Ethical Dilemmas and Moral Distress in Veterinary Support Staff

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Abstract

In medicine, clinical scenarios arise that require practitioners to balance conflicting professional obligations. These ethical dilemmas can cause moral distress, which is defined as knowing the right thing to do but being unable to do it. Moral distress contributes to burnout and the intention to leave a job. Ethical dilemmas and moral distress have been explored in veterinarians but not for other veterinary team members, such as veterinary technicians, technologists, and assistants. Quantitative and qualitative methods were employed to determine how frequently veterinary support staff (N = 174) are exposed to ethical dilemmas, to characterize the types of ethical dilemmas, and to measure moral distress. Median frequency of exposure to ethical dilemmas was a few times a year. Participants reported experiencing conflict related to patient care and related to witnessing or participating in unethical acts. Interventions targeted at increasing moral agency and building moral community may effectively reduce employee attrition.

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Ethical Dilemmas and Moral Distress in Veterinary Support Staff

Ethical dilemmas commonly arise in the practice of medicine because of the need to balance patient care with demands from family members while operating within financial or organizational constraints. In an ethical dilemma, an individual is required to make a choice between competing professional obligations or values and, no matter which choice is made, there will be consequences. Ethical dilemmas occur during routine care (e.g., choosing a less effective medication due to financial constraints) as well as during life-or-death situations. Encountering ethical dilemmas may cause moral distress. Jameton (1984) first identified moral distress in nursing as the result of knowing the right thing to do but being unable to do it. Moral distress contributes to burnout and the intention to leave a job (Karakachian & Colbert, 2019).

The impact of ethical dilemmas and moral distress has been explored with some depth for veterinarians (Batchelor & McKeegan, 2012; Kipperman et al., 2018; Moses et al., 2018), but researchers have so far neglected support staff such as veterinary technicians, technologists, and assistants, even though support staff (210,000; Data USA, 2019, 2019b) outnumber veterinarians (85,100; Data USA, 2019a) in the profession. Data from one study suggested that there are specific ethical dilemmas that support staff may encounter more frequently than veterinarians or that they may be more likely to consider distressing for them (Kramper et al., 2021). The aim of this study is to use qualitative methods to characterize the types of ethical dilemmas reported by veterinary support staff and develop a rich sense of what these dilemmas look like in this specific population. To augment this approach, this study will also incorporate results from a moral distress inventory with the goal that this combination of qualitative and quantitative data will illuminate specific situations in which interventions could be applied within this population with the goal of increasing employee retention.

Ethical Dilemmas in Veterinary Medicine

The National Association of Veterinary Technicians in America (NAVTA) has a membership comprising credentialed veterinary technicians and technologists. Veterinary technicians are analogous to a licensed practical nurse (LPN) and have completed an associate's degree and passed a licensing exam. Veterinary technologists are analogous to a registered nurse, have completed a bachelor's degree and passed the same licensing exam as technicians. Veterinary assistant is a job title that describes individuals who have mastered their skills through on-the-job training or have completed a degree but failed to pass the licensing exam. All three job titles describe individuals who assist veterinarians in providing care to animal patients,[1] though the scope of responsibilities varies based on state regulations.

Credentialed veterinary professionals are expected to perform their duties in accordance with professional and ethical standards set forth by their professional organization, NAVTA. Ethical dilemmas arise when there are two equally good or equally poor choices; ethical standards are intended to assist practitioners in making a choice. There is an opposing tension, though, because the standards must also be ambiguous enough to accommodate a broad range of circumstances. This ambiguity results in a lack of clarity about how to resolve specific conflicts between competing professional obligations.

For veterinarians, the American Veterinary Medical Association (AVMA) Principles of Veterinary Medical Ethics cite a triad of professional obligations: the welfare of the patient, the needs of the client, and the safety of the public (AVMA, n.d.). NAVTA also has a Code of Ethics, but, because their membership is composed only of credentialed individuals, a large number of uncredentialed individuals work in support staff roles without the benefit of a Code of

[1] From this point, the word *patient* will be used without the specifier animal. *Client* will describe the custodian of the animal as it relates to its medical care.

Ethics. Some of the professional obligations outlined by NAVTA's Code of Ethics include preventing and relieving the suffering of animals, promoting public health, assuming accountability for one's actions, ensuring conditions that promote the excellent care of animals, and collaborating with veterinary team members (NAVTA, n.d.). Unlike the AVMA ethical standards, the NAVTA Code of Ethics does not include an obligation to meet client needs, although it makes reference to protecting confidential client information. Rather than this obligation to the client, their obligation is to the veterinary team to carry out treatment faithfully and to report individuals who demonstrate deficits in competency.

Considerations of animal care and animal welfare apply to a variety of situations and environments. Ethical dilemmas related to animal welfare can include a community deciding whether to attempt to rescue a beached whale or euthanize it while it lays on the beach suffering, or poultry farmers deciding between options such as whether to kill surplus one-day-old male chicks or genetically modify their laying hens (Gremmen, 2020). Not all of these situations are applicable to veterinary support staff. For the purposes of the proposed study, the focus will be on environments that regularly employ support staff, such as small animal, large animal, and mixed animal veterinary practices.

One example of an ethical dilemma relevant to companion animal practice is a veterinary team who is asked by a client to euthanize a middle-aged, healthy patient because the family is moving and does not want to or is unable to take the pet with them to their new home. Although some clinics may have guidelines for performing euthanasia on healthy patients (e.g., "we do it" or "we don't do it; refer them elsewhere"), often these decisions are left up to the practitioner to navigate. Without clear rules, it can be difficult to determine the best outcome for all involved – patient, client, and veterinary professionals. A support staff member, who may be excluded from

the decision-making between the veterinarian and client, may be expected to commiserate with the veterinarian through the decision-making process, restrain the pet while a catheter is placed and injections are administered and, in cases where the client elects not to stay for the euthanasia, may be the one offering comfort to the patient as it passes.

In a "good" euthanasia, the staff member may perceive their role as assisting in a service that is in the patient's best interests by relieving pain and suffering. In a convenience euthanasia[2], the staff member may feel that they are being compelled to act against the patient's best interests, which introduces conflict between their obligation to the patient's welfare and to performing their duties faithfully and competently. Support staff may find situations in which a client's needs are prioritized over a patient's interests to be especially distressing because their professional role emphasizes the prevention of suffering and the promotion of excellent care for each patient rather than emphasizing service to the client.

So far, there has been limited exploration of the types of ethical dilemmas reported by veterinary support staff; however, reviewing the literature for the types and frequency of ethical dilemmas encountered by veterinarians may inform hypotheses about types and frequency of ethical dilemmas encountered by support staff as well as differences that could exist between the two groups. In a survey of 58 veterinary surgeons[3] in the United Kingdom, 57% reported that they faced one to two ethical dilemmas per week, and 34% stated that they faced three to five dilemmas per week (Batchelor & McKeegan, 2012). The study's authors chose three common scenarios to describe to participants: convenience euthanasia of a healthy patient, financial

[2] A convenience euthanasia is when the decision is made to end the life of a patient that would be considered to still have a good quality of life if it were not euthanized. For example, a client may request euthanasia because they lack funds to pursue treatment, because of an addressable behavioral issue (e.g., aggression or anxiety), or because they no longer choose to keep it in their residence.

[3] The term veterinary surgeon is used in the United Kingdom rather than veterinarian though the scope of practice is identical.

limitations that restrict treatment options, and a client who wishes to continue treatment despite the patient's already compromised welfare or quality of life. All three scenarios were rated by participants as highly stressful (i.e., median stress rating of 7, 8, or 9 out of 10), and they reported encountering financial limitations most frequently.

Moses, Malowney, and Boyd (2018) surveyed 889 US veterinarians to assess the frequency of ethical dilemmas. They formulated questions such as, *How often have you been asked to do something in the course of your clinical practice that feels like the wrong thing to do?* and *How often have pet owners' attitudes or beliefs about treatment made it difficult to provide the care you think is appropriate?,* and participants could select from *Never, Rarely, Sometimes, Often,* or *Always* (Moses et al., 2018). In response to the first question, 51% endorsed *Sometimes* or *Often* (Moses et al., 2018). When asked to report what hindered them from doing "the right thing," participants most often cited financial constraints, policy constraints, or pressure from their employer (Moses et al., 2018). Seventy-nine percent reported being asked to provide care that they consider "futile," and 60% reported feeling like they had prioritized the needs of the client over the patient.

In another study of 484 US veterinarians (69% general practice; 31% specialty or referral practice), practitioners reported encountering an ethical dilemma at a median frequency of once per week, although 19% reported daily encounters (Kipperman et al., 2018). Overall, practitioners reported financial constraints as the ethical dilemma they encounter most frequently, with three-quarters reporting multiple dilemmas related to finances per week (Kipperman et al., 2018). Euthanasia requests due to financial constraints occurred with a median frequency of once monthly (Kipperman et al., 2018).

To summarize, veterinarians encounter ethical dilemmas at least weekly, and these ethical dilemmas involve balancing their professional obligations to clients, to public health, and to the welfare of the patient. Common ethical dilemmas for veterinarians fall into categories such as financial limitations that compromise patient care; euthanasias based on lack of finances; euthanasias based on a client's unwillingness to treat; and clients selecting a therapeutic trial instead of diagnostic testing. Ethical dilemmas caused by financial constraints appear to be the most common type of dilemma.

