

The Role of the Veterinary Technician in the Emergency Care System for Small Companion Animals

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Abstract

Emergency care for small companion animals depends on speed, coordinated action, and stable clinical judgment under pressure. Within that chain, the veterinary technician connects triage, early stabilization, monitoring, communication with owners, and transfer of information across the treatment pathway. The article examines how this position has moved beyond procedural assistance and taken on a coordinating function inside emergency and critical care. The aim is to determine how veterinary technicians support early prioritization, how their technical work shapes continuity of treatment, and how workforce conditions influence the dependability of emergency services. The study draws on recent peer-reviewed publications and professional guidelines published between 2021 and 2025. Comparative analysis, source analysis, conceptual synthesis, and analytical generalization were used. The results identify three interlinked functions of the veterinary technician in emergency systems: accelerating first-line intervention, reducing information loss during handoffs, and sustaining team performance under pressure. The conclusions have direct practical value for staffing models, protocol design, and clinical training.

Keywords: veterinary technician, emergency care, small companion animals, triage, critical care, CPR, referral systems, veterinary nursing, client communication, workforce sustainability

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Introduction

Emergency treatment in small animal medicine unfolds inside a narrow interval where hesitation in prioritization, delayed access, fragmented communication, and weak handoffs can turn instability into deterioration. In that setting, the veterinary technician cannot be placed outside the main treatment process. The technician often becomes the first structured clinical filter, the person who turns urgency into a working sequence, and the team member who keeps monitoring, documentation, equipment readiness,

and bedside continuity aligned while the veterinarian moves between diagnosis and treatment decisions.

The article proceeds from a simple premise. Emergency care in dogs and cats works as a chain of linked actions, not as a set of separate procedures. On that basis, the research aim is to define the place of the veterinary technician in the emergency care system for small companion animals and to explain how that place shapes the stability of clinical response. Three connected objectives follow from that aim. The first is to clarify how technicians contribute to triage and the opening stage of stabilization. The second is to examine how

technicians preserve continuity through monitoring, communication, and referral transitions. The third is to evaluate how training conditions, role design, and occupational strain affect the dependability of emergency services.

The novelty of the article lies in shifting the discussion away from a narrow inventory of duties and toward a system reading of emergency care. The technician is considered here through the way technical tasks, communication work, and coordination obligations hold together time-sensitive treatment, information flow, and team performance. The hypothesis states that emergency outcomes in small companion animal practice depend in part on the degree to which veterinary technicians are integrated into prioritization, procedural readiness, monitoring, and inter-team communication. Incomplete integration weakens speed, coherence, and resilience across the emergency pathway.

Methods and materials

The literature corpus was assembled through a targeted search of PubMed, journal publisher platforms, and peer-reviewed veterinary databases focused on emergency and critical care, companion animal practice, and veterinary workforce research. Search strings combined terms such as “veterinary technician,” “veterinary nurse,” “small animal emergency,” “critical care,” “CPR,” “triage,” “referral,” “community care,” “burnout,” and “companion animal.” The inclusion window covered 2021 to 2025. Only English-language peer-reviewed articles, formal clinical guidelines, and specialty-oriented reviews directly related to dogs, cats, veterinary technicians, nurses, or emergency team organization were retained. Editorials, general news pieces, conference announcements, and non-scholarly materials were excluded. The initial search pool contained more than forty items. Relevance screening reduced that pool to ten sources that together cover procedural intervention, triage logic, CPR, client-facing decision points, continuity across referral systems, community access, professional development, and workforce strain [1]–[10].

The study uses source analysis, comparative analysis, conceptual synthesis, and analytical generalization. These methods were selected to connect procedure-centered literature with system guidelines and workforce studies, allowing the veterinary technician’s role to be

reconstructed as a functional element inside emergency care rather than a list of delegated tasks.

Results

The emergency care system for small companion animals begins before a diagnosis has been finalized. It starts at the point where urgency is recognized, prioritized, and converted into action. That opening stage explains why the technician’s position carries structural weight. Reviews of advanced vascular access in dogs and cats show that delays in access interfere with the delivery of fluids, drugs, and blood products in hemodynamically unstable patients [1]. In practice, the technician’s contribution extends beyond the manual act of catheter placement. The larger contribution lies in preparing alternative access routes, identifying failed peripheral access early, staging equipment before deterioration progresses, and limiting repeated unsuccessful attempts that consume time and add stress for the patient. Once vascular access is treated as part of time management in collapse medicine, technician proficiency becomes one of the conditions that shape treatment tempo [1].

