PETS Referral Center to You

2026: January Issue

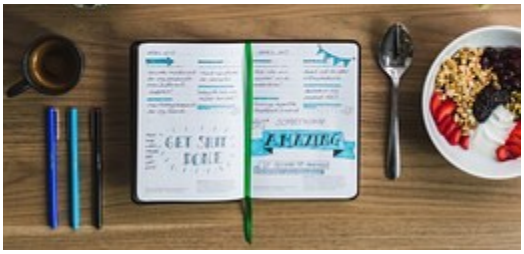
Maintaining Compassion in the Field

By Lisa Touhy, Surgery Technician

When I first joined PETS in 2019, I was working emergency. After a particularly difficult case, my shift-lead noticed me wiping the tears that wouldn't stop welling up under my eyelids. With care, he asked me why I would choose to work emergency, as it's one of the most traumatic jobs you can do in vet med. In fact, during my initial reviews, staff, shift leads, and doctors remarked on how fast I was advancing, how meticulous my work was, that I got along well with everyone, and handled my patients and clients with care. But there was one concern that continued to arise. Worry that I would fall victim to compassion fatigue. In response to my lead, I replied, "I've been crying for over 20 years. Don't worry, this is just what I do."

Over the years, I've worn many different hats. Always a hands-on RVT, but in many different settings and positions. GP, Surgery, HR, Emergency, and back to Surgery. One thing has never changed. My love, respect, and advocacy for our patients, our friends, and our fellow beings on this earth. There is a beauty and consistency in who they are, and I try to keep that at the forefront of my work with them. I have not become jaded, as many a disgruntled old tech warned I might. I never stopped feeling. I just kept learning and practicing healthy coping strategies.

If you are one of the more sensitive team members, as I am, I have found journaling to be an invaluable tool. For cases that I carried on my back...that I took home with me...that I thought about even after I closed my eyes....I write about them. I put to paper that I recognized them. I set down in black and white that I wish things would have turned out differently. There is something so cleansing about putting words to paper. Recording their names. Sorting through my feelings, my regrets, my grief. In that, I pay tribute to them and acknowledge my own depth of feeling.



Secondly, when needed, I have found professional therapy to be helpful in processing not only the emotional aspects of the job, but also in developing better techniques to manage the stress of the work in general: the fast pace, the physical load, the intellectual challenges, the workplace personality menagerie, the client idiosyncracies, and the intense grief.

Besides the above, most importantly, I wouldn't be able to survive this work without the team camaraderie...to be able to stand outside by the dumpster and cry with a colleague over a patient....to come apart from stress...and to know nobody understands us better than us.

I'm here to get it right...
not be right.
—Brené Brown

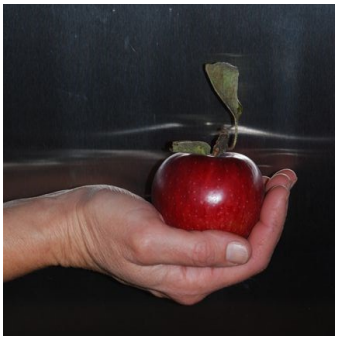
Sign up for emailed newsletter!

Special points of interest:

- *Foot splints*
- *AAHA talks to us*

Inside this issue:

Referral Logistics Like a Pro— AAHA's Thoughts



The 2025 AAHA Referral Guidelines (https://www.aaha.org/resources/2025-aaha-referral-guidelines/) are a treasure trove highlighting the concept of Collaborative Care in veterinary medicine. The introduction highlights the social and financial benefits published in three recent studies— improved survival times, enhanced disease management/recovery, boosted pet quality of life, and upgraded client perception of and satisfaction with care.