The ethical obligations of support staff, as outlined by the NAVTA Code of Ethics, are different from those of veterinarians; therefore, the type and frequency of clinical scenarios that they encounter and then label as ethical dilemmas may be different. For example, conflict related to a client's financial constraints may be less frequent or less salient for support staff compared to clinical scenarios that involve conflict with team members. There is some initial support for this hypothesis. Kramper et al., (2021) performed a qualitative analysis of narratives of *highly stressful* events provided by veterinary professionals from the United States (N = 359). Forty-seven out of the 48 instances of highly stressful events related to client interactions were reported by veterinarians, indicating that the stress from difficult client interactions was more conspicuous for veterinarians than for support staff. On the other hand, veterinary support staff were significantly more likely to report highly stressful events such as witnessing a veterinarian use excessive force on a patient, being asked to lie about a veterinarian's medical error, or instances of patient neglect. Therefore, it seems plausible that conflict related to morally questionable acts perpetrated by veterinarians or other team members may be a more common or more salient experience for support staff than client interactions. That conflict surfaces because of the power

differential that exists between veterinarians and support staff, which may result in support staff experiencing a lack of autonomy or agency in their workplace.

These differences in clinical scenarios identified as *highly stressful* by veterinarians versus veterinary support staff suggest that further analysis is warranted to collect and categorize the clinical scenarios that veterinary support staff report as ethical dilemmas. Moreover, it is important to note that *highly stressful* scenarios are not necessarily equivalent to scenarios identified as ethical dilemmas. To my knowledge, the latter have not been studied within the veterinary support staff population. To inform the approach taken in the current study, I therefore surveyed the literature on ethical dilemmas in an analogous profession, nursing, to supply some insight.

Ethical Dilemmas in Nursing

The ethical literature for nurses is robust and well-established; two literature reviews that include global data have been included here to summarize this body of information. There are similarities between the scope of practice for nurses and for veterinary technicians and technologists. A partial list of analogous duties includes drawing blood, placing catheters, administering treatments, assisting in procedures, and providing post-surgical care. For both nurses and veterinary support staff, their duties exclude responsibilities that are reserved for physicians or veterinarians such as diagnosing, prescribing, and performing surgery.

In one review of published research on ethical dilemmas in the nursing profession from 2000-2017, Rainer, Schneider, and Lorenz (2018) synthesized the results of 35 studies and reported a list of common themes that included end-of-life issues, conflict with physicians or families, patient privacy concerns, and organizational constraints. The thread throughout these dilemmas is that the nurses believed others (e.g., physicians, family members, workplace

policymakers) were making decisions that were not in the best interest of their patient, which led to a conflict between their obligation to the welfare of their patient and their obligation to the treatment team, the patient's family, or their employer.

Haahr, Norlyk, Martinsen, and Dreyer (2020) also assembled a review of ethical dilemmas in nursing, analyzing 15 studies from 2011 to 2016[4] and producing a list of three themes: balancing harm and care, work overload, and navigating disagreements. The theme of balancing harm and care described dilemmas wherein nurses felt they were forced to act against their judgement of what was best for their patient. The second theme, work overload, was cited as a factor in providing inadequate patient care, which was perceived as conflicting with their obligation to the patient's welfare. Heavy workload (i.e., too many patients assigned per nurse) was also viewed by nurses as causing ethical insensitivity, which is a failure to detect ethical dilemmas (Choe et al., 2015). In the third theme, disagreements between nurses and physicians generated ethical conflict as did poor communication between providers leading to unclear or conflicting treatment plans.

A third qualitative analysis of moral distress in critical care nurses in Korea was selected for inclusion here because the themes that emerged from their analysis appear to reflect ethical dilemmas that would most likely also be relevant for veterinary support staff (Choe et al., 2015). In this phenomenological study, the following themes emerged from interviews with nurses: (1) ambivalence towards treatment and care when they were unable to respect a patient's dignity, including the compulsory application of restraints; (2) observing other nurses commit medical errors or being forced to cover up another's mistakes; (3) limited autonomy, or lacking the

[4] Only 2 studies were reported in both Rainer, Schneider, and Lorenz (2018) and Haahr, Norlyk, Martinsen, and Dreyer (2020).

authority to advocate for patients or correct misinformation given to patients; (4) conflicts with physicians; and (5) conflicts with institutional policy (Choe et al., 2015).

In summary, across many studies, the ethical dilemmas nurses experience often involve conflict with physicians, families, or their organization over treatment plans they do not feel are in the patient's interest. Then, due to a lack of autonomy, they are forced to administer treatment and act against their best judgment. In addition, their heavy workload prevents them from providing quality care; it may lead to ethical insensitivity and medical mistakes. Nurses also reported being asked to cover for the mistakes of other providers and to conceal relevant information (e.g., terminal diagnoses, treatment options) from patients.

While all of the previously listed themes are likely relevant to veterinary support staff, there are two noteworthy differences between veterinary medicine and human healthcare that may affect the type of ethical dilemmas reported. First, financial constraints are especially salient in veterinary medicine because veterinarians are required to present the cost of a treatment plan to the client, gain approval before proceeding, and receive payment when services are rendered, whereas nurses and physicians are not. Second, euthanasia is available as an option in veterinary medicine but not in human healthcare. Still, I would hypothesize that the ethical dilemmas veterinary support staff encounter more closely resemble the dilemmas reported by nurses (conflict with physicians, lack of autonomy, heavy workload, covering for mistakes) rather than those linked to veterinarians (i.e., client financial limitations, convenience euthanasia, choosing therapeutic treatment over testing).

Partly, this expectation is based on the strong similarity of duties between nurses and veterinary support staff, which are distinct from the duties of veterinarians. There is also a parallel between the professional obligations in nursing, wherein advocating for patient care is a

top priority, and those for veterinary support staff. As mentioned previously, veterinary technicians and technologists have an obligation to collaborate with other treatment team members whereas veterinarians have an obligation to the client, whose decisions are often guided by their budget. Based on this difference, it is plausible that common ethical dilemmas for veterinary support staff will involve conflict with veterinarians (rather than clients) over treatment planning they believe is not in a patient's best interest and being compelled to administer a treatment plan that is disagreeable to them.

In addition, as with nurses, a heavy workload may interfere in an individual's ability to provide care with ethical sensitivity because it denies individuals the time to pause to explore the impact of conflicting obligations and consider a range of solutions. In veterinary medicine, the two most prominent constraints on good decision making in clinical practice are time and finances (McKenzie, 2014), and heavy workload does appear to be a concern among support staff. In a study of occupational stressors, members of the Alabama Veterinary Technician Association (N = 104; 52% were credentialed veterinary technicians) reported workload as their top stressor, followed by dead and dying patients, and conflict with a veterinarian (Foster & Maples, 2014). In a study of burnout among veterinary support staff (N = 1,642), almost half (46.9%) of veterinary technicians surveyed reported working more than 40 hours per week, indicating that staff may be overworked and unable to complete their tasks in a regular work week or are habitually working overtime to cover when short-staffed (Kogan et al., 2020).

Moral Distress, Burnout, and Job Turnover

Ethical dilemmas play a role in the development of moral distress and burnout, and there is evidence that both of these variables are related to an individual's intention to leave their job. The term *moral distress* originated in the nursing literature to describe the feeling that results

when a nurse is prevented from taking an action they perceive is ethically correct (Jameton, 1984). Thus, if the term *ethical dilemma* describes a situation involving conflict between professional obligations, then moral distress is the emotional outcome of that conflict. One assumption implicit in the concept of moral distress is that an individual knows what the right action is based on their values (e.g., liberty, justice, dignity, happiness, or peace; McCarthy & Deady, 2008). Often, professional values such as beneficence (doing good to others), nonmaleficence (not inflicting harm on others), confidentiality, and fidelity are written into Codes of Ethics for health practitioners. When an individual's ability to act on these values is curtailed, they can feel of powerless to act morally, which can trigger moral distress (McCarthy & Deady, 2008).

Exposure to prolonged emotional and interpersonal stressors in the workplace results in burnout, which is defined as a feeling of emotional exhaustion brought on by chronic workplace stress (Maslach & Jackson, 1981). This exhaustion is accompanied by an increase in cynicism (i.e., distancing oneself and developing indifference to others), and the exhaustion and cynicism combined appear to lead to a decrease in professional efficacy (Maslach et al., 2001). Research in the nursing field has demonstrated a positive correlation between moral distress and burnout, and there is evidence that an elevated level of moral distress is correlated with nurses' intention to leave their job (Karakachian & Colbert, 2019). Across six studies that explored the relationship between moral distress and nurses' intention to leave their job, between 10% and 49% of the samples were thinking about leaving their job due to moral distress (Karakachian & Colbert, 2019). In one sample of pediatric physicians and nurses (N = 1,113), 35.7% endorsed either leaving a past position or thinking about leaving their present position due to moral distress (Trotochaud et al., 2015).

The relationship between moral distress and either burnout or the intention to leave a position has yet to be explored in either veterinarians or support staff, although the impact of environmental stressors and burnout on job satisfaction variables has been scrutinized to some extent. In one study of burnout in veterinary technicians (N = 1,642), the authors reported that 58.3% of their sample scored above the cutoff for high levels of burnout and that the mean score on a measure of professional fulfillment fell below the cutoff (Kogan et al., 2020). Likewise, burnout was common in a survey of veterinary technicians (N = 327) employed in four teaching hospitals in the United States and Canada, and it was positively correlated with an increase in medical errors and with a desire to change jobs (Hayes et al., 2020). Foster and Maples (2014) employed a mixed-method analysis to describe the impact of occupational stress on veterinary support staff members, which included a question about the respondent's intent to leave their current job. The authors reported no relationship between occupational stress and intention to leave, although they noted that including additional questions about job satisfaction may have more effectively probed for a relationship (Foster & Maples, 2014).

Identifying workplace factors that impel employees to leave is important because the veterinary profession is experiencing a shortage of workers. In 2021, the American Animal Hospital Association estimated that industry-wide turnover was at 23% while recommending that employers aim for 13% turnover (Rose, 2021). Moreover, the rate at which recently graduated veterinarians, veterinary technicians, and veterinary technologists join the job market will not meet the growing demand for their services (Mars Veterinary Health, 2022). Retention of existing employees and recruiting new ones will be paramount to sustaining the profession; therefore, it is crucial to identify causes of job turnover, such as burnout and moral distress, as

well as the reasons that veterinary support staff leave the industry so that preventative measures can be developed and implemented.

