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from the editor's desk



IT'S A NIGHTMARE SCENARIO: an active shooter or other violent criminal enters your practice with the intent to cause harm. What do you do? Without a plan, you could be looking at a very bad outcome. Unfortunately, we live in a world where this type of violence is all too common (at least in the United States). This month, our cover story looks into options for making a plan to prepare for this worst-case scenario and what some practices are doing to get ready for something that will hopefully never occur.

On a lighter note—what do you think about boarding? It might seem like a no-brainer for animal hospitals to offer boarding—after all, clients trust their veterinary teams. But is there enough revenue potential to make the staffing issues and added workload for veterinarians worth it? This article interviews experts at AAHA-accredited practices about the pros and cons of offering pet boarding at veterinary hospitals. It can be a divisive issue, but the main question is, is it worth it to you?

TRENDS/CARECREDIT EMPLOYEE OF THE MONTH CONTEST

Have you entered our Employee of the Month contest yet? Eligible practices can enter the contest online by filling in a few details about why your employee is the best, and then we will randomly select one winner each month to win a \$500 Amazon gift card, courtesy of our friends at CareCredit. If you don't win, don't worry, you can enter again the next month! Enter today at aaha.org/EOTM.

COMING NEXT MONTH

In June, you will discover our next themed issue, the Recruitment Issue. This issue will feature an article that talks about recruiting with diversity, equity, inclusion, and belonging (DEIB) in mind. We'll also look at the role of social media and how it can help with hiring efforts.

As always, let me know what you think at trends@aaha.org.

—Ben Williams, Editor

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View from the Board

Be Prepared for Anything

It's hard to ignore the fact that disasters have been impacting many teams and communities lately. From natural disasters to horrific events like mass shootings, we know it is only a matter of time before something impacts us or one of our colleagues. We can choose to ignore this or decide to be proactive on behalf of our teams.

While it's critically important to train and have policies and procedures in place for specific disasters such as hurricanes if we live in a coastal community, or active shooters anywhere in the country, the reality is that no two disasters are created equal. No amount of training around a specific disaster will allow us to anticipate all the specific challenges we face when disaster hits. However, there are two things that we can state with a reasonable level of certainty.

1. Having a clear understanding of the roles and responsibilities of all team members is critical if we are to successfully navigate any challenge.
2. While the specific disasters we may face are infinite, the number of different aspects of our hospital operations that will be impacted is finite and can be categorized into specific areas on which different members of our team can focus during a disaster.

This approach to crisis management involves placing just as much emphasis on preparing for a specific crisis such as a hurricane, as it does understanding individual responsibilities and roles during any crisis. The reason why developing this mindset is so important is that disasters are unpredictable and chaotic. When a disaster strikes, people tend to panic, and it can be challenging to keep things organized and under control.

Each member of the team should know what their responsibilities are, and what others are responsible for. When the person tasked with communicating with clients knows that other teammates are focused on other equally important challenges such as team safety, communicating with emergency services, reestablishing

practice infrastructure, securing equipment and supplies, addressing needs for immediate funding, etc., they can focus on the task at hand.

A well-prepared team also knows who will oversee the entire team during the crisis. They know that this person will need others to be executing on the many tasks at hand so that they can have the necessary time to collect information from their team, coordinate efforts, make well-informed decisions quickly, and provide clear, effective updates to the entire team.

I challenge you to work with your team on developing a mindset around disaster preparedness and management in general. Because at its core, disaster preparedness is not solely about preparing for a specific situation, it is about building effective teams that are empowered to tackle any disaster that might arise.



Dermot Jevens, MVB, DACVS, is secretary/treasurer on the AAHA board. A 1987 graduate of University College Dublin in Ireland, Jevens practiced in Connecticut and Pennsylvania before moving to South Carolina in 1997 to found Upstate Veterinary Specialists. He is currently CEO of AcharaVet.

This month in AAHA's Publicity Toolbox...

Here are the downloadable social media images available for AAHA-accredited members at aaha.org/publicity this month:

Arthritis Awareness Month
National Specially-Abled Pets Day

May 3

Happy Mother's Day

May 14

Happy Memorial Day

May 29



“What are some of the best ways to handle inactive clients and pets?”

I am definitely not new to customer service but am new to handling the topic of inactive clients and pets. Is there a best practice or standard? I have sent a “we haven’t seen you” letter noting that after 18 months we consider you inactive.

Should I use this opportunity to ask if they are using a different practice? Or do we just move on?

A: Most people do use 18 months. We used to send a letter letting them know their pet is past due. It asks if we can update records because services were done elsewhere or if they’d like us to forward records. We just recently started using a service to help us with this.

A: In general, you can never get enough feedback—everything from good to ugly. We use a software app that automatically emails folks after each appointment (minus euthanasias) that asks for their feedback. However, a follow-up phone call can work all the same and is less expensive to implement.

A: When rabies vaccines are good for 3 years we usually leave folks active until 6 months past that deadline. We send electronic newsletters a couple of times a year. That helps to cull the folks who have moved or changed vets for whatever reason. A few will reply with the unsubscribe option and we mark them inactive.



Community

AAHA members, see the full replies and add to the conversation at community.aaha.org. For help, email community@aaha.org.



notebook

Health Screening Test Instituted for Brachycephalic Dog Breeds

The Orthopedic Foundation for Animals (OFA), a US-based nonprofit dedicated to promoting the health and welfare of companion animals through a reduction in the incidence of genetic disease, has licensed the Respiratory Function Grading Scheme (RFGS) for use in the United States and Canada. The RFGS was developed by the University of Cambridge and The Kennel Club in the United Kingdom to objectively measure the severity of brachycephalic obstructive airway syndrome in dogs and help make a clinical diagnosis. The OFA is instituting respiratory function grading of brachycephalic breeds as one of its health screening tests.

QUOTE OF THE MONTH

“You don’t build a business, you build people. Then people build the business.”

—Zig Ziglar, motivational speaker

Congressional Offices Consider Making Xylazine a Controlled Substance

Both congressional lawmakers and the Drug Enforcement Administration (DEA) are reported to be in serious discussion about making the veterinary sedative xylazine a controlled substance.

In a statement, the American Veterinary Medical Association (AVMA) said that it is “closely engaged with the relevant congressional offices and committees” that are discussing scheduling xylazine, noting that it understands that the DEA “has begun its internal process to schedule the drug.”

AVMA reports that this change in status from a veterinary prescription drug to a drug scheduled under the federal Controlled Substances Act is intended to provide additional tools for law enforcement and bring stricter punishments to bear on the illicit market. While there is no significant xylazine diversion from veterinary channels, the AVMA says that scheduling xylazine to help control the illicit trade will impact use of the drug in veterinary medicine.

In the statement, the AVMA states, as policy discussions on the topic move forward, the AVMA is working to lessen the impacts of such a decision on veterinary practice. Advocacy efforts on this issue include educating members of Congress and their staffs about the legitimate uses of xylazine across many areas of veterinary medicine; working to prevent xylazine from being scheduled federally at a higher level than necessary; and advocating for a reasonable implementation timeframe to allow for manufacturers to transition to a scheduled status.



Genetic Test Can Detect Deadly Bleeding Disorder in Dogs

A team led by Washington State University (WSU) researchers developed the DEPOHGEN test following a study in which they examined Scottish deerhounds and identified a gene associated with the condition known as delayed postoperative hemorrhage or DEPOH. Animals with a mutation in the DEPOH gene are significantly more likely to experience the condition. The study was published in the *Journal of Veterinary Internal Medicine*.

“Dogs with the DEPOH mutation have a much higher risk than other dogs of developing this after undergoing surgery,” said Michael Court, PhD, BVSc, the study’s corresponding author. “The DEPOHGEN test will allow us to prevent delayed postoperative hemorrhage by administering antifibrinolytic drugs to dogs that test positive for the gene before any surgery.”

The researchers report that delayed postoperative hemorrhage was first recorded in greyhounds, but it has also been noted in other sighthound breeds, like Scottish deerhounds and Irish wolfhounds. Following the identification of the DEPOH gene, the team examined samples from WSU’s pet DNA bank and discovered the mutation in additional sighthounds, like Italian greyhounds and salukis, as well as in some other popular breeds, such as golden retrievers and border collies.

Court, a veterinarian and professor of pharmacology and genomics in WSU’s College of Veterinary Medicine and Program in Individualized Medicine, said “Clotting factors stop the bleeding when you’ve had surgery, but you don’t want that blood clot to hang around forever. Normally, the body breaks down that clot as the tissue heals, usually over days to weeks, not just one or two days as it does in dogs with the mutant gene.”

The new test, which is available through WSU, will make it possible to detect the gene in pets prior to nonemergency surgeries and give preventative treatment when warranted. Court is also hopeful the test will eventually be included in common health panels used to evaluate puppies and dogs for many conditions.



Bree, an Irish wolfhound owned by Thomas Pare, has a saliva sample taken from her at WSU’s College of Veterinary Medicine in Pullman.



Feline Veterinary Scholarships Announced

The American Association of Feline Practitioners (AAFP) and EveryCat Health Foundation are delighted to announce they are offering two \$2,500 scholarships for veterinary students enrolled in accredited veterinary colleges or schools in the United States or Canada. The purpose of the scholarships is to support and encourage veterinary students who are interested in careers in feline medicine or clinical scientific research of felines. Available for third- or fourth-year veterinary students (classes of 2023 and 2024), the scholarships will be awarded based on academic achievement, financial need, leadership skills, and excellence in the study of feline medicine.

“The future of feline veterinary care is dependent on students with a passion for feline medicine and research,” said Jackie Jaakola, executive director of EveryCat Health Foundation. “These scholarships will help facilitate that passion for two deserving students.”



Pet Behavior Lessons Learned During the Pandemic

The AVMA recently reported on industry predictions that were made about pet behaviors during the pandemic. During a presentation for the Small Animal Behavior Symposium at the Veterinary Meeting and Expo in Orlando, Florida, two members of the American College of Veterinary Behaviorists (ACVB), Valarie Tynes, DVM, DACVB, DACAW, and Laurie Bergman, VMD, DACVB, discussed those predictions. They stated that fears about a rash of canine separation anxiety cases and related behavioral problems once pandemic-related lockdowns were lifted appear to be unwarranted.

The AVMA reported that anecdotal evidence so far shows no significant increase in cases of canine separation anxiety, according to Tynes, owner of a veterinary behavior practice in Texas.

“The message I had then, and I still have now, is we don’t know what causes separation anxiety,” Tynes said. “There is often this suggestion that a big change in the owner’s schedule causes the dog to develop separation anxiety, but how can you really know that? You’re talking about a condition that, by definition, occurs when you leave.”

Bergman noted two behavior studies published recently, one concerning dogs and facial recognition and the other concerning the stress of clinical examinations on feline patients.

The first study, “Comparative brain imaging reveals analogous and divergent patterns of species- and face-sensitivity in humans and dogs,” was published in *Journal of Neuroscience*. Researchers wanted to know whether dogs are primed to see faces the same way that humans do.

“Dogs read human facial expressions, but our expression isn’t the first thing they see,” Bergman explained. “The study showed dogs recognize human head shape and canine head shape, and anything that disrupts that outline can cause alarm.”

The second study, published in *Journal of Feline Medicine and Surgery*, looked to quantify the effects in cats on fear, anxiety, and stress of separation from the owner at a veterinary clinic and of the location of the physical examination. The findings showed that cats’ heart rates were substantially elevated when their owners were not in the room.

Veterinary staff members may find curbside appointments without the owner preferable, but they may not be ideal for the feline patient, the presenters said. They added that a cat may become immobile during examination without the owner, and while that may be good for the veterinarian and veterinary technician, it can be a sign of learned helplessness.

Forfa Named New Director of FDA Center for Veterinary Medicine

The Food and Drug Administration (FDA), announced the appointment of Tracey Forfa, JD, as director of the agency’s Center for Veterinary Medicine (CVM). Forfa has been with CVM since 2002 and was appointed the Deputy Center Director in 2008. She previously served as acting director in 2016, and again in early 2023 prior to her permanent appointment.

Before joining CVM, Forfa helped to support the FDA’s mission in other capacities. In 1996, she worked in the Office of the Chief Mediator and Ombudsman, working on product jurisdiction and external dispute resolution. She joined the agency in 1993 as a member of the regulations and policy staff at the FDA’s Center for Biologics Evaluation and Research, working on issues such as human tissue and blood banking.

Forfa earned her bachelor’s degree from the College of Wooster in Wooster, Ohio and her law degree from the University of Baltimore in Maryland. She has also completed the FDA’s Executive Education Program in Regulatory Policy through the University of Maryland.

Statement Issued on the Standardization of the Abdominal Ultrasound Examination

The American College of Veterinary Radiology (ACVR) and European College of Veterinary Diagnostic Imaging (ECVDI) recently released a consensus statement for the standardization of the abdominal ultrasound examination in dogs and cats. The statement was published in the journal *Veterinary Radiology & Ultrasound*. Gabriela Seiler, DVM, DACVR, DECVDI, professor at North Carolina State University, chaired the joint committee that prepared the consensus statement.

“It was helpful to have a committee of many radiologists with different backgrounds and different work environments,

from academia to private practice and teleultrasonography,” Seiler said in an announcement. “Every comment and suggestion was discussed by the committee—even if not included because our consensus opinion differed.”

The guidance includes illustrated images for each organ or system, tables listing still images and video clips to be acquired, and recommendations on documentation, patient preparation, and equipment. The ACVR states that ultrasound is a modality that is easily accessible to veterinarians and technologists as well as others and that these guidelines can be used as a tool to enable consistent image quality across practitioners and aid in interpretation.

Breakthrough Surgical Procedure Relieves Dogs from Chronic Pain

After Finn, a two-year-old Labrador retriever started having trouble walking up the stairs, his owner Amanda Rinderle noted that he became increasingly sore, he was not pushing off with his back legs, and he needed to be carried upstairs. After seeing an orthopedic surgeon and a neurologist and trying conservative treatments including steroids, painkillers, and physical therapy, nothing seemed to help.

“If your dog is acting abnormally, pain is a common cause, but it can be difficult to diagnose,” says Elizabeth Parsley, DVM, assistant professor in the Department of Clinical Sciences at Tufts University Cummings School of Veterinary Medicine. “An MRI is where we find abnormalities consistent with tethered cord syndrome. We look at the end of the spinal cord for a tethered appearance or if it is pulled upward. We will also move the dog’s back in different positions to see if the spinal cord is moving as we’d expect. With a tethered cord, the abnormal tension does not allow normal movement of the spinal cord.”

Finn’s orthopedic surgeon had previously worked with Parsley and knew that she had worked with dogs who had been diagnosed with tethered cord syndrome. An MRI and additional testing confirmed the surgeon’s suspicions, that it was most likely tethered cord syndrome, and that surgery was Finn’s best option to relieve his pain.

“The surgery to address tethered cord syndrome entails cutting the piece of connective tissue at the end of the

spinal cord called the filum terminale,” Parsley explains. “You transect the filum to release that tension. In veterinary medicine, the only documented approach is the extradural approach, or the part of that connective tissue outside the sac around the spinal cord. Human medicine recommends doing the intradural approach, or the part that’s inside the sac around the spinal cord, which is what I did.”

The night after the procedure, Rinderle noticed a profound difference in Finn. “Despite having this invasive surgery, he was already more comfortable. He would not let us touch his back half before, which he lets us do now. He’s running around outside with his friends now and is so much happier.”

Parsley reports that all eight of her surgical tethered cord cases are doing markedly better. “It’s been a fascinating, translational One Health–type of approach,” she said.



Finn, a two-year-old Labrador retriever, has recovered well after an innovative surgery to address tethered cord syndrome.



Knee Replacement Surgery at Texas A&M Changes Canine Patient's Life

Delilah, a black Labrador retriever–Great Pyrenees mix puppy became the first knee replacement patient at the Texas A&M School of Veterinary Medicine & Biomedical Sciences' (VMBS) Small Animal Teaching Hospital (SATH), reports Megan Myers of VMBS Communications.

Delilah has osteochondrosis (OC), a developmental skeletal disorder.

