximately 6.3 seconds. This is terminated by a narrow QRS complex without any preceding P wave, indicating a junctional (a.k.a. "nodal") escape beat.

Lucy, a one-year-old Labrador retriever, had presented to her primary care veterinarian for acute onset of lethargy and syncope. Auscultation revealed a bradyarrhythmia and a new heart murmur. ECG evaluation indicated the presence of atrial standstill. Hypoadrenocorticism was initially considered, so baseline lab work was ordered and provided evidence of a normal cortisol concentration and a normal potassium concentration. Thoracic radiographs revealed marked cardiomegaly but no evidence of congestive heart failure. Lucy was subsequently referred to a cardiologist for evaluation. Echocardiography revealed marked biatrial dilation consistent with an atrial myopathy. Despite a guarded long-term prognosis, a permanent transvenous pacemaker was implanted. Lucy recovered well, and went on to live for over 11 years with her pacemaker in place.

There are three main indications for implantation of a pacemaker, collectively referred to as symptomatic bradycardias: AV blocks (high-grade second and third degree), sick sinus syndrome, and persistent atrial standstill.

AV blocks are the most common reason to implant a pacemaker in a dog. "High-grade second-degree AV block" is the term used when multiple P waves are present before a single QRS complex occurs (e.g., three P waves but only one conducts into the ventricles to create a QRS). Third-degree (a.k.a. complete) AV block describes a total lack of conduction through the AV node, resulting in dissociation of P waves and QRS complexes (Figure 1). High-grade and complete AV blocks are typically due to

idiopathic degeneration or fibrosis within the AV node. Other causes include myocarditis or endocarditis, cardiomyopathy, neoplastic infiltration, electrolyte abnormalities (e.g., hyperkalemia), and toxin exposure (e.g., foxglove ingestion). Any breed can develop AV block; however, it is most commonly reported in breeds including Labrador Retrievers, Cocker Spaniels, and Dachshunds.

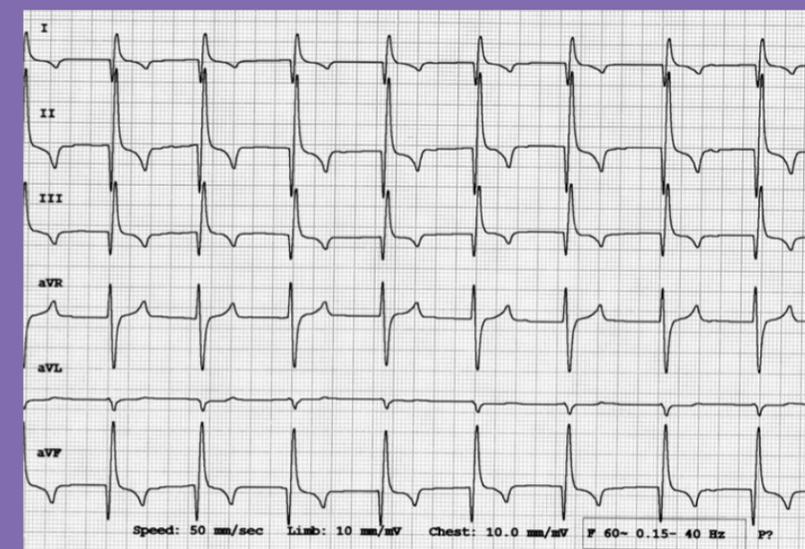
Sick sinus syndrome can have numerous manifestations in dogs, including periods of sinus arrest, AV block, supraventricular tachycardia, or combinations of all these (Figure 2). This condition is most commonly seen in Miniature Schnauzers, West Highland White Terriers, and Cocker Spaniels, although any breed can develop the condition. Atrial standstill is recognized on the ECG by a regular bradycardia with an absence of P waves in all leads (Figure 3). The most important differential is life-threatening hyperkalemia; however, this can also be due to an uncommon condition whereby the atrial myocytes are progressively replaced by fibrous scar tissue, called persistent atrial standstill. This leads to massive atrial dilation, and often, congestive heart failure. Predisposed breeds include English Springer Spaniels and Labrador Retrievers.

Failure of a supraventricular impulse to conduct through the AV node can lead to a subsidiary pacemaker taking control of the heart rhythm, called an escape rhythm. In dogs with AV block or atrial standstill, this can manifest from either just below the AV node where QRS complexes are still narrow, or from the ventricular Purkinje cells where conduction is slow and the QRS is resultantly wide. The ventricular escape rate of dogs is very low, often 20–40 beats/min. Dogs with the various forms of bradycardia

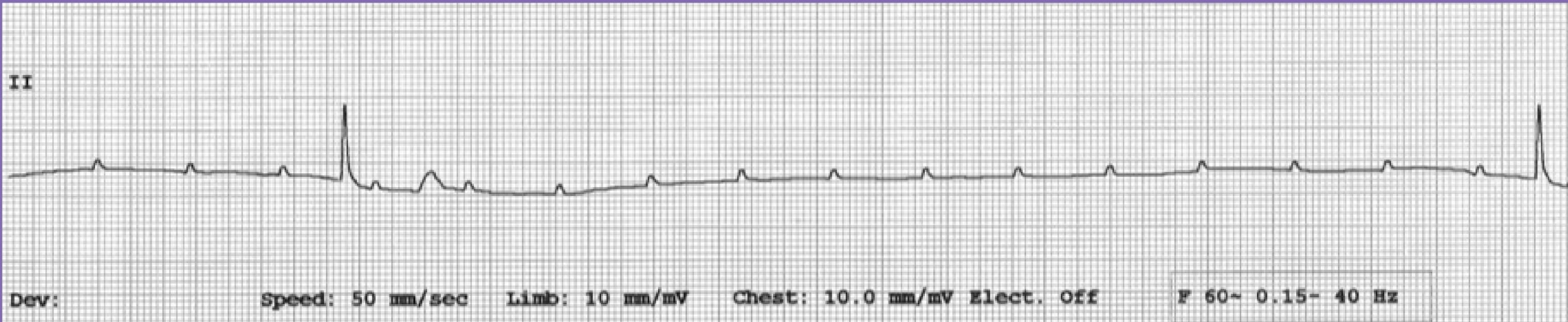
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# PACEMAKER INDICATIONS AND THERAPY

BY MARK HARMON, DVM, Dipl. ACVIM (Cardiology)



**FIGURE 3:** ECG tracing in a patient with atrial standstill. Note the lack of atrial activity (i.e., P waves) in any lead. Although other ECG findings of hyperkalemia are not identified on this recording, these are inconsistent, and this would remain the most important emergent rule-out.



**FIGURE 4:** Lead II ECG tracing in a dog with third-degree AV block and an unusually profound bradycardia of approximately 16 beats/min. This patient initially responded well to pacemaker implantation but died suddenly about six months later. Histopathologic evaluation of the heart identified myocardial lymphoma.

described above often have similar clinical signs, including lethargy, weakness, and syncope. Dogs with AV block are at a high risk for sudden death with about 25 per cent dying within the first month; this risk may be higher in dogs with more profound bradycardias (Figure 4). Sudden death is very uncommon in dogs with sick sinus syndrome. Congestive heart failure is common in dogs with atrial standstill, can occur in dogs with chronic bradycardia due to AV block, and is not expected in dogs with sick sinus syndrome unless they also have severe concurrent degenerative valve disease.

The majority of dogs with symptomatic bradycardia tend to be older, and a complete diagnostic evaluation is always recommended prior to pacemaker implantation. This should include complete blood work and urinalyses, proteinuria quantification, thoracic radiographs, echocardiogram, and other testing as clinically indicated. A cardiac troponin-I blood test can be performed to evaluate for myocarditis. An atropine response test should also be performed in cases of high-grade AV block. There are a few protocols for this published, but I prefer to obtain a baseline ECG, administer 0.04 mg/kg atropine IV, wait 15 minutes, and then recheck an ECG. A positive response to atropine, evidenced by a persistent tachycardia of more than 160 beats/min and resolution of any AV block indicates a vagally mediated bradycardia. Vagal tone can be pathologically increased due to increased intraocular pressure, increased intracranial pressure, chronic respiratory disease, or intra-abdominal (typically gastrointestinal) disease. Treatment of the underlying condition should resolve a vagally mediated bradyarrhythmia. Third-degree AV block and persistent atrial standstill do not tend to improve following atropine administration. Dogs with atropine-responsive sick sinus syndrome may be medically manageable with sympathomimetics (e.g., theophylline, terbutaline) or vagolytics (e.g., propantheline, hyoscyamine). It is important to note that anesthesia can still be quite unpredictable in these dogs—that is, atropine responsiveness when awake does not

mean that atropine responsiveness will persist when under anesthesia. In dogs not requiring a permanent pacemaker, transthoracic pacing may be a prudent consideration.