The Current Study

The aim of the current study was to ascertain how frequently veterinary support staff are exposed to ethical dilemmas, to characterize the type of clinical scenarios that they label as ethical dilemmas, and to measure moral distress related to their exposure. Descriptive statistics were calculated for demographic variables, frequency of exposure, and moral distress. A qualitative analysis of ethical dilemmas reported by veterinary support staff was performed to explore the boundaries of this phenomenon in context. Based on research cited here for veterinarians and nurses, I theorized that some of the common themes that would emerge would include conflict over patient care with veterinary team members, conflict with organizational policies, lack of autonomy, heavy workload, and requests to cover up others' medical mistakes.

Method

Participants

Participants were required to work in the United States, speak English, be at least 19 years old, and be employed as support staff in veterinary medicine. Recruitment materials were targeted at veterinary technicians, veterinary assistants, veterinary technologists, practice managers, and receptionists/front desk workers. Licensed veterinarians were excluded from taking the survey. Because the focus for this study was on individuals whose working hours bring them into contact with patients, veterinarians, and clients in such a way that they are likely to encounter ethical dilemmas, participants were included based on their scope of responsibilities rather than their job title. In veterinary medicine, especially in smaller practices, there may be

individuals whose job title masks the range of duties they perform. Thus, only participants who reported that 50% or more of their working hours involve job responsibilities within the scope of practice for a nursing-type role or a managerial role were included in the study results (henceforth, the *job-hours inclusion criteria*).

For example, a practice manager may perform tasks associated with a receptionist (e.g., answering the phone, confirming appointments) for 15% of their work hours, perform tasks as a veterinary assistant (e.g., handling patients, assisting veterinarians with administering treatment plans) for 60% of their work hours, and perform managerial tasks (e.g., resolving customer issues, creating staff schedules, and training support staff) for 25% of their work hours. This individual would be included in the current study because they spend more than half of their working hours performing a role that is likely to expose them to ethical dilemmas. An individual who labels themselves a receptionist and reports that 100% of their working hours are spent on tasks such as answering phones, scheduling appointments, and taking payment for services would not be included based on their job responsibilities.

A total of 213 participants provided valid responses to the survey, of which 174 met the job-hours inclusion criterion (Table 1). Most of the 174 participants were female, white, non-Hispanic, and heterosexual, with a mean age of 36.3 (*SD*= 10.8; range 19 to 62). Of those 174 participants, 120 (69.0%) endorsed experiencing an ethical dilemma in the workplace, although 24 out of 120 participants left the open-text field blank, providing no data for the qualitative analysis. Thus, 96 participants were ultimately included in the qualitative analysis (Figure 1).

Recruitment strategy

Veterinary support staff were recruited via social media ads and emails from professional organizations. Each participant completed an online, anonymous, 20-minute Qualtrics survey.

No identifying information was collected within the survey to preserve anonymity. However, participants were given the opportunity to receive a $10 Amazon gift card to compensate them for their time. For individuals who sought compensation, their email addresses were collected separately from the survey, and they were emailed a link to their gift card. The Auburn University Internal Review Board (IRB) approved these procedures.

Data Quality Strategy

Utilizing social media advertisements for recruitment can leave online, anonymous surveys vulnerable to being spammed by bots (i.e., computer programs that automatically complete surveys), especially when compensation is being offered (Chmielewski & Kucker, 2020). This can lead to poor data quality for the study. To address this potential vulnerability in the current study, I enabled validity indicators provided by Qualtrics which increased my ability to screen and flag responses that seemed to be of poor quality. Data collection was initiated on January 24, 2023; on January 30, 2023, there was a sudden, rapid increase in the number of responses being submitted, and the responses were marked by Qualtrics as being low in quality and validity. Thus, data collection was temporarily suspended to evaluate data quality. After consulting with Qualtrics technical support, I adjusted the validity indicators and relaunched data collection on February 1, 2023 with a new link. Data collection continued until February 8, 2023, when sufficient responses had been received to fulfill the recruitment goal of at least 160 eligible participants.

To evaluate responses for quality, I reviewed the information provided by the validity indicators, and then I scrutinized each individual record to make a final determination on its validity. Responses were considered for exclusion from the study for the following reasons: 1) the survey duration was less than 300 seconds because it was expected that it would take

respondents more than five minutes to complete the survey thoughtfully; 2) the response was submitted during a surge of responses with start times that were almost identical (e.g., less than 60 seconds between the start of each response) which was unlikely to happen by chance (Storozuk et al., 2020); 3) a RelevantIDFraudScore[5] of ≥ 30 which Qualtrics has determined likely indicates a response was provided by a bot; and 4) open-text fields that were duplicated across multiple responses or demonstrated a lack of awareness of the question asked (e.g., *At work, the attending doctor deliberately overstated the condition, and many drugs on the medicine list were not used on pets)*. This particular response to a question asking respondents to briefly write about an ethical dilemma they experienced was submitted 20 times. All questionable responses were examined for evidence within the open-text prompts that the survey had been answered thoughtfully. If I was unable to confirm the quality of the entry, it was excluded from the study.

Measures

Demographics. Demographic data collected included gender identity, race, ethnicity, age, sexual orientation, marital status, annual household income, and disability status (Table 1).

Job-related questions. Additional demographic questions related to each participant's employment in veterinary medicine were synthesized from a review of relevant studies (Gilliam & Coates, 2020; NAVTA, 2016), and can be found in Table 2. In addition, there was a question that gathered a breakdown of the percentage of hours worked per week in various support staff roles to determine which participants met the job-hours inclusion criterion. Of the eligible 174 participants, almost half were employed as veterinary technicians, and an additional one-quarter

[5] Qualtrics employs an algorithm, RelevantID®, to detect responses when multiple email accounts are being accessed from the same computer utilizing geo-location, time, language, IP address and other data (Imperium, n.d.). A fraud profile score, RelevantIDFraudScore, is then generated (Min Value = 0, Max Value = 130). According to Qualtrics, a RelevantIDFraudScore of ≥ 30 indicates a high likelihood that the response is fraudulent.

were employed as veterinary assistants (Table 2). Most participants reported being employed in a small animal practice and having been employed in veterinary medicine for six or more years but being with their present employer for five years or less. Most participants reported earning a degree after high school, with nearly half earning an associate's degree. Of those who earned any type of degree, three quarters reported earning a degree related to animal sciences. Of the 91 (52.3% of n = 174) participants who reported graduating from an AVMA-accredited veterinary technology program, nearly half received accreditation (i.e., passed a licensing exam).

Ethics Training. To determine the amount of education participants may have regarding detecting and resolving ethical dilemmas, I included questions about their exposure to ethics theory or training. Participants who reported that they had attended an AVMA-accredited veterinary technology program (n = 111) were asked, *To the best of your recollection, in your AVMA-accredited program, how many hours of instruction or training did you receive in ethics theory or training?* This same subgroup of participants were also asked to respond to the question, *How many hours of instruction or training have you received in ethics theory or training since graduation? This may include continuing education courses, workshops, seminars, or on-the-job training* (see Table 3). Of those 111 participants, 47 (42.3%) reported receiving at least one hour of training during their training program, 28 (25.2%) reported receiving none, and 36 (32.4%) endorsed *I don't know*. Post-graduation, 52 (46.8%) participants reported receiving at least one hour of training, 40 (18.0%) reported none, and 19 (17.1%) endorsed *I don't know*.

Participants who denied attending an AVMA-accredited veterinary program (n = 63) were asked *How many hours of instruction or training have you received in ethics theory or training? This instruction may come from sources such as on-the-job training, workshops, seminars, or other coursework.* From those 63 participants, 36 (57.1%) reported receiving one or

more hours of ethics training on the job, 12 (19.0%) reported receiving none, and 15 (23.8%) endorsed *I don't know*.

Ethical dilemmas. To gather qualitative data for an analysis of types of ethical dilemmas encountered by veterinary support staff, participants were presented with the following prompt: *An ethical dilemma refers to a situation in which you know the right thing to do but you are prevented from doing it. Have you ever had a case or procedure where you felt like you couldn't do the right thing? Or have you ever been asked to do something at your job in veterinary medicine that felt like the wrong thing to do?* (Moses et al., 2018). If they responded affirmatively, then they were asked, *Please briefly describe the event like this that bothered you the most. Who was involved? What did you think was the right thing to do? What prevented you from doing the right thing? What would have made it easier to do the right thing?* To gather quantitative data for an analysis of frequency of exposure, respondents were asked to estimate how often they encounter ethical dilemmas. Response choices were *Multiple times a day, Once a day, A few times a week, Once a week, A few times a month, Once a month, A few times a year, Once a year, Every few years, and Never* (Kipperman et al., 2018).

Moral distress. The Measure of Moral Distress for Health Care Professionals (MMD-HP) was developed to assess the impact of moral distress on healthcare professionals such as nurses and physicians, and it was designed to be applied across all specialties (Epstein et al., 2019). It consists of 27 statements that address components of moral distress, including being complicit in "wrong" actions, having one's insights or opinions ignored, witnessing ethical violations, and the chronicity of these encounters at three levels of root cause (patient, unit, system). Each statement is assessed by the respondent for both frequency and level of associated

distress; frequency is scaled from 0 (*Never*) to 4 (*Very frequently*) and level of distress is scaled from 0 (*None*) to 4 (*Very distressing*).

Ordinarily, to calculate a respondent's moral distress score, frequency is multiplied by distress for each item; the product for each item ranges from 0 to 16. To produce a composite score of moral distress, the products from all 27 items are summed, and the final score has a range of 0 to 432. A high score indicates a high level of moral distress. For this study, rather than calculating a composite score, an item-level analysis was completed to identify which types of workplace situations participants reported encountering most frequently and which types they reported as being most distressing. The wording of this measure was adapted for the population of veterinary support staff (see Table 4).