A comparable pattern appears in recent CPR guidance. The RECOVER 2024 documents place emphasis on preparedness, rapid recognition, high-quality basic life support, monitoring, and treatment sequences that depend on role clarity and rehearsal [2], [3]. Within that framework, the technician supports chest compression workflow, airway preparation, monitoring logistics, drug readiness, record keeping, and equipment control while CPR is underway. The literature does not support an image of the technician as a passive assistant waiting for isolated instructions. It points to a model in which effective resuscitation depends on distributed competence, because CPR quality declines when timing, technical actions, communication, and monitoring stop moving together [2], [3].

Point-of-care imaging reveals the same shift from task execution to system maintenance. A 2025 clinical review of lung ultrasound in small animal emergency and critical care describes thoracic point-of-care ultrasound as a rapid bedside method suited to respiratory instability and repeated reassessment [4]. For the technician, its value does not rest on image interpretation alone. The practical value lies in restraint strategy, patient positioning, equipment availability, repeat scanning during deterioration, and continuity between the emergency room and intensive care area. A portable

diagnostic tool changes bedside work. It requires a team member who can keep the patient stable enough for repeated imaging, reduce disruption during handling, and preserve procedural flow while the clinician interprets findings [4].

Triage makes that structural position even clearer. VetTriS, evaluated in 2025 for cats and dogs in a veterinary emergency department, supports the use of a defined multi-level triage system with substantial interobserver agreement [5]. A triage tool still depends on the person who applies it. Someone has to turn observed instability into categorization and immediate escalation. That task often falls to the technician. Respiratory effort, changes in mentation, perfusion deficits, bleeding, collapse, pain expression, and rapid deterioration appear first as bedside signals before they become formal diagnostic categories. The technician occupies the point where presentation is translated into clinical priority [5].

These sources converge on one conclusion. The technician anchors the first operational layer of emergency medicine. The vascular access literature identifies delay-sensitive procedures [1]. RECOVER identifies the need for protocol-driven response and clear role allocation [2], [3]. The emergency ultrasound review points to repeated bedside support during instability [4]. VetTriS formalizes prioritization [5]. Taken together, they describe the same functional pattern. Emergency care becomes safer when the technician is integrated early, trained for escalation, and positioned inside the opening decision architecture. Without that integration, the first minutes of care break into disconnected acts.

Continuity forms the second line of analysis. Emergency systems do not fail only through technical mistakes. They also fail when information is lost between presentation, stabilization, owner discussion, admission, referral, discharge planning, and return visits. Client communication during CPR provides a concentrated example. A 2024 JAVMA study on small animal client preferences found that many clients preferred the veterinarian to decide when to stop resuscitation and to be informed after CPR efforts had ended [6]. That finding matters for technicians because communication timing changes the distribution of work during an active resuscitation. A clinic that leaves this question undefined can force bedside staff into conflicting roles while CPR is underway. A clinic that assigns communication roles

in advance protects treatment continuity and owner trust at the same time [6].

Institutional guidance on spectrum-of-care medicine points to the same continuity problem from another angle. The 2024 AAHA Community Care Guidelines argue for a broader model in small animal practice that links clinical needs with family circumstances [7]. Emergency hospitals encounter this issue every day when ideal plans are constrained by time, transport limitations, financial pressure, or uneven access to referral services. In that setting, the technician often becomes the team member who turns the treatment path into an operational plan. Estimates have to be explained. Discharge instructions have to be made usable. Medication schedules have to be translated into home routines. Transport preparation and follow-up steps have to be organized. Community care therefore expands the technician's place in the emergency system. The technician helps preserve continuity when full-service care is delayed, declined, or unavailable [7].

Referral guidance published by AAHA in 2025 reinforces the same point. Referral is framed there as a structured communication process requiring clearer transfer of information and stronger coordination across teams [8]. Emergency cases move fast, and that pace increases the cost of incomplete records, vague handoffs, or undocumented changes in patient status. A technician who keeps accurate treatment logs, sampling timelines, monitoring trends, and owner-side updates reduces friction during transfer. Referral quality is often discussed as a veterinarian-to-specialist matter. The system literature suggests a wider picture. Reliable referral depends in part on whether technicians keep the operational chain intact while the case moves between services [8].

Recent work on professional development and transition into practice makes that continuity problem more concrete. A 2024 study from a companion animal referral setting describes the need for flexible and personalized development pathways for veterinarians and veterinary nurses working in referral care [9]. A 2025 qualitative study of newly credentialed veterinary technicians reports that transition into the profession is shaped by stress, role ambiguity, and uneven support structures [10]. Read together, these studies suggest a practical conclusion for emergency medicine. Emergency competence does not arise from credentialing alone. It grows through supervised integration into high-pressure

workflows, repeated exposure to escalation logic, and explicit guidance on how technical tasks, communication, and documentation fit together [9], [10]. Informal onboarding leaves inexperienced technicians inside the most time-sensitive clinical environment without a stable map of the work they are expected to perform.