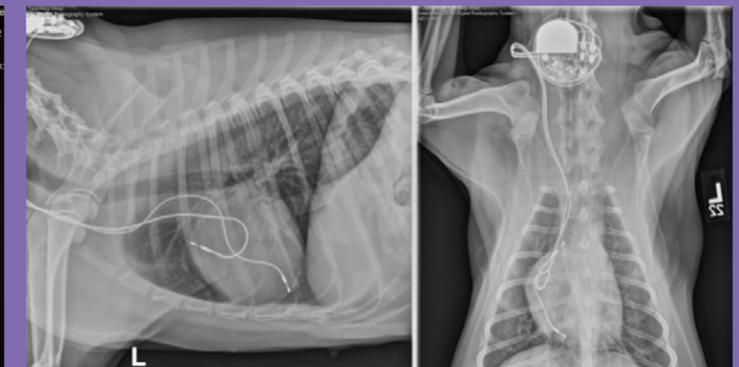
Cats can also develop AV block and rarely persistent atrial standstill; however, their ventricular escape rate tends to be much higher than in dogs, often 100–140 beats/min. Given the higher rate, symptoms such as syncope are seen much less frequently. AV block is typically due to underlying cardiac disease, and these cats may be in congestive heart failure at the time of diagnosis.

The pacemaker generators used in animals are often the same types used in people, although some veterinary companies have recently developed models specifically for animals. The pacemakers can be programmed into different pacing modes and directed in how to respond to electrical activity sensed by the device. Electrical output, lower heart rate, and maximal heart rates are also programmable. Finally, most pacemakers are rate responsive. Accelerometers in the pulse generator are similar to those in smartphones. Motion stimulates the generator to pace at a faster rate, allowing animals to have an appropriate increase in heart rate with activity.

Most pacemaker leads in dogs are implanted in the endocardium through the jugular vein and use only a single lead positioned in the right ventricular apex under fluoroscopic guidance (Figure 5). With this system, the ventricles are paced but the atrial electrical activity is ignored. Dual chamber pacemakers (i.e., two



**FIGURE 5:** Left lateral and VD thoracic radiographs in a patient with an appropriately positioned right ventricular endocardial pacing lead (i.e., single lead pacemaker). The pacemaker pulse generator is present in the right cervical region.



**FIGURE 6:** Left lateral and DV thoracic radiographs in a patient with an appropriately positioned dual endocardial lead pacemaker. The lead that terminates near the cranial cardiac waist is positioned within the right auricle with similar positioning of the right ventricular lead as can be seen in Figure 5.

leads) are sometimes used with positioning of one lead in the right atrium and one in the right ventricular apex (Figure 6). This would allow a more physiologic approach to pacing in that the sinus node could still dictate the heart rate of the patient; however, this increases anesthetic time and significantly complicates the programming of the pacemaker. Additionally, there is no current evidence that dual chamber pacemakers confer any survival or quality of life benefit in dogs. With transvenous leads, the generator is implanted subcutaneously in the cervical region or behind the shoulder. In dogs who are too small for transvenous pacemaker implantation (less than 3 kg), pose a high risk for infection, or are hypercoagulable, an epicardial pacemaker lead is preferred. This requires a laparotomy and transdiaphragmatic approach. With epicardial leads, the generator is implanted subcutaneously caudal to the costal arch (Figure 7). If a cat were to be symptomatic from AV block, epicardial pacemaker implantation would generally be preferred, as the size of the pacing lead within the heart and



**FIGURE 7:** Post-operative right lateral thoracic radiograph in a patient with an epicardial pacemaker; the pacemaker pulse generator is positioned subcutaneously caudal to the costal arch. A thoracic drainage catheter is also present to aid in evacuation of air and fluid from the chest during the immediate post-operative recovery period.

within the cranial vena cava could lead to obstruction of blood flow and development of congestive heart failure signs (e.g., pleural effusion).

The major complications of concern following pacemaker implantation include lead dislodgement and device infection. These may occur in up to 10 per cent of patients, and the risk is higher in procedures performed after hours. Dislodgement of the lead can lead to ineffective pacing and return of a bradycardia below the base pacing rate. Dislodgement is confirmed on thoracic radiography and is usually easiest to identify in the left lateral projection since this mimics the patient positioning at the time of placement (Figure 8). If a transvenous lead dislodges, I prefer to replace it with an epicardial lead, as simple repositioning of the transvenous lead increases the risk of an infection, which could be catastrophic. Infection of the pulse generator and/or lead can occur. Infections of the generator site typically lead to erosion through the skin with typical purulent discharge (Figure 9). Conservative treatment with wound culture, debridement, and flushing of the generator site can be performed, but in my experience, often leads to chronic, non-healing draining tracts. Ideally, a generator site infection is treated by removal of the transvenous hardware and replacement with an epicardial pacemaker.

Benign complications such as seromas are not uncommon. Importantly, a needle should never be inserted into the fluid pocket, as this could introduce an infection and/or damage the pacing hardware. Neck collars should never be used in pacemaker patients as this

could damage or dislodge the lead; owners are instructed to use harnesses instead. Transvenous leads are generally placed in the right jugular vein, after which the vein is permanently ligated. As such, no phlebotomy attempts should be made in this region. Antibiotic prophylaxis should be considered following any surgery, including dental cleanings. If a disease develops that could induce hypercoagulability (e.g., hyperadrenocorticism, protein-losing nephropathy, etc.), the disease should be stabilized and treatment with clopidogrel should be initiated to decrease the risk for thrombosis of the pacing lead. Finally, a common question is how to approach euthanasia in these patients. The drugs used for euthanasia put the heart into a non-responsive state, so the euthanasia procedure itself is unchanged. However, it is important to remove the pulse generator in these patients as they pose an explosion risk during cremation.

Prognosis for dogs with pacemakers depends upon the underlying disease. Barring complications, dogs with sick sinus syndrome have an excellent prognosis. Shorter survival times of three to four years are reported for dogs with AV block, although this likely reflects the older age of the population at diagnosis. Dogs with atrial standstill have a more guarded prognosis and may succumb to heart failure within a few years of pacemaker implantation; however, Lucy from the case history at the beginning of this article is a testament that some individuals can do much better than this mark. **WCV**



**FIGURE 8:** Right lateral and VD thoracic radiographs in a patient with a dislodged right ventricular endocardial pacing lead. The lead appears to have backed into the right atrium in this patient. Less overt dislodgements are generally easier to identify on left lateral projections in conjunction with an orthogonal view.



**FIGURE 9:** Patient positioned in left lateral recumbency with the right cervical region shaved. There is regional redness around the pacemaker generator site with erosion of the generator through the skin. Purulent discharge had been present prior to surgical preparation, indicating infection of the pacing generator.

# QUIET FOR THE CATS!

BY BAILEY H. EAGAN, MSc, EMILIA WONG GORDON, DVM, Dipl. ABVP (Shelter Medicine), AND DAVID FRASER, CM, PhD

If you have ever been bothered by noise in an animal shelter or clinic, spare a thought for the cats. The hearing range of cats extends from a rumble 48 hertz to an ultrasonic 85 kilohertz—one of the broadest hearing ranges known. To make matters worse, sound levels of 100 decibels (considered damaging to human hearing if prolonged) are commonly recorded in animal shelters and veterinary clinics.

What do cats do when they are bothered by this amount of noise? Mostly they hide. Some cats in shelters simply retreat to the “Hide, Perch and Go” box that is now routinely provided as a hiding place in all BC SPCA shelters. But others go further. In our observations, we have often witnessed cats responding to a sudden increase in noise by squeezing behind the hide box or under the bed, where they can be completely invisible. Apart from hiding, it is not uncommon for cats to startle, crouch, or position their ears back or flat—activities widely recognized

by cat behaviour specialists as indicators of fear.

But how serious is the problem of noise for cats in shelters? We tried to shed light on this question by keeping detailed behavioural records on about 100 shelter cats from March to July 2017 for 30 minutes every morning (when

**“...WE HAVE OFTEN WITNESSED CATS RESPONDING TO A SUDDEN INCREASE IN NOISE BY SQUEEZING BEHIND THE HIDE BOX OR UNDER THE BED, WHERE THEY CAN BE COMPLETELY INVISIBLE.”**

the shelter was more active) and every evening (when staff and visitors had left). We recorded the amount of time cats spent hiding, holding their ears back or flat, and showing other fear-related behaviours. We also recorded “maintenance” behaviours such as grooming, playing, and eating, which generally indicate an absence of strong fear.