Data Analysis. Frequency counts and descriptive statistics on demographic variables and the item-level analysis for the MMD-HP were performed using SPSS version 29. To characterize the types of ethical dilemmas encountered by veterinary support staff, I conducted a qualitative analysis of themes that were common in the participants' ethical dilemma narratives. One of the advantages of qualitative analysis is that it allows exploration of a specific phenomenon from the point of view of the individuals who have experienced it using their personal narratives (Vaismoradi et al., 2013). Specifically, thematic analysis provides an opportunity to sift through large amounts of textual data, describe it, and then develop an interpretation of that data based on patterns or "common threads" (Vaismoradi et al., 2013, p. 400). The steps for performing a thematic analysis include becoming familiar with the data and noticing remarkable features, developing codes to identify those features systematically, then organizing those codes into themes and refining them. Codes generally reflect the literal content of the textual data while themes provide a broader, more abstract interpretation of that content (Vaismoradi et al., 2013).

The final output Is a list of the themes, examples of the themes taken from the narrative data, and a description of how the themes relate back to the original research question and relevant literature (Vaismoradi et al., 2013). These results can also be displayed in a thematic map, which visually illustrates how the themes relate to each other.

When little is known about a phenomenon, researchers apply an inductive approach during analysis. For this study, I had developed hypotheses about the content that would emerge based on my review of previous research on veterinarians and nurses plus my personal experience working in veterinary medicine; therefore, I employed a deductive approach. Note that employing a deductive approach does not prevent a researcher from remaining open to modifying a theory or framework as needed, based on the actual data (Vaismoradi et al., 2013).

The qualitative coding for this study was performed using Dedoose™ (*Dedoose*, 2023), an online software application that was designed for the analysis of qualitative data, such as text narratives. Two graduate students completed the coding process with supervision from a licensed clinical psychologist. One challenge in qualitative analysis is determining whether content is thematically significant because this part of the process can be heavily informed by a researcher's expectations or personal bias. To reduce the potential for bias on this project, the second coder on the project (HS) was an individual whose exposure to veterinary medicine was limited to visiting veterinary offices with a companion animal.

First, each student independently reviewed a subset of the collected data to develop an initial list of codes, and then we collaborated to organize those codes into one codebook. Each code reflected content in the narratives that the researchers deemed significant based on the research question. The coding process was iterative so that as more data were accommodated, the codebook was repeatedly modified. For instance, new codes were added or existing codes were

combined if they occurred infrequently but had a common thread. Although each subset of data was coded independently, the coders met at regular intervals to discuss which codes seemed significant, to decide how to name each code, and to describe each code with enough clarity that an individual outside of the project would be able to faithfully apply the codes in the codebook. The codebook was considered complete when reviewing the data no longer precipitated changes to the codes.

Next, I extrapolated themes from the codebook and generated a thematic map; the process of generating a thematic map informed the organization of the themes and vice versa. To generate the thematic map, I began by identifying which codes co-occurred in the narratives and used co-occurrence to define the concept of a *relationship* between codes. Then, I explored various methods of organizing and arranging the themes and codes until I found a configuration that allowed for the relationships between codes to be visually ascertained. Finally, I ensured that the output reflected the data and addressed the aim of the research.

Results

Frequency of ethical dilemmas

Of the 120 participants who met inclusion criteria and endorsed exposure to an ethical dilemma, the median frequency of exposure was a few times a year, although 23.3% (n = 28 out of 120) reported being exposed to an ethical dilemma at least once a week. Three (2.5%) participants endorsed *Never* as the frequency after responding *Yes* they had experienced an ethical dilemma. These responses appear to contradict each other, but a review of the data revealed that one participant had left the open-text field blank for their ethical dilemma while the other two had written the following: 1) *There hasn't been any since my old boss is gone*. and 2)

n/a. Compared to a previously published study of veterinarians (Kipperman et al., 2018), support staff in our study reported encountering ethical dilemmas less frequently (Figure 2). Veterinarians reported median frequency of once a week, and 19% (out of $N = 484$) reported a frequency of at least once a day.

Qualitative analysis of ethical dilemmas

Of the 96 participants who provided a narrative for qualitative analysis, 14 (14.6%) provided a response that did not contain an ethical dilemma. Some of these statements included an example of a stressful situation that did not involve conflicting professional responsibilities (e.g., *A client was not satisfied with their bill and demanded a reduced rate. Client didn't want to wait for supervisor and berated me and fellow workers)*[6] or indicated that the participant could not remember a specific instance (e.g., *I am sorry, I cannot remember the situation, but I know it has happened*). Others provided a re-statement of what an ethical dilemma is without providing an illustration from their own experience (e.g., *The hardest dilemmas are when I am in a position that requires me to choose between the right thing for the client, patient, and my team*.) Each of these 14 statements was coded as *Not an ethical dilemma*.

From the remaining 82 narratives, four themes emerged: *Conflicts between competing professional obligations*, *End-of-life issues*, *Contributing factors*, and *Actions taken by respondents to resolve an ethical dilemma* (Table 5). These themes were extrapolated from 17 codes and 5 child codes that comprised the final codebook; each narrative could have multiple codes applied. The results of the qualitative analysis have been presented without including frequency counts for the themes and codes because the goal of the qualitative analysis was to

[6] Narratives have been edited for spelling and grammar to improve clarity and remove profanity without altering the meaning. Gender specific pronouns have been edited to non-gendered pronouns to protect anonymity.

fully explore the phenomenon based on text and context rather than number of instances (Vaismoradi et al., 2013).

One theme involved conflict between at least two professional obligations; generally, participants reported conflict between what they felt was the best care for the patient and what other entities were asking them to do. These entities included clients, veterinarians, laws or the lack thereof, or the organization and its policies. This theme was titled *Conflicts between competing professional obligations*, and it included codes such as *Conflict with client over patient treatment plan*, which captured situations in which the participant's obligation to accommodate the client's wishes conflicted with the participant's obligation to provide the best care for the patient. One example of this type of ethical dilemma was provided by a participant who shared their conflict regarding the client's choice of diet for the patient. They recalled that,

> The other week, a [client] came in with a very ill kitten. When asked the diet of the pet, [the client] informed us that it was on a vegan diet. There was not much we could do except try to educate [the client] as much as possible. The pet stayed with us for a few days and was fed an intensive care food and quickly began to turn around for the better. However [the client] later refused to be sent home with the food or any information. [The client's] lack of knowledge inhibited [them] from seeing that while being vegan may be the best thing for [them], it is slowly killing the cat.[7]

Some of the narratives that described conflicts with clients specified that the client's financial constraints impacted whether or what type of treatment was pursued, so financial constraint emerged as a significant child code under the code *Conflict with client over patient treatment plan*. In one example, a participant broadly described this dilemma as "financial

[7] Felines are obligate carnivores, meaning that they require amino acids that are found mainly in meat to develop and thrive. The health impacts of applying a vegan diet to felines is a topic that is undergoing research.

hardship preventing best medicine/care of patients," while another stated they experience an ethical dilemma "when a client comes in with a sick patient (such as parvovirus)[8] and can't afford to pay so we have to decline or send them somewhere cheaper."

This theme also included a code for *Conflict with a veterinarian over patient treatment plan*, which was applied to narratives when the participant outlined a conflict between what they believed was best for the patient and what a veterinarian asked them to do. One participant briefly stated, "A patient had an injured paw and my experience told me that there was a better way to treat the paw." Another participant described a surgical experience in which,

> The DVM performed a surgery on a rabbit without enough anesthesia. The DVM refused to allow a block or to intubate the rabbit for an enucleation and insisted on having the veterinary technician hold an ill-fitting mask on the patient.[9] The rabbit woke up twice and screamed each time. The rabbit survived the surgery but died in recovery. I wanted to intubate the rabbit and provide a retrobulbar block for the enucleation. The DVM refused and threatened me with disciplinary action if I did not comply.

The next code, *Conflict with organization or policy,* captured statements by participants that the policies enacted by their employer interfered with what they believed was the best care for patients. We interpreted references to *manager* or *management*, as in "The management also was shielding the doctor's behavior," as being a conflict with the organization because we construed individuals in managerial positions to be responsible for interpreting an organization's

[8] Canine parvovirus (CPV) is a highly contagious virus that causes gastrointestinal symptoms and is transmitted through contaminated feces. It can be fatal to puppies when not caught early and treated immediately which is why it is included in common vaccinations administered to puppies. Treatment can involve multiple days in a hospital and result in a large hospital bill.

[9] *Intubation* (feeding a tube down the patient's trachea) would have delivered a steady flow of anesthetic gas during the procedure, ensuring a complete loss of consciousness. Administering a gas anesthetic via a mask (a.k.a., "masking down") can be effective, but less so if there is a poor seal which allows the gas to flow into the air around the patient rather than into the patient's nose and mouth, leaving them susceptible to wakefulness during a procedure. An *enucleation* is a surgery that involves removal of an eyeball. A *retrobulbar block* is a nerve block in the space behind the globe of the eye.

policies and procedures. One common type of scenario included in this code were statements that the organization neglected to provide payment options to clients unable to afford necessary medical care. A participant explained this dilemma as,

> Having to send a critical patient home from the ER before treatment because the owner couldn't afford treatment or didn't want to consent to treatment. The right thing would be to work with the owner's finances. Our policies state no payment plans which I do understand, but it's painful to turn away a patient in need.