Types of Veterinary Referral Collaborations

Type of referral	Description of referral
General collaborative conversation	Phone, video meeting, or written (e.g., email, text) conversations between two veterinary professionals intended to facilitate collaboration and exchange of general, non-specific information between veterinary professionals at different practices. General collaborative conversations do not address specific patients or cases unless the conversation serves as preamble to initiating a hands-on patient referral with the specialist.
Professional-to-professional consultation	Phone, video meeting, or written (e.g., email, text) conversations between two veterinary professionals, whereby the general practitioner seeks advice from the veterinary specialist about a patient or case. Consultations enable virtual collaborative care for a patient under the VCPR of the consultee. The veterinary professionals may decide during the consultation that a hands-on referral is the best option for the patient and client.
Hands-on referral	A hands-on referral is a joint decision between the PCT and the SCT for a patient requiring help with a specific condition. Upon accepting the referral, the SCT establishes a VCPR and assumes the role of directing veterinarian for the patient for a particular health concern. At the end of the referral timeline and process, the PCT resumes the role of directing veterinarian.

PCT, primary care team; SCT, specialty care team; VCPR, veterinary-client-patient relationship

Their key client communication points are:

- Discuss clients' goals
- Mitigate client concerns
- Explore information needs
- Ask re: previous experiences
- Personalize education re: collaborative care.
- Manage client expectations
- Designate team members leading collaborative care.
- Re-assure client along the way.

More next month, but until then, let's see how we can continue and enhance the collaborative care model in our shared relationship!

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In addition to the quality of medicine practiced at PETS, and the minds behind it, the PETS community excels at building a loving and respectful team culture. I consider these folks my friends, even family. They know me inside and out, as I know them. We may not always agree, but we respect each other. And we foster a deep understanding for one another, that others outside of this work couldn't do in the same way.

These are just a few of the things that have helped me to stay in the game as long as I have and still keep my heart, and most of my sanity. I encourage vet staff to make the conscious choice to still practice and share your empathy. Sometimes we have to understandably put up walls to survive in this field. Even given that, when I say "conscious choice", I mean **choose to remain connected with our patients**. Even as we protect ourselves by dissociating from our own pain, we choose to still share our energy with a dying friend. A gentle touch, a soft voice, and a connection of spirit. **It matters**. We carry a lot on our shoulders in this field; **there is no bigger honor** than in carrying it.

MicroCE from Team Surgery: *MetaCarpal/MetaTarsal fractures*

Lara Rasmussen, DVM, MS, Diplomate, American College of Veterinary Surgeons

The fracture of one or more metacarpal or metatarsal bones is quite common in our small animal patients. Dropped, stepped on, hit by car. The degree of trauma to the surrounding periosteum, muscles, tendons, vessels, nerves is variable. The number of bones is variable. The location on the diaphysis/metaphysis is variable. But the take away message is quite similar when it comes to treatment plan—***most patients have a good functional outcome.***

Another commonality to treatment is external coaptation. Regardless of the addition of surgery or not, (the oft times headache of) **external coaptation is required**. *The benefit of **surgery is alignment**, not healing. In fact, **healing** is likely, technically, **delayed by surgery** given soft tissue disruption (which due diligence must be given to reducing!) Surgical repair options include dowel/toggle/IM pin, plate/screw, external fixator. (Ok, I am realizing a bit of mis-statement here; external fixator does both the alignment and the stabilizing, so a splint isn't needed. But ex fix on feet are rarely indicated and a hassle to manage, so, let's move on.)*

Custom Spoon Splint for the Micro-feet! Don't go big!!



Guidelines for Treatment Decision-making:
(note, it's not "black and white! " you type A, literal veterinary-types out there! Ok, well technically this IS black ink on a white page…)

The more bones involved, the less inherent, internal, self-splinting the foot has to maintain gross alignment of carpus/hock & toes.

The more **active** a patient is, the more all-around **stress** (for everyone and everything) will be placed on a splint.

The **heavier** a patient is, the more **stress** placed on a splint alone (this applies to obesity as well as patient size.)

The more **trauma** to the foot soft tissues, the **longer** the healing process will be. Counter-intuitively, this might mean accurate surgical alignment (tho disruptive, technically, to healing) might speed things up.

The **older** a patient is (into his/her geriatric years), the **longer** the healing process will be.