The first finding was that morning observations involved much more noise than evenings, and that the cats did much more hiding and other fear-related behaviour during morning sessions. If anything, however, our data underestimated the difference because we deliberately timed the morning observations to coincide with the daily staff meeting when human activity in the shelter was relatively low. During evening recordings, we observed maintenance behaviours such as grooming, eating, and playing much more often.

Because this difference between morning and evening behaviours could merely reflect a diurnal cycle rather than an effect of sound, we compared relatively noisy mornings versus relatively quiet mornings. As expected, the cats showed more fear-related behaviour in the noisy sessions.

To make the comparison even tighter, we found 13 periods when a fairly quiet five minutes was followed by a fairly noisy five minutes. Of the 57 cats present on these days, only 10 were hiding during the initial quiet period, but this increased to 26 once the noise began.

But—as any cat lover will know—not all cats are the same. To illustrate this, we compared the 10 cats who showed the most fear-related behaviour with the 10 who showed the least. The “scaredy-cats” remained in hiding—either in the hide box or squeezed into some other concealed location—for virtually all our observation periods. In contrast, the 10 “chill cats” stayed mostly in the open and were often seen eating, drinking, grooming, and carrying on as usual, seemingly not bothered by a level of noise that affected the others.

Much remains to be discovered, of course. In particular we would like to know whether specific sounds—dog barking, loud human voices, clanging gates—create more fear and anxiety than others. Our hypothesis, based on what we saw, is that loud barking is especially problematic for cats.

The obvious conclusion from our research is that noisy environments—perhaps especially if they are also unfamiliar—are upsetting to many cats and that shelters and clinics can take steps to control noise to improve cat welfare. Shelters and clinics could serve their cats by implementing simple changes such as keeping voices low, keeping doors between rooms closed, and using rubber-coated dishes, quiet-closing latches on metal enclosures, and silicone bumpers on doors and cupboards. By using free sound-measurement apps now available on most smartphones, facilities can easily monitor their daily sound levels and use this information to help keep both animals and people comfortable in a quieter environment. **WCV**

# VETERINARY PRACTICE IN THE TIME OF COVID-19

BY ROCKY LIS, BSc, MSc, DVM

“SUDDENLY, EVERYONE HAD SICK PETS AND WAS CLAMOURING TO SEE THEIR VETERINARIAN.”

On March 18, 2020, the province of British Columbia declared a state of emergency in an attempt to rein in the scourge of the novel coronavirus, or COVID-19. Three days later, personal service businesses were ordered to shut down. I am a locum veterinarian with no contract for security. I had already booked time off for spring break with a clinic that I frequently worked at, and I did not know whether I would be back to work in a couple of weeks as scheduled. My anxiety grew as my family (my wife and two young children) and I practised social isolation, wore masks while shopping at barren-shelved grocery stores, and closely followed the CBC news updates on the spread of COVID-19 and the advent of further lockdown measures. I worried that my job was in jeopardy, as the veterinary industry might also be ordered to shut down or at least might have fewer clients willing or able to seek veterinary care. However, no one could have predicted what would instead unfold.

Veterinary clinics were designated essential services and were allowed to remain open. The clinic contacted me halfway through my break to ask whether I might be able to come in for a few days to help out with the overwhelming workload. Suddenly, everyone had sick pets and was clamouring to see their veterinarian. In part, the heavy caseload felt similar to the one clinics often experience during summer or winter break, when people are at home with their pets perhaps feeding them things that they should not, getting outside more with their dogs and creating more opportunities for them to get into trouble. Not only were people isolated and brimming with society-wide COVID-19-related anxiety, but they were at home with more time to worry about their loved ones, including their furry companions.

It took several weeks to get used to the new practices: all staff were required to wear masks, gloves, and scrubs; non-emergency appointments had to be delayed or rescheduled; and importantly, clients were no longer permitted within the premises, which made many parts of veterinary practice more labour intensive. We simply did not have sufficient staff to keep up with the new protocols. The new process is exhausting even to describe: clients call to announce their arrival in the parking lot, a veterinary assistant retrieves their pet (swapping off their leash and collar with our own sanitized slip leashes), and the assistant brings the pet into the clinic and holds the animal while the veterinarian completes the examination. The veterinarian then phones the client to discuss diagnostics and treatment, and then may perform the agreed procedures. Finally, the assistant returns the pet to the client, and a receptionist calls the client or goes out to the parking lot with a mobile payment device to collect payment and deliver medications or food.

Many pets were more anxious entering the clinic without the safeguard of their owners being present. Previously well-behaved cats and dogs were now being assigned cautionary notes on their files. Many of these patients were too fractious to examine and were sent home with oral sedatives and a rescheduled appointment. I have seen many clients express frustration and lose patience with this adapted admission process and the fact that invariably clients have to wait longer. Unfortunately, their anger is often misdirected at the clinic

staff who themselves are continuing to do their best at managing the flow of patients and clients under these unprecedented circumstances.

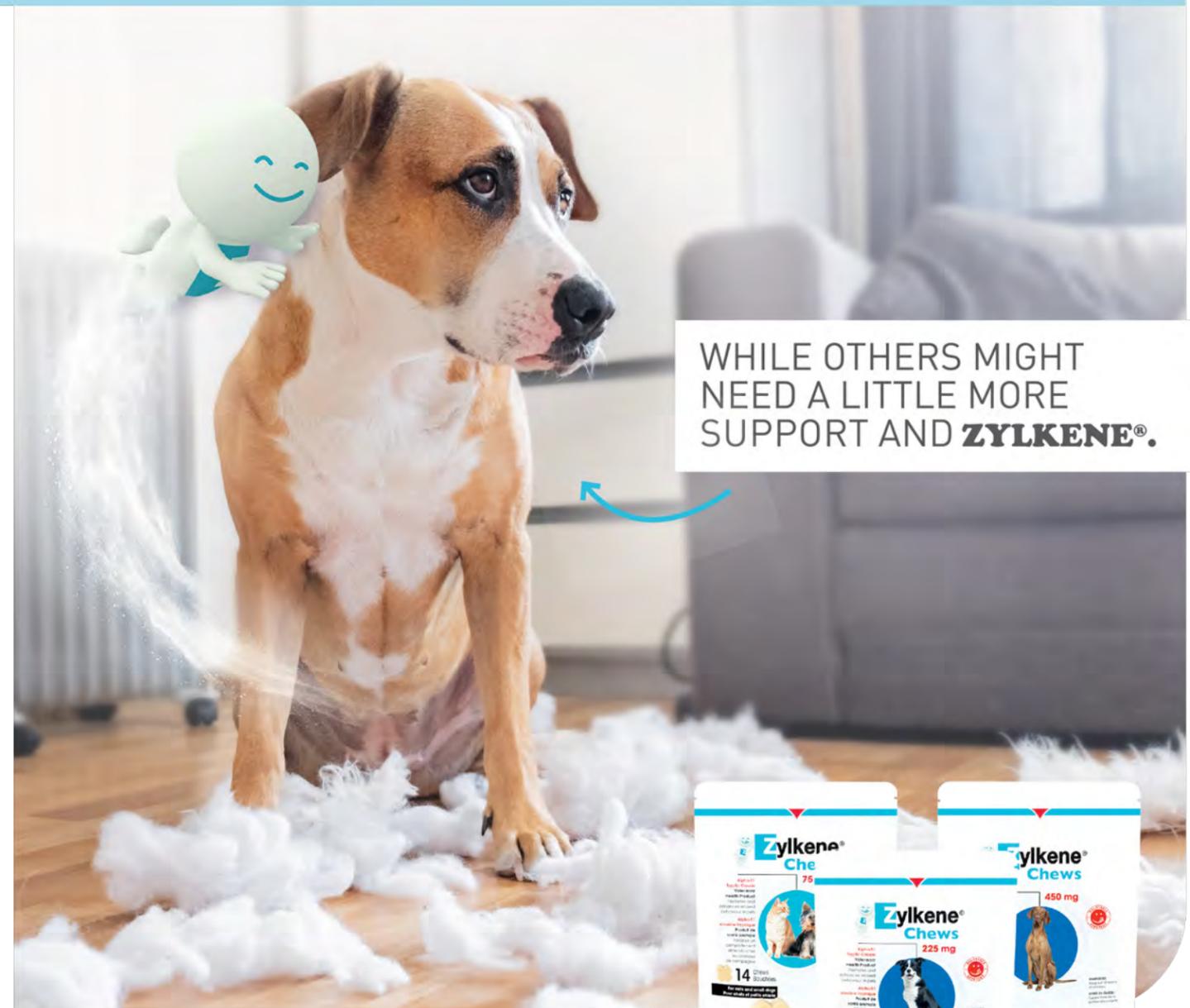
The process also requires more time and effort for me as a veterinarian. After examining a patient, I call each owner to discuss diagnostic and treatment plans, which sometimes turns into a game of phone tag or other times requires multiple prolonged phone conversations to describe a physical condition with words and to obtain informed consent to pursue procedures. Although I still had non-emergency appointments for conditions such as ear infections, there seemed to be an increase in appointments involving complex cases that required more time and effort.