Another type of ethical dilemma involved situations in which the participant reported being opposed to a particular procedure, but they could be asked or compelled to participate. This was notable in narratives about declawing felines, as in this example wherein a participant reported an ethical dilemma "assisting with a declaw where I knew the cat was an indoor/outdoor cat.[10] The right thing to do would have been to decline helping. The risk of losing my job prevented me from doing that." Yet another participant listed a series of policies or protocols in their work environment that they believed impacted patient care or workplace safety,

> Across current and former workplaces - Performing procedures or animal care not aligned with ALAAS/IACUC.[11] Being asked to train coworkers with zero veterinary education or experience on advanced lab animal technique which shows a lack of understanding/respect for veterinary skills and expertise, IACUC standards, and animal welfare. Poor controlled substance handling. Electing euthanasia not to reduce suffering but to reduce workload or over-crowding.

[10] Some individuals believe that felines who spend time outdoors are safer if they retain their claws to help them defend against other predators. Individuals who may not be morally opposed to declawing felines in general may feel that it is wrong in certain instances.

[11] *ALAAS* stands for the American Association for Laboratory Animal Science which is an association of professionals employed in academia, government, and private industry that advances responsible laboratory animal care. *IACUC* stands for the Institutional Animal Care and Use Committee which refers to any institutional-level (e.g., a university, Veterans Affairs) committee responsible for oversight of animal care for that institution.

The code *Conflict with legal requirements* addressed statements from participants that existing legal guidelines lack solutions for ethical dilemmas that involve patients who are not being cared for well. Generally, participants noted that it is not lawful to take custody of a patient even in cases where the patient's removal from their custodian might be in the patient's best interest. Regarding a case involving a client who stated they were going to take their canine home to shoot it rather than pursue treatment, one participant stated,

> The right thing would have been to tell the client they are out of their mind, and we are going to keep the dog and re-home the dog. It would have been easier if there were provisions in law that allowed for veterinarians to have the legal authority to take possession of animals in situations like these.

Likewise, in a case of a client requesting convenience euthanasia, a different participant explained that "because the dog was the client's 'property,' we had to euthanize the dog. If we had the option to have the owner sign over rights, we could have found suitable placement. Instead we all left broken-hearted."[12] In these statements, participants reported a conflict between what they believed was best for the patient and what they were legally allowed to do.

In addition to conflicts with entities such as clients, veterinarians, organizations, and legal requirements, some participants provided examples of ethical dilemmas in which they witnessed excessive use of force or restraint, were asked to participate in deceptive practices, or witnessed negligence from a coworker. According to NAVTA's Code of Ethics, one professional obligation of credentialed individuals is that they are expected to take steps to protect the public

[12] In the United States, pets and livestock are considered property with little to no legal rights, and animal custodians have the right to dispose of their "property" as they decide. On the other hand, all 50 states have felony animal cruelty laws, and legal cases at the federal and state level have determined that animals can count as crime victims. Under this system, it is legal to humanely euthanize your own pet either by lethal injection or by shooting it, provided the euthanasia is justified (e.g., terminal illness or aggressive behavior). However, if the euthanasia is reported as being unnecessary, the custodian could be reported and investigated for animal cruelty.

and the profession from individuals who demonstrate a deficit in competence or ethics (NAVTA, n.d.). Upholding this obligation might involve disclosing deficits in competence or ethics to an appropriate party (e.g., the client, medical licensing board) so they can be addressed, but the individual may hesitate to make a disclosure because they fear retaliation. Moreover, they may be directed by a supervisor to not report an error to the appropriate party.

The code *Conflict over use of force or restraint* reflected conflict between a participant's belief that applying minimal restraint was best for the patient and being compelled to administer excessive restraint or witness a coworker apply unnecessary or excessive force. Applying excessive restraint risks harming the patient, as demonstrated in one narrative, "Restraining an older cat that was struggling to breathe. Vet took over and was too rough, and pet passed away." Some participants suggested that, instead of applying excessive restraint to a fearful, stressed, or anxious patient, "the right thing to do would recommend the owner to give calming meds at home and try the procedure again at a later date." In another example, a participant reported "watching a doctor hitting an animal on the head, but since the doctor was the medical director in the practice, no one was brave enough to say anything." This statement demonstrated that the participant was aware of wrongdoing in the use of unnecessary force against the patient but was fearful of the negative consequences of reporting the behavior.

Some participants reported that they encountered a request to cover up an error or were asked to assist in deceiving a client, and we created the code *Request to cover up an error* to address these narratives. In one narrative, a participant recalled that a veterinarian neglected to deliver lab results in a timely manner to a client and then asked them to lie to a client to cover up this error. The participant wrote that,

> Lab work sat on a veterinarian's desk for a couple of days. When the client called about the results, the veterinarian told me to tell them we had just gotten them back, when in fact they had been sitting there on [their] desk. I ended up lying to the client but let the veterinarian know I would not do that in the future.

In another narrative, a participant recounted an ethical dilemma regarding a surgical case in which they assisted. After surgery, the patient stayed overnight at the hospital to recover, but when the participant came in the next morning, the patient had died under the care of the coworkers who had been responsible for patient care overnight. Upon reviewing the chart, the participant believed that a medical error overnight caused the patient's death, but when they asked for clarification, they reported being told, "there was an 'incident,' and he had passed away, but I was not allowed to talk about it or ask questions." This participant added that the death was described to the client as a "rare post-surgical/anesthetic complication" and that staff members were "threatened by management if we talked about it or even had questions about it." Regarding the expectation that they participate in covering up the coworker's medical error, the participant stated,

> It made me feel extremely uncomfortable and further reinforced my gut feeling that the owners were lied to. I was young and naive and felt trapped with the risk of losing my job, plus without solid concrete evidence (or without someone else willing to "testify") I didn't feel empowered to raise concerns or reach out to the owners.

In these examples, the participants seemed to believe that they or their organization had an obligation to disclose an error to the client and that not doing so created a conflict with their sense of what was right.

Some participants reported being asked to misrepresent events in a medical record or an invoice. We applied the code *Request to falsify records* to these narratives. In one example, a participant reported that the shelter that employed them adopted out animals that were not suited to live safely alongside humans. These animals would be returned and eventually euthanized. The participant reported being instructed to falsify documentation to maintain the organization's image as a no-kill shelter, stating, "When we would euthanize one of those dangerous dogs, the paperwork had to be filed as a health issue for the euthanasia and not behavioral because that information was public, and the shelter wanted to look good." Within this narrative, the ethical dilemma involved discord between obeying the employer's directive and what the participant believed to be their obligation to safeguard the public. There was a *Conflict with organization or policy* regarding the adoption of dangerous animals, but in addition, they were asked to maintain the shelter's deceptive practice, which warranted the application of the *Request to falsify records* code. In a different type of case, a participant reported that "A veterinarian asked to use some of my continuing education certificates, and I declined." Without more context, the coders interpreted this example to mean that a veterinarian had implied that they would use the participant's certificates as if they were their own as part of the licensure renewal process.

The last code related to the theme *Conflicts between competing professional obligations* was *Witnessed negligence by coworkers*. Similar to narratives that depicted conflicts with veterinarians over patient treatment, cases that included witnessing negligence involved a conflict between what the participant believed was best for the patient and the care they witnessed being administered by a veterinarian, so these narratives could have been subsumed under the *Conflict with veterinarian over patient treatment plan* code. However, through consultation, the coders deemed this code significant enough to be listed separately because we

believed it would be impactful to distinguish between instances of disagreeing with the veterinarian and instances where the veterinarian was providing care that did not meet a reasonable standard because of the increased risk of harm to the patient. In one narrative, a participant reported,

> I notified a doctor of an increase in respiratory effort. The dog had been previously diagnosed with congestive heart failure. The doctor dismissed me several times then came to treatment room and wanted to sedate the dog for an oral exam. The dog arrested during sedation.

In another example, a participant recalled, "Doing a home euthanasia, the veterinarian did not bring enough [euthanasia solution]. In the end, [the veterinarian] ended up suffocating the dog to death." In a third example, a participant recalled a pattern within a past work environment wherein,

> the clinic owner would cut corners. It was often about how quickly things could get done, instead of focusing on quality of care. For example, to save time in surgery they would not follow aseptic technique.[13] I worried about the safety of the pet and following standard of care. It would have been better to slow down to ensure proper care could be provided for the patient.

The second theme that emerged from the coding process was that ethical dilemmas were often related to *End-of-life issues*. Although end-of-life issues also involved conflict between what the participant believed was best for the patient and the course of action requested or compelled by the client, veterinarian, or organization, this theme was separated out from *Conflicts between competing professional obligation* for two reasons. One, the role that euthanasia plays as a method of treatment to alleviate suffering, as a tool to address public health

[13] *Aseptic techniques* are precautions taken to maintain a sterile environment and prevent contamination.

concerns (e.g., culling cattle with mad cow disease), and as a solution for eliminating unwanted animals is uncommon outside of veterinary medicine and deserved special attention. Two, the role of support staff during euthanasia cases is distinct from the role of veterinarians and therefore their perspective on this phenomenon warranted exploration.

The *End-of life-issues* theme arose from codes that reflected two opposite dilemmas: cases in which participants believed euthanasia was the best option for the patient and cases in which participants believed euthanasia was not the best option for the patient. The code *Continuing to provide care to patients that should be euthanized* captured dilemmas in which support staff were required to continue to provide care rather than euthanizing a patient that they believed was suffering or unable to be rehabilitated. For example, one participant shared that their work in oncology exposed them to cases in which,

> Owners wish for us to continue treatment in the face of a terminal diagnosis and poor quality of life. It feels cruel to administer medication that will likely cause side effects that will further diminish the quality of life when there is unlikely to be any benefit for the animal.

In another type of case, a participant discussed the dilemma they experienced working on cases that came to their hospital from an animal rescue, stating that the rescue "would pour hundreds to thousands of dollars into [unadoptable] patients because they wouldn't euthanize, wasting money on an animal that would never live anywhere but a cage and putting them through unnecessary pain and procedures." In both examples, the participants appear to believe that euthanasia would be the best option for the patient rather than treatment.