“At a very young age, [Delilah] was missing a major component of the weight-bearing surface of the knee, a critically important joint for canine mobility,” said Brian Saunders, DVM, PhD, DACVS, a VMBS associate professor and veterinary orthopedic surgeon. “Our normal treatment methods to address OC (such as arthroscopic surgery, followed by rest, rehabilitation, and medications) were not going to be able to address Delilah’s defect because it was so large.”

Many dogs are not eligible for a knee replacement because of a history of previous infections. But Delilah was young (only a year old) and had never had knee surgery or any other major medical issues. That made her a candidate for knee replacement surgery, and further investigation confirmed she was a good candidate for the procedure. Eric Golestan, Delilah’s owner, was part of the final decision.

Saunders said, “This is a lifelong investment in a pet, and a lot of long-term monitoring and follow-up care is necessary to make sure everything’s going well.”

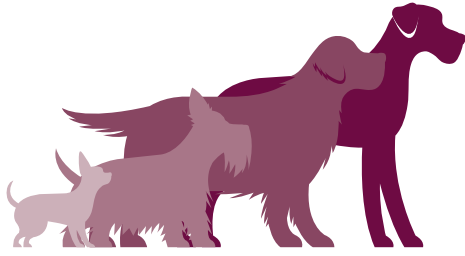
Golestan accepted the challenge, and surgery was scheduled.

During Delilah’s surgery, Saunders removed the cartilage from the femur and tibia. Next, metal implants were placed on the bottom of the femur and the top of the tibia, with a polyethylene (surgical plastic) liner inserted between them. These implants are shaped somewhat like a normal knee and allow the joint to function properly.

After Delilah’s procedure ended, the real work began for Golestan and Delilah. As summarized by Saunders, “Leash walks only for three months, and no off-leash activity indoors or outdoors; two to four medications for several weeks after surgery; rehabilitation exercise; and re-check visits for examinations and x-rays.”

At Delilah’s six-month postsurgery appointment, her implant was found to be fully secure and she was given the “all clear” to return to full activity levels.

“She runs at 110%, and now she can do anything she wants,” Golestan said.



Size, Sex, and Breed May Predict Dogs' Cancer Diagnosis

A recent analysis of several thousand dogs finds that traits such as size, breed, and whether an animal has been spayed or neutered may be associated with whether a dog may be diagnosed with cancer. The AVMA reports that about one in four dogs will develop cancer at some point during their lifetime, a number that rises to nearly 50% after a dog's 10th birthday.

In a study published in *PLOS ONE*, veterinary oncologist Andi Flory, DVM, DACVIM (Oncology), co-founder and chief medical officer of PetDx, a California-based pet diagnostics company, and her team evaluated previously collected data from 3,452 dogs in three separate groups. Based on their findings as well as evidence regarding tumor size and progression from prior studies in humans and canines, the authors of the study recommended that all animals start cancer screening at age seven and that breeds with a lower median age of diagnosis get screened earlier.

In an article in *Scientific American*, experts who are not involved in the study report being wary of the cancer screening recommendations. The article states that a key problem, according to Cheryl London, DVM, PhD, DACVIM (Oncology), a veterinary oncologist at Tufts University, is the lack of effective early canine cancer screening tools. "If we're talking about true cancer screening, we don't have the tools in veterinary medicine to actually do that yet," London says.

Dry Food Effects on the Antioxidant Profile of Dogs

A recent article in *Pet Food Industry* discussed a collaboration of Colombian researchers who observed that dog foods with different antioxidant levels didn't have the effects on dogs' blood chemistry that the scientists had predicted. The results were published in the journal *Veterinary Medicine and Science*.

Antioxidants play a double role in dog food, both preserving the food and benefiting the animals' health. The researchers reported that the relationships among ingredients and associated changes in the antioxidant levels in dogs' bodies may be complicated.

They related that antioxidants in dog food can counteract free radicals and certain oxygen molecules, called reactive oxygen species, in dogs' bodies. An imbalance in the reactive oxygen types and antioxidants, oxidative stress, can alter the structure of DNA, proteins, and other molecules, leading to cell degeneration associated with aging, diabetes mellitus, osteoarthritis, kidney disease, and cancer.

In their article, Colombian scientists noted that little research has focused on how variations in dogs' diets can influence pets' levels of oxidative stress. They conducted an experiment using six beagles and ultimately observed that while the antioxidant profile of the dogs' blood seemed to be influenced by the diet's nutritional profile and the act of eating it, the largest effect seemed to result from the individual dogs themselves. The scientists concluded that the biological process relating dog food formulation to oxidative/antioxidant equilibrium in dogs remains unclear.



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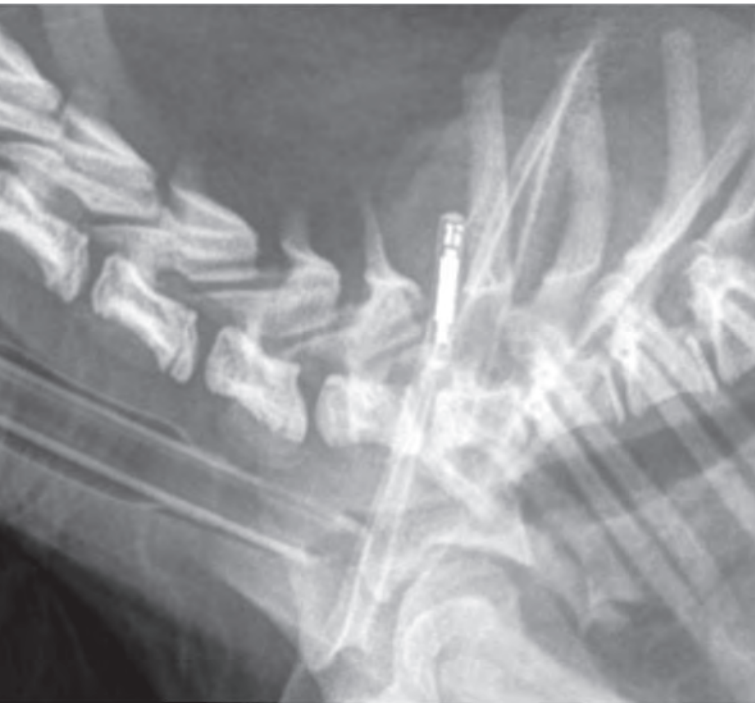
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JAAHA[®]

JOURNAL OF THE AMERICAN ANIMAL HOSPITAL ASSOCIATION

ABSTRACTS



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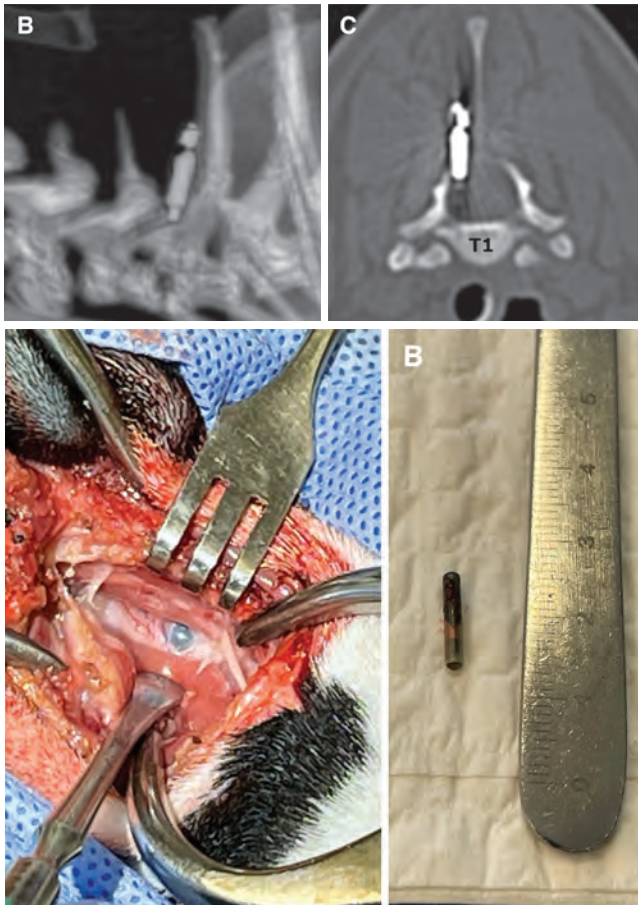
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VETERINARY PRACTICE GUIDELINES

2023 AAHA Selected Endocrinopathies of Dogs and Cats Guidelines

Andrew Bugbee, Renee Rucinsky, Sarah Cazabon, Heather Kvitko-White, Patty Lathan, Amy Nichelason, Liza Rudolph

Canine and feline endocrinopathies reflect an endocrine gland disease or dysfunction with resulting hormonal abnormalities that can variably affect the patient's wellbeing, quality of life, and life expectancy. These guidelines provide consensus recommendations for diagnosis and treatment of four canine and feline endocrinopathies commonly encountered in clinical practice: canine hypothyroidism, canine hypercortisolism (Cushing's syndrome), canine hypoadrenocorticism (Addison's disease), and feline hyperthyroidism. To aid the general practitioner in navigating these common diseases, a stepwise diagnosis and treatment algorithm and relevant background information is provided for managing each of these diseases. The guidelines also describe, in lesser detail, the diagnosis and treatment of three relatively less common endocrinopathies of cats: feline hyperaldosteronism, feline hypothyroidism, and feline hyperadrenocorticism. Additionally, the guidelines present tips on effective veterinary team utilization and client communication when discussing endocrine cases.



CASE REPORTS

Microchip Implantation Within the Cervical Spine, a Neurologic Evaluation, and Surgical Correction

Breanne Morrell, Charlotte E. Gillis, Katheryn C. Wolfe, James T. Giles, III

A 5 mo old male Japanese chin was examined 1 mo following the sudden onset of pelvic limb weakness and ataxia immediately after microchip placement. Neurological examination revealed an ambulatory paraparesis, which was worse on the right side, with additional weakness noted in the right thoracic limb. Lesion localization was C6–T2 spinal cord segments, worse on the right. Radiographic imaging of the cervical spine revealed a microchip at the location of the C7–T1 intervertebral space. Computed tomography revealed a microchip within the spinal canal causing spinal cord compression at the level of the C7–T1 intervertebral disc space. Surgical removal of the microchip was performed, and the patient recovered well. A 6 wk follow-up neurologic examination showed persistent mild ataxia in the pelvic limbs. This case supports previously reported cases of permanent spinal cord damage caused by microchip placement. Surgical removal of the microchip resulted in the improvement of neurologic signs. Although extraction of the microchip did not resolve all neurologic deficits, surgery prevented further migration and possible damage to the spinal cord.

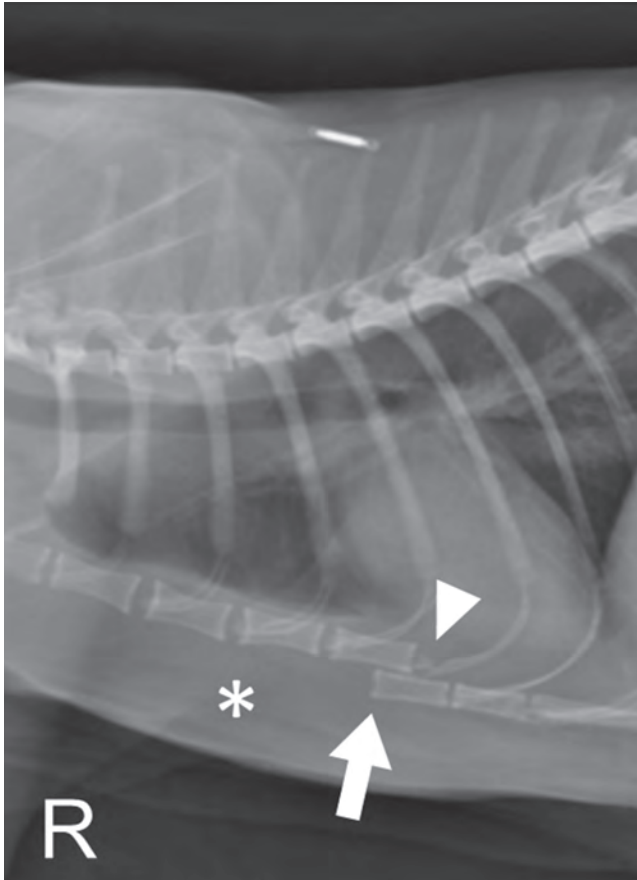
CASE REPORTS

Successful Management of Severe Manganese Toxicosis in Two Dogs

Jacob Wolf, Levi Hoffman, Carl Southern

Manganese is a common component of human joint supplements and may be a source of ingestion and subsequent toxicosis in dogs. Although hepatotoxicity secondary to manganese toxicosis has been reported in dogs before, no descriptions of successful management of manganese toxicosis has been reported in veterinary literature. A 5 yr old spayed female Shetland sheepdog and a 5 yr old female Shetland sheepdog were evaluated following accidental ingestion of a joint supplement. Consultation with a toxicologist revealed concern for manganese toxicosis resulting in hepatic injury. Both dogs developed subsequent acute liver injury, despite decontamination and initial management with N-acetylcysteine and cholestyramine. The patients were managed with calcium ethylenediaminetetraacetic acid, paraaminosalicylic acid, allopurinol, Vitamin E, ginkgo biloba, and S-adenosylmethionine/silybin. Liver values returned to normal in both dogs. Manganese exposure was confirmed with urine manganese analysis in one dog and fecal examination in the other dog. A previous case report detailed the fatal manganese toxicosis in a dog; this case report describes the successful management of severe acute hepatic injury secondary to manganese toxicosis. The combination of medications used above may be used for successful treatment of manganese toxicosis in dogs.



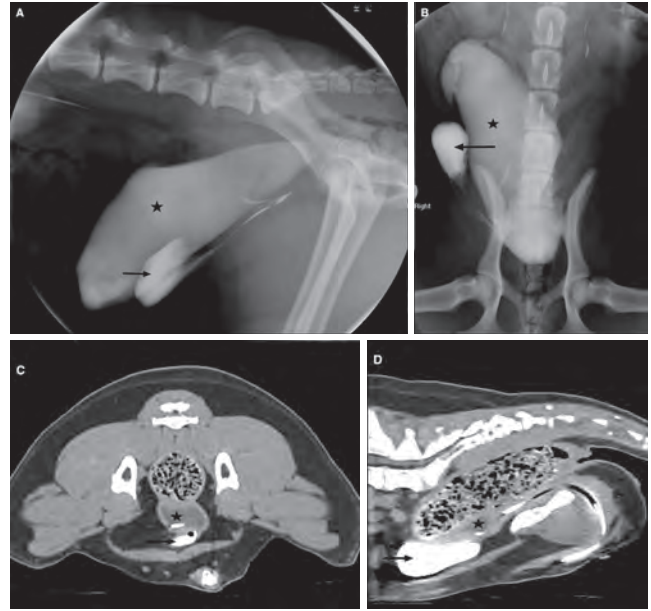


CASE REPORTS

Successful Medical Management of an Acute Traumatic Sternal Luxation in a Cat

Jesse Grady, Shanna Marroquin, Alison Lee

A 5 yr old indoor–outdoor domestic longhair red tabby cat presented for evaluation of a 1 day history of hiding, urinating and defecating outside the litterbox, and vocalizing when picked up. Physical examination revealed significant pain on palpation of the caudal sternum where an approximately 8 × 6 cm contusion was noted. Sedated thoracic radiographs revealed a luxated fifth intersternbral joint with the sixth sternebra being cranioventrally displaced (along with the seventh and eight sternebrae) to the level of the mid fourth sternebra. There were sharply marginated, short oblique fractures of the distal sixth costal cartilages bilaterally with mild dorsal displacement of the distal segment. The sternal luxation was palpated more aggressively once the patient was sedated and deemed to be stable. Because of the stability of the luxation and absence of sternebra fractures, conservative medical management in the form of analgesics and rest was instituted. Repeat thoracic radiographs 2 wk after presentation revealed an unchanged sternal luxation. Twelve months after presentation, the patient presented for an unrelated lameness and, in that timeframe, has exhibited no sequelae to the sternal luxation, which still palpates stable and is radiographically unchanged.