Now, a year into the COVID-19 pandemic, the “new normal” of veterinary practice feels well entrenched. I’m still officially a locum veterinarian, but now work mostly full time at the same clinic. I have had discussions with veterinary colleagues and clinic staff about feelings of being overrun and feeling burned out at times, made worse by the seemingly new normal of impatience and misdirected anger of some clients during these already trying times. Yet we have hired more staff and created some ways to be more efficient. At the moment, we are still catching up on our backlog of routine appointments like annual health examinations and vaccinations, but overall we continue to be busier than we were before the pandemic. I no longer expect the pace to abate. Rather, the influx of calls seems to have increased as COVID-19 restrictions tightened in British Columbia in recent weeks. With people spending more time at home with limited social bubbles, pet shelters and breeders are reporting abnormally long wait lists to become prospective adopters.

Yet I have also experienced several unanticipated positives during COVID-19 in my daily routine as a veterinarian. I still wear a mask at work but try as much as feasible to get outside to chat with clients at a distance in the parking lot. I love being outside whatever the weather, and this has created a new opportunity to get out and move around more. Having a trained veterinary assistant hold animals has also been a blessing in disguise, as examination can be done more efficiently with animals being properly restrained. On a personal note, although I am a people person, I find I can now dedicate more time to examination, procedures, and medicine. Although conversations with clients can be the highlights of my day, they are naturally more limited in time in the parking lot or over the phone.

At least from my own experience, the veterinary industry has been fortunate to be one of the businesses that continues to thrive during the pandemic. (However, some local clinics have also had to temporarily close due to COVID-19 exposure.) For me, the most stressful part of work during the earlier days of the pandemic was working while balancing a household with two frustrated young children who could no longer see their extended family members or friends. We were lucky to get in 30 minutes of “homeschooling” a day for my school-aged daughter. My wife, in particular, had no break. While I was at work, she was at home with the kids simultaneously trying to balance working her job from home. COVID-19 has changed my life at home and work; both are busier than ever, necessitating that I adjust my expectations. From my perspective, all my veterinary colleagues and staff are doing their very best, but as a practice we could benefit by working to adjust and manage the expectations of clients to garner more understanding and patience during these unprecedented times. <sup>WCV</sup>

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# OCCUPATIONAL HAZARDS IN VETERINARY PRACTICE: NEW UBC STUDY WANTS YOUR HELP

BY HUGH DAVIES, BSc, MSc, PhD, CIH, AND FIONA SENYK, BA

COMPLETE THE SURVEY AT  
[tinyurl.com/ubcvet](https://tinyurl.com/ubcvet)

All clinics eligible—you do not have to use antineoplastic drugs. Just one survey per clinic, please. A \$10 donation to the SPCA for animal welfare will be made for each participating clinic.

**T**reatment for cancer in companion animals often includes the use of antineoplastic (chemotherapeutic) drugs, which are a known occupational hazard in human health care settings. Accidental exposure could also present an occupational health hazard for veterinary workers. Currently, little is known about the applications, risks, and safety precautions regarding antineoplastic drugs in veterinary practices across different veterinary care settings.

The survey addresses questions about preparation, administration, training, and PPE to acquire an understanding about how the sector is currently handling antineoplastics. We are asking one knowledgeable employee from your veterinary practice (for example, oncology specialists, veterinary technicians, veterinary pharmacists, or administration staff) to **participate in a 15-minute survey on behalf of your clinic.**

**“EVEN IF YOUR CLINIC DOES NOT ADMINISTER CHEMOTHERAPY, THIS INFORMATION IS IMPORTANT FOR OUR RESEARCH, AND WE WOULD BE GRATEFUL IF YOU COULD TAKE THE TIME TO COMPLETE THE FIRST FEW QUESTIONS.”**

anonymous; results will only be tabulated and communicated confidentially to the participating veterinarian. Your participation in this survey is optional.

For questions about the survey or research project, please contact Fiona Senyk at [fsenyk@gmail.com](mailto:fsenyk@gmail.com). The deadline to complete the survey is March 31, 2021. [WCV](#)

behalf of your clinic.

Even if your clinic does not administer chemotherapy, this information is important for our research, and we would be grateful if you could take the time to complete the first few questions. As recognition for your time and effort, we will donate \$10 to the SPCA for each participating clinic.

This research is conducted at the University of British Columbia to characterize antineoplastic drug use in BC and Minnesota veterinary practices. The primary investigator of the project is Dr. Hugh Davies, and the information gathered by the survey will be used strictly for research purposes. Your responses will be kept confidential and

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# A COACH APPROACH TO LEADERSHIP

BY ELAINE KLEMMENSEN, DVM

“...HUMANITY IS BOTH MORE CONNECTED AND MORE DISCONNECTED THAN EVER BEFORE.”

**G**rowing up on the Canadian prairies I didn't play team sports, and my athletic pursuits were usually independent affairs involving the outdoors and adventure. Until I owned a veterinary practice, I never felt the camaraderie of a team and never experienced great coaching. Yet here I am, completing a Certificate in Executive Coaching, stepping into this new persona of coach, and somehow it feels right. Perhaps, if you pay attention, the universe delivers you exactly where you need to be.

In 2020, change was a constant and nagging companion as leaders in all industries navigated the uncertainty and fear associated with COVID-19. As the pandemic unfolded, it became clear that a hierarchical or command-and-control model of leadership was not the most effective in the evolving, complex, ambiguous environment of COVID-19. In this new digital age, humanity is both more connected and more disconnected than ever before. When information is available with the click of a mouse, and rapid, disruptive change is unrelenting, a different type of leadership is required. We need leaders who are willing to move from telling people what to do and demanding compliance to instead believing in the capacity and creativity of their team and leveraging their collective strengths. This shift to focusing on unlocking people's potential to maximize their performance is the essence of a coach approach to leadership. Organizations needed agile leaders able to:

- **Optimize trust** to decentralize control and create agility and speed in decision-making
- **Engage people** to amplify communication and improve problem-solving and collaboration at all levels of the organization
- Step back from having the right answers and instead **ask the right questions** to empower the entire team in finding solutions

As a leader with a coach approach, your job is to draw creativity and insight out of your team, empowering them to embrace challenges, find solutions, and make sound decisions on their own. This requires skills that don't come naturally for many leaders. Bringing the benefits of coaching to your hospital starts by adopting five key coaching principles into your leadership practice.

## 1. COMMITTED LISTENING

Learn to listen at a deeper level. Most of us listen with the intent to reply. Some of us listen to understand. Few of us listen to find the deeper meaning behind the words being spoken. With practice, we can train ourselves to hear the context, values, and belief systems behind what is being said and use this understanding to bring awareness to our team. In this way, a leader can safely challenge existing mind-sets and create new thinking and behaviour patterns. This expands a team's sense of what is possible and enlists them in finding ways to bridge the gap. Developing this skill requires courage, humility, and willingness to let go of judgment and admit you don't have all the answers. As you build your listening skills, ask yourself these questions:

- “Am I about to give advice before attempting to understand this person?”
- “What might I learn if I let myself get curious?”

- “What don't I know that might change my thinking about this person or situation?”
- “Who can provide a new perspective?”

## 2. POWERFUL QUESTIONING

In turbulent times, organizations need to create new knowledge and innovate to meet the demands of rapid change and ambiguity. The way we have always done things is no longer a guarantee of success. A different kind of thinking is needed to meet the challenges of a world in flux—creative thinking.

As veterinarians, we are trained to follow a logical set of steps to diagnose disease (the problem). We then set about treating disease (or fixing the problem) using well-researched and scientifically sound methods. While this logical approach reduces risk (mistakes) and increases the likelihood of a successful outcome when dealing with medical cases, it may not be as effective in exploring the complexity of decision-making in the information age. Creative thinking leverages the collective capacity of an entire team to discover fresh perspectives and innovative solutions. It requires a shift from a problem-solution orientation where we focus on finding the right answers to admitting we don't have all the answers and asking the right questions instead.

In formulating powerful questions, it is important to challenge assumptions, let go of judgment, and engage curiosity. Instead of “What did we do wrong and who is responsible?” leaders need to ask “What did we learn from this and what possibilities do we now see?” Consider posing questions that do the following:

- Provoke thought
- Engage curiosity in the listener
- Stimulate reflective conversation
- Surface underlying assumptions
- Invite creativity and new possibilities
- Touch deep meaning
- Evoke more questions

## 3. CREATING IMAGES OF POSSIBILITY

While the past can teach us many lessons, human systems grow toward what they persistently focus on and ask questions about. Leaders who can paint a picture of what is possible and inspire their team to co-create this future have the opportunity to grow in new directions and tap into innovative sources of knowledge and energy to move forward.

