Central Line: The AAHA Podcast Transcript

Episode Title: Empowering Veterinary Technicians to Advocate for Their Patients – and Themselves
Guest: Tasha McNerney, BS, CVT, CVPP, VTS (Anesthesia and Analgesia)

0:00:22.3 Katie Berlin: Hi, welcome back to Central Line. I'm your host, Dr. Katie Berlin, and I'm joined today by somebody who I bet a lot of you are already pretty familiar with: Tasha McNerney of Veterinary Anesthesia Nerds. She is a certified veterinary technician and a certified veterinary pain practitioner, and has her veterinary technician specialist in anesthesia and analgesia. She's definitely somebody that I am really excited to have on the podcast today, given the recent release of our new pain management guidelines. So, Tasha, thank you so much for joining us today.

0:00:57.7 Tasha McNerney: No problem. Thank you so much for having me. Very exciting.

0:01:00.8 KB: This is exciting. I have been looking forward to this conversation, and I want to talk to you about so many things, but first would you mind just giving us a little bit of a window into what you're doing now and what you're liking most about it?

0:01:13.9 TM: Yeah. Right now, I actually have kind of a fun job in that I don't have any official job at all. Actually, last October, I quit my full-time job. I had a research position. And I just had an epiphany on a family vacation that this was the first time I had really slowed down to enjoy time with my family. I am very good at telling others that they should practice self-care and telling others that they should take time out and fill their cup, etc, and I realized that I was definitely not taking the advice that I was giving out. Which I think we're probably all guilty of at some point.

0:01:58.0 KB: Yeah, that sounds familiar.

0:02:00.0 TM: But I had this epiphany that this was the first time I had really slowed down. I was really enjoying some time with my husband and my son, and then about a week later my son was at basketball, and during the basketball game I was answering emails from work. And my son, being a typical 10-year-old and not having much of a filter, definitely called me out on it. He was like, "You missed my shot because you were on your phone."

0:02:28.4 KB: Ouch.

0:02:28.6 TM: And, you know, if you're a parent, that definitely hurts. I was like, "You know what, buddy? You're totally right, you're so right." So those two things combined - I was kind of like, you know, I gotta quit my job. So I went home to my husband and I said, "I have to quit my job." This is the first time in my life I've ever quit a job with no other job waiting and ready.

0:02:51.5 KB: It's scary.

0:02:54.5 TM: Yeah. I realize I was definitely in a privileged position; I had some savings, so I could decide what I really wanted to do. And I had some talks with some mentors. I think that in this business you can surround yourself with people that have your best interests at heart, but also are people that you look up to and you're like, "Yeah, I love what you're doing, I love your message." So I called on those people and I said, "Hey, what do you think?" And it was such a good

support network that I really had time to focus on “what do I want?”

And when I say time, I meant I took a couple of weeks to decide: what do I really love doing and what do I want to do? And I really love anesthesia. I love anesthesia, I love pain management, and I love working with teams to bring teams together, to get them motivated and energized, to take their anesthesia to the next level, if they're already doing good anesthesia and now they want to take it to the next level and they want to start, I don't know, incorporating epidurals or something fun. And I want to go in clinic with them and teach.

And not only do I do in-clinic teachings, I do relief work for some local practices that have surgery days where they need additional anesthesia help, or they have critical anesthesia cases that they call me in for. And I go around to conferences. And then I teach on the Veterinary Anesthesia Nerds page and I do webinars and all that kind of stuff. So I am very lucky in that I've been able to create a job around kind of doing whatever I want – and when I say doing whatever I want, I mean because I'm passionate about anesthesia and pain management, and I want to be able to go into as many clinics as I possibly can to talk about good anesthesia and pain management and how we can make things better from a patient care perspective.

0:04:39.8 KB: That is so amazing. I love hearing stories from people who are taking this field and making it their own. And obviously, like you said, there's always going to be a little bit of privilege involved when you can take time off and think about that and create that job for yourself, but you worked really hard to get where you are. I mean, you put in long hours over many years in situations that were both great and not so great, and you got to a place where you could do this for yourself and your family. And I think that's really important to say - you got here because of that passion and that drive that you have.

And it's bettering the profession for everyone, because you're spreading really good medicine in an area that’s evolving a lot and where we all could use some help. So, I just think that's wonderful, and I'm glad that you're finding that path now. Did you ever think, if someone had said to you 10 years ago that this is what you'd be doing in 10 years, would you ever have believed that?