There were two child codes related to the code *Continuing to provide care to patients that should be euthanized*. One captured scenarios in which the client's indecision or refusal to

euthanize contributed to the dilemma, and the other code captured scenarios in which the participant believed the veterinarian contributed to the dilemma by being evasive or indirect in treatment discussions with the client. The code *Client indecisive or refuses euthanasia* was exemplified by statements like the one which recounted the case of a terminally ill feline who was "suffering/suffocating in its own fluid. Owner did not want to euthanize, and I had to watch for hours as he suffered a horrific death." The code *Veterinarian evasive or indirect about euthanasia* was exemplified by narratives such as,

> Another instance [of an ethical dilemma] is when a euthanasia would be the best option for a very ill patient, and I think we should recommend that as an option to the owner, but the doctor/tech will not recommend it, and we are forced to continue treatment in a chronically ill patient. Usually they don't want to recommend it for fear the owner will become upset or offended.

These examples demonstrated the conflict participants experienced when they believed euthanasia could end an animal's suffering, but they were obligated to acquiesce to either the veterinarian's or client's wishes to continue treatment instead.

The second code under End-of-life issues, *Convenience euthanasia*, captured dilemmas wherein the participant did not feel that euthanasia was in the patient's best interest. In these narratives, euthanasia was regarded as undesirable because the participant believed that, with appropriate treatment or training, the patient could be restored to a good quality of life. One participant articulated the dilemma this way: "A client wanted to euthanize their animal for convenience. I did not agree but it is the doctor's discretion, so there wasn't anything I could do." As this participant stated, a convenience euthanasia is initiated by the client, and it is the veterinarian who decides whether to perform the service or decline.

Narratives that mentioned convenience euthanasia sometimes distinguished between whether the euthanasia was due to behavioral issues or due to financial constraints, thus child codes were created to identify cases of *Convenience euthanasia due to behavior* and cases of *Convenience euthanasia due to finances*. An example of an ethical dilemma related to a behavioral issue was,

> The veterinarian/practice owner at my last job would euthanize anything. The one that really got to everyone was a puppy. One of the people in management had gotten a puppy, and it was mouthy/would jump on people. Instead of seeking any kind of training or literally any options, they brought it to [the veterinarian] to be euthanized. All of us spoke up about it and were told if we didn't like it, we could leave, but they were going to put the dog down. The owners didn't even stay for it. Despite all of us trying to talk the vet out of it, [they] didn't care.

Regarding cases involving financial issues, a participant related that the ethical dilemma they encountered was "whether or not to euthanize an animal where the owner didn't have money but would go home and shoot it if we didn't figure something out." These participants believed that euthanasia has a role to play in providing the best care to patients, but they experienced an ethical dilemma when euthanasia was misapplied due to the action or inaction of the client or the veterinarian.

Two more codes that were identified during analysis, *Heavy workload* and *Lack of autonomy*, were combined under the theme *Contributing factors*. Neither *Heavy workload* nor *Lack of autonomy* reflect a type of ethical dilemma, but they instead describe environmental or personal factors that contributed to problematic situations. The first, *Heavy workload,* was originally drawn from the literature review. It was only mentioned once by our participants, but

the code was retained to explore its role in contributing to an ethical dilemma in this population. In the example provided by a participant, they explained,

> One [ethical dilemma] was when I was incredibly overworked and sent a pet out as communal instead of private.[14] My manager told me to put on my 'big girl panties' and explain my mistake to the client without offering a resolution. And then had the audacity to try to 'help' me by getting communal ashes and passing them off as the client's pet.

In this example, the participant made an error due to their heavy workload. That mistake led to a conflict for the participant who had to decide whether to be honest with the client about the mistake or conspire with the manager and engage in deceitful behavior.

The second code under *Contributing factors*, *Lack of autonomy*, was also drawn from the initial literature review. Within the narrative data, this code was applied to statements in which participants chose not to speak up about unethical behaviors they witnessed, either because they believed they lacked expertise or out of a fear of negative consequences. In an example of the first type of dilemma, a participant stated that "what prevented intervention was my lack of legal credentials and lack of support concerning [the veterinarian's] actions from higher ups. I was a very young technician, and the doctor was very intimidating. I was afraid of angering [them]." Regarding being asked to assist in a procedure they believed to be wrong, another participant stated, "The right thing to do would have been to decline helping. The risk of losing my job prevented me from doing that."

[14] When companion animals are euthanized in an animal hospital or are brought to the hospital deceased, most hospitals arrange for cremation of the bodies with an outside contractor. Clients are given the choice to have their animal's body cremated communally, in which case multiple bodies are cremated in a chamber at the same time, and the client does not receive ashes back for remembrance, or the client can elect to have their animal's body cremated privately, in which case their animal's ashes can be returned to them for remembrance. In this example, it appears the participant mistakenly sent the body to be cremated communally with no ashes to be returned when the client had wanted the body cremated privately so that they could receive ashes.

The fourth theme, *Actions taken by respondents to resolve an ethical dilemma*, coalesced around codes that reflected participants' attempts to resolve the conflict inherent in the ethical dilemma(s) they reported. For example, some participants described attempts to discuss the situation with the veterinarian on the case, as in "The DVM decided to perform [a] necropsy[15] on the pet without [client] consent. I spoke up and was instantly reprimanded and told that the owner would never know." Other participants initiated discussion with individuals in positions of authority when they were unable to resolve the dilemma with the veterinarian on the case. Regarding a surgical case, a participant reported, "A DVM did an emergency testicular torsion neuter.[16] The DVM refused to remove the non-affected testicle because the owners had limited funds. I voiced my concern during surgery and then to our medical director the next day."

Some participants reported that they refused to perform tasks they believed to be ethically wrong; these narratives were coded as *Refused to complete task*. One reported,

> Clients wanted to euthanize a healthy pet, and the veterinarian was going to do it. I stated I wasn't comfortable in assisting in the procedure which made [the veterinarian] go to another employee. That employee also refused to help. The veterinarian finally listened to us and spoke to the client more thoroughly. They opted for diagnostics, and the pet went home that day.

A few participants reported that they quit their position because of their on-the-job exposure to ethical dilemmas. For example, one participant wrote about their experience working in shelter medicine where they witnessed coworkers falsifying documentation, and they concluded, "I finally had enough and left because I couldn't watch that and other stuff continue anymore."

[15] *Necropsy* is the terminology describing the autopsy of an animal.
[16] In testicular torsion, the patient's testicle becomes twisted around a cord that provides blood flow to the testicle. Surgery is required to either untwist the testicle or remove it if it has become damaged from lack of blood flow. Removing the unaffected testicle during the same surgery could prevent the situation from re-occurring and prevent the client from having to pay for a second procedure in the future.

Two additional codes that were relevant to this theme were whether the *Concerns were addressed* or the *Concerns were dismissed*. In one example wherein a participant's concerns were addressed, the participant was working with a veterinarian who did not apply the standard of care (SOC) the participant believed was best. Regarding that situation, the participant wrote,

> I often felt uncomfortable that [they] did not provide that care, and I did not have the knowledge or confidence to advocate for the same level of care I was witnessing from the rest of the [veterinary] team. I had a reasonably positive working relationship with this DVM, and as I learned more, I felt more comfortable upholding SOC as I felt I needed to and did not experience push back from this DVM. However, other team members did, and ultimately, I advocated for how difficult it was to work with this DVM, as did many other members of our team. [Their] contract was not renewed.

In a second example wherein the participant's concerns were addressed, the participant reported,

> A veterinarian nearly killed a cat during a spay procedure, and [they] did not know how to fix the damage [they] did. I wanted to keep my job but also did not want a patient to get hurt. I wrestled with reporting [the veterinarian to the licensing board] but settled on speaking to upper management about it, and [the veterinarian] was dealt with by them.

In an example wherein the participant's concerns were dismissed, a participant reported,

> We had a relief vet in office for the day. We had a patient come in with jaundice. The relief vet would not offer hospitalization, even at my request. I advised the owner to proceed to 24-hour care, and they did not because the relief vet didn't also urge them to go. The patient passed the next morning.

In a second example, a participant reported, “I have had a few situations where I believed a patient was getting the wrong dose of medication, but feel I was ignored when I brought it up to the veterinarian.”

To summarize, four themes were identified during the qualitative analysis, and these themes as well as their codes and child codes were consistent with scenarios cited by veterinarians in previous studies and with themes previously identified in qualitative analyses of ethical dilemmas for nurses. Some codes described conflicts over patient care; this type of dilemma was captured by the codes *Conflict with client, Conflict with veterinarian, Conflict with organization or policy, Conflict with legal requirements,* and the four codes included under the theme *End-of-life issues*. Participants also reported dilemmas that involved conflict between their professional obligation to safeguard the public from practitioners who are deficient in ethics or competence and their obligation to perform their responsibilities as requested. This type of dilemma was reflected in the development of codes for *Conflict over use of force or restraint, Request to cover up an error, Request to falsify records,* and *Witnessed negligence by coworkers*.

The codes that aligned with scenarios that have been commonly cited by veterinarians as common, stressful scenarios involved providing treatment within a client’s financial limitations and resolving end-of-life issues. Many more codes strongly resembled those reported in qualitative studies of ethical dilemmas in nursing, where prominent themes included conflict with physicians or families, organizational constraints, heavy workload, and limited autonomy.

Mapping of Themes from Qualitative Analysis

Rather than just one map, a series of thematic maps were generated to illustrate relationships between the codes that were identified in qualitative analysis (Figures 3-6). Each figure highlights the codes from one theme and illustrates how they related to the codes from the

other three themes. In the figures, a line between two codes indicated that those two codes co-occurred, or are mentioned within the same narrative, one or more times within the data. For example, in Figure 3, the code *Conflict with legal requirements* co-occurred with two other themes, *Client indecisive or refuses euthanasia* and *Lack of autonomy*. Although codes within the same theme could co-occur or be mentioned within the same narrative, these relationships were not included in the thematic mapping process; there are no lines drawn between codes within the same theme. Also, frequency of co-occurrence was not incorporated in these figures; however, some codes co-occurred with a larger number of codes than others.