As you adopt a coach approach, instead of focusing on solving problems and controlling situations, try to paint a mental image for your team of what is possible and what the future could look like. This moves the team from a focus on short-term solutions (reacting to the situation) to building sustainable, satisfying long-term results (responding intentionally to the current reality). When creating a powerful, shared vision and purpose for your organization, take time to explore the following:

- What do we value about our work? Our team?
- What is special and unique about our organization?
- What strengths are represented on our team? How do we leverage these strengths to meet our vision?
- When are we at our best?
- What achievements are your team most proud of?
- Apart from money, what makes it worth coming to work?
- If you had three wishes for our organization, what would they be?

## 4. FEEDFORWARD INSTEAD OF FEEDBACK

People want to know how they are doing and whether their performance is in line with what leadership expects. Great coaches have mastered the skill of creating awareness with respect and compassion while empowering individuals to take ownership of their growth. One way to do this is to move beyond the traditional employee evaluations with a focus on past performance to feedforward sessions that invite employee participation and focus on building skills to prepare for future opportunities. Consider trying this introduction to the benefits of feedforward with your team:

1. Have each participant pick one behaviour they would like to change. Changing this behaviour should make a significant, positive difference in their life. For example, “I would like to learn how to control my temper when stressed at work.”
2. Break the group into random two-person teams. Have one person start by describing the behaviour they want to change and ask for feedforward.
3. The second person responds with two suggestions for the future that might help their teammate achieve a positive change in their selected behaviour. There is one rule—they are not allowed to give any feedback or examples from the past. Only ideas about the future.
4. The first person should listen attentively and take notes

if desired. They are NOT allowed to comment on or critique the suggestions in any way, even to make positive statements like “That's a great idea!” Teammates are only allowed to say “Thank you for your suggestions” and “You are welcome.”

5. Participants change roles and repeat the process. When they have finished, they change partners with another group and repeat the process until the exercise is stopped.

When the exercise is finished, ask participants to provide one word that describes their reaction to this experience. You might be surprised to learn that the response is almost always positive. This game is a great way to start creating self-awareness and teaching your team valuable skills in interpersonal communication while learning to give and receive feedforward directly with a high level of care.

## 5. CELEBRATING TOGETHER

The final principle requires moving from the rescuer mind-set that says “Let me fix it for you” or worse, “Let me fix you” to a coaching mind-set that says “I will stand by you, challenge you, and inspire you because I believe in you.” This helps team members take ownership of their role on the team and become accountable for their success. Pay close attention to your team's progress. Acknowledge behaviours that align your values and support your shared vision and watch for opportunities to celebrate as you teach your team that the best wins are team wins.

A coach approach to leadership will move your team from a problem-solving mind-set to a creative one, stimulating the innovation and collaboration needed to thrive in a climate of rapid change and uncertainty. Like any new skill, shifting from telling people what to do and demanding compliance to listening, asking questions, and growing capacity takes time. It requires a dedication to the long game, ongoing practice, and an unflinching belief that the people in your organization are your biggest asset. This leap of faith has the power to reap big rewards for your team and your organization.

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# UBC'S LSLAP ANIMAL LAW CLINIC

BY EMILY WILSON, MA

**A**nimal law continues to inch its way into the mainstream. In the fall of 2020, the Peter A. Allard School of Law at the University of British Columbia introduced Canada's first animal law clinic (ALC). I am a third-year law student and serve as the co-clinic head along with Animal Justice Chapter co-president Marie Turcott, supporting a handful of student clinicians who volunteer to assist people with low income with their legal issues involving animals.

The ALC is under the umbrella of the law school's Law Students' Legal Advice Program (LSLAP), a student-run program that offers legal advice and representation to people with low income. There are various "clinics" within the program, with animal law being its newest addition.

What is animal law? Basically, any time that the law affects animals' interests, or humans' interests with respect to animals, this can be deemed animal law. An obvious example is the animal protection legislation (albeit woefully inadequate) at the federal and provincial level, but animal law extends beyond that. Essentially any area of law can intersect with animal law: Property law—who gets to keep the family pet in a divorce? Municipal law—do the zoning bylaws allow an animal sanctuary in a given location? Consumer protection law—are "humane" certifications on animal products misleading to consumers? The list goes on and on.

Given LSLAP's mandate to assist low-income *human* individuals, the slice of animal law that it focuses on is relatively narrow. The cases will often have to do with pets or service and support animals, but not always. The clinic is also designed to assist someone who encounters a legal issue as a result of their efforts to help animals or promote their rights or welfare.

For example, there may be a scenario in which someone's dog bites another dog at the park, and the former is deemed "dangerous" by the city. If the owner would like to challenge this designation, they may come to the clinic to ascertain the procedure of going about this, or even be represented in any ensuing legal proceedings.

Another situation that might call for the assistance of the ALC could involve an individual who has a support cat for their mental health. If, for instance, their school did not allow them to bring the cat into the classroom, they may have recourse under the law, such as claiming a human rights violation on the basis of disability.

A scenario that would not involve the client's pet would be as follows: A person notices a dog in a car on a hot day. The dog appears to be suffering a great deal, and the person sees no other way of relieving the suffering than to break the car window. They are then charged with the crime of mischief. Since the person committed the alleged crime in the furtherance of an animal's interests, this would fall under the purview of the ALC.

The scenarios outlined above should not be construed as legal advice or information; they are merely provided to illustrate the scope of the clinic. They are hypothetical scenarios, and even if a situation resembles these, that does not guarantee that the clinic would be able to represent or otherwise assist a client. Additionally, there is no guarantee of the outcome should the ALC provide assistance. The clinic does not take on any veterinary malpractice cases. Finally, it is worth noting that while

**"...ANY TIME THAT THE LAW AFFECTS ANIMALS' INTERESTS, OR HUMANS' INTERESTS WITH RESPECT TO ANIMALS, THIS CAN BE DEEMED ANIMAL LAW."**

contravention of animal protection legislation (for example criminal cruelty to animals) technically falls within the scope of animal law, the ALC may decline to represent people charged with or accused of such acts, if it is not in animals' best interests.

I am thrilled that the law school has been so receptive to such a novel clinic and sees the importance of being leaders in social change. What was once a fringe issue that was typically met with a blank stare or a polite "That's awesome" when I mentioned it is becoming increasingly recognized within the field of law.

I was inspired to spearhead the clinic by Harvard Law School's Animal Law and Policy Program, which is home to its own animal law clinic. I approached my law school's director of experiential learning with the idea, and he was incredibly helpful in advocating for the clinic and pitching it to LSLAP. Two adjunct professors who teach the law school's Animal Law course were similarly instrumental in getting the ALC off the ground, and have since been enthusiastically raising the profile of the clinic in the community.

Due to the somewhat niche nature of animal law, we also brought on board Vancouver lawyers who have experience in animal law to help guide students in their cases as needed. Again due to its nascence, and in an effort to ensure the clinic's success and therefore longevity, I am organizing a series of practical training sessions led by these supervising lawyers (who, again, have generously offered their time and expertise) on how to conduct client interviews and begin cases in several specific areas within animal law: these include dangerous dog cases, human rights cases involving service and support animals, and pet custody issues.

I am optimistic about the ALC's impact both at a local level and on a broader scale: while I of course hope that it will prove a useful tool in helping individual people and animals, I also see it as an important step in advancing animal interests in general.

First and foremost, having a law school establish a clinic solely dedicated to animal law indisputably strengthens the credibility of this area as a field of work and study, which in turn serves as recognition of the importance of animals and their well-being. Even if a student never directly interacts with the clinic, as they move up in their career into positions of influence and have the power to take animals into consideration in a legal decision or legislative change, it will not be a novel concept to them.

Moreover, having the backing of LSLAP is hugely beneficial, as it is unparalleled in its ability to give students hands-on experience; this is especially critical in animal law, given that this is such a foreign and nebulous concept to most students. Many students care about animals and their well-being but are unsure how to include helping animals in their career. The ALC demonstrates the myriad ways in which legal issues involving animals can present themselves, thus illuminating potential career paths for future lawyers. Simply put, the more opportunities there are for students to become involved with animal law, the better, and the more the field will grow.

LSLAP is a program designed to address the "access to justice" crisis in Canada, which is the sad reality that the justice system is largely, and increasingly, unavailable to those who are not wealthy or powerful. I believe that, in addition to the noble cause of helping low-income (human) individuals, it is critical to make justice accessible for the most marginalized, silenced, and hidden members of our society: nonhuman animals.