0:05:39.8 TM: I would have hoped so. Yeah, I will say that I'm pretty - I don't know what the right word is, but I am... Not to say that I can't be spontaneous, because I can be, but at the same time, I'm pretty... When I have determined that I'm going to do something, I'm going to do it. And I don't care if it takes me 10 years, 10 months, I'm going to do it. Heads up, you guys, I failed my first CVPP exam and got right back up there, studied for another year, and did it.

I think that you have to be able... If you really want to do something and you're passionate about it, whether you want to graduate from that CVT program or you want to go get a specialization, or you want to, I don't know, get off the clinic floor and take on practice management – there are so many different avenues that you can pursue within this field, and for me I was really, right from the get-go, as soon as I was in the surgery room, participating in anesthesia.

For me anesthesia is such a fascinating field, in that it's a puzzle, like a lot of medicine is, but each patient is going to present a little bit differently. How their puzzle pieces fit together is going to be different than the last patient, and I think that's what's really interesting to me. And then also with anesthesia, what's super cool is that as you have a patient on all of these monitors and you're really watching everything that's going on with them; you get to watch physiology play out in real time in

front of you. And if you're really into anatomy and physiology, like I am, if you're really nerdy about these things, it's really cool and fascinating to see these things. So for me, I don't get super jacked up about ECC and the emergencies, and I'm glad that there are people out there that do.

0:07:32.9 KB: Same, same.

0:07:33.8 TM: For me it's really like I love taking a patient from pre-op to recovery. And then, and the whole reason I got my CVPP, or Certified Veterinary Pain Practitioner, is that I want to know what's going on with the patient, not only in recovery and making sure they walk out that door, but in the weeks that follow. Is their pain being adequately managed? Are we choosing the right analgesic regimen for this patient to make sure that chronic pain doesn't develop in the future? Or if they are a patient dealing with chronic pain, how are we going to manage them so their quality of life is what we want it to be?

So I think that, yeah, if somebody 10 years ago had said, "You're going to be doing this and going into all these clinics and teaching analgesia and anesthesia," I would have been like, "Yeah, alright. Dude, let's go. Let's do it, that's exactly what I want to be doing."

0:08:22.7 KB: I love that answer, love it. And I definitely want to get back to some of the things that you just said a little bit later. One of the things that you were saying there is that pain management and anesthesia really is a process. It's not just that the animal's in front of you, so you do what you're supposed to do and then you send them out the door. It really starts before then and it ends long after that in some cases. And that's a message that the updated pain management guidelines that came out this year are really trying to drive home as well - that pain management starts long before you see that pet, because you have to have a way that you're going to approach cases where pain might be involved.

I wanted to ask you, since we've got pain on the brain, if you could tell the veterinary profession one thing regarding pain management, put it on a billboard and make sure that every single person saw it, or tweet it out to the entire universe, what would it be?

0:09:28.4 TM: Oh man, you know there's so many things.

0:09:31.1 KB: I know, so many.

0:09:34.2 TM: So many things. I try not to be like soap box all the time, but I do have a few. And for pain management, I think one of the big things for me is that sedation does not equal analgesia.

0:09:47.6 KB: Yes.

0:09:48.5 TM: So I think that we... I'm probably guilty of it as well. Sometimes in our post-operative patients, or even when we have owners evaluate patients at home, we've sent them home on medications like Tylenol with codeine, we maybe have sent them home with gabapentin. I hate to say we've sent them home with tramadol, given the evidence that we have, but I do know that I still hear about that. So, let's say you have a patient on these things and you're evaluating their pain score and they're really drowsy or they're sedate; it can be harder to really evaluate their pain. And I think that a lot of times technicians who are doing the pain scoring, clinicians, and owners at home will mistake a sleepy sedated pet for comfortable. And there are things that we need to do to really

evaluate whether or not a patient is truly comfortable, especially with the guidelines that came out - looking at feline facial scoring and pain recognition in that regard.

You could have a cat that could be kind of like bread-loafed in and sleeping in their crate, but if you look at some of these other clues, you could see that maybe they are sedate from having some gabapentin, but are they truly non-painful? Are we truly giving them drugs that work on nociception? And I think that that's where we have to look at your pain management protocol as being truly multimodal. Is it multi-modal? Are you utilizing drugs that are multi-modal and hitting different pain pathways all together, or are you just relying on a heavy dose of gabapentin to do what it needs to do for that cat? If so, we're probably seeing a lot more sedation than we are true analgesia.