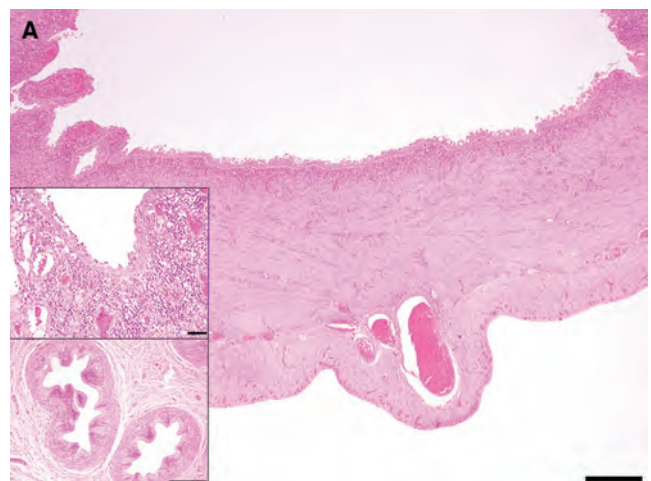


CASE REPORTS

Uterus Masculinus with a Patent Urethral Communication Documented with Positive Contrast Computed Tomography

Jilli Crosby, Alexandros Hardas, Karla Lee, Lynda Rutherford

A 9 mo old male Labrador retriever presented for investigation into persistent urinary incontinence. Abdominal ultrasound and retrograde urethrocytogram with computed tomography documented a uterus masculinus (UM), which was confirmed on histopathology after surgical removal. A connection between the UM and the urethra was present, documented by positive contrast retrograde urethrocytography and confirmed with surgery. Typically, in the literature, UM are blind ending, and there are only a few case reports that demonstrate an assumed connection. This case has demonstrated a patent connection between the UM and the urethra, which should be considered a differential diagnosis for persistent urinary incontinence and urinary tract infection in juvenile male dogs.

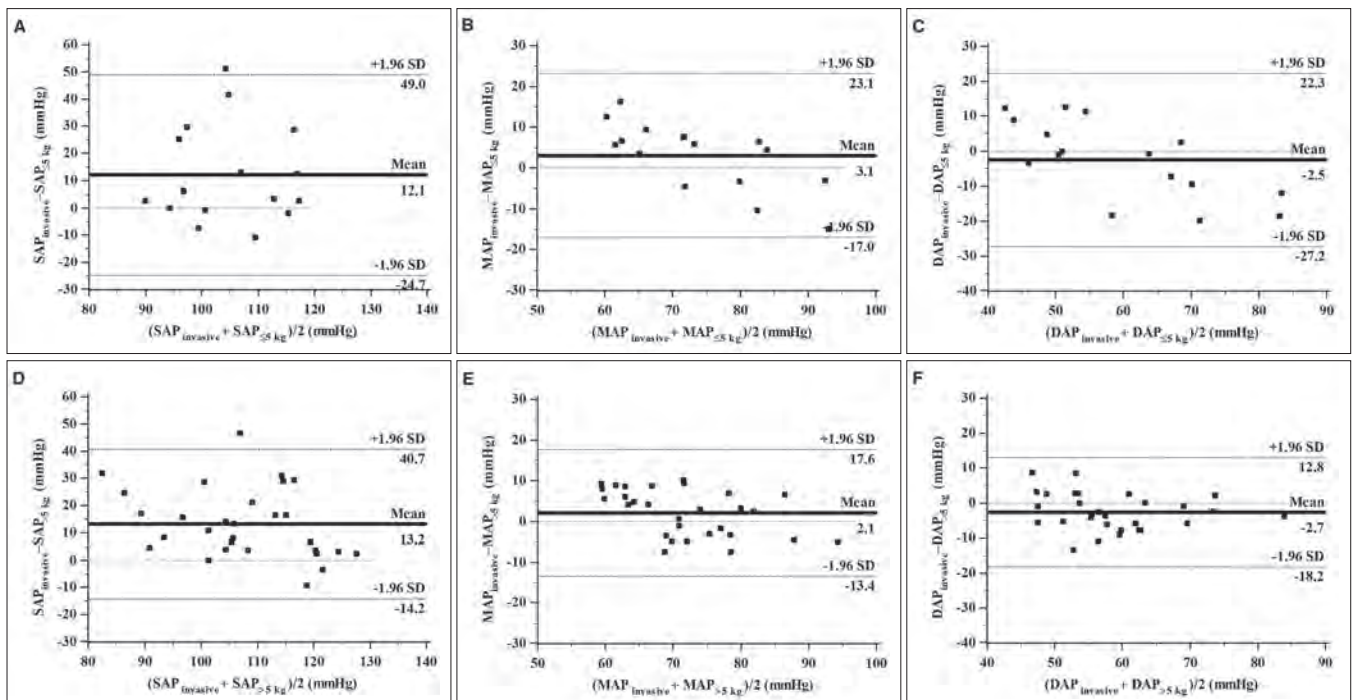
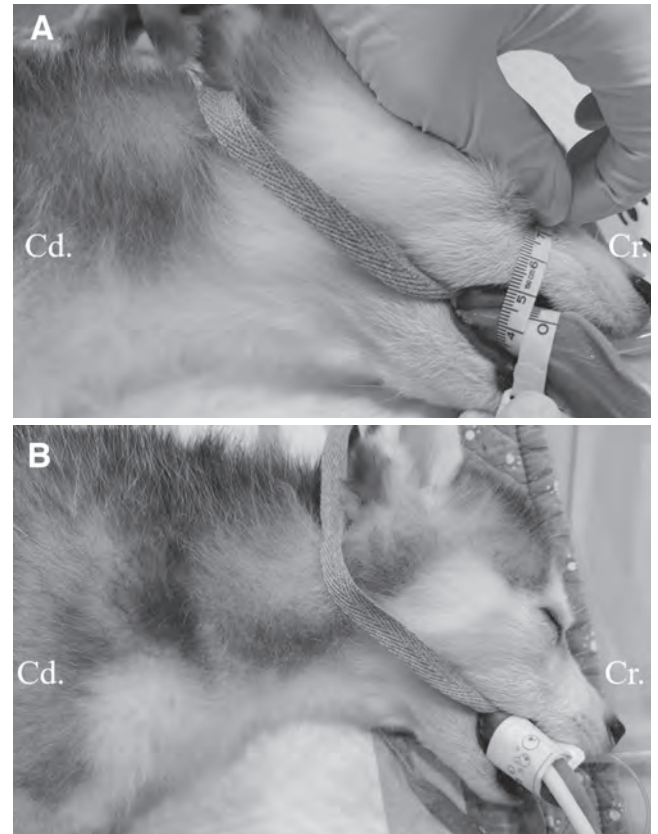


ORIGINAL STUDIES

Agreement Between Tongue-Based Oscillometric and Invasive Blood Pressure in Anesthetized Dogs of Various Weights

Dalhae Kim, Jiyoung Kim, Donghwi Shin, Inhyung Lee, Won-gyun Son

This study aimed to evaluate the agreement between oscillometric blood pressure (OBP) measured from the tongue and invasive blood pressure (IBP) measured from the dorsal pedal artery in anesthetized dogs of various body weights. Forty-five client-owned dogs undergoing general anesthesia for surgery or imaging scan were included; weights ranged from 2.5 to 42.6 kg. Agreement between paired IBP and OBP during normotension was verified with reference standards used in small animals and humans. The data were stratified by body weight (≤ 5 kg versus > 5 kg). In the > 5 kg group ($n = 29$), the bias \pm standard deviation for mean (2.1 ± 7.9 mm Hg) and diastolic pressure (-2.7 ± 7.9 mm Hg) exhibited reliability that met human standards ($< 5 \pm 8$ mm Hg). However, in the ≤ 5 kg group ($n = 16$), the bias \pm standard deviation met only veterinary standards ($\leq 10 \pm 15$ mm Hg) for mean (3.1 ± 10.2 mm Hg) and diastolic pressure (-2.5 ± 12.6 mm Hg). Agreement for systolic pressure did not meet either standard for both groups. This study demonstrates that tongue-based OBP is a close estimate of mean/diastolic blood pressure in anesthetized dogs (> 5 kg) during normotension by small-animal and human criteria.



A modern office interior with a reception desk, glass partitions, and a tiled floor. The scene is brightly lit, with a large window in the background showing greenery outside. The reception desk has a wooden top and a glass base. The floor is made of light-colored square tiles. A modern chair is visible on the right side of the frame.

PREPARING FOR THE UNTHINKABLE

Active Shooters and Violence at Work

by Maureen Blaney Flietner



IN JANUARY 2023, THERE WERE ONLY EIGHT DAYS in the United States without any “mass shooting,” as defined by the nonprofit online Gun Violence Database. By mid-February, there were 22 more mass shootings year to date than any of the last three years. Those numbers do not include incidents where fewer than four were killed or wounded, not including the shooter. Now add in whatever nongun violence or crime that can occur with distraught or angry clients, disgruntled staff or former staff members, and others.

It may make you wonder: Is it time to review your active shooter and violence prevention plans?

Cherie Scheurich, hospital administrator and director of client relations at the AAHA-accredited Absecon Veterinary Hospital, Absecon, New Jersey, put an active shooter plan in place late last summer to help her staff stay safe.

The busy emergency and general practice hospital of 140 employees sees an uptick in traffic May through October as visitors flock to the South Jersey shore. “Lots of people come down this way with their pets in the summer, and the hospital takes in overflow from all over,” she explained. The hospital is familiar with its local police department as calls for assistance are not uncommon. “For people who love their animals, emotions can escalate quickly,” said Scheurich.

Not wanting to start off on the wrong foot and waste hours on an improper strategy, Scheurich contacted the local police for help with an active shooter plan. An officer surveyed the building and offered a template she customized. “We held small group training sessions. Everyone had to review the plan and take the quiz. New hires get trained as soon as they are on board. The plan is reviewed once a year. Everyone gets a copy in their email, at training sessions, and it is available anytime on a shared drive,” said Scheurich.

In addition, the hospital has installed panic buttons, and staff members have learned that they should use their PA system to announce if there is an active shooter in the building. “As per police psychological profiles, intruders are not expecting an announcement, and it throws them off. They also don’t expect people to fight back,” Scheurich explained. “Everybody should create a plan, especially in areas that have a lot of tourism. The way the

world is today, prevention is the best medicine. There are so many more benefits than costs.”

At Valley Veterinary Care based in Friendswood, Texas, Meghan S. Bingham, CVPM, senior operations manager, created an active shooter protocol after she was asked about one several times by a customer service representative. That team member had worked at the hospital before Valley Veterinary Care acquired it and had experienced a lockdown after a robbery attempt escalated in its strip mall location.

“It seemed important to her, so I sat down and created a standard operating procedure (SOP) before we left that day. Since then, we’ve fleshed it out and shared it across the group’s 14 general practices and nine emergency clinics—17 AAHA accredited,” explained Bingham.



“The way the world is today, prevention is the best medicine. There are so many more benefits than costs.”

—CHERIE SCHEURICH, HOSPITAL ADMINISTRATOR AND DIRECTOR OF CLIENT RELATIONS AT ABSECON VETERINARY HOSPITAL, ABSECON, N.J.

Bingham’s education about security measures began when she accompanied her mother, a teacher, to an in-person active shooter protocol course. “I tagged along and applied what I learned there to create a comprehensive guide for our practices. When we initially rolled out the plan, we had the practice managers train on the protocol during a staff meeting. We also post our SOP near the alarm keypad and review it yearly as part of our ongoing OSHA training.”

The plan is just another competency in the hospital’s safety skill set. “Unfortunately, the nature of emergency medicine lends itself to emotionally charged visits, and a few of our practices have experienced aggressive or threatening behavior from clients,” Bingham said. “Luckily our staff are trained for situations like that and are usually able to calmly de-escalate the situation.”

“A few of our regional managers were lucky enough to attend in-person de-escalation training from KimberlyAnn Mackey, CVPM, a former practice manager and a longtime parole supervisor for the Commonwealth of Pennsylvania, which they shared with their practice managers and staff. The Veterinary Hospital Managers Association has also hosted webinars on de-escalation, and our in-house OSHA training covers violence prevention and response.”

“Part of our customer service training is to know when to walk away or pass an angry client on to someone who can help defuse the situation. Beyond that, we will always support our staff refusing service or reaching out to authorities when necessary. If anyone expresses a safety concern, we act upon it as soon as possible,” said Bingham.

The hospital also reviews how to use its security systems and panic buttons and makes sure all security cameras work properly and are directed toward the appropriate areas. “No one wants to think it’ll happen to their practice, but ignoring it doesn’t protect your staff,” said Bingham. “Proactive training is always better than reactive training. It’s just like any other skill we train for: The more you’ve practiced or planned for something, the better your reaction will be.”

One veterinary hospital that has experienced violence is Maplewood Animal Hospital in Bellingham, Washington.



This front desk area at VCA Vancouver provides a place for staff to retreat back in the event of a threat, instead of having to come forward around the desk to escape.

David Rabkin, DVM, owner and medical director, recalled how in 2014 on a Thursday morning—his day off—a client came in to talk to a veterinarian about his cat that had unexpectedly died the night before. “They were sitting on a bench in the waiting room when the client pulled out a knife and stabbed the vet several times,” he explained. “The man then left the hospital and drove to another local veterinarian who had previously seen his cat and attacked a receptionist there.”

Rabkin explained that the veterinarian who was attacked was only a few years out of veterinary school and so traumatized by the incident that she left the field for several years. “After that incident, we worked on developing evacuation plans and made sure everyone was aware of the locations of panic buttons,” said Rabkin. “We had the local police department come in to do a talk and training. We facilitated counseling for the employees interested in that modality. Thankfully, no further incidents have occurred since that event. I would say that every practice should have in place response/evacuation plans in the event of this type of assault and reinforce these plans on a regular basis.”

From her unique perspectives of law enforcement and veterinary care, Mackey said she believes that more hospitals are seeing the need to look at security.

“Up until 2020, many veterinary practices didn’t have a lot of incidents where people were as vocal and physical as they are now,” she said, noting that veterinary practices’ access to controlled substances, both for pet owners and staff members, means security isn’t only about active shooters.

Design for safety

In a holistic approach to safety, even hospital design plays a role.

“It’s the world we live in,” said Heather Lewis, a licensed architect and principal at Animal Arts Design Studios, Inc., Boulder, Colorado. “It’s better to prepare for dangerous situations. There is a risk for every business, and veterinary care is not immune. It may not help in an active shooter situation since that person has already set their course, but it can help with de-escalating a threatening person.”

She offered these ideas:

- Have an entry vestibule—two sets of doors. It both prevents escapes in case a pet gets loose in the lobby and, if set up correctly, allows the front desk to control the inner doors, which works particularly well for 24/7 emergency hospitals.
- Have a safe space behind the reception area. “It’s bad design if a receptionist has to come out front and then run,” said Lewis.
- Because veterinary hospitals can be targets for drug-seeking behavior, consider enclosing pharmacies instead of having them in hallways, and use inventory management systems like CUBEX for dispensing pharmaceuticals.
- Add a panic button at the front desk that can not only call the police but make a loud noise to disorient an aggressor.
- Place the manager’s office near the lobby so that person can assist or call the police if someone’s actions are getting out of hand.
- Consider glass with an embedded break detection system that sends an alert when broken.
- Consider a few two-door exam rooms for difficult conversations. A room that has a door to the exterior, such as one used for euthanasia, could be an option.
- “Have a hospital that is open, welcoming, and nonjudgmental,” she suggested. “Design with safety—not fear—in mind. You don’t want a concrete bunker. That’s just going to make people angrier and more frustrated.”



A vestibule—two sets of doors—can prevent a loose pet from escaping but also, if set up correctly, allows the front desk to control who can enter. This vestibule is at Adobe Animal Hospital of Petaluma, California.

“Hospitals sometimes don’t see that they have an issue or just ignore and hope it never comes up. Practices think of themselves as family oriented and don’t think anybody would do anything violent,” said Mackey, who offers Zoom sessions and in-hospital training on conflict de-escalation. She suggested that veterinary hospitals develop a relationship with their local police and ask for their help in creating an active shooter plan or have them refer you to an agency that could. “Get the police familiar with your hospital by offering discounts for their pets or their K9 officers.”

De-escalation training can help in difficult situations, advised Mackey. She noted that staff members can learn to read the body language of someone who might be upset or a threat, listen to clients and not talk over them, and use their own voice and body

Getting better? Getting worse?