First, within the theme *Conflicts between competing professional obligations*, the codes *Conflict with clients*, *Conflict with veterinarians*, and *Conflict with organization or policy* exhibited relationships to multiple codes as well as to all three of the other themes (Figure 3). The range of relationships exhibited by these three codes may indicate that a more common or more archetypal ethical dilemma is one that involves conflict between providing the best patient care and complying with the wishes of other entities (i.e., client, veterinarian, organization). All three codes co-occurred with *Lack of autonomy*, as well as with the codes *Attempted to resolve dilemma through discussion*, *Quit*, and *Concerns were Dismissed*. On the other hand, *Conflict over use of force or restraint*, *Conflict with legal requirements*, and *Request to falsify records* may be less common or less archetypal ethical dilemmas encountered by veterinary support staff due to their comparable sparseness of relationships.

Next, under the theme *Contributing factors*, the code *Lack of autonomy* co-occurred with most of the codes under all three of the other themes, but *Heavy workload* only co-occurred with *Request to cover up an error* (Figure 4). The pervasiveness of *Lack of autonomy* across codes and themes suggests that autonomy plays a critical function when support staff face an ethical

dilemma. In contrast, experiencing a heavy workload seldom contributed to the experience of encountering an ethical dilemma, according to participants.

Then, of the five codes that comprise the *Actions taken by participants to resolve an ethical dilemma*, three codes demonstrated a high level of interrelatedness to codes from other themes while two were infrequently related (Figure 5). *Attempted to resolve dilemma through discussion, Concerns were dismissed*, and *Quit* were well-represented across many different types of dilemma, and these codes also co-occurred with *Lack of autonomy*. *Attempted to resolve dilemma through discussion* and *Concerns were dismissed* also exhibited relationships with *Continuing to provide care to patients that should be euthanized*. From this map, it appeared that there were many conditions under which participants spoke up to try to resolve the ethical dilemma, but that their concerns were usually dismissed. The codes *Refused to complete task* and *Concerns were addressed* exhibited few relationships, possibly indicating that refusal is seldom employed as a tactic and that reporting concerns was seldom a successful tactic for resolving an ethical dilemma.

Fourth, the codes associated with *End-of-life issues* co-occurred mainly with codes under *Conflicts between competing professional obligations*, and then with *Lack of autonomy*, *Attempted to resolve dilemma through discussion*, and *Concerns were dismissed* (Figure 6). The co-occurring codes for *End-of-life issues* provided more evidence that lack of autonomy was a pervasive experience for support staff during an ethical dilemma. Moreover, it appeared that when participants did exercise autonomy, it was predominantly through discussion, and their concerns were likely to have been dismissed.

Measure of Moral Distress for Healthcare Professionals (MMD-HP)

The item-level analysis of the MMD-HP attested to the types of distressing situations that veterinary support staff encounter in the workplace most frequently and the level of distress associated with these situations (Table 4). According to participants, the three situations they most reported encountering *Often* or *Very Frequently* were *Unable to provide optimal care due to pressures to reduce costs* (*n* = 61; 35%), *Required to work with other healthcare team members who are not as competent as patient care requires* (*n* = 45; 26%), and *Required to work with abusive clients who are compromising quality of care* (*n* = 25; 25%; see Table 6). The three situations that participants most often reported as being *Distressing* or *Very Distressing* were *Required to work with abusive clients who are compromising quality of care* (*n* = 88; 51%), *Work with team members who do not treat vulnerable animals with compassion and respect* (*n* = 78; 45%), and *Required to care for more patients than you can safely care for* (*n* = 77; 44%; Table 7).

Comparing the results of the themes that emerged during the qualitative analysis to the results of the item-level analysis, there was considerable overlap between the themes and the situations identified by participants as most frequent and most distressing on the MMD-HP. Similar to the theme *Conflicts between competing professional obligations*, many of the items that were either most frequent or most distressing related to being unable to provide the best patient care due to conflicts with clients (Item 22), client financial limitations (Item 4), and conflicts with other healthcare team members (Items 13 and 27). On the other hand, one item participants reported as being most distressing, Item 16, aligned with the *Contributing factor* code *Heavy workload* which was only mentioned once in the narratives.

Discussion

The aim of the current study was to characterize the types of ethical dilemmas reported by veterinary support staff whose experiences had previously been neglected in the literature. Because the professional obligations of veterinary support staff are different from those for veterinarians, I had hypothesized that the type of dilemmas reported by support staff would differ from those that have been cited in research studies on veterinarians. For veterinarians, scenarios have focused on conflict with clients about patient treatment plans, including end-of-life issues. In the current study for support staff, the themes that emerged involved conflict over patient care and conflict over witnessing or participating in unethical practices. Identifying the type of ethical dilemmas support staff encounter along with their frequency of exposure and the amount of moral distress they report associated with these exposures can provide insight into when and how targeted interventions could potentially be applied to prevent qualified individuals from leaving their current position or leaving the veterinary profession entirely.

When asked to report their overall frequency of exposure to ethical dilemmas, veterinary support staff reported encountering ethical dilemmas less frequently than published data from veterinarians (Kipperman et al., 2018). This discrepancy was notable since veterinarians and support staff collaborate on the same cases; therefore the rate of exposure would be expected to be similar. One possible explanation for this discrepancy is that veterinarians demonstrated increased detection of ethical dilemmas, or *ethical sensitivity*, due to their exposure to ethics training during their veterinary education. Thus, the level of exposure may be the same between the two groups, but their level of awareness may be different. In contrast to this notion, participants in our sample reported comparable rates of ethics training (i.e. 42% for those who attended a veterinary technology program; 57% of those who did not attend a veterinary

technology program) to Kipperman et al.'s (2018) survey of veterinarians (i.e. 51%). These are small sample sizes, and *ethics training* was not clearly defined in either study, but, given that there was only a modest difference among the populations, amount of ethics training is not the most plausible reason for the frequency discrepancy.

A second explanation is that the most common ethical dilemmas are situations that veterinarians encounter in the absence of support staff or in which the involvement of support staff is peripheral to resolving the dilemma, thus reducing their frequency of exposure. The most common ethical dilemma that veterinarians report is being unable to provide the best care due to client financial limitations (Batchelor & McKeegan, 2012; Kipperman et al., 2018). Similarly, support staff in the current study reported that pressure to reduce costs[17] was the most common dilemma (Table 6). However, conversations about the cost of care are often centered between the veterinarian and the client, particularly for high-cost treatments such as surgical interventions and hospitalization. Thus, it seems probable that veterinarians would report encountering these common situations with greater frequency than support staff and report higher rates of exposure to ethical dilemmas.

If the goal is to determine when and how to intervene to prevent veterinary support staff from deciding to leave a job, it is critical to know whether a scenario is distressing in addition to being common since moral distress is related to burnout and intention to leave a job. Although scenarios involving financial constraints occur frequently, it was not the most distressing

[17] There may be some ambiguity in the interpretation of this item because the MMD-HP was originally designed for healthcare professionals in human medicine, and the phrase *pressure to reduce costs* may be interpreted differently in human healthcare versus veterinary medicine. For example, in human healthcare, the pressure directed at practitioners to reduce costs may come from administrators or insurance providers whereas in veterinary medicine, the pressure to reduce costs is more likely to come from the paying client. In either case, the result is that the practitioner is asked to pare down the level of care to accommodate financial constraints. For the current study, based on my personal experience working in a support staff role, I believed most participants would assume that the client is applying the pressure and not the organization, although participants could have applied alternate interpretations.

experience for support staff, as evidenced by being ranked fifth for level of distress among the items from the MMD-HP (Table 7). Likewise, veterinarians have reported financial limitations as less stressful than other scenarios, such as performing euthanasia of healthy animals or prolonging treatment on animals with a poor expected outcome (Batchelor & McKeegan, 2012; Kipperman et al., 2018). There may be important factors that contribute to why some types of dilemmas are less distressing than others, and understanding how those factors reduce the risk of employees leaving their job may be beneficial. Batchelor and McKeegan (2012) provided two plausible reasons why scenarios involving client financial limitations received a mildly lower stress rating for veterinarians, and these reasons may also extend to support staff. The first reason is that financial limitations are commonplace and expected, and solutions are sometimes available to address this constraint. The second is that treatment costs can be viewed as being the client's responsibility to address rather than the medical provider's responsibility.

However, I theorize there is a third reason why financial constraints may be a less distressing type of dilemma, which is that this type of dilemma evokes a sense of solidarity between members of the veterinary team whereas other types of dilemmas emphasize the power differential between them. Dilemmas that involve being able to share disappointment or frustration with coworkers may reinforce the belief that individuals are working together as a team that holds similar values and faces similar obstacles, and this belief may act as a protective factor. In fact, a qualitative study of experienced nurses extrapolated three themes in the narratives that they referred to as *antidotes* to the moral distress that develops as a result of exposure to ethical dilemmas: moral agency, moral imagination, and moral community (Traudt et al., 2016). Moral agency was defined as "as an individual's ability to make a moral judgment based on a commonly held notion of right and wrong and to be held accountable for their

actions" (Traudt et al., 2016, p. 204). Moral imagination refers to an individual's ability to envision outcomes, such as a good death, and moral community involves individuals working together to support each other and make moral decisions (Traudt et al., 2016). Individuals who nurture these antidotes may experience lower levels of moral distress despite continued exposure to ethical dilemmas.