And I think that that's where, as a collective, as doctors together with the nurses that are doing these evaluations - hopefully at your practice you have your technicians doing post-operative pain evaluations or pain scoring - I think it's together, the clinicians with the technicians, have to evaluate: are we truly seeing sedation, or do we think this patient has adequate analgesia?

0:12:05.4 KB: Yeah, and that highlights another big aspect of this whole thing, which is that this is a team effort, and we have to listen to each other, because somebody is going to catch something that somebody else might have missed, sometimes just through being with the patient more. And we as doctors have to trust our technicians when they say this pet is not comfortable, and technicians need to have the freedom and the empowerment to speak up and say, "I don't think this pain is adequately controlled."

And that can be a paradigm shift for some people. There are a lot of practices where I don't know that the technicians feel like they can speak up, or I don't know that the veterinarians trust technicians to tell them things and then listen. And that's really a shame. I do think it's changing even since I've been in the field, but we've got a long way to go still.

You've done a lot of teaching about pain, and as a technician you have a lot of qualifications and a lot of experience, but do you find that people approach you differently or are sometimes less receptive because you're a technician, or do you feel like that's been pretty good for you?

0:13:14.6 TM: I will say that it depends on the culture of the practice that I go into. And that's really... That could probably even be a whole episode, just creating that practice culture so people have collaboration and psychological safety and all of the things that go along to make really excellent patient care.

For me personally, because I have a lot of letters embroidered on that scrub top, I do think that I get a little bit of leverage over - I don't want to say a regular CVT, but I do think that I probably get more leverage than a newly graduated CVT might get. And I get it, I have a lot of experience, but also I do think that sometimes I can be... I have been told that I am intimidating when it comes to my advocacy for patient care. And I will say that you're probably not wrong. I don't have a problem being a little bit intimidating for good patient care, especially when it comes to post-operative pain management and analgesia or even pre-med, post-operative pain management analgesia, etc. My job is to advocate for that patient, and if I see that that patient is suffering, stressed, etc, I'm going to advocate for that patient.

And I will say that now, because I have the letters after my name and I have so much experience, I have the information to back it up. So if you say to me, "I don't really think that I want to utilize this drug in this protocol," I feel comfortable having a conversation with the clinician and saying, "I'm used to using this and here's why, and here's a study I can refer you to, and then here's this proceedings that we did at WSAVA," or something like that, "that I can give you." Or, "Hey, why don't you check out the new AAHA publication on pain management guidelines," especially when you have some brilliant people like Mike Petty, Sheilah Robertson - these are the people who are really working in pain management and they're making these recommendations, so why don't we follow them?"

So I don't myself have a problem being that advocate, but again, I also know that it depends on the clinic. And some technicians are working in clinics where the technicians do not have autonomy, they do not have that safety where they feel that they can go to the clinician, or even offer a disagreement. And not everything has to be confrontational, right? I'm not talking about going up to your clinician and saying, "Hey, you gave this dog this and that's wrong." Absolutely not. Of course, how we approach things is going to help our cause.

But at the same time, you do need a culture within your practice, that says that all staff members, whether they be a receptionist or a kennel technician, anyone... Right? Because if a kennel technician is feeding the animal and notices that they didn't eat two of their meals, I want that kennel technician to feel like they can come to me and say, "Hey, I think the drugs this patient is on are making them nauseous. They don't want to eat. What can we do about it?" I want everyone in that clinic who is spending time with that animal to feel like they have ownership in the management of that case and can go to the clinician with these concerns and have a conversation. That's what it should be, it should be about collaborative conversations in the best interest of the patient. We have to take the ego out of it.

0:16:48.1 KB: Yeah, I so agree. And I can think of times at the hospital where I most recently worked where the front office staff would need a little bit of a break from the constant onslaught of phone calls, and they would come back and just kind of hang out with some of the post-op patients while they were recovering, or hang out with a hospitalized patient and feed them a snack. And even when we normally don't think of front office team as being involved in patient care at all, sometimes it takes somebody who hasn't been staring at that pet all day to say, "He looks different than he did this morning," or, "He's not greeting me like he did yesterday," and those things matter, they're so important. We take for granted that we know the most, and this is just not the way it is, especially for doctors, who often have the least contact with those patients over the course of a day.

So I absolutely agree with what you're saying, I feel like it is a systemic change.