It can be difficult to understand what is happening because of how gun violence and other crimes are categorized and counted.

The FBI calls “active shooter” incidents as those where one or more individuals are actively engaged in killing or attempting to kill people in a populated area. However, the agency does not include gang violence, drug violence, and residential or domestic disputes. Its reports are only intended to provide a baseline understanding of active shooter incidents with no mandated database collection or central intake point for reporting active shooter incidents as exists for other crimes.

The Gun Violence Archive, a nonprofit online database of gun violence incidents in the United States, considers “mass shootings” as incidents in which four or more

people are either injured or killed, not including any shooter. Its extensive database provides data on mass shootings as well as any gun violence in the last 72 hours and gun violence by state and district. Check out its numbers here: gunviolencearchive.org.

As for crime in general, a full picture is not available.

The FBI’s Uniform Crime Reporting Summary Reporting System (SRS), used since 1930, was an aggregate monthly tally of 10 major crimes. It was found to be technologically and procedurally outdated decades ago. The solution was a National Incident Based Reporting System (NIBRS) and the transition to it was supposed to be complete by January 1, 2021. The NIBRS can dive deeper and into more data for more types of

crimes, including animal cruelty, identity theft, and computer hacking. However, participation is voluntary.

For 2021, the FBI reported that it only received data from 9,881 or 53% of the 18,818 law enforcement agencies (LEAs) in the country. Because that fell short of its 60% threshold, it only released 2021 quarterly data from “individual city agencies with populations of 100,000 or greater” but noted that it would not release state-level estimates if the participating LEAs in a state cover less than 80% of the state population.

For its 2022 statistics, the FBI has decided to accept SRS data submissions from any agency that has not yet completed its NIBRS transition.

stance to help calm others. She shared these ideas for security considerations:

- Have working security cameras in several areas, including the pharmacy and waiting room.
- Consider having a safe room with a steel door.
- Conduct CPR/first-aid training and have a first-aid kit available.
- Consider interteam communication devices.
- If there is an incident, immediately write down a clear physical description and details before memories get clouded.
- If a hospital uses curbside service, have a plan to ensure the safety of any staff member who has to go outside to interact with clients.
- Consider having code words for potentially dangerous situations, including ones that would prompt someone to call 911.

At Maplewood, Kristina Laux, hospital manager, noted how the pandemic “really brought out the worst in some people, and we were taking the brunt of people’s frustrations. People were upset that they couldn’t come in, that they had to wear a mask, that the wait time was so long.”

“Hospitals sometimes don’t see that they have an issue or just ignore and hope it never comes up.”

—KIMBERLYANN MACKAY, CVPM, A FORMER PRACTICE MANAGER AND A LONGTIME PAROLE SUPERVISOR FOR THE COMMONWEALTH OF PENNSYLVANIA

Most survey respondents not having problems

A January 2023 survey report on crime and violence in the veterinary practice recorded 175 responses by the Veterinary Hospital Managers Association:

- 80% have not experienced any crime; 6% vandalism; 2% equipment theft; 5% money theft; 1% unknown; and 6% “other,” including attempted break-in, phoned-in death threat, and person high on meth harassing staff and clients and trying to break into the clinic and a car.
- 89% have experienced no incidences of violence against a person at their practice; 5% have a staff member who was a victim of violence at the practice; 1% did not know; and 5% “other,” including threats but no acts and verbal abuse without physical contact.
- 51% provide facility safety or awareness training; 37% do not; 4% contract with a third-party consultant to provide training; 3% don’t know; and 5% “other,” including OSHA safety only and fire safety and evacuation plans.
- Of 174 responses, 28% have a written policy or procedure for an active shooter situation; 67% do not; 1% don’t know; 4% “other,” including having panic buttons and a policy not written but reviewed at multiple staff meetings.



Absecon Veterinary Hospital worked with its local police department and rolled out its active shooter plan late last summer.



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She said the hospital has put up in-house signs and added call-waiting messages that focus on respect and zero tolerance for aggression. “They have really made people think a bit more, and overall, I believe it’s working,” she said. “I really feel that we need to spread as much positivity as possible, as it’s so easy to spread negativity and hate. We’re here to be healers and help in any way possible.” ✧



Maureen Blaney Flietner is an award-winning writer living in Wisconsin.

Resources

- The Veterinary Hospital Managers Association is offering a preconference workshop: “Understanding, Preventing and Responding to Violence and Conflict in the Workplace” from 8 a.m. to 4 p.m. Sept. 20, 2023, featuring Ray McGury and Mike Zegadlo from RJM Strategy Group. The VHMA Annual Meeting and Conference runs Sept. 21–23 in Glendale, Arizona.
- The FBI offers active shooter training for businesses. Reach out to your local FBI field office, and ask for the Active Shooter Coordinator.
- US government agencies have many active shooter planning resources online, including:
 - The FBI’s realistic, informative video on suggested “Run, Hide, Fight” tactics at fbi.gov/how-we-can-help-you/safety-resources/active-shooter-safety-resources.
 - The Cybersecurity and Infrastructure Security Agency’s fact sheet for businesses: cisa.gov/sites/default/files/publications/hometown-security-fact-sheet%2004022019-508.pdf and emergency action plan guide and template: www.cisa.gov/publication/active-shooter-emergency-action-plan-guide.
 - The Department of Homeland Security’s “Active Shooter: How to Respond” guide: dhs.gov/xlibrary/assets/active_shooter_booklet.pdf.



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To Board or Not to Board

Pros and Cons of Offering Pet Boarding at Your Practice

by Jen Reeder

THE FIRST TIME ANN SNYDER TOOK HER DOG BULLET TO THE BOARDING FACILITY at AAHA-accredited Lafayette Veterinary Care Center in Lafayette, Louisiana, she felt “scared.” It’s not that she didn’t trust the reputation of the 2022 AAHA-Accredited Practice of the Year, just that her rescued terrier mix had been reactive to other dogs at a commercial boarding facility.

“I don’t know what happened to him in his first three years, but he gets intimidated, and he tries to bite and snap and carry on,” she said. “He got to the point where he wouldn’t go in the door at the other one.”

Things proved different at Lafayette Veterinary Care Center, where the staff gave Bullet the extra attention he needed to feel safe. Now the little dog has been a loyal

attendee of both the practice and its boarding facility for a decade.

“To this day, he runs in the door,” Snyder said. “Whatever your dog or cat needs, they will provide it. Everything is just over the top: their staff, their knowledge and services available are all just wonderful. I couldn’t ask for anything better.”

When animal hospitals offer boarding, it can be a terrific service to clients like Snyder, providing convenience and peace of mind in knowing veterinary care is readily available if necessary. But while it might seem like adding boarding could easily boost revenue, there are major considerations to weigh when contemplating the question of whether or not to start offering boarding at your practice.

While it might seem like offering boarding could easily boost revenue, there are major pros and cons to weigh when contemplating the question of whether or not to start offering boarding at your practice.

Service or Liability?

At Lafayette Veterinary Care Center—which offers boarding, daycare, and grooming services in addition to veterinary medicine—the pros outweigh the cons, according to Resort Director Brittlyn Boudreaux. “It absolutely brings in revenue,” she said.

Around 15 pet care specialists staff the boarding facility, which can host up to 150 dogs and cats each night in “condos” or luxury “suites” replete with televisions to feel more like home. All guests receive a complimentary “VIP snack” their first night—typically a dog biscuit covered in peanut butter and kibble—and the team texts photo updates from the two resort cellphones to owners during each stay.

Owners can also purchase add-ons like snacks; daycare playtime with toys, pools and sprinklers; and a departure bath or a “spa” that includes two shampoos, conditioner, nail trim, and ear cleaning. Clients sign a contract that says the team can seek medical care if needed, and team members follow safety tips in a protocol binder to protect the pets and the staff. One protocol states that employees must check on a dog 15 minutes after a meal, which once led to saving a dog from bloat.

“We are definitely a one-stop shop, which I think is our biggest feature,” Boudreaux said. “Most of our clients who board their babies here also see some of our veterinarians. They already have that trust built with us.” Boudreaux feels it’s crucial to have different personnel for the various departments (the hospital employs around 150 people between the hospital, boarding, daycare, and grooming departments); she calls hers “the Fun Side.”



“A con is that it’s hard for smaller facilities that can’t facilitate their own team for this,” she said. “But if you can, it’s absolutely worth it.”

Staffing can be a major con, with kennel assistants making low pay for a physically demanding job in the midst of nationwide staffing challenges. In fact, just 25 minutes before an interview for this article, a boarding employee texted Megan Danner, practice manager at AAHA-accredited TotalBond Veterinary Hospital at Forestbrook in Gastonia, North Carolina, to say she didn’t want to work that weekend—and quit.

Danner sent a message to the practice’s group chat looking for a volunteer to fill in. She’s personally had to cover boarding shifts when employees have called in sick at the last minute or quit. “That’s probably one of the biggest cons: the turnover rate for kennel attendants,” she said. “It is a constant revolving door.” Either boarding employees leave for higher-paying work or have a strong work ethic and are quickly promoted to technician assistant or other jobs at the practice, Danner noted.

The boarding—which features seven large runs, 10 cages that could each fit at least two small dogs, and eight cat enclosures—brings in “a little revenue.” But the headache is no longer worthwhile. After the employee quit, Danner instructed her staff to honor existing boarding reservations but stop taking new ones.

When the practice is renovated later this year, it will phase out boarding and instead add amenities like another treatment room and large break room. (The hospital will continue to offer *medical* boarding in a few runs, which will help chemotherapy patients who typically aren’t allowed to board elsewhere in the area.) In fact, TotalBond has five practices in North and South Carolina, and each location phased out boarding during renovations to expand veterinary services.

“That’s probably one of the biggest cons: the turnover rate for kennel attendants.”

—MEGAN DANNER

Danner’s advice for practices considering boarding pets is to be sure to offer a yard and enrichment activities. “If you’re thinking about doing it as a veterinary clinic, then you need to invest in making it worthwhile for the pets,” she noted.

More Considerations

It’s also important to consider how adding boarding to a practice will impact the veterinary team, according to Page Mader, DVM, co-owner of AAHA-accredited Five Parks Animal Hospital in Arvada, Colorado.

Early in her career, Mader worked at a large practice in Arizona that offered extensive boarding. Owners could schedule vaccinations, wellness exams, and other services while their pets were boarded, plus the team treated any issues that arose.

After that experience, she vowed never to work for a practice with pet boarding again. “Each veterinarian had a day where we were responsible for all the boarding dogs. The kennel staff would bring the medical charts over,” she said. “Some days, it was fifteen dogs you had to look at on top of your shift.”

Many boarding cases involved diarrhea from stress colitis, eye infections, or simply “ADR,” (short for “Ain’t Doing Right”). “Then sometimes we can’t get ahold of the owners,” she recalled. “Are we allowed to treat? Are we not? And some of these people are in places where they can’t really be reached all that well with cell service. That was another complication that you throw into the mix.”

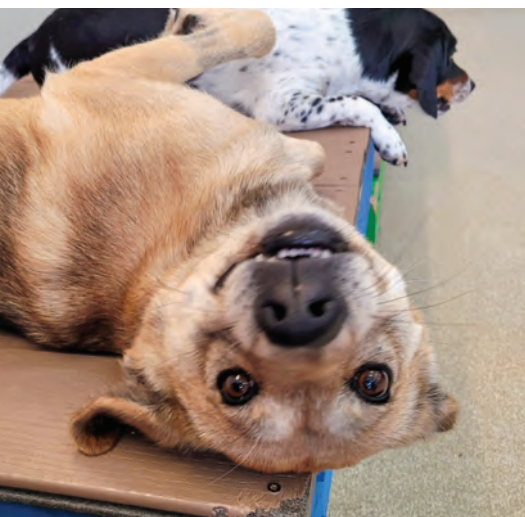
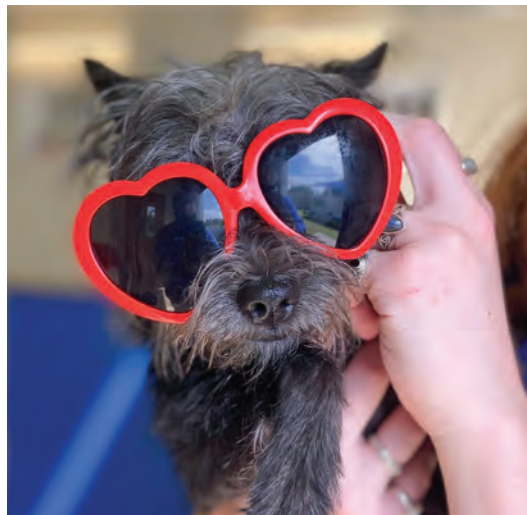
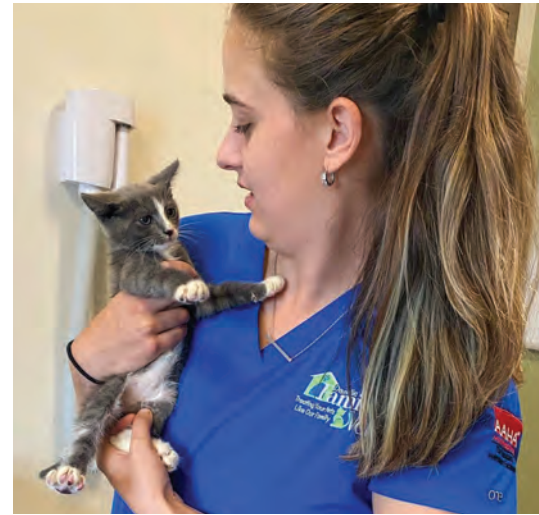
Unsurprisingly, the animal hospital she opened in 2020 doesn’t offer boarding. However, for over a year after opening, she personally offered pet sitting services to pets of clients and friends in her home above the practice because she and her business partner prioritized paying their staff rather than their own salaries.

It proved too much on top of a full caseload at work as well as taking relief shifts at a regional hospital. She grew tired of dogs destroying her property; her schedule doesn’t allow her to house sit, where pets would feel less anxious in their own environment, plus she’s seen a rise in separation anxiety and general anxiety in patients (and people) during the pandemic.



“We are definitely a one-stop shop, which I think is our biggest feature.”

—BRITTLYN BOUDREAUX





After having to euthanize a dog she was pet sitting over the holidays, she drew the line and stopped pet sitting. “It’s also just the liability,” she said. “I felt like I was always responsible for the wellbeing of someone’s pet. And the stress: What if something were to happen on my watch? I already deal with that at work.”

Still, she permits her employees to pet sit since any liability belongs to the pet sitter, not the hospital.

Life-Saving Side Gig

Keali Stewart, RVT, has been a veterinary technician for 13 years and pet sitting on the side for 10. She used to work at a corporate practice that didn’t allow employees to pet sit for clients, but her current hospital does: AAHA-accredited Urban Vet Care in Denver, Colorado. Clients often email the practice asking for help finding a pet sitter to come to their home, and she’s one of several technicians who offer their services.

As a veterinary professional, clients trust Stewart more than a stranger working for a pet sitting app, which also means she can charge a little more. “I personally love pet sitting as a technician,” she said. “It’s nice that they have trust in you.”

The trust can pay off for pets. Once while sitting, Stewart noticed a cat going into heart failure and Urban Vet Care

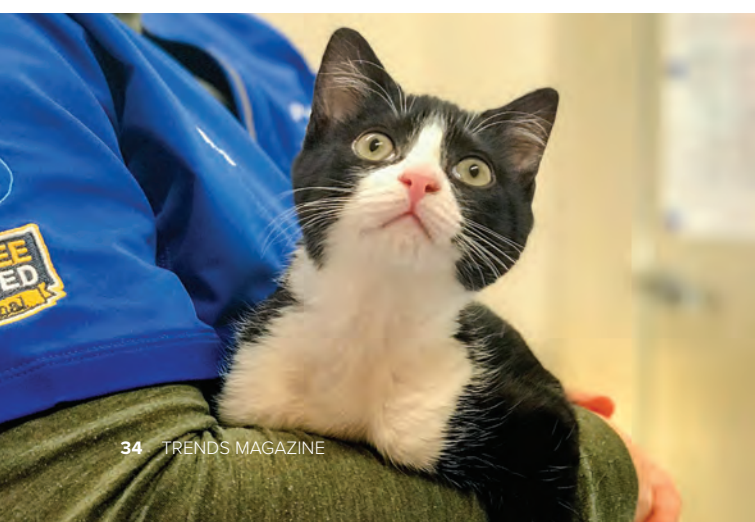


Price Advice

Pet boarding fees can fluctuate based on additional services like bigger rooms, number of pets in a kennel, add-ons like group play, treats or grooming, and holidays.