Figure 1. Functional placement of the veterinary technician in the small animal emergency care system (compiled by the author based on Lee et al., 2021; Hopper et al., 2024; Burkitt-Creedon et al., 2024; Armenise, 2025; Groesser et al., 2025; Burney et al., 2025) [1]–[5], [8].

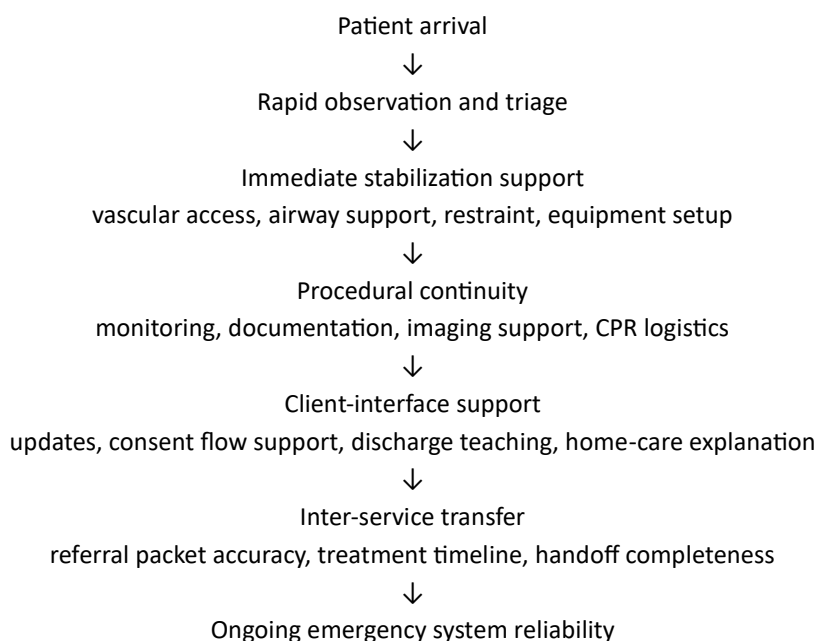


Figure 1 clarifies the technician's placement across successive treatment zones. The emergency system does not move in a straight line from diagnosis to treatment. It moves through repeated transitions. The technician keeps those transitions in working order.

The third line of analysis concerns reliability under pressure. Emergency care depends on personnel who can preserve precision while facing overload, repeated exposure to distress, and uneven organizational support. A 2024 systematic review on burnout in veterinary nurses identifies workload, limited control, inadequate support, and value conflict as recurring contributors at the organizational level [9]. The 2025 study of newly credentialed veterinary technicians adds that early-career technicians often face a mismatch between expectations and clinical reality [10]. In emergency hospitals, these pressures affect more than morale. They change task consistency, documentation quality, communication stability, and retention of trained staff. Once retention declines, emergency services lose cumulative expertise and enter a cycle of repeated novice onboarding, which slows collective performance and weakens shared anticipation during crisis care [9], [10]. The technician's

position therefore has a labor dimension that enters clinical reliability in a direct way.

Discussion

The literature supports a stronger interpretation than the conventional one. The veterinary technician in emergency care cannot be defined through delegated procedures alone. The technician stabilizes the movement of the emergency system itself. That reading follows from three recurring patterns. Speed-sensitive interventions depend on technician readiness before the veterinarian completes a diagnosis. Continuity across bedside care, owner communication, and referral transfer depends on technician-managed information flow. Team reliability declines when technician development and retention are treated as secondary staffing matters.

A workable implementation model for emergency hospitals can be built around staged responsibility instead of a generic job description. The first stage concerns arrival and prioritization. The technician needs a formal place in front-end recognition of decompensation, escalation triggers, and preparation for likely first-line procedures. The second stage concerns treatment continuity. At that point, the technician should carry defined responsibility for monitoring sequence integrity, equipment readiness, real-time documentation,

and procedure support during CPR, respiratory distress, shock, and trauma. The third stage concerns continuity after the critical moment has passed. That stage covers discharge teaching, referral packet quality, and communication support during movement between services. Explicit design changes the technician's work from invisible infrastructure into measurable system function. Comparison across emergency functions makes that point more concrete.