While the law school and LSLAP's administration have been supportive of this initiative, I am even more heartened by the response from students. There are some very dedicated people for whom this is their first foray into animal law and who otherwise might not have been exposed to it.

I started this article by saying that animal law is moving slowly away from the fringes. The creation of this clinic follows a couple of years of huge and very exciting developments in the world of animal law: namely, historic legislation passed in the summer of 2018 banning the captivity of cetaceans and closing several loopholes in the Criminal Code, as well as the inaugural Canadian Animal Law Conference co-hosted by Animal Justice and the Schulich School of Law at Dalhousie University in the fall of 2019. I hope that the Animal Law Clinic at my law school is the first of many, and that animal advocates continue to make noise until animals are adequately protected under the law. I think we can all agree they deserve it. **WCV**

CUT OUT THIS PAGE IF YOU WISH TO SAVE IT.

## THE VETERINARIAN-CLIENT-PATIENT RELATIONSHIP

BY SCOTT NICOLL, BA, MA, LLB

**P**revious articles in this column have discussed the relationship between the College of Veterinarians of BC and you, its registrants. We have touched on what to do and what not to do if you become the subject of a complaint to your college. We have also discussed some key strategies to avoid becoming the subject of a complaint. This column will focus more closely on your relationship with your client and specifically the professional practice standard that governs that relationship.

I want to start by stating the obvious: for those of us in private practice, professionals are businesses. As businesses, we need to take the precautions that every business must take. We need to protect our businesses, ourselves personally, our employees, and our clients. The difference for us, as professionals, is that we must put protection of the public (our clients) ahead of all other interests. That is a unique requirement that only regulated professional businesses face. It is a significant additional obligation that we, as professionals, must meet.

I have mentioned previously, but it bears repeating, that the College exists to protect the public interest, not your interest. Where your interest diverges from the public interest, your interest will be in conflict with the public interest and, therefore, with the College's interest. You will find no mention in Section 3 of the BC Veterinarians Act of the College having a purpose to assist you as an individual registrant. To that end, the obligation is yours to ensure that you understand and comply with your obligations regarding your interactions with your clients. As a professional and a business person, you need to balance the protection of your business with the simultaneous compliance with your professional obligations to your clients. I will have more to say about general business considerations for professional businesses in future columns. This column will focus on the specifics of protecting the relationship with the client. This is the first and most important component of the balancing of interests you must accomplish.

### VCPR PROFESSIONAL PRACTICE STANDARD

You will know that the College has set out your professional obligations with respect to your relationship with your clients and patients in the *Professional Practice Standard: the Veterinarian-Client-Patient Relationship (VCPR)*. A copy of this standard may be found on the CVBC's website under "Resources," and then "Legislation, Standards and Policies" ([portal.cvbc.ca/wp-content/uploads/2020/03/Standard.pdf](http://portal.cvbc.ca/wp-content/uploads/2020/03/Standard.pdf)).<sup>1</sup> The VCPR standard requires that a veterinarian-client-patient relationship (VCPR) exist prior to you recommending or providing any veterinary services to a patient, unless one of the exceptions applies. You do not get to turn your mind to the existence of the VCPR after the fact. Your file should reflect this. You should be able to show that prior to providing any services you turned your mind to the existence of the VCPR. Attempting to show that it exists after the provision of services is a failure to comply with the standard. Notably, the standard also makes clear that such services include the prescribing, dispensing, or administering of any drugs to a patient.

Your "client" for the purposes of the standard, and based on the information reasonably available to you at the time, is either the owner of the animal (or group of animals), the authorized representative of that owner, or an individual "acting in the interest" of the animal(s). Make sure that the client you obtain instructions from is the one with whom you have entered into the agreement for the provision of services. Your file should clearly document this relationship.

### PRACTICE EXPECTATIONS

Assuming that none of the exceptions listed below apply, you must meet the "Practice Expectations" regarding the establishment, maintenance, and termination of the VCPR. To do that, as we have noted, you must establish your VCPR *before* recommending or providing your services, including in herd medicine scenarios (more on that below). Again, it is not sufficient to go back and attempt to comply with this requirement after you have provided your services. To that end, I recommend you note in your file that you have considered each of the criteria necessary to establish the VCPR when you do so. I have suggested in other columns the use of checklists for this purpose (and others). I reiterate that here. To borrow from Alexander Pope, while to err is human, your clients, the College, and tort law are not divine. Checklists help you to avoid that most human of foibles, particularly when repetitive tasks are involved. You will put yourself at an automatic and significant disadvantage if your file does not disclose that you turned your mind to the elements necessary to establish the VCPR when you should have.

Your file also needs to reflect that you reached "an agreement" with the client as to the scope of services to be provided. The VCPR guide referenced above suggests that it is sufficient for you to have a "conversation" with a client to establish this agreement. I respectfully and strongly disagree. This agreement should always be in writing. You should consider it your obligation as a professional business person to reduce any agreement with a client to writing. A written agreement is the only form of agreement that should give you any confidence regarding the terms of that agreement.

There are templates available for this form of agreement. No lawyer, however, will recommend that you adopt a template without first obtaining legal advice on whether that template is sufficient for your own circumstances. I am no exception in that regard. Litigators such as myself derive a significant portion of our work from clients who have used forms of agreements that have not first been reviewed by a lawyer. It is significantly less expensive to have an agreement drafted for your specific purposes by your lawyer at the outset than to pay a litigator to go to court once a dispute has arisen about an agreement that was not properly drafted in the first place.

Your written agreement should expressly provide that the services you are agreeing to provide will be provided only in accordance with all applicable law and regulations, including the College's bylaws and professional practice standards. It should also reflect those elements the VCPR standard identifies as being necessary to show that the VCPR has been established and is being maintained. Your agreement should specifically state that you have assumed responsibility for making the clinical assessments and recommendations regarding the animal's health. It should state that the client has agreed to follow your recommendations and to administer (if necessary) those medications you prescribe for the animal. It should address the requirement for you to have "recent and sufficient" knowledge of the animal (or group of animals) sufficient to permit you to make your assessment, diagnosis, and treatment of the animal(s) (more on this below). It must also acknowledge that you will ensure your availability for follow-up and emergency care of the animal, or that you will make arrangements for such with another veterinarian.

The agreement should also set out that you will provide the client with reasonable notice of your intention to terminate the VCPR and how that notice will be provided. It should include the period of time during which emergency services will be available after notice of your intention to terminate the VCPR has been provided. It should also set out how the animal's medical records and other information will be transferred to the new veterinarian.<sup>2</sup>

This agreement is important. You should take care that it is thorough and well-drafted, and you should review it at least annually to determine if you believe any revisions to it are necessary.

### RECENT AND SUFFICIENT KNOWLEDGE

The VCPR standard provides specific direction on how you must determine if you have "recent and sufficient" knowledge to establish and maintain a VCPR in each instance. It provides that it is a matter of "professional judgment" in each case. It also provides, however, that such knowledge is a matter of history and inquiry as well as a physical examination of the animal(s). In a herd medicine scenario, the physical examination requirement is satisfied by "medically appropriate" and timely visits to the premises where the animals are kept (again, more on this below). The VCPR guide provides some additional direction on this point that is helpful. It provides that there are "certain factors" that "may assist" you in considering whether your knowledge of the animal is "recent and sufficient" and whether an examination or other assessment is warranted prior to providing your services. These factors include but, as always, are not limited to the animal's age, species, health status (including current medical condition), recorded medical history (including immunization history), nutrition, environment, hygiene, the type of treatment plan and medication being considered, and the recognized best practices (if any) as to how often you should see and assess an animal(s) of that species. I recommend that these criteria be added to a checklist as a reminder for you to record evidence

in your file that you expressly considered each of them when necessary. The VCPR guide also recommends that you ask if the client has had the animal seen by another veterinarian recently and, if so, that you obtain the records from that veterinarian. The guide also specifically advises that you should document your “clinical reasoning process” regarding how you determined that you have or do not have “sufficient and recent” knowledge. You document that process by recording it in your file and by showing that you considered at least the criteria set out above.

This bears repeating. I cannot overstate the importance of you recording in your file how you determined that you have “recent and sufficient knowledge” when necessary. Your file will be conclusive evidence that you did what you were required to do and that you met your professional obligations if you take the time to record the information when you go through the steps you are required to perform. You must make it a priority to give yourself the time to record the steps you take to comply with your professional obligations. Your failure to do so may well result in the College concluding that you did not, in fact, take those steps. I repeatedly tell my professional clients that it is not an exaggeration to say that when the question of compliance with your professional obligations arises, the thoroughness of your file will determine your professional reputation.