Jeff Smith, DVM, medical director of AAHA-accredited Danville Family Vet, suggests counting how many people call looking for Fourth of July boarding and charging according and keeping an eye on how much rates for human hotels increase around special events.

“I think you should really look to the hotel industry,” he advised.



saved him. It happens at veterinary boarding facilities, too. Members of the veterinary team at AAHA-accredited Harbor Point Animal Hospital in Mooresville, North Carolina, rushed to the practice one Sunday—when they're closed—to provide emergency surgery to remove a urinary stone from a bulldog boarding at the practice's Harbor Point Hotel, according to Practice Manager Diane Vermillion.

"It was a good thing he was here because we were able to see it and handle him. We knew the dog—he was a long-term patient of ours, so we knew the history," she shared. "But certainly, it's nonstop when you have that boarding part and you still have to address these pets."

Staffing and Size

Harbor Point Hotel can host about 20 dogs and cats in a separate area of the hospital and opened when the practice did in 2016. Each suite is destination-themed—think Paris, Tahiti, Tuscany—with soothing music piped in and filled Kongs at naptime.

Initially anyone could board at the practice, but as of 2023, it's only available to hospital patients with updated annual exams on file. The practice also offers grooming and daycare.

"Six years into it, I think there are cases to be made for not having all those ancillary departments and being able to focus truly on veterinary medicine," she said. "Take a look at (boarding) staffing: it's seven days a week through holidays. Unless you've got a really large facility to make it work, I don't know if it's worth all of that, to be honest."

Jeff Smith, DVM, medical director of AAHA-accredited Danville Family Vet, a Galaxy Vets location in Danville, Virginia, agrees that size is important. The practice has offered boarding for nearly 30 years and expanded capacity five years ago when he built a new animal hospital with an adjoining luxury pet resort that can accommodate up to 70 dogs and 10 cats.

"That's one of the keys to having a pet hotel: if you're going to do it, you have to commit to it," Smith said. "It can't just be a little add-on boarding wing for 10 patients. It doesn't work financially or staffing-wise or anything else."



"You run it like a separate business, and you run it by the same standard of high quality that you run your vet clinic by."

—JEFF SMITH, DVM

Just as he enjoys being part of Galaxy Vets so he can focus on practicing medicine rather than tasks like hiring and firing, he strongly recommends hiring a resort manager "with a passion for it" to handle boarding separately.

"A common concern of veterinarians is that it's just a big headache. Somebody's dog collar got lost, and then the people are very upset about it and there's a lot of follow up with that," he said. "Those headaches happen because people are not focused on having a pet resort. You run it like a separate business, and you run it by the same standard of high quality that you run your vet clinic by."

He noted there's a reason why pet resorts are popping up around the country. "Pets are becoming more part of the family," he said. "People want a supervised boarding facility where there's a veterinarian on staff, and they know they can trust their little member of the family is going to be safe while they're gone for the weekend. It is really a growing industry." ✨



Award-winning journalist Jen Reeder is former president of the Dog Writers Association of America.

include some basics, such as those noted below and paraphrased from the Society of Human Resource Management. For more in-depth information, check out the *AAHA Guide to Creating an Employee Handbook, Fourth Edition* by Amanda L. Donnelly, DVM, MBA, Charlotte Lacroix, DVM, JD, and Kellie G. Olah, SPHR, SHRM-CP.

Welcome. This message sets the stage for success for a new employee. It outlines the clinic's mission and some of its history. It can also build excitement about the role of the new employee in furthering the clinic's vision. Legal information is also included, such as an Equal Opportunity statement.

Policies and Procedures. This section outlines the "rules of the game," such as the clinic's hours and attendance expectations. It shares the clinic's policy on such things as overtime pay and performance reviews. It also provides the boundaries for an employee's use of the internet and social media.

Common Employee Handbook Blunders

- Failing to spotlight your clinic's brand by using a boilerplate template.
- Skipping the opportunity to use the handbook as a communication tool.
- Omitting policies or applying policies inconsistently.
- Being too strict with social media and disciplinary policies.
- Forgetting to train those who will administer the handbook.
- Failure to get input from your legal team before distributing.

Source: From "Top 10 Mistakes to Avoid with Employee Handbooks" by Jeffrey M Beemer, Society of Human Resource Management.

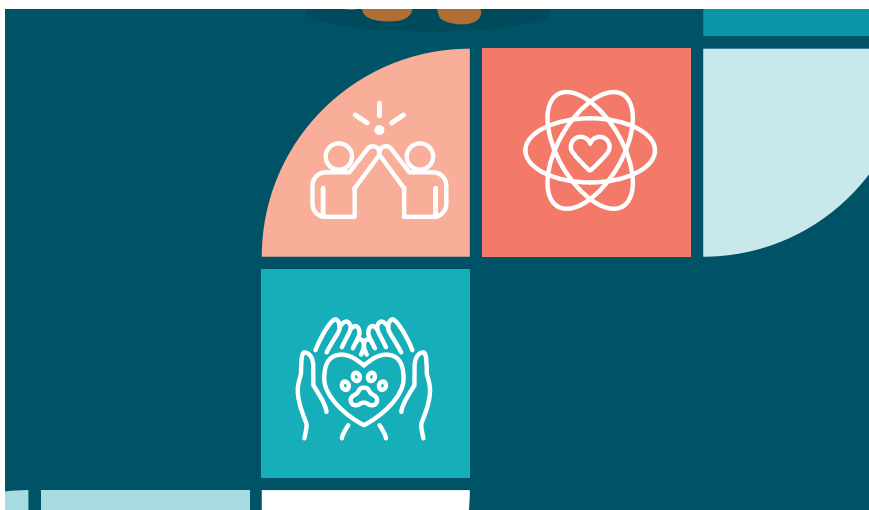
Benefits. This section specifically outlines the "rewards" a new employee gains when coming to work at your clinic. That can include vacation and sick leave or Family and Medical Leave (FMLA). It can also note any educational benefits and/or health insurance information.

Safety. The game space is always a safe space, and this section creates just that. It documents the clinic's commitment to practical employee

safety, by, for instance, outlining emergency procedures in the event of a fire. It also includes OSHA requirements and any Personal Protective Equipment (PPE) requirements.

Procedures. A game penalty has its own process, such as moving back three spaces, or going to jail in *Monopoly*. That's what this section outlines. It notes what disciplinary action the employee can expect should he/she/they not follow the rules of the game. It also outlines what to expect in an exit interview.

Employee Acknowledgement. This section reiterates the importance of the "rules of the game" outlined in the employee handbook. Here, the employee acknowledges, by signature, that he/she/they has received and understands them. ※



The employee handbook is a living document that communicates what your practice stands for.



M. Carolyn Miller is an employee development consultant, writer and instructional designer. www.cultureshape.com

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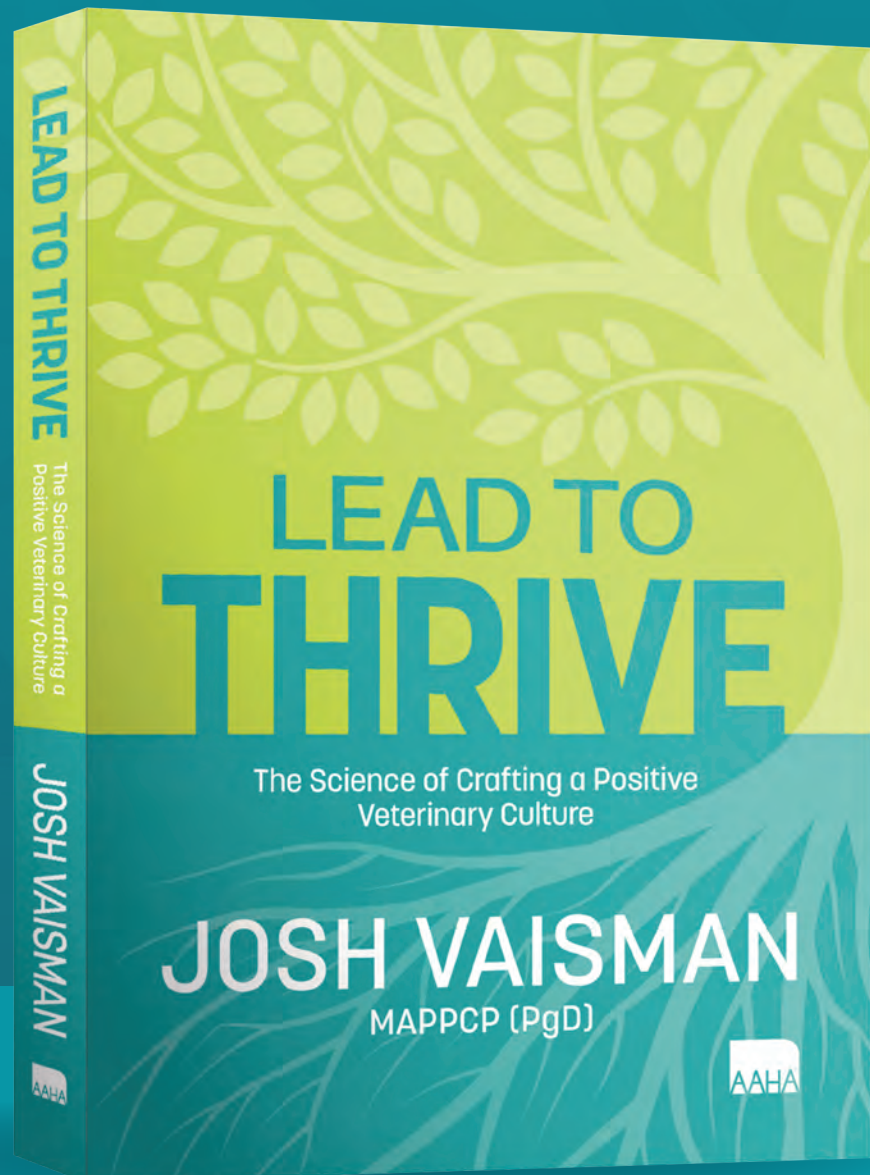
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Dental Case Study: Tella

Thinking Creatively to Treat Advanced Periodontal Disease

by Jan Bellows, DVM, DAVDC, DABVP

Tella, a seven-year-old, 21 kg rescue Belgian Malinois, presented for evaluation of a three-month intermittent swelling underneath her left eye (Figure 1). Oral administration of Clavamox prescribed by the referring veterinarian would temporarily resolve the swelling only to return once medication was discontinued. Tella's other problem was that her mouth would not open greater than 15 mm. Her owners suspected previous trauma earlier in life before she was adopted (Figure 2).

Marked oral malodor was noted. Facial examination confirmed a broad soft swelling below the left eye. Fine-needle aspiration of the facial swelling revealed nondegenerative neutrophils, few macrophages, and cocci bacteria consistent with neutrophilic inflammation. Periapical periodontitis affecting the left maxillary fourth premolar was suspected. Intraoral buccal examination of the left upper cheek teeth revealed swelling, inflammation, and gingival recession of the surfaces surrounding the mesial palatal root of the left maxillary fourth premolar. (Figures 3a, 3b).

Ideally, the next step would have been to anesthetize for an in-depth, tooth-by-tooth examination including probing and intraoral radiographs. Unfortunately, this case presented two challenges: (1) how to intubate a dog whose mouth cannot be opened



Figure 1: Swelling is evident beneath Tella's left eye.



Figure 2: Tella's mouth could not be opened more than 15 mm.



Figure 3a: Clinical appearance of the left cheek teeth.



Figure 3b: Swelling surrounding the mesiolabial root of the left maxillary fourth premolar.



Figure 4a: CO₂ sampling tube placed over urinary catheter.



Figure 4b: CO₂ reading consistent with endotracheal intubation.



Figure 4c: Endotracheal tube threaded over the urinary catheter.

sufficiently to visualize the larynx; and (2) how to extract the maxillary fourth premolar if the mouth could not be opened sufficiently to access the tooth palatally.

The plan for anesthesia included tracheal intubation. If tracheal intubation was not possible, temporary tracheostomy was considered a secondary option. Before the clinical examination, Tella received 200 mg gabapentin, 50 mg trazadone,

and Cerenia 1mg/kg. Butorphanol 0.2mg/kg was administered for premedication; methadone 0.1 mg/kg, midazolam 0.2mg/kg, and alfaxan 3.0mg/kg for induction. Isoflurane was used to maintain anesthesia.

Tracheal intubation was initially accomplished by threading a #10 French plastic urinary catheter into the trachea with the neck extended. A normal carbon dioxide level (versus zero if esophageal intubation) confirmed tracheal location of the

catheter (Figures 4a, 4b, 4c). An endotracheal tube was then threaded over the urinary catheter.

Once tracheal intubation was confirmed, cone beam computed tomography (CBCT) imaging was performed, which showed advanced periodontal and periapical disease of the left maxillary fourth premolar, advanced periodontal disease of the second molar (which was virtually floating in the caudal oral cavity), as well as the left mandibular first,

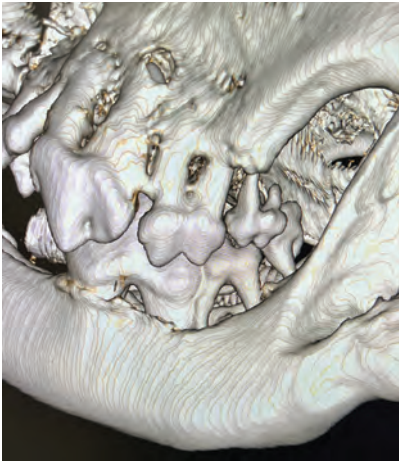


Figure 5a: Confirmed advanced periodontal disease.

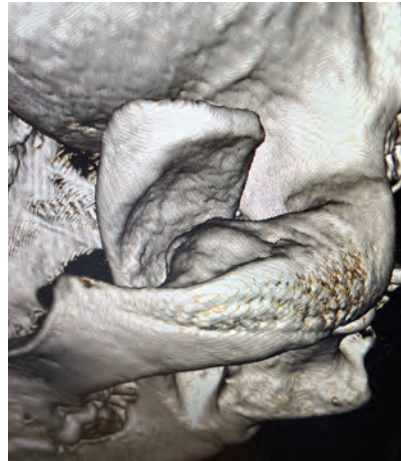


Figure 5b: CBCT imaging of the left temporomandibular joint area.



Figure 6a: 701 surgical bur used to remove the crown of the mandibular first molar.

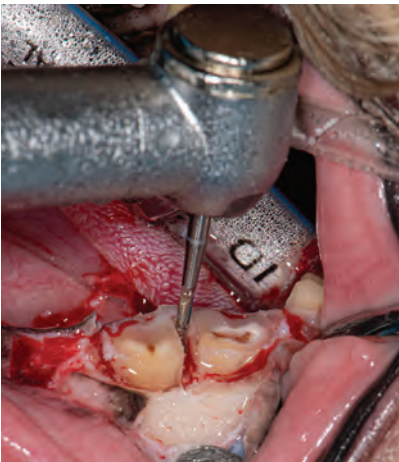


Figure 6b: Hemisection mandibular first molar before extraction.



Figure 7: Postoperative CBCT imaging confirmed complete extractions.

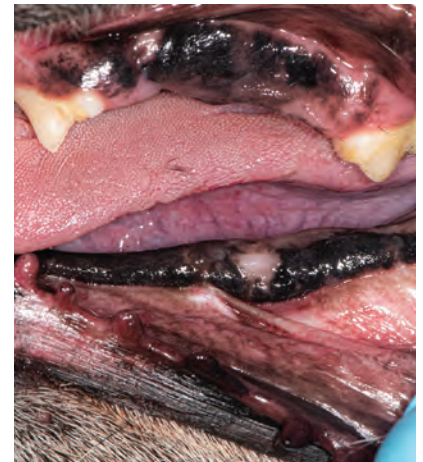


Figure 8: Normal postoperative appearance of the left cheek teeth.

second, and third molars (Figure 5a). Further CBCT evaluation revealed a large callus just rostral to the left temporomandibular joint, which explained why Tella could only partially open her mouth (Figure 5b).