What have you learned from all of those hours that you've logged teaching and lecturing and educating about what it really takes to make a systemic change like that in this profession?

0:18:02.3 TM: Oh man, I'll tell you, it's hard, right? It's hard. And especially when anesthesia and pain management comes into it, because anesthesia is scary, and anesthesia in veterinary medicine has a much higher morbidity and mortality rate than human medicine, and anesthesia's scary. Making changes in your protocol that has worked for so long, or again, what we think has worked for so long, is scary, and I totally understand that. And so that's where, when I go into clinics, I like to say to people, "You want to make a change and you want to start doing something? If you want

to start implementing CRIs, I'll come into your clinic. I will be there with you while we do it." I have a great dentistry practice in Tennessee that had me come out just last week because they want to start implementing CRIs. So we did a fentanyl CRI on one animal and then a ketamine CRA on the next animal, just to get them used to it. Because change is hard.

0:18:58.4 KB: Yeah.

0:18:58.8 TM: And I'm talking about individual clinics, right? If I think about the big bear, these big behemoth corporate practices, to make and instill change, it really has to come from the top, and it has to be a shift from the top, where the management of the hospital and the clinicians and everyone is in agreement that this is where we want to go. We want to have the best pain management protocols. We want to have not only the kennel staff, but the receptionist and the technicians and the assistance and everyone, involved in it, and we want everybody to be proud of our patient care and proud of our pain management and analgesia.

Ultimately, you can make little changes here and there, but if you don't have buy-in from the very top and the practice owners or the hospital director or the medical director, it is going to be an uphill battle, and probably very frustrating.

0:19:55.8 KB: Yeah, that's such a good point. We can lead by example inside the team, but that's only going to go so far, for sure. And I think we are kind of ending up with this episode talking about this, because this dynamic between the technicians and veterinarians and front office team and managers, and especially people at the corporate level, affects pain management and patient care so profoundly.

And I also think every vet clinic that I know is having trouble hiring and retaining staff members, and I have to think this is something you think is probably related to that. Would that be fair to say?

0:20:37.1 TM: Oh, 100%, 100%. We have a lot of information out there to tell us, especially when it comes to technicians and assistants, one of the big reasons that we are not retaining them... Yes, we can always say, "Money," or, "They went somewhere else because of money," and I'm telling you right now, it is not all about money. Could be a little bit about money, but it's not all. Technicians, especially certified veterinary technicians who went through an accredited program, who put the work in and put the time in and they want this to be their career, they want to use those skills. They want to be fully utilized, and when I say fully utilized, I mean really fully utilized, you guys.

I worked at a practice, and I really think that the reason I stayed at that practice for 15 years... Yeah, I stayed at this GP for 15 years. I stayed there after I got my CVPP, after I became a VTS. I stayed there because I was so fully utilized, and I got to use my brain and my skills so much every day. I was never bored, and I think that that practice still today does not have a very high turnover.

There was one technician there for 28 years. I still know one of the techs that's there. She's going on 18 years, and then we had another for 12 years. So this practice has figured out that if they really fully utilize the technicians, not only do the technicians enjoy their work, but also it makes it better overall for patient care. The patients are getting better care, the technicians are enjoying their work, the overall practice efficiency is better, which means, guess what? The overall practice profitability and Yelp reviews are better.

0:22:22.3 KB: Yeah. Dang Yelp reviews.

0:22:24.1 TM: I think that makes a lot of sense, that we as technicians, if we have decided that this is our career... If you have a certified veterinary technician in your practice and they have decided they want this to be their career, man, use those skills. Find out what skills they have graduated with.

I think that part of it is some of the veterinarians don't understand all that a certified veterinary technician can bring to the table. All of the veterinarians that I know went through vet school and at vet school, they worked with really bad ass techs who just ran everything. And if you had a difficult intubation, they were there to help you with. If you couldn't hit that arterial, they were there to help you. So technicians have these really advanced skills that you could be utilizing in your general practice. Right?

I think that that was a key with my future as a technician, is that I worked with a clinician who saw that I was interested in anesthesia, and he said, "Hey, I see you have an interest in anesthesia. Would you want to be our technician point person for that?" And he sent me to anesthesia CE, and that really got me going in anesthesia and surgery and pain management and all of that. It was just having that mentor and having somebody say, "Hey, I see you're interested in this. How can we help you flourish within that, and bring it and make it even better at the practice?"