#### HERD HEALTH AND GROUPS OF ANIMALS

The VCPR standard provides that in herd health situations you do not need to examine each animal before making your recommendations. You must, however, through “periodic visits” to the premises where the herd is maintained and through discussions with the client, “acquire and maintain” a current understanding of the level of husbandry practiced on the premises. You must also acquire and maintain a current understanding of the client’s ability to recognize the signs of disease, administer drugs, and follow treatment plans. The standard also expressly provides that you may use the herd-health model to provide services to groups of animals such as those kept by shelters or breeders. Again, you should record the details of each visit in your file and ensure your file entry is sufficient to show that you have turned your mind expressly to the aforementioned requirements.

#### MULTI-VETERINARIAN CLINICS AND CHANGING CLINICS

Notably, the College takes the view that the VCPR is established by the clinic rather than the individual veterinarian. That can be the only explanation for why the College advises that it is unnecessary for each veterinarian in a multi-veterinarian clinic to establish and maintain the VCPR. You should explain to the client that once the VCPR has been established with a particular veterinarian in the clinic, any of the veterinarians within that same practice may provide care to their animal. This, the College says, is to ensure the continuity of care for the animal. Similarly, and consistent with that position, the College takes the view that when you change clinics, the VCPR does not travel with you. You need to establish the VCPR again with a client if that client follows you to your new clinic.

#### EXCEPTIONS

There are circumstances in which you are permitted to provide your services without having a VCPR in place. You are permitted to do so if any of the following apply:

- If an animal reasonably requires emergency veterinary services
- If you are a government employee and you are providing your veterinary services within the scope of that relationship
- If you are providing veterinary services permitted or required by law other than pursuant to the Veterinarians Act
- If you are providing an independent medical examination regarding an animal to someone other than the animal’s owner
- If you are administering or dispensing a drug pursuant to a prescription, other than for a controlled substance and all of the following conditions are satisfied (in the absence of a VCPR prior to administering or dispensing):
  - o The drug was issued by another Canadian veterinarian (registered to practise with another Canadian veterinary college)
  - o It is not reasonably possible for the client to obtain the drug from the prescribing member or from a human pharmacy
  - o There are exceptional and extenuating circumstances, and it is in the best interest of the patient to dispense without delay

- o You have confirmed the registration status and facility affiliation of the prescribing veterinarian
- o You have made reasonable efforts to discuss the matter with the prescribing veterinarian
- o You have carried out a sufficient assessment of the animal’s circumstances
- o The quantity of the drug dispensed by you is no more than would reasonably enable the client to return to the prescribing veterinarian for future prescriptions
- o You make a written record of the transaction

Notably, the VCPR standard further expressly provides that these exceptions do not absolve you from the need to confirm the appropriateness and safety of dispensing any prescribed medication to an animal, including the performance of a physical exam and the review of medical records if appropriate. While you may provide your services to an animal without first establishing a VCPR in these instances, you may not neglect to consider the appropriateness of those services. You should also not neglect to record the fact that you have done so in your file.

#### A NOTE ON COVID-19 AND TELEMEDICINE

This article is being published during a pandemic, and COVID-19 has required an amendment to the strict application of the VCPR requirements. You have likely already reviewed the CVBC’s March 24, 2020, position statement titled “Telemedicine in the Face of COVID-19” that can be found at [portal.cvbc.ca/wp-content/uploads/2020/03/Telemedicine-Position-Statement\\_March-24\\_.pdf](http://portal.cvbc.ca/wp-content/uploads/2020/03/Telemedicine-Position-Statement_March-24_.pdf). You will know, therefore, that the CVBC has said that you are not automatically relieved from your obligations set out above regarding compliance with the VCPR. They nonetheless recognize that “veterinarians may find themselves in situations where it is not possible nor in the best interest of the animal or the public to strictly abide by the CVBC’s standards.” The statement expressly acknowledges that you may be asked to provide care for an animal with whom you do not have a pre-existing VCPR. You are being asked to use your best professional judgment in each instance in determining whether you have done everything reasonably possible in the circumstances to establish the VCPR.

This means that you will need to determine whether you have sufficient knowledge of the patient to make a presumptive or tentative diagnosis and to direct treatment. The statement provides that such knowledge may come from the animal’s medical records from another veterinarian, for example, or any new information that is available from other sources or through the use of telemedicine. You are required to always act in the best interests of the health of your patient, the public health, and the safety of the food supply. This means, in this case, that you are expected to take all reasonable steps to prevent harm to patients and the public when deciding whether to provide your services, making conclusions about your patient’s condition, providing advice and prescribing treatment. “Reasonable” does not require perfect adherence. It does require you to show your work, however, and in this case, specifically to show how and why you made the choices you did.

The CVBC says that they will consider the individual circumstances if a complaint is received about services provided during the pandemic. They state very expressly that “failure to meet the expected professional standards may not give rise to a finding of unprofessional conduct if a registrant demonstrates that he/she took all reasonable actions in the circumstances in service to patients and clients.” Which brings me back to your record-keeping practices. Any compromises you may be required to make in your adherence to the VCPR requirements before providing treatment may well be excused by the College, but only if your records sufficiently illustrate why the compromise was necessary. COVID-19 is not a “get out of jail free” card if you are the subject of a complaint for failing to adhere to your professional obligation to establish the VCPR before you administer treatment while the pandemic continues. Your properly documented reason for doing so, however, that is contained in your properly maintained medical record for that patient, could well be exactly that.

#### FOUNDATION OF CARE

The VCPR standard provides that the VCPR is one of the foundations for effective veterinary care and service. The VCPR establishes the expectations that are fundamental to establishing and maintaining the veterinarian-client-patient relationship. It is not an exaggeration to say that this practice standard is one of your most important obligations as a veterinarian. It is important that you take the time to review and understand its elements. It is even more important, from the standpoint of a lawyer who acts for professionals, that you carefully, thoroughly, and consistently document your adherence and compliance with its requirements in your file. [WCV](#)



Scott Nicoll, BA, MA, LLB, is a member of the Law Society of British Columbia and a partner at Panorama Legal LLP. He acts for professionals, including defending professionals who are the subject of complaints to their professional colleges.

1 Please note that this article by Scott Nicoll does not discuss or review the College’s Council Policy on Requirements of a Veterinarian-Client-Patient Relationship for Bee Medicine ([portal.cvbc.ca/wp-content/uploads/2020/03/Bee-Medicine-VCPR-Policy.pdf](http://portal.cvbc.ca/wp-content/uploads/2020/03/Bee-Medicine-VCPR-Policy.pdf)). The College has also set out a helpful guide to your interpretation and use of the VCPR standard at [portal.cvbc.ca/wp-content/uploads/2020/03/Guide-to-the-VCPR-Standard.pdf](http://portal.cvbc.ca/wp-content/uploads/2020/03/Guide-to-the-VCPR-Standard.pdf). I have borrowed from both the standard and the guide for the content of this article. I recommend that you review each of them in turn regularly.  
 2 Note that the CVBC’s guide to the VCPR standard contains a sample termination letter to clients.

THE SBCV CHAPTER PRESENTS



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DR. JACQUELINE PEARCE, DVM, DACVO



SUNDAY MAY 2, 2021  
OPHTHALMOLOGY OF DOGS WITH  
DR. MARNIE FORD, PhD, DVM, DACVO



SUNDAY MAY 16, 2021  
CARDIOLOGY OF CATS WITH  
DR. MEG SLEEPER, VMD, DACVIM  
(Cardiology)



SUNDAY MAY 30, 2021  
CARDIOLOGY OF DOGS WITH  
DR. MARK HARMON, DVM, DACVIM  
(Cardiology)



THE CVBC STRONGLY RECOMMENDS THAT BC VETERINARIANS TAKE THE TWO ONE-HOUR SESSIONS OFFERED AT THE BEGINNING OF EACH OF THE FOUR SUNDAYS:

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COMMUNICATION IN PRACTICE IS NOT A SOFT SKILL WITH  
DR. CINDY ADAMS, MSW, PhD  
*How to build a relationship, discover what clients want, and improve adherence for practice success*



EACH SUNDAY IS APPROVED BY THE CVBC FOR SIX CE CREDIT HOURS.



**JANGI BAJWA, BVSc & AH, Dipl. ACVD**, is a board-certified veterinary dermatologist with the American College of Veterinary Dermatology. He works at the Veterinary Dermatology and Ear Referral Medical Clinic in Surrey, BC. He is also a consultant with the Veterinary Information Network and is a dermatology feature editor for the *Canadian Veterinary Journal*. His dermatology interests include otitis and its treatment, microbial resistance, canine and feline allergic disease, and continuing education of veterinary professionals and pet owners.