The left maxillary fourth premolar, second molar, and the mandibular first, second, and third molars were extracted, approaching all teeth buccally. To aid the extraction process, the crowns were removed, then the roots (Figures 6a, 6b).

Postoperative CBCT imaging was performed confirming complete extractions. (Figure 7).

Tella was sent home on gabapentin and meloxicam. No antimicrobials were prescribed. On re-examination two weeks postoperatively, the swelling below the left eye had resolved, and all surgical sites appeared to be healed. Tella's owners are considering surgery to remove a section of the left caudal mandible to allow her to facilitate a larger mouth

opening and future dental procedures to address the remaining teeth affected by moderate to advanced periodontal disease (Figure 8). ✖



Jan Bellows, DVM, DAVDC, DABVP, is owner of AAHA-accredited Hometown Animal Hospital and All Pets Dental Clinic in Weston, Florida.

It Takes a Village

Supporting DEIB Efforts in the Veterinary Field

by Linda Childers

A lifelong lover of animals, Tierra Price, DVM, MPH, remembers watching the movie *Dr. Doolittle* as a child and feeling inspired by Eddie Murphy's title character, a Black physician who cared for animals. Yet in real life, Price found that Black veterinarians were a statistical anomaly. It wasn't until she turned 19 and participated in a veterinary program for minority undergraduates that she first met a Black veterinarian.

Price's situation isn't unique. According to 2022 data from the Bureau of Labor Statistics (BLS), approximately 91.4% of veterinarians are white, 2.2% are Black, 4.3% are Asian, and 0.5% are Hispanic/Latinx.

To help other Black veterinarians, students, techs, and assistants find mentorship and support, Price, who now works as a community medicine veterinarian in Los Angeles, California, launched [BlackDVMNetwork.com](https://blackdvmnetwork.com), an online platform in 2018.

"As a veterinary student, I often felt isolated from my classmates and colleagues," Price said. "To connect with others, I started an Instagram (@blackdvmnetwork) to connect with other Black veterinarians and veterinary students and quickly learned there was a gap in resources for Black veterinary professionals."

Price decided to develop her Instagram account into Black DVM Network, a networking community



"To catalyze lasting change, we must drive awareness of why diversity, equity, inclusion, and belonging are valuable to our profession and the people we serve."

—JENNIFER OGEER, DVM, MSC, MBA, MA

she wishes had existed when she first started veterinary school. Today, the organization offers webinars, a directory of Black veterinary professionals, and support to members, especially those who have experienced racism.

The topic of increasing diversity, equity, inclusion, and belonging (DEIB) in the veterinary field isn't new, and there are many initiatives underway to recruit and retain a diverse workforce. But professional organizations such as Black DVM Network can't undertake this work alone.

"To catalyze lasting change, we must drive awareness of why diversity, equity, inclusion, and belonging are valuable to our profession and the people we serve," said Jennifer Ogeer, DVM, MSc, MBA, MA, vice president of medical science and innovation at Antech Diagnostics and chair of the Diversify Veterinary Medicine Coalition (DVMC). "Through the DVMC website, social media presence, and events, we facilitate storytelling and fellowship, creating a coalition for change inclusive of our broader colleagues and professional associations."

As a nonprofit, DVMC brings together veterinary leaders from diverse backgrounds who are committed to increasing BIPOC (Black, Indigenous, and People of Color) representation in the veterinary community. They believe this will not only make the veterinary field more inclusive, it will also improve access and expand quality of care for more animals.

Ogeer said the mission of the DVMC (diversifyvetmed.org), established in 2020, is to create lasting and

significant change, sparking a movement that ensures the veterinary profession is synonymous with diversity, equity, inclusion, and belonging. "The goal of DVMC is to support a diverse group of veterinary students at each step in their educational journey—from youth to adulthood," Ogeer noted.

Since financial support is a key barrier for many BIPOC students who want to enter veterinary medicine, Ogeer said that DVMC works to reduce financial barriers by offering students scholarships, internships, and educational and travel grants.

Becoming Advocates for Change

Creating a diverse, equitable, and inclusive veterinary community demands sustained effort, continuous improvement, and accountability, said Karl Jandrey, DVM, MAS, DACVECC, associate dean, admissions and student programs and professor of clinical small animal emergency and critical care, at the University of California, Davis School of Veterinary Medicine.

"Since the majority of veterinary leaders are older, white men, DVMs and other leaders in the veterinary profession can begin by asking themselves who is represented in and by their organization, as well as who is missing from their organization and the population they serve," Jandrey said. "The next step is to begin to amend those deficiencies."

Jandrey encourages veterinarians, especially those who aren't in underrepresented groups, to strive to surround themselves with staff who aren't like them. "Search

for employees with different backgrounds, experiences, and educational levels," Jandrey said. "Attempting to mix up the homogeneity in their everyday lives—both at work and in their community—should be the goal of veterinarians on a daily basis."

Besides being the right thing to do, having a diverse veterinary practice makes good business sense. The National Society for Leadership and Success (NSLS) noted that "cognitive diversity," which mixes different thinking-styles, habits, and perspectives, creates a sense of community within a practice, and helps teams solve problems more quickly and efficiently. A report by McKinsey and Company also found that diverse practices outperform their less diverse peers by 36% in profitability.

Learning to Be an Ally

Jandrey says there are many affinity veterinary organizations representing BIPOC or other underrepresented and underserved populations that are open to all veterinarians.

"Whether a veterinarian identifies with an affinity group that focuses on DEIB or is an ally, supporting these affinity groups through active membership can allow veterinarians to understand the common struggles we all face," he said. "Those struggles that aren't common can be discussed and tackled from many levels when everyone can add important value to the resolution."

Jackie Dueñas, DVM, of Sunset Animal Clinic in Miami, Florida, said she was fortunate to grow up in Miami with Latinx and Hispanic veterinarians

Resources to Help Increase DEIB in Your Practice

A number of affinity groups exist within the veterinary field that welcome new members who are committed to taking action and ensuring DEIB.

PrideVMC (pridevmc.org), an organization that represents the LGBTQ+ community. Their website provides allyship resources, a conscious language guide, tips on how to create an inclusive practice, a job board, and more.

Black DVM Network (blackdvmnetwork.org) offers a vibrant online networking community, a forum for safe discussions, a job board, a directory of Black veterinarians, webinars, and more.

Latinx Veterinary Medical Association (LVMA) (latinxvma.org) focuses on professional development, mentorship, outreach, and scholarships designed for Hispanic and Latinx veterinary students and professionals working in the veterinary field.

Multicultural Veterinary Medical Association (mcvma.org) is for any veterinary professional looking to promote diversity and cultural competency in the field. They offer a variety of initiatives designed to promote DEI in the workplace, as well as scholarships, awards, and grants for students and events for veterinary professionals.

American Association of Veterinarians of Indian Origin (aavio.org) has regional chapters, events, resources, and networking opportunities for veterinarians of Indian origin.

Association of Asian Veterinary Medical Professionals (aavmp.org) offers a space where Asian preveterinary and veterinary professionals can find support, mentoring, and scholarships and connect with other Asian veterinary professionals internationally.

Women's Veterinary Leadership Development Initiative (wvldi.org) is where women in the veterinary field can learn leadership skills, network with their peers, learn about jobs and volunteer opportunities in the field, and more.

National Association for Black Veterinarians (nabvonline.org) is a nonprofit offering an annual conference held in June, scholarships, a directory of Black veterinary professionals, a job board, and more. They are committed to providing mentoring and support to Black veterinary professionals across the country.

Prefer to be a mentor or become involved in a new diversity initiative? Consider the following:

Mentorvet (mentorvet.net) offers mentors and professional development programs to promote early career well-being. Scholarships are also offered to students pursuing a career in veterinary medicine.

Journey for Teams (journeyforteam.org) is a profession-wide program that engages veterinary professionals to enhance DEI efforts. Designed for animal hospitals, vet practices, academia, and other veterinary settings, Journey for Teams is sponsored by the American Veterinary Medical Association (AVMA) and Veterinary Medical Association Executives (VMAE).





“Since the majority of veterinary leaders are older, white men, DVMs and other leaders in the veterinary profession can begin by asking themselves who is represented in and by their organization, as well as who is missing from their organization and the population they serve.”

—KARL JANDREY, DVM, MAS, DACVECC

who served as her role models. She acknowledges that not all veterinary staff may reside in a diverse area and said that affinity groups such as the Latinx Veterinary Medical Association (LVMA), of which she is a member, provide valuable resources to all veterinary professionals.

Dueñas said allies who want to learn more about the Latinx culture can join LVMA for a membership fee of \$10 a year. The organization launched in 2020 to empower Latinx veterinary professionals and provide scholarship, mentorship, professional development, and community outreach to veterinary students and prospective students.

“In a previous role, I visited local schools to talk about pet ownership and to also generate an early interest in the veterinary field,” Dueñas said.

In addition, emphasizing a culture that promotes DEI principles is a win-win for both veterinary practices and clients, said Dueñas.

“Having an inclusive veterinary practice enables veterinary staff to understand cultural differences in the ways our clients see pets,”

Dueñas says. “In a lot of Hispanic communities, pets are viewed differently; for example, my grandma, who is Cuban American, once made a comment that pets in Cuba never get sick. It’s not that they don’t get sick, but life in Cuba is very different. With families struggling to provide for themselves, medications such as heartworm prevention and flea and tick are considered luxuries.”

Committing to Hiring and Training a Diverse Staff

Pets now live in 67 million households, and multicultural pet owners represent a growing percentage. According to a study by Packaged Facts, between 2008 and 2018 the increase in the number of Hispanic, African American, Asian, and other multicultural pet owners was five times higher than the increase in the number of non-Hispanic white pet owners.

To ensure a veterinary practice is more inclusive, Price emphasized that it’s important to address culture. “Recognize that communication, style, and beliefs can vary among people and that those differences can make your practice stronger,” she said.

When looking to add veterinary staff, Jandrey suggested casting a wide net and reaching out to colleagues, veterinary schools, and job boards offered by affinity groups in order to identify BIPOC candidates.

“Today’s veterinary school grads are looking to work in a culture that incorporates diversity, environmental sustainability, and a future-focused mindset,” Jandrey said, citing a recent paper written by his students for the AVMA Journal. “Through word-of-mouth, veterinarians can actively look for diverse candidates to join their practice.”

In addition, Ogeer said DVMC provides resources that can help veterinary professionals interested in offering diversity training at their practice and addressing unconscious bias.

A diverse staff can also remove communication barriers with clients. Dueñas said affinity organizations such as LVMA can help veterinary practices connect with bilingual candidates when they have job openings and offer Spanish-language resources.

“If a client only speaks Spanish, it can be difficult to explain why their pet needs a specific treatment or diagnostic test,” she said. “If you can’t effectively communicate with your clients, it’s the pets that lose out.” ✖



Linda Childers is a California-based freelance writer who regularly writes on a wide variety of health-related topics.



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Peter Weinstein, DVM, MBA



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The Art of Bandaging

Advanced Training for Techs

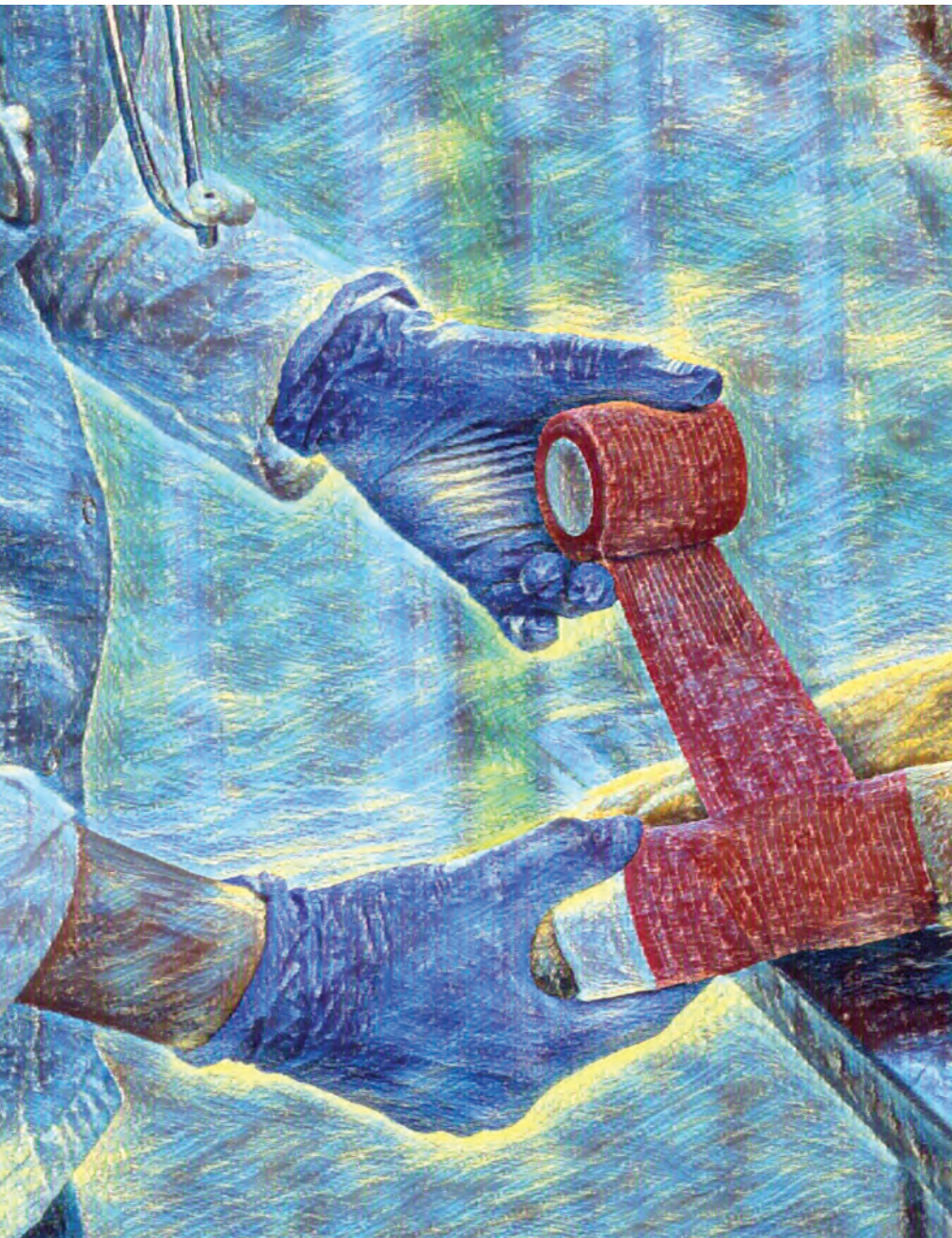
by Danielle Browning, LVMT, VTS (Surgery)

Bandages are used to provide stabilization, compression, absorption, and protection and to deliver medications, and proper bandaging is an art. It is a skill that every technician, new or experienced, should continue to hone throughout their career. Bandages themselves are multifaceted. Proper selection and application are critical components of wound healing. Understanding the properties and functions of bandages is key to correct selection and will aid in a successful application.

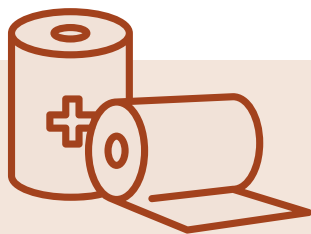
Depending on the desired function, selecting the bandaging materials used for each layer will vary from case to case. Considerations for choosing a particular dressing or material will depend on a range of factors. Some factors to consider would be the presence of an open wound, recent surgery, wound drains, infection, environment, patient temperament, cost, inventory, and owner compliance.

Generally, bandages can be broken down into three layers: the primary, secondary, and tertiary layers. There are times when only a primary layer is necessary or a secondary layer may be left out entirely. Remember to use an aseptic technique, wash hands, and wear clean gloves when applying a bandage, especially when handling materials that come in contact with the wound.