If you have technicians who are interested and they really want to be using all of their skills and using their brain, let them do it, right? And I understand that it's a little bit of trust, so if you're like, "Well, I don't want to just tell my techs to do epidurals, what if they do it wrong?" So practice the few first of them together. Say, "Hey, I think you can take over epidurals. I see that you've been practicing other local blocks. Do you want to do the epidurals with me? And then after about three, four epidurals, I'm going to let you take over."

That kind of stuff is huge for technicians. They want to be fully utilized, and most of the time when technicians leave practice, it is because they are feeling stagnant. They're feeling like they're not learning anything. They don't have any place to advance in their career. They don't feel like they are being utilized in bringing new information to the table, etc, so not only is it going to be in the best interest of the practice, and you're going to retain your technicians even longer, but the patient care efficiency and ultimately profitability is going to go up for your clinic, so yes, utilize your technicians to the fullest extent.

0:25:05.9 KB: I feel like that should also be on a billboard, because I know I've been guilty as a vet of feeling like I didn't want to burden them with these things and say, "Well, okay, I know I'm getting paid more than they are, and I can stay late and do my records. I'm going to get this done so that they don't have to worry about it." And working at a hospital with... I think we had 13 CVTs? It was insane how much could get done without me being even there. And they could do it faster and better, and I could get my charts done.

It was really amazing, and they really thrived on being able to use those skills that they work so hard to get, and I realized how much I had been laboring under that false belief in my mind that I was sort of foisting my work off on other people, when, in fact, it wasn't my work. It was their work, and I'd just been doing it this whole time. And that practice, compared to other ones that I've

been to, has a very low turnover, and nobody ever leaves because they can't do enough. That's never a reason. And that was really eye-opening. So everybody take note of that billboard. We're going to tweet it out.

0:26:28.4 TM: Yes, yes. Let us do our jobs. Man, we want to utilize the skills that we have worked really hard for. And I think that some of it may come down to just simply that there are some clinicians who don't know exactly what a technician can do. So look into some of the practice laws or practice acts in your state, because every state is a little bit different. But I know at least for Pennsylvania, one of the things that really helped, once my clinician felt like he had seen enough to know I was capable, if we had a simple laceration repair or a urethral obstruction cat, he honestly... We went over the anesthetic plan, we went over the estimate. Once everything was signed off, the patient pretty much got turned over to me as the technician.

So it was me as a technician and an assistant. We would sedate the patient. I would do the unblocking of the cat. I would do the simple laceration repair... Again, I'm saying simple lacerations and repairs and stuff like that. But think about it, timewise from the clinician's perspective, he comes in, he checks over everything, hands it over to me, the assistant and myself are doing it, monitoring the anesthesia, performing the tasks, and then when the patient is starting to recover, he comes in, does another exam, everything looks good, I'm the one writing up the discharge instructions, the assistant and I are the ones filling the medications to go home, communicating with the client, and then at discharge, my clinician is then talking with the client. So it really is a team effort. The clinician cannot and should not be doing everything.

0:28:09.9 KB: Yeah, and that is a disease, I think, that a lot of us have - we feel like we have to do everything and be everywhere, and then we get really burned out and tired and we don't understand why, but we are taking all of that on ourselves. And I know you just probably blew a lot of people's minds when you said that, you know, that you're doing... You're unblocking the cat, and that just blew my mind because I thought about how lovely life would be if someone else unblocked that cat.

And I think that alone is a huge testament to how much we're underusing our really skilled team members. And also when you find a team member who has that desire, and if they don't know how to do it right then, to take the time to nurture that desire and make sure that they have a way to learn those skills. It’s absolutely worth the time and money to do that.

Okay, so we’re talking about all of the different ways to make sure that your team is challenged and utilized to their fullest potential, which will keep them happy as well - I know I'm not happy if I'm not learning anything and I'm just going through the motions. Growth is really important for everybody at every level, in every job, and I feel like there are probably people listening who are having trouble picturing how that would happen in their hospital, what the workflow would look like.

Let's use pain management as an example. So they're trying to bring the rest of their team into the pain management plan for, say, not just a post-op patient, but maybe a patient who's dealing with some chronic arthritis pain, and we're trying some new therapies. Can you talk about how you would recommend a hospital use, say, somebody from the front office team and somebody from the technician team to sort of bolster that workflow and change it up a little bit, so that the whole team is involved?