Metaphyseal location or extensive comminution of a fracture, usually reduces surgical options for alignment.

Larger bones are easier to deal with surgically! (FYI, there is NO appreciable medullary canal in those 5# chihuahua foot bones!)

Radiographic union with **mature remodeling is not the end-goal**. If it were, those foot bandages would be on for 6mo. The end-goal is a clinically stable foot without pain.

Everyone needs **patience** in these cases. Spread the word!

To minimize the challenge of external coaptation (splinting) for owner and vet professionals alike, the following information is offered:

Most foot splints are **too big**, in my 20+ years of observation.

Most off-the-shelf splint products **MUST be cut to size;** plan for that when you buy supplies.

The thick, **white plastic/blue foam** splints are **lousy**. (Remember, all of this is opinion!)

Custom splints are great—either tongue depressor-types or casting tape-types. Reduce your inventory instantly!

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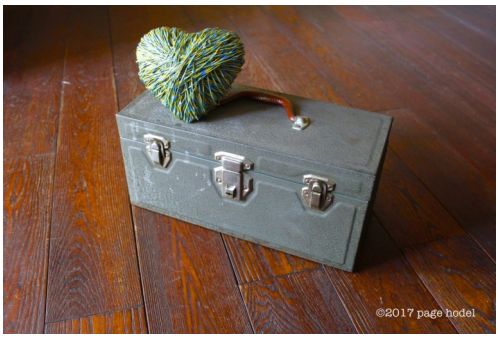

Primary Care — Surgery Specialty Communications:
Optimizing Collaboration without Onerous Workload

Following on last 6 month's communication highlight regarding the:

ACVS Collaborative Relationship Communication Tool...

There are always questions moving forward! Any good relationship/ collaboration related to medicine will generate essential questions about a plan. When we have the option of NOT flying by the seat of our pants, I really, really like to go that route. :\

To that end, when the questions bubble up from a review of our record summaries or conversations with your clients about their pets' experience, please hop on email or phone and start a conversation to get them resolved. We are available Monday through Friday (and probably checking emails on weekends!) at the contact details below.

MC/MT Frx, con't pg3

The splint is best applied to **palmar/plantar surface**

Rearlimb applications do NOT need to extend the rigid splint above the hock; the soft part of the bandage applied above the hock is helpful for retention.

Forelimb applications need only go 1/3 up the antebrachium.

Cast padding **thickness should vary** through the healing process. Thicker earlier when soft tissue swelling/ wounds need compressing. Thinner when just bones need good support.

Frequent re-applications are needed. Get that clear to an owner from the get-go. If there are wounds, q1-2d. If things are limited to fractures only and compliance is 100%, q7d.

Feet don't like bandages. Plan for that in client prep, foot care during changes, frequency of change, and duration of wear.

Listen to your patient. If they are chewing on the bandage, it's not their fault!!!!!!!!! Don't blame them with a tighter, larger E-collar. Blame the foot, the bandage, the owner first. Then, when all of those variables are evaluated, put on an e-collar. Your patient will suffer fewer extensive bandage complications and more minor bandage complications if you do.

Surgeon provides the **P**rimary **C**are **V**eterinarian access to the surgeon/surgery practice prior to referral **to discuss case**.
Surgery staff communicates to PCV on behalf of surgeon.
Surgeon confirms with PCV that the client booked the appointment with surgery department.
Surgeon sends results of the consultation to PCV.
Surgeon sends the plan for the patient to the PCV.
Share with PCV the ongoing communication being sent to the client.
Surgeon provides timely records and updates to PCV.
Surgeon provides the PCV access to surgeon/surgery practice for follow-up questions after referral appointment.
Follow-up plan, expectations of involvement, and mapping of continued care.

Please feel free to use our direct email surgery@petsreferralcenter.com or the main desk phone (and ask for Surgery Team) **510 548-6684** when you or your staff need to chat (Meltzer M-Th, Rasmussen W-F)

— See ya on the flipside, *Meltzer and Razz*