The *primary layer* is the first layer of a bandage that comes in direct contact



Proper skin preparation, before placement of tape or transparent film, is key to ensure good adherence.



Tips for Soft Limb Bandage Application

- Apply 1-inch white tape stirrup strips (optional).
- Begin at the toes, leaving the toenails of digit 3 and 4 exposed.
- Hold the roll so the outside of the dressing is down against the patient, rolling “off” the roll.
- Choose a wider size material (4-inch instead of 2-inch) when applicable to avoid the tourniquet effect.
- Apply layers in a spiral fashion, beginning at the most distal area working proximal.
- Leave a few millimeters of each underlayer exposed as you build up the bandage.
- Aim for 50% overlap of material.
- Avoid excessive wrinkles in the material.
- Pull cast padding to flatten the quilted appearance. The cotton cast padding material will tear before it is too tight.
- Use even tension (not too tight) when applying the rolled gauze layer.
- Adequately pad around bony prominences with a donut.

with the patient. Rolled cotton and cast padding are often used as the initial layer; however, these materials should never be placed directly on an open wound surface, since the cotton fibers can become lodged in the wound bed, inciting inflammation. If the primary layer is covering an open wound surface, a nonstick material such as a Telfa pad should be used. Stirrup tape strips can be useful to hold the bandage in place (Figure 1). The stirrup is first applied directly to the skin, then folded over attaching to the last gauze layer (Figure 2). Stirrup tape strips should never be placed directly on an open wound, skin graft, incision, or over the accessory carpal pad since excessive traction may result in tissue necrosis. The stirrup technique is commonly used when bandaging the limbs and can be applied to the head and tail as well.

The *secondary layer* provides absorption, compression, and stabilization to the bandage.

Multiple layers of cast padding, followed by one to two layers of rolled gauze, comprise this layer in most soft padded bandages (Figure 3). If a splint is also being used to add support, it will be incorporated into the gauze layer, and additional layers will be required to hold the splint in place. Rolled gauze is at risk of being wrapped too tight, so care should be taken to pull the gauze tight enough to not sag, but not overtightened so it results in constriction. Adequate padding under the splint and around bony prominences helps to reduce the risk of pressure sores associated with bandages. Sponges, foam, cast padding, and orthopedic felt are materials that can be used to provide adequate padding. A common mistake

is to add additional layers of padding on top of bony prominences, but this is counterproductive, creating more pressure on the area. Instead, utilize a “donut” technique, which distributes the pressure around the area to reduce the incidence of pressure sores (Figure 4).

The *tertiary layer* is the outer covering of the bandage (Figure 5). This layer’s primary role is to hold the first two layers in place; it also protects the wound from potential infectious agents and shields the environment from contamination by the wound. Adhesive surgical drapes, or transparent films, can be used to create an occlusive barrier. Bandages are further broken down into occlusive and semioclusive, which relate to the breathability of the material. Occlusive bandages are impervious to air and fluid, creating a “waterproof” layer, while a semioclusive layer will be moisture-retentive and absorbent, allowing for some evaporation and vapor transfer. Understanding the properties of the bandage material is prudent for getting their most effective use. The most common tertiary layer is an elastic wrap, and care is taken to not put this material on too tight. The higher the elasticity of the material, the greater the constriction risk.

Alternative Bandaging Techniques

Keeping a wound covered is crucial and can be a straightforward process. However, when dealing with wounds located on the head, chest, flank, tail, and inguinal region, a traditional padded bandage may not be the best option.

A tie-over bandage is an alternative method to keeping wounds in these areas covered. To place a tie-over



Figure 1: Applying stirrup tape strips to the skin.



Figure 2: Folding stirrup tape strip into the secondary layer.

bandage, the patient is sedated, and suture loops are placed in the intact skin. The loops are placed around the perimeter of the wound bed approximately 2 to 4 cm from the wound's edge. The primary and secondary layers of the bandage are applied to the wound and held in place by passing umbilical tape (or a clean shoelace) through the loops, similar to lacing a shoe. This technique is also useful to help stretch the intact skin when skin-to-skin apposition is difficult. An adhesive drape can be added over the top of a bandage for an occlusive tertiary layer. When changing a tie-over bandage, cut the umbilical tape and leave the suture loops in place. Once removed, the wound can be cleaned and redressed; often this change can be performed without sedation. Wound drains should be covered with a tie-over bandage or soft padded wrap to decrease the risk of ascending contamination and infection. This is especially important with the use of passive (Penrose) drains.

Less is often more, especially when dealing with cats and small dogs. Consider the use of an adhesive

bandage (e.g., a Band-Aid) to cover smaller wounds and incisions when compression is not needed. An adhesive bandage can be easily constructed using a nonadherent dressing and a slightly larger size transparent film. The intact skin should be clean and completely dry to allow the tape to adhere. Spraying the intact skin with an acrylate polymer will help with tape adhesion and prevent stripping of the skin when the adhesive is removed. This type of barrier film is also used to protect the intact skin from body fluids that may lead to maceration, causing an increase in the risk of infection. Proper skin preparation, before placement of tape or transparent film, is key to ensure good adherence.

When to Change a Bandage

When wound care is not required, a bandage that remains intact, clean, and dry may stay on for weeks. Bandages should always be changed when a strike-through (appearance of fluid or blood to the outer layer) occurs and preferably before that happens (Figure 6). When dealing with open wounds, the decision



Figure 3: One to two layers of rolled gauze comprise the secondary layer in most soft-padded bandages.

for when to change the bandage will depend on the status of the wound, the primary layer chosen, and, ultimately, is the decision of the veterinarian. As a rule, if the integrity of a bandage is questionable, err on the side of the caution and change the bandage.

During all bandage changes, the surrounding areas (periwound skin) should be monitored for swelling, edema, skin irritation, or pressure sores. If any are noted, adjust the next bandage to elevate or prevent



Figure 4: The “donut” technique, which distributes pressure around bony prominences to reduce the incidence of pressure sores.



Figure 5: The tertiary layer is the outer covering of the bandage.



Figure 6: An example of an adhesive bandage with strike-through on the hip of a dog.

the issue from worsening or consider leaving the bandage off. Use a silicone medical adhesive remover to remove any tape and adhesive from the skin.

At-Home Care

Owners should be given clear instructions on bandage care and encouraged to call if they have any concerns. When sending a patient home with a bandage, make sure to keep good communication with the owner and give them written discharge instructions on proper bandage care. For example, when sending a patient home with a soft padded limb bandage, the instructions should include: keeping the bandage clean and dry; checking the toes for coldness, separation, and swelling; and keeping the e-collar on *at all times*. Owners will need to monitor the bandage for any

discharge, foul odor, slippage, or swelling around the bandage. They should notify their veterinarian’s office immediately if any of these signs occur.

An effort needs to be made to make sure the patient does not prematurely remove their bandage. Patient molestation (chewing at the bandage) could result in infection, additional wounds, incisional dehiscence, or a gastric foreign body. Patient molestation is a serious concern and needs to be prevented. Neck collars, e-collars, side-bars, body suits, and t-shirts can be used to deter the patient from traumatizing the affected area. It is important to note that e-collars must extend past the patient’s nose to be effective. If a patient suddenly begins to chew on the bandage, consider there may be

an underlying problem rather than just an unruly animal—immediately remove and replace the bandage.

Commercial protective boots, empty IV fluid bags, plastic bags, and shower caps are often used to keep bandages dry. These protective bandage covers should only be used when the bandage is at risk of getting wet, not left on continuously. Lastly, make it clear how many days the bandage should be left in place. Setting a recheck appointment at the time of discharge or calling owners as a reminder can help ensure they come back to have it removed.

It is important to note that only needing a bandage to last for a couple of hours is not an excuse to improperly place a bandage. In

Recommended Reading

Swaim, S., Renberg, Walter C., and Shike, Kathy M. *Small Animal Bandaging, Casting, and Splinting Techniques*. Iowa: Wiley-Blackwell, 2011.

Pavletic, M. (2018). *Atlas of Small Animal Wound Management and Reconstructive Surgery, Fourth Edition*. New Jersey: Wiley-Blackwell, 2018.

Fults, M., Yagi, K. *Technician Daily Reference Guide, Fourth Edition*. Iowa: Wiley-Blackwell, 2022.

busy clinic life, we as technicians, are bombarded with things to do “right now” and our good intentions may often be replaced with “I meant to take that off hours ago.” Life does happen, so taking a few extra moments to perform a job correctly the first time can save time and prevent future complications. ✨

Danielle Browning, LVMT, VTS (Surgery), is a senior veterinary technician for University of Tennessee Veterinary Medical Center. Browning began working for the university in September 2000 and became the small animal soft tissue ward technician in 2003. In April 2020, she made a lateral move into the large animal department, where she is currently working as the head operating room technician for both farm animal and equine surgery.



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Guidelines

Why Care about a Positive Culture?

A Healthy Culture Has All the Vibes

The following is excerpted from *Lead to Thrive: The Science of Crafting a Positive Veterinary Culture*, by Josh Vaisman, MAPPCCP (PgD), (AAHA, 2023)

“If you don’t have any solutions, I don’t want to hear about your problems.”

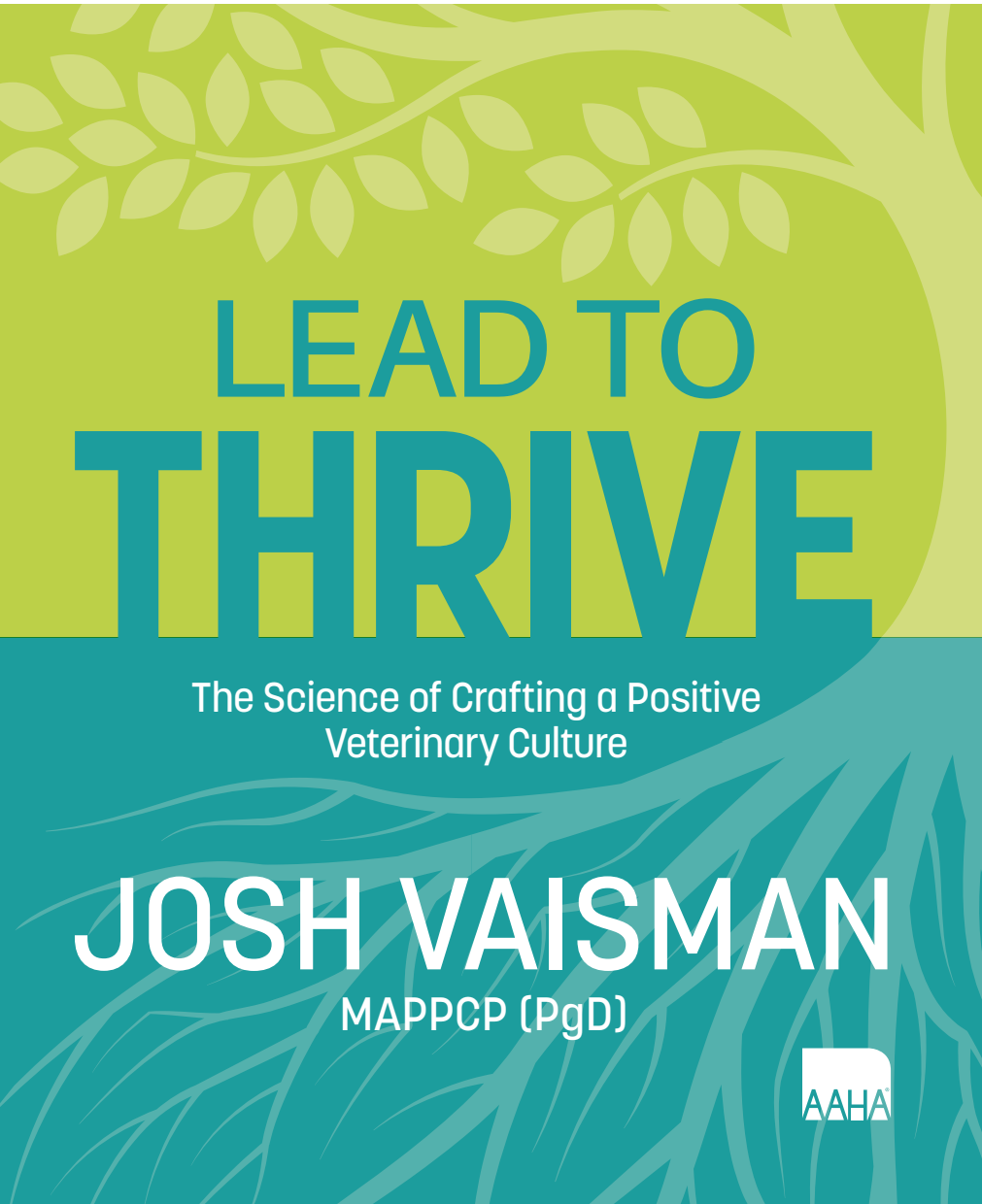
“Good vibes only.”

“This is a negativity-free zone.”

“If you have a bad attitude, don’t come to work.”

In far too many veterinary practices, leaders attempting to create a positive work environment demonize any expression of negative emotion. As we’ve learned from second-wave positive psychology, this misguided approach fails to understand what a positive culture really is. We know that negative emotions are both normal and necessary to human thriving, so a positive culture must allow for their healthy expression.

For decades now, spearheaded by American culture but certainly not limited to the United States, we have become obsessed with feeling good. We continually strive for more convenience, time, leisure, wealth, and happiness. It’s not our fault; the pursuit of happiness is foundational to our country’s ethos! And this obsession clearly has an upside: Our deep drive to improve life conditions has contributed to incredible innovations—the light bulb, condensed milk, the hearing aid, the disposable diaper, Crumbl Cookies.



Living in a world of unicorns and kittens does not necessarily lead to boundless reservoirs of wellbeing.

But it may have also made us utterly impatient and deeply intolerant of life's many discomforts.

Back when I was in junior high school, in order to download anything off the internet (in my case, usually a game created in MS-DOS) I had to rely on a rather large, clunky modem to transfer the information onto my home computer, byte by painful byte, over the course of several hours. At the time, the long wait was totally worth it (if it meant finally getting to play *Oregon Trail*—“*You have dysentery*”). Today this entire technological process is obsolete—and my patience for long download times hasn't aged so well either. If the three-hour documentary I'm streaming in high definition freezes up for even just a few seconds, I burst into a tirade of four-letter words I didn't even realize I knew. But even aside from thrown



One of the fascinating discoveries of modern social science is the fact we are terrible at predicting future happiness

remotes, this increasingly prevalent kind of impatience may signify a deeper problem.

By just about every objective measure, it is better to be alive now than at any point in human history. Today we live longer, healthier lives. Our risk of being affected by starvation, crime, and even war is lower than it's ever been. Access to resources continues to increase, and I can have just about anything I could ever desire swiftly delivered to my home by barking orders at the digital assistant embedded within my phone. Yet collective wellbeing has not improved apace; we do not thrive in the ways we might expect, despite all of these advances. These days people suffer clinical depression at rates at least ten times those of the 1960s, and the mean onset age of mental-health maladies is half of what it was then (14.5 years of age today compared to 29.5 years of age back then). In fact, it may be our obsessive efforts to make our lives as easy and “positive” as possible that are increasing our own incidence of suffering.

Why a “Good Vibes Only” Approach Doesn't Work

One of the fascinating discoveries of modern social science is the fact we are terrible at predicting future happiness. Our experiences typically fail to live up to our predictions. We think, “If only I'd win the lottery, I'd be happy.”

Or “If I got a new job/went to Hawaii/earned a promotion . . . then I'd really have hit the happiness jackpot.” Yet this “if-then” belief about our future happiness often proves wholly inaccurate. For example,

research suggests that people who win large sums of cash in a lottery do not see a long-term change in their overall happiness. Sure, they feel a significant wellbeing boost when they first win, but the feeling does not seem to last. In a relatively short period of time—often merely months—their overall wellbeing returns to precisely where it was before the supposed “life-changing” event despite their massive influx of wealth. The same is true in the opposite direction: Research consistently shows that people tend to return to the same levels of overall happiness they were at prior to suffering a traumatic injury, such as damage to the spinal cord resulting in paralysis—and the return to baseline happens fairly quickly.