0:30:01.5 TM: Yeah. I think that that's really important to have the whole team involved. One person can't be the pain police for the entire practice, and you have a hand on every single patient that comes in. I think if you just put it out there to your staff, right? "Hey, who's interested in pain management? I want one technician representative, I want one kennel attendant representative, I want one clinician, and I want you guys to form a little task force on pain management, and I want you guys to look over…" - this could be the practice manager talking, or the medical director or whoever - "I want you guys to talk about what do you think about instituting maybe the Colorado State pain scoring here. How can we get everybody on board with that?"

And if everybody has a seat at that table to make the decisions, the buy-in is going to be greater. Then they can talk to other technicians and other assistants, and all of the clinicians put that information out there, whether you guys do staff meetings or staff newsletters or emails or you Slack it, and the best thing is just communication, right?

We don't want to just have these four task members, and then everybody else in the dark. You're going to say, "Hey guys, at the staff meeting, the Pain Management Task Force is going to talk about some of the new things that we're going to be rolling out. And we need your help with it. So if you guys have any ideas, let us know. Or if you want to try the Glasgow short form pain scoring instead of the Colorado, let's talk about it as a group."

And it doesn't have to be two or three hour long staff meetings. These don't have to be drawn out. It really can be succinct information, as long as the information is getting out there to your team, but also that they feel like they have some ownership in it. Right? I think that it doesn't work if it's just a memo from the Medical Director. "Hey, we're going to start instituting pain scoring. Here's a link to the pain score. We want you to do it."

I think that if we have a different member of each team of the hospital on board with it, and they understand why we want to implement these pain scorings, why we want to bring about this level of patient care, and that they have buy-in, then also they can make recommendations based on what they're seeing, right? Because if somebody says, "Hey, let's try the Glasgow form," then another person says, "Well, that might not work because we don't have enough nurses post-operatively to spend the 20 minutes needed on a Glasgow form for each patient." But it's a conversation, again, collaborative communication to best interests of the patient. That's what I like to see teams do.

0:32:49.7 KB: Yeah, I love that. And I was going to ask you something similar to the answer you just gave, which was, "What can a practice do, say, tomorrow to start improving the way that they're using their entire team and educating their entire team about pain, if they feel like that's really not a part of the process already?" But I'm going to switch it up because you really just answered that, and the answer is you ask them. We start talking to each other.

And I want to switch it up and think about what it would be like if you're a CVT or an RVT or LVT, and you're in a practice where you feel you're not utilized. You feel like your skills aren't being used and you're not being challenged. This is really a crucial conversation, the need to have a difficult conversation with somebody in management about what you're not happy with at your job. So what can somebody like that do tomorrow to try to start investigating whether that situation can be changed and made better?

0:33:55.8 TM: Yeah. I think... I hear this a lot from technicians. They write to me or we talk in

practice, and they have asked if they could start doing CRIs, and they kind of got shut down, or they've asked if they can start doing local blocks, or doing this, and they kind of got shut down. And guess what? This job market right now, they're looking elsewhere. They're going to find some place that's going to let them do those epidurals, or let them work on their VTS, or really foster their growth.

And if your practice isn't fostering growth, you're going to be losing technicians. I don't ever tell technicians, like, "Go in guns blazing and just quit your job." Everybody in the practice has good intentions. I think the intent is good. Oftentimes, the execution is not. And that's just because sometimes management just doesn't have the training tools.

I think that this is kind of a larger problem in veterinary medicine, in that we promote people to management who maybe have seniority, but don't have interpersonal skills, management skills, leadership skills. And I think that one of the biggest things that can help is if you have put a technician or anyone into a leadership or management position, invest in the same way you would in your technicians. Send them to a leadership training program. Send them to management programs. Give them the tools they need to do their job, right? The same way that I couldn't do a cystocentesis without that ultrasound, I can't be an effective manager if I've never had any leadership or management training. And I think that's huge, because a lot of the problems that I see are because technicians will go to their supervisor or a manager, and the manager will maybe not take them seriously.

The perception is that the manager doesn't listen to them, and I think that oftentimes, it's because the manager does not know how to implement changes that need to be done, and because of the way that we are as people, it's looking at whether or not you want to be thought of as nice or you want to be kind. I think that that's really a big thing in veterinary medicine if you have to go talk to management about something. And I think that if we can get away from just being nice for the sake of being nice, saying nice things and saying what the other person wants to hear, and instead be kind - the kind thing for me as a technician is to go to my superior and say, "Hey, I'm not being utilized and I really want to do this with my career, and if that's something that this practice cannot do, I totally understand, but I'm probably going to look elsewhere."