Table 1. Operational zones of veterinary technician involvement in emergency care for small companion animals (compiled by the author based on Lee et al., 2021; Hopper et al., 2024; Burkitt-Creedon et al., 2024; Armenise, 2025; Groesser et al., 2025)

Emergency zone	Technician contribution	System effect	Main failure if underdeveloped
Triage	Early recognition of instability, urgency categorization, escalation trigger	Faster prioritization	Delayed placement into treatment queue
Immediate stabilization	Vascular access preparation, equipment setup, restraint, sampling support	Shorter time to first intervention	Treatment lag during shock, collapse, or trauma
Resuscitation	CPR role execution, monitoring logistics, drug and airway support, recording	Higher procedural consistency	Fragmented team performance during arrest
Bedside reassessment	Repeated monitoring, ultrasound support, trend recognition	Earlier detection of deterioration	Missed change in respiratory or perfusion status
Handoff and transfer	Accurate documentation, referral packet preparation, discharge explanation	Lower information loss	Breaks in continuity across services

Table 1 shows that technician involvement changes from across the emergency pathway, while the underlying function remains stable. In each zone, the technician reduces delay and protects coherence. That observation has a practical consequence. Emergency departments should not evaluate technician contribution only through the number of isolated procedures completed. A better approach is to examine whether technician work reduces time loss, prevents information gaps, and preserves treatment continuity during transitions.

That shift requires operational metrics linked to role execution. A clinic seeking stronger emergency performance needs indicators that track system integrity rather than patient volume alone. Useful internal measures include time from arrival to triage completion, time from triage to first vascular access attempt, the proportion of CPR events with full role allocation, the share of referrals sent with a complete treatment chronology, the frequency of incomplete monitoring records, and early re-presentation linked to discharge misunderstanding. These measures are not abstract management tools. They show whether the technician

has been placed inside the emergency system at the points where fragmentation usually begins. Workforce sustainability forms the second comparison, because

clinical reliability cannot be separated from the conditions under which technicians work.

Table 2. Organizational conditions that shape veterinary technician reliability in emergency services (compiled by the author based on Chapman et al., 2024; Reinhard et al., 2025)

Organizational condition	Positive effect on emergency care	Negative effect when absent
Structured onboarding	Faster acquisition of role clarity in urgent settings	Early-career hesitation and error-prone adaptation
Role clarity	Better coordination with veterinarians during escalation	Duplication, omission, and communication drift
Supported skill progression	Stronger procedural confidence in unstable cases	Overreliance on a few senior staff members
Feedback and debriefing	Better learning after critical incidents	Repeated operational weakness across shifts
Workload control and support	Greater consistency and retention	Burnout, turnover, and loss of cumulative team knowledge

The comparison in Table 2 leads to a demanding conclusion. Emergency services need organizational design, not only more training. Training without role clarity produces confusion during unstable cases. High expectations without supervised progression produce attrition. Debriefing without operational change leaves the same weak points in place. Emergency care gains resilience when technician development becomes part of clinical governance.

A sequence-based model fits the evidence best. New technicians enter through tightly supervised triage and preparation tasks. They then move into monitored procedure support, followed by greater responsibility in CPR logistics, monitoring trend recognition, and transfer coordination. Progress should be tied to scenario-based assessment rather than time served alone. This sequence matters because emergency competence grows through anticipation. A technician becomes effective when able to identify the next clinical need before the system begins to stall.

The most persuasive reading of the literature is that emergency hospitals for small companion animals underuse technicians when they frame the role as supplemental labor. Current evidence points elsewhere. The technician functions as a coordinating clinical

operator inside a fast-moving care environment. Hospitals that organize work around that premise are more likely to preserve speed, continuity, and team stability. Hospitals that leave the role underdefined place too much of the emergency burden on veterinarian decision moments, even though many treatment failures begin earlier in preparation gaps, handoff failures, and monitoring inconsistency.

Conclusion

Emergency care for small companion animals becomes more dependable when the veterinary technician occupies a formal place in the first operational layer of triage and stabilization. Recent literature on vascular access, CPR, bedside imaging, and triage supports the conclusion that technician competence affects the speed with which unstable patients enter organized treatment.

The technician's contribution extends beyond immediate procedures into continuity work that holds the emergency pathway together. Communication during CPR, community-oriented care, and referral transfer all depend on structured handling of information and clear operational roles. In that chain, the technician reduces loss of time and loss of meaning at the points where cases move between people, rooms, and services.

The broader emergency system remains vulnerable when technician development is inconsistent or when occupational strain is separated from care quality. Studies on burnout, professional transition, and referral-care development indicate that role clarity, supervised progression, and organizational support shape how reliably emergency teams' function. The hypothesis stated in the introduction is therefore confirmed. Emergency service quality in small companion animal medicine depends not only on veterinary decision-making, but on the degree to which veterinary technicians are integrated into prioritization, stabilization, continuity management, and team sustainability.

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