**HUGH DAVIES, BSc, MSc, PhD, CIH**, is a senior researcher at the School of Population and Public Health at the University of British Columbia with expertise in exposure assessment. He is currently the primary investigator on an ongoing study of antineoplastic drug surveillance in Alberta and Minnesota hospitals. He has been a principal investigator on over 25 previous studies and has authored over 60 peer-reviewed publications in the field of occupational and environmental exposure assessment.



**BAILEY EAGAN, MSc**, is currently a PhD student in Applied Animal Biology at the University of British Columbia Animal Welfare Program. Her work focuses primarily on companion animal behaviour and welfare in a shelter environment. She completed the study described in this issue as part of her MSc.



**DAVID FRASER, CM, PhD**, joined UBC in 1997 as NSERC Industrial Research Chair in Animal Welfare. His work has led to many innovations in animal housing and management, from designing better pig pens to reducing highway accidents involving wildlife. He was appointed Member of the Order of Canada in 2005 for his work in animal welfare science.



**LAUREN FRASER, MSc, CHBC**, completed her MSc in clinical animal behaviour through the University of Edinburgh's Royal (Dick) School of Veterinary Studies. Her research there examined the behaviour of horses subjected to forced "laying down" during training. She sees horses, dogs, and cats with behaviour problems, both in person and remotely. She also teaches and lectures on horse behaviour and training.



**EMILIA WONG GORDON, DVM, Dipl. ABVP (Shelter Medicine)**, is the only board-certified shelter medicine specialist in Canada and serves as the senior manager, animal health, for the BC SPCA. She provides animal health support, training, and oversight for 34 animal shelters provincially. Dr. Gordon also conducts shelter medicine research, works with veterinary students, participates in community partnerships and outreach, and volunteers on several committees including the SBCV-CVMA Chapter Animal Welfare Committee.



**MARK HARMON, DVM, Dipl. ACVIM (Cardiology)**, is a cardiologist at Boundary Bay Veterinary Specialty Hospital in Langley. He obtained his DVM from the University of Missouri in 2011 and completed a rotating small animal internship at the University of Pennsylvania followed by a cardiology specialty internship and then residency at the University of Missouri. He has been a board-certified cardiologist since 2017, at which time he began practising at a large private practice in Seattle. In May 2020, he and his wife moved to British Columbia and are excited to continue hiking, kayaking, and exploring the region.



**ELAINE KLEMMENSEN, DVM**, is always up for an adventure, especially if it involves people, pets, and creating connections within the veterinary profession. Her adventures in veterinary medicine have included being an associate veterinarian, partner, practice owner, locum, and international volunteer. Passionate about leadership development and workplace culture, she recently embarked on her latest adventure, founding Evolve Leadership Coaching and Consulting where she is determined to help veterinary leaders discover the "secret sauce" that will move their team from surviving to thriving. A student at Royal Roads University, Elaine is a graduate of the Values-Based Leadership Certificate and is currently enrolled in the Executive Coaching program.



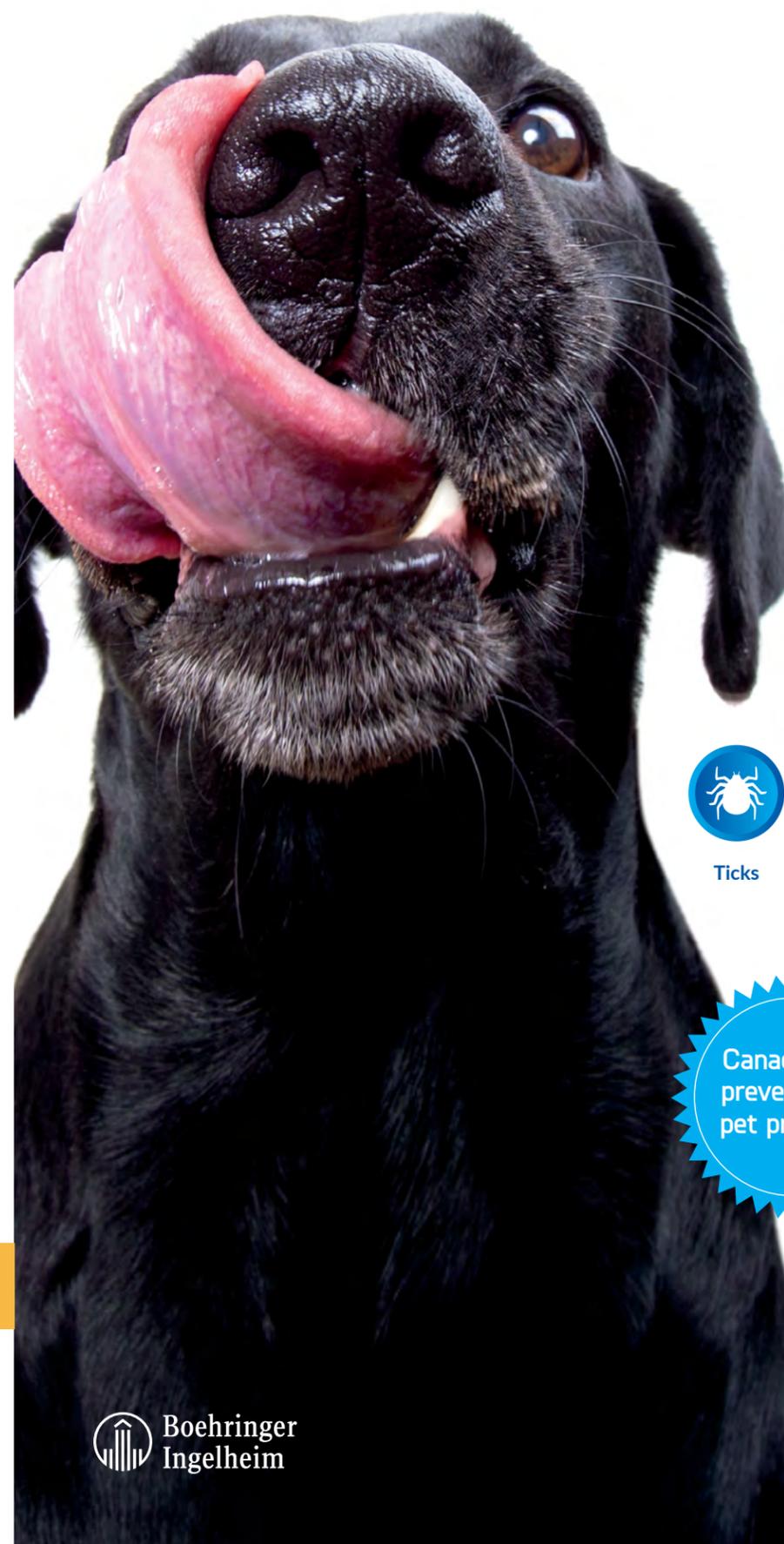
**ROCKY LIS, BSc, MSc, DVM**, has taken a circuitous route to becoming a veterinarian, travelling and working internationally as a wildlife biologist for several years before attending the Western College of Veterinary Medicine. Following completion of his DVM in 2009, he volunteered in Uganda with Veterinarians without Borders. In 2016, he completed a Masters of Applied Science at the University of British Columbia with a thesis project that developed and piloted a collaborative moose health monitoring program. Currently, Dr. Lis works as a locum veterinarian and enjoys outdoor adventuring near his home in North Vancouver with his wife and two young children.



**FIONA SENYK, BA**, is completing her master's degree in the School of Population and Public Health at the University of British Columbia and completed her Bachelor of Health Sciences at Simon Fraser University. She is passionate about recognizing and controlling workplace hazards so that workers return home to their families healthy and safe.



**EMILY WILSON, MA**, is in her final year of law school at the Peter A. Allard School of Law at UBC. She has a Master's Degree in Economics from the University of Toronto. She has worked as a summer student for Animal Justice, for which she was awarded the Dean's Public Interest Fellowship, and has volunteered for Mercy for Animals and the Good Food Institute. During the summer of 2020, she worked for the Competition Bureau. This past summer, she also co-founded Living Tree Foods, which produces plant-based foods such as cashew cheese.



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## 2020 AND 2021 DR. CAROL MORGAN MEMORIAL AWARD WINNERS

The Dr. Carol Morgan Memorial Award has been awarded annually since 2018 in honour of Dr. Carol Morgan, a tireless advocate for animal welfare and ethical veterinary practice and BC SPCA member, who died in 2015. The 2020 award recipient was Dr. Laurie Gaines, a shelter veterinarian from Ontario. She will use the grant to virtually attend Humane Canada's National Animal Welfare Conference in April 2021. The 2021 award recipient has been awarded to Dr. Laurie McDuffee from Prince Edward Island, who will use the grant to pursue a certification in the human-animal bond.



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