That is a kind conversation to have. The nice thing would be, like, "Oh yeah, everything's great." And then the next day I give you my notice. Right? No, we don't want that. We want people to say, "Hey, this is what's happening. How can we fix it?" And if we can't fix it, maybe this isn't the place for you, but if I really am a technician, if I want to be further utilized, I have to advocate for myself and say, "Hey, I've had this training. I've done an epidural before. Let me try it with you and maybe we can work on it." And if they're really resistant to it and you're not getting anywhere, I think that that today's job market, especially, you can kind of... I never encourage people to quit their job, but at the same time, if you really aren't being fulfilled, and that work doesn't light you up in the same way you did when you were graduating tech school or vet school, if this work doesn't light you up anymore, find work that does.

0:37:33.1 KB: Yeah. So have that difficult conversation, because you never know what's going to come out of it, but don't be afraid to look for a better situation if the one you're in is not... if it doesn't seem like it's going to change. But it does seem fair to give that situation a chance, especially if you like other aspects of where you are.

And we could be talking to associate vets, too, right now. I know, because we have had a lot of those same conversations. But it never hurts to ask, especially if you do it in a clear and not accusing way.

0:38:06.9 TM: 100%. I think that this is not just a technician issue. This is definitely a newer clinician issue, or even an experienced clinician issue. It really is about working together with the management or the hospital administrators to not only have a fulfilling workday, but also provide the level of patient care that you want to provide, and making sure that you go... You're not going to go home at the end of every day thinking, "Oh my gosh, sunshine, sparkles, rainbows. This is the best." But your majority of your day should be that, and if the majority of your days are not lighting you up and you're not proud of the work that you do and excited about it, then... Yeah, I think you have to have a conversation with your management, and if it's not going to be the place for you, that's okay. Right? That's okay. It is what it is, and if you have to move on, move on in the best way possible.

0:39:06.2 KB: This is too hard a job not to love it most of the time.

0:39:10.7 TM: 100%. I mean, it is an emotional roller coaster. And, again, I do think some of that could be fixed with the way that our interpersonal and maybe our leadership skills that we have coming into it. But just the work itself is very emotionally draining. It's hard, right? It's hard to see a two-year-old dog that you know could be... I'll just use this as an example. This is the one dog that really got to me. Two-year-old, gray-silvery pittie mix, sweetest girl ever, and the owner... It was a GI foreign body. She'd eaten some cloth, and the owners didn't have the money for surgery, and they chose to euthanize. We even asked the owners if they would consider signing her over to the hospital. We would do the surgery, she'd get adopted. And they said, "No." And you know what? That's their right to say no. And that sucked. That day really, really was horrible, and a lot of us cried, and that's the stuff that we're dealing with.

And I do think that it's very important to understand that those days are going to happen. You don't want those days to happen all the time, but it's important to have a good support network, so you have to have a good team at work. You have to be able to lean on your team members. So when you have those really awful days, you can come together as a team and process it, and then regroup and move on, and if you don't have that team, it's going to be a really hard job every day. And I'm lucky enough that I have not only a really good professional team, but also I have a very good team at home. And you know what, I have a great therapist.

0:40:54.8 KB: Yeah, let's hear it for therapy. Kudos to the therapists out there because you have a hard job, too. And I don't know where we would be without you, so yeah, thank you for saying that. They deserve that thanks.

Tasha, thank you so much for spending this time. Your passion is infectious. I knew that I was going to love this conversation and feel super inspired after talking to you, and I know everyone listening is going to as well. And I hope that you continue to love what you're doing, and that people who are listening will realize that they have some real rock stars working for them, and if they're not challenging them to all the extent that they could, I hope they do that now, after listening.

0:41:36.7 TM: Yeah, me too. I mean, there's so many great veterinary technicians, assistants, just

veterinary professionals out there, just putting in the work and being ultimate... Just badasses at this. So this field is amazing, and I'm very hopeful for the future that we can continue to just grow it and have people love what they do.

0:41:58.2 KB: Thank you so much, Tasha, and thanks to everyone out there for joining us. We will put links to where you can find Tasha in our show notes for this episode, and also link to the updated pain management guidelines, which I hope everybody checks out, and we'll catch you next time on Central Line.