In other words, living in a world of unicorns and kittens does not necessarily lead to boundless reservoirs of wellbeing. But does optimizing for unicorns and kittens actually make it harder on us? In fact, as our need to feel good, never be challenged, and have all we want when we want it grows ever more obsessive, our ability to cope with the normal, inevitable adversities of life appears to diminish. The more *we obsess about feeling good, the worse we feel*. In some ways, in chasing happiness we are chasing a ghost. The human brain is simply not built to be in a state of constant contentment. In fact, a powerful psychophysiological phenomenon prevents us from getting stuck in any one emotion for long. It is called *hedonic adaptation*.

Imagine you walk into a room where a vanilla-scented candle is burning. You immediately notice the pleasant



A powerful psychophysiological phenomenon prevents us from getting stuck in any one emotion for long. It is called *hedonic adaptation*.

aroma and smile as you take a seat. After a few minutes, however, without your having actively realized it, the scent has become imperceptible to you—though the flame is still burning as brightly as before. This is *olfactory adaptation*, part of your body’s way of giving you the information you need—in this case, through your nose—and then moving on to other things so your conscious mind can focus on the conversation you’re having with your friend or noticing the new person who just walked into the room or paying attention to the announcement being made on the radio. Of course, were the scent in the air to change drastically, your brain would notice (much like I’m immediately aware when my 14-year-old Great Dane has an accident in the house).

Hedonic adaptation is the emotional form of the same brain mechanism: our mind and body adapt to contextual elements so we can focus our attention on other things.

In this way, we grow accustomed to our life circumstances—happy or sad, interesting or dull, comforting or frightening. So, sure, winning millions of dollars in the lottery is life-changing (maybe you can pay off your mortgage or even quit your job!), but even these heightened emotional shifts quickly become our “new normal.” Before long, being rich feels no different from how we felt when we were a few million dollars poorer.

And thank goodness for it. Could you imagine if your best friend won the lottery and lacked hedonic adaptation? At first they would be overcome with joy. As their friend, you would gladly share in their genuine excitement. Now imagine they were to stay in that state forever. Every time you saw them—the day after, a week later, months, years on—they’d be as elated as if they’d just discovered their lottery win mere moments ago. How long would it take for you to find their company totally unbearable?

Hedonic adaptation is important. It gives us the ability to move on, refocus, and experience *all* the things that come after. If emotions are pieces of information that are critical to our ability to survive and respond to our circumstances, then we must be able to feel all of our emotions as they occur. And this is why we instinctively get annoyed when someone chides us that “Good vibes only” are welcome, even expected. It doesn’t feel right. It actually feels fake or forced—even toxic.

So when a leader in our hospital tells us that at work a large part of the normal human experience is simply not allowed, problems ensue. Humans are not built to be positive and joyful all the time, and if our environment expects that of us, we inevitably struggle. It is psychologically laborious to put on a *good vibes only* front. And, quite honestly, leaders who expect that of us are dismissive—intentionally or not. When we feel dismissed, we withdraw and withhold. A team that is withdrawn or withholding cannot reach its full potential; each person must be engaged and communicative.

A workplace must allow for the whole emotional enchilada. We need all the vibes. ✨

Josh Vaisman, MAPPCC (PgD), is a self-described Positive Change Ninja, speaker, and co-founder of Flourish Veterinary Consulting. Josh combines more than 25 years of veterinary experience, a master’s education in applied positive psychology and



coaching psychology, and a passion for guiding leaders to cultivate work environments in which people can thrive. His new book, *Lead to Thrive: The Science of Crafting a Positive Veterinary Culture*, will be available in the AAHA Store on May 22, 2023.



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Diversity, Equity, Inclusion, and Belonging in Veterinary Education and Beyond

An Interview with Tina Tran, DVM

Interview by Katie Berlin, DVM

When we asked Tina Tran, DVM, associate professor and clinical relations lead veterinarian at the University of Arizona, to chat with us for *Central Line: The AAHA Podcast*, we had a hard time narrowing down what to talk about. Besides being an educator, she's a mom, a past president of the Multicultural Veterinary Medical Association (MCVMA), and a leader in veterinary telehealth. In the end, Tran discussed

how intertwined diversity, equity, inclusion, and belonging (DEIB) are with her work in helping veterinary students enter the field as confident, empathic colleagues with the ability to handle conflict and to examine their own biases.

Katie Berlin: When I suggested that we talk about DEIB and your work with the MCVMA, you said, "Well, that's great. I'm happy to talk about

that stuff. But I also want to make sure people know that I don't just talk about DEIB." And I was glad you said that, because DEIB is not a separate topic anyway.

Tina Tran: DEIB finds its way, quite honestly, into every part of veterinary medicine and outside of veterinary medicine. It may just not look exactly the same in every instance. If you think about client compliance, you

have to consider the fact of access. Do they have the ability to do the things that you're asking them to do as a veterinarian, as a technician?

When I was very young in the profession, I thought, "Well, why are they not complying, why are they just flat out ignoring me?" I was working under the assumption that, "Well, if you want your dog's eyes to get better, then you need to do this." But I didn't think about the fact that they don't have the ability to go home every two hours to do that. Or in some cases, they physically can't do that. Like elderly owners that are not able to manipulate their hands or restrain [pets] in order to do those things.

When I came into the profession, I didn't have kids. And then three or

DEIB finds its way, quite honestly, into every part of veterinary medicine and outside of veterinary medicine.

four years into the profession, we started our family, and it gave me a whole new perspective when families come in. You have a limited amount of time, so you have to decide what takes precedence. I think there are a lot of opportunities where we talk about DEIB, but maybe it doesn't sound like that, right?

I have that conversation in veterinary conferences and then also with veterinarians that are working with our students out in practices to say, "This is how bias shows up; it's a very natural thing to try to make order out of all the pieces of information coming in, and that is oftentimes based on your previous experiences."

And sometimes there's harm that's caused in that—in the evaluation process, and in the way that you give feedback to people, and those types of things.

KB: What you said really resonates because if you have certain privilege and you are learning about people whose lived experience is different from yours, then you think, "Okay, DEIB is learning about *other* people." But we all know the feeling of not belonging somewhere. Or of not being treated like we're understood, and we're heard. And one of the things that the focus on DEIB does is make us more empathetic to other people's experience, whether it's



somebody who can't get down on the floor and pill their dog, or somebody who is a single mom and has kids at home and just can't do another thing that week.

So do you feel like people zoom in on you to talk about DEIB a lot and forget that you can talk about other things? Do you feel sort of pigeonholed?

TT: You know, I used to feel that way, particularly when I was still on the board for the Multicultural Vet Med Association. They knew that I was an officer and so they just assumed that's my identity. [But] I can also talk to you about telemedicine. I can talk to you about nonclinical careers. I can talk to you about vet tech utilization. I can talk to you about what the current state of veterinary education looks like. And those things do have some intersection with DEIB. When you think about access to care, spectrum of care, how we're evaluating [and] mentoring students, how we're bringing people into the pipeline.

KB: I was wondering, in the distributive model of veterinary education, if students can choose hospitals where—say a student is Black, and they want to go to a hospital where they're not going to be the only Black person—is there a way that you provide guidance for workplace education like that, or is that a roll of the dice?

TT: We don't have a formalized system where students can search for people that have similar identities at the practice regarding race and ethnicity, or even gender identity. Those things are not searchable within our database. I have been fortunate enough to build my network



over time, and so I know that within our network, there are veterinarians and technicians at some of these hospitals that are Black, indigenous, and people of color.

In every class of students [at U of Arizona], we have more than 30% that identify as underrepresented in veterinary medicine with respect to race and ethnicity. I've had individual students reach out to me—they want to see representation; they want to be able to be in community with and mentored by somebody who looks like them. If I know that is one of their interests, then I will do my best to pair them with someone of a similar race or ethnicity.

That being said, there's an interesting conversation around the idea of

“does a mentor have to look like you?” Because I think to a certain extent, that can be misleading, and in the worst case, harmful. Just because you and I are Asian does not mean that we approach things the same, does not mean that we align around DEIB. I think that's where it gets a little bit tricky to make this database, because at the end of the day, that won't necessarily help a student. If [a Black student] gets into a situation where they're being microaggressed and they turn to the Black veterinarian, the Black veterinarian might be like, “What's the problem?”

KB: That's a really good point. And when I asked that question, I was thinking about, say, if I went to a hospital where I was the only person who identified as female, and it

I can talk to you about vet tech utilization. I can talk to you about what the current state of veterinary education looks like. And those things do have some intersection with DEIB.

would be hard for me to focus on my education if I felt like everyone was looking at me as a representative of an entire community because they're not used to seeing somebody like me. So I was thinking about it more from that point of view versus a mentor, but obviously having a mentor who understands that your experience might be different because of your background or how you identify is helpful. But you're right. We can't assume based on how someone looks that they're going to understand that.

TT: Yeah, and that their views are going to align with yours, whether it's around gender identity or race and ethnicity. I'm sure that there's a population of women veterinarians that will tell you that they went into a practice where there was

another woman veterinarian [who] did not support them the way that they needed to be supported. At the end of the day, representation is important, and there are other things that are also important in order to support a student in that clinical setting.

KB: I've seen discussions where people feel like you can't get a consistent education, [or] the same level of education, in a distributive model where you are going out into real world clinics and not at a teaching hospital. I wanted to ask what your thoughts are on that and what you see that says otherwise.

TT: I guess one of the things I will point out is, if you think about it, vet tech education is oftentimes utilizing the distributive model, and they have

been from the jump. There are very few instances where tech students are actually working in a teaching hospital as part of their education. And that's why I thought it was really interesting when I came to a DVM program as faculty and people said, "Oh no, this can't happen, we can't let people out into practices, they can't learn stuff." But we do it for vet tech students all the time.

I can only speak for our model. The way that we do distributive is that, yes, there are opportunities for the students to learn in general practice and shelter, and there are also opportunities for them to learn in specialty settings alongside boarded specialists, internists, orthopedic surgeons, equine internists, you name it. I always encourage the students, even if they think they know what they want to do, to get a breadth of experience. I do get a little bit soapboxy with students that say, "I'm doing small animal, I don't want to do any equine. No large animal, nothing. I'm not doing any of it, Dr. Tran." And I'm like, "But are you sure? Because how do you even know? Maybe there's a piece of large animal that is your jam." It's not a job, you're not signing a contract saying, "I'm working here, I'm moving here indefinitely." It's four weeks.

Particularly in a teaching hospital setting, oftentimes there are a lot more required rotations you have to complete. And that's one of the real benefits of being in our distributive model. We don't track [the students] per se, but they have the ability to make decisions about, "Do I want to spend more time in small? Do [I] want to spend more time in large or with equine, or do [I] want to try a research





At the end of the day, representation is important, and there are other things that are also important in order to support a student in that clinical setting.

rotation or something like that?” It gives them the flexibility to pursue the types of rotations that they think are going to be most meaningful for their education—within guardrails, obviously, because they have to be within our network.

All of the distributive models have some checks and balances in place to say, “Here’s what our expectations are for you to be a practice in our network, and here’s how we’re going to check in and look at feedback from the students, consider what our communications have been like, all those things, to decide moving forward if you stay in the network or not.”

KB: I’m one of those people who loved clinics. But then when I got out into practice, it was a little bit of a shock because you can’t just go around the corner and be like, “Hey, Derm, can you look at this?” No, Derm could not look at it. I was Derm.

TT: You were Derm!

KB: I was Derm, yes. In general practice in upstate New York, you are always Derm! I could have used more time in a different atmosphere where I learned different ways to do things and that not everybody was going to draw blood the same way, and not everybody was going to do this procedure set up the same way. That would probably have lessened the shock of launch.

TT: One of the things that our model does in Arizona, which I think is fantastic, is we have a group of veterinarians that are called Clinical Year Mentors. Essentially, they are remote veterinarians that have multiple years of practice, oftentimes are either boarded or have gone through internship and residency, and oftentimes are very active in organized veterinary medicine, that serve as another layer of support for our students when they’re in rotation.

So they’ve got their on-site veterinarian who is serving as their physical mentor when they’re in the clinic setting, then they’ve got us at the college full time. And then to have these Clinical Year Mentors has been great because it gives them a sounding board to say, “Okay, Dr. Berlin, I don’t know if this is okay, but I saw one of the doctors here doing X today.”

Clinical Year Mentors [are] helping to reinforce this idea that there’s not one way to do everything. And [they are] also validating some of their concerns and serve as the advocate for the student if they’re in challenging situations where they don’t necessarily feel comfortable asking that on-site veterinarian or addressing it directly with them.

I was in charge of the search where we hired probably 35 or so veterinarians to do this. I had no idea so many people wanted to do this part-time.

KB: That's really encouraging. That makes me feel very hopeful. I would have loved a person I [could have called] because I was freaked out by something that happened or I needed encouragement or they told me to do something and then they all went to lunch and I didn't know what to do. And those nights where you're just like, "Did I do the right thing?"

TT: Yeah, I think it's a very common thing for our veterinary students to put so much pressure on themselves to be perfect and to know how to do the right thing in every situation. And one of the things I tell them is, "I don't want to burst your bubble, but veterinary school is actually more about learning how to learn and how to communicate with people."

I guess the other thing I'll add about the distributive model is those practices are opting in; we are not forcing them to take students. They have had conversations with us to say, "These are our expectations of what's happening in four weeks." They get to decide which rotations they want to have students; they get to decide the maximum number of students they host in any one rotation. They have a lot of say in that part of it.

And I think a lot of the veterinarians love it. They love the opportunity to influence that next generation of veterinarians and to get up close to some of their soon-to-be colleagues. I think that's a way to keep them on their toes and to keep them really excited about being in the profession too.

KB: Do you have any last thoughts you'd like to leave us with?



TT: I'm a big Winnie the Pooh fan. I want to leave everybody with one of those quotes, which is, "You are braver than you believe, stronger than you seem, and smarter than you think." Because there is some version of that that I tell my students on a regular basis, when they're doubting their abilities, when they're feeling scared. And the same thing with new grads and quite honestly, anyone who's in the profession—you have these moments of doubt. Just realize, you can do it. You can do it. You might not be able to do it alone all the time, but you can do it. ✨

Catch a new episode of Central Line: The AAHA Podcast every Tuesday on all major podcast platforms, YouTube,

and aaha.org/podcast. Send us feedback or questions anytime at podcast@aaha.org.

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Katie Berlin, DVM, CVA, is AAHA's Director of Content Strategy.

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Jamie Swick

Veterinary Assistant

Pine Grove Veterinary Hospital, Severn/Ontario

Year started in vet medicine: **2014**

Years with practice: **9**

Nominated by: **Jenn Bristow**

AAHA MEMBER

Employee of the Month



Why Is Jamie So Awesome?

Jamie is critical to our day-to-day operations. You have a fractious cat to hold for a blood draw? Suddenly it is purring and happy to be here. The next appointment has arrived and you haven't had a chance to clean the room? Don't worry, because Jamie already has it sparkling and set up for the next patient! She is empathetic, compassionate, and understanding when someone else isn't at 100%. Patients and clients alike all love Jamie and are happy to see her.

How Does She Go Above and Beyond?

Jamie is always the first one to help if you need a hand or a shoulder to cry on. She remembers everyone's birthday, and even their pets' birthdays! If Jamie is ever in a bad mood, you would never know it as she always has a smile on her face and communicates that calm happiness to all our clients and pets.

In Their Own Words

Why do you love your job: I love being able to make a difference in animals and their humans' lives, as well as be there for them when they need me through happy and sad moments.

Pets at home: Sirius Black, an 11-year-old wolfhound mix, and Hank the betta fish!

What brought you to the profession: It is something I always wanted to do; I always wanted to make a difference.

Hobbies outside of work: I love to read, take walks with Sirius, and spend lots of time with family and friends.

Favorite celebrity/book/TV show: Sandra Bullock; I love the *Lord of the Rings* books, all of them! Favorite TV show is *SpongeBob*.

Each month *Trends* spotlights an AAHA member, with generous support from **CareCredit**.^{*} If you want to nominate someone, visit aaha.org/EOTM and enter them for a chance to win \$500!

*The Employee of the Month contest is administered by AAHA.

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- Microaggressions
- Client communication
- Recruitment in the veterinary workplace
- Understanding race and racism



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