In contrast, factors such as poor team communication or organizational policies can contribute to moral distress and disengagement from work (Hamric, 2012). In a study of team effectiveness, burnout, and job satisfaction in Canadian animal hospitals, a *toxic team environment* was associated with decreased job satisfaction and increased levels of burnout while a *coordinated team environment* was associated with increased professional efficacy and decreased cynicism (Moore et al., 2014). A participant from the present study highlighted the role that a lack of supportive coworkers played in an ethical dilemma they encountered, stating, "Faculty member asked me to perform sedation with a protocol I was unfamiliar with and without support during my first year as a technician. Supportive peers would have been helpful." Another participant described the role that their organization could have performed after witnessing a veterinarian "mishandle" a patient. They reported that, "the right thing would have been [to] report it. What prevented it was possible loss of job (never go against a Dr). Had there been a protocol in place [and] a feeling of security, maybe [it] would have been easier."

As these examples demonstrate, the ethical dilemmas uncovered in the current study generally reflected a lack of support, or moral community, in participants' work environments. In fact, participants frequently mentioned fearing negative consequences if they were to act as their ethics dictated. Moreover, in addition to a lack of support, veterinary support staff described the tension involved in being in a subordinate position while attending to the demands of clients,

veterinarians, and organizational policies with a limited amount of autonomy. *Lack of autonomy*, which could be interpreted as being the opposite of moral agency, was a pervasive motif throughout the narratives, as demonstrated by the co-occurrence of this code with most types of conflict and most types of action pursued to resolve an ethical dilemma (see Figure 4). Even in narratives where the participant did not explicitly discuss lack of autonomy, every ethical dilemma involved a power differential with the participant in a subordinate position. To illustrate how this power differential manifested with clients, one participant reported, "Medicine is being dictated by the owner as opposed to allowing us to advocate for patients' wellbeing." Another participant succinctly demonstrated the power differential between them and a veterinarian, stating that their ethical dilemma "involved a doctor and their judgement. I disagreed with their treatment plan and was told that it wasn't up to me." Regarding their organization's policy of declawing felines, a third participant acknowledged the conflict inherent when advocating for patients from a subordinate position, explaining, "Being an assistant, I don't have much of a voice when it comes to what surgeries we perform, but I never shy away from voicing my opinion on declawing."

Lack of autonomy has also been noted as a prominent theme for nurses reporting on ethical dilemmas, and one theory is that nurses' powerlessness to influence patient care may cause them to feel guilty for acting unethically (Choe et al., 2015). On the other hand, choosing to voice a concern even though one lacks the agency to refuse to perform a task may benefit an individual by ameliorating feelings of guilt for engaging in an act that they deem unethical. Although guilt was neither thematically present in the current study nor measured in the items from the MMD-HP, future research could explore the role that guilt may play in the experience of moral distress and burnout as well as how it may motivate efforts to address the situation.

In the current study, discussion was the most common action participants reported engaging with to resolve an ethical dilemma. For each of the relevant narratives, the discussion was held with a veterinarian or with management; only one narrative mentioned addressing concerns directly with a client. In that example, the participant's concerns were dismissed by the client because the veterinarian had not delivered the same guidance. From the thematic map, it is apparent that support staff attempted to resolve a variety of different types of ethical dilemmas through discussion and that their concerns were more likely to be dismissed than addressed. Participants were less likely to report they had refused to complete a task or quit a job due to their concerns about unethical practices. In all, these results contribute to the supposition that the power differential in the workplace works against support staff being able to voice their concerns and have them acknowledged.

A handful of participants suggested that experience or age may counterpose lack of autonomy. In some narratives, participants mentioned their youth or inexperience as a reason for not voicing a concern, as in this example,

> A veterinarian euthanized an injured abandoned animal by taking all of its blood as a donation. The abandoned animal should have been turned over to animal control for a chance at rescue. I was a very young technician, and the doctor was very intimidating. I was afraid of angering [them].

Along the same lines, a second participant reported the following about their inexperience with a rushed euthanasia protocol, "I was fairly new and intimidated by the veterinarian working, so I didn't say anything. Having more experience and confidence to speak up would've helped me to do the right thing." A third participant described how their ability to voice their concerns changed over time, with experience, and in the absence of negative consequences. They

recounted the following trajectory in their relationship with a veterinarian who failed to provide what they considered the best standard of care (SOC),

> I often felt uncomfortable that [the veterinarian] did not provide that care, and I did not have the knowledge or confidence to advocate for the same level of care I was witnessing from the rest of the team. I had a reasonably positive working relationship with this DVM, and as I learned more, I felt more comfortable upholding SOC as I felt I needed to and did not experience push back from this DVM.

Understanding the factors, as cited in this example, that increased a staff member's comfort when voicing concerns to a veterinarian provides valuable insight into how interventions might be implemented to retain employees.

Effective interventions will likely focus on addressing the power imbalance in the workplace and creating a culture where all staff members can voice opinions and suggestions without fearing retribution. Although it would seem plausible that ethics training could buffer individuals from moral distress, there is some evidence from veterinarians that it does not provide a sufficient level of preparation for handling ethical dilemmas (Kipperman et al., 2018). Moreover, credentialed support staff are already required to complete coursework in ethics or professionalism as directed by their state for license renewal, and there is no evidence that this training offers them protection from moral distress when compared to their uncredentialed coworkers.

To create an ethical culture and a moral work community, effective interventions will need to be more comprehensive than requiring a course in ethics and will also need to be scalable so that both large practices and solo practitioners can implement them. First, because uncredentialed employees are not working under a professional code of ethics, employers can

create a code of ethics at the organizational level that outlines their expectations for ethical behavior and includes guidelines for handling common, predictable ethical dilemmas that are relevant to their business. Employers are encouraged to include support staff in the development of the code of ethics to ensure a range of perspectives are reflected in the outcome. Second, as part of a comprehensive approach, employers can provide formal and informal forums for employees to discuss ethical issues. These might range from regularly scheduled all-staff meetings to one-on-one debriefs. Third, employers can ensure that employees have a resource for reporting ethical violations and that employees can trust that they will not suffer negative repercussions for submitting a report. Fourth, people in positions of authority can model behaviors that demonstrate that they value input from support staff. These behaviors could include purposefully and publicly seeking their thoughts and suggestions. A combination of approaches could contribute to a feeling of moral community and moral agency, providing opportunities to work together to resolve dilemmas.

Due to the pervasiveness of lack of autonomy as a factor in ethical dilemmas, future studies could explore the relationship between lack of autonomy and moral distress, burnout, and intention to leave a job. Also, future research might attempt to determine protective factors that buffer individuals from moral distress. Possible variables for exploration include years of experience and team effectiveness. In addition, although the impact of a heavy workload was minimal in the qualitative results of the current study, evidence from the item analysis of the MMD-HP indicated that caring for a large patient load is distressing. Further exploration might be warranted to understand the role that heavy workload occupies for support staff.

One limitation of the current study was the lack of diversity among participants. The proportion of female participants in this study (96.6%; $n = 168$) was higher than that reported for

the general population of veterinary technologists and technicians (87.9%) and veterinary assistants and laboratory animal caretakers (85.9%; Data USA, 2019b). In addition to a lack of gender diversity, our sample demonstrated less diversity in race and ethnicity (93% white and 92% non-Hispanic) than the general population of support staff (79% white and non-Hispanic for veterinary technologists and technicians; 72% white and non-Hispanic for veterinary assistants and laboratory animal caretakers; Data USA, 2019b). Thus, the experiences of individuals who claim minoritized identities may have been minimized, and challenges related to managing ethical dilemmas in the workplace as a member of a minoritized group may have been obscured.

A second limitation related to recruitment resulted from the survey being advertised as relevant to wellbeing in veterinary support staff; it is possible that there was a response bias for participants who wanted to report on a crisis in their wellbeing, but it is also possible that there was a bias for participants experiencing positive wellbeing because they were more likely to have the bandwidth to respond. Third, there was the potential that, despite efforts to carefully screen the data, illegitimate survey responses were included in the analysis or that legitimate responses were excluded due to bot activity. This limitation would have had less impact on the qualitative analysis since efforts were made to include every participant with a text response that appeared authentic.

A final consideration for future research is that the term *ethics training* was used in the current study without being defined for participants. More than half of the participants in the current study who reported not attending a training program reported receiving ethics training on the job, and it might have been valuable if we had been able to scrutinize what type of experiences individuals referred to when they reported on-the-job ethics training.

Conclusion

The findings of the present study confirmed that veterinary support staff are regularly exposed to ethical dilemmas at work, albeit less frequently than veterinarians. Support staff reported conflicts related to their ability to provide the best care for patients and being forced to choose between reporting unethical behavior and facing possible retaliation. Applying qualitative methods allowed us to identify the important role that lack of autonomy performs as a contributing factor when support staff encounter dilemmas. Implementing interventions that increase moral agency and build a sense of moral community in the workplace could buffer individuals from the effects of moral distress and reduce employee attrition due to exposure to ethical dilemmas.

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Table 1

Demographic characteristics of participants

	Participants who met inclusion criteria (n = 174)	*Participants who endorsed exposure to an ethical dilemma and were included in qualitative analysis (n = 96)*	*Participants who endorsed exposure to an ethical dilemma but left text field blank (n = 24)*	*Participants who did not endorse exposure to an ethical dilemma (n = 54)*
	n (%)	n (%)	n (%)	n (%)
Gender Identity [a]				
Female	168 (96.6%)	94 (97.9%)	24 (100%)	50 (92.6%)
Male	5 (2.9%)	2 (2.1%)	0 (0.0%)	3 (5.6%)
Nonbinary	1 (0.6%)	0 (0.0%)	0 (0.0%)	1 (1.9%)
Race				
White	162 (93.1%)	91 (94.8%)	22 (91.7%)	49 (90.7%)
Asian	4 (2.3%)	1 (1.0%)	1 (4.2%)	2 (3.7%)
African American/Black	3 (1.7%)	1 (1.0%)	0 (0.0%)	2 (3.7%)
More than one race [b]	2 (1.1%)	1 (1.0%)	1 (4.2%)	0 (0.0%)
A race, ethnicity, or origin not listed here [c]	1 (0.6%)	0 (0.0%)	0 (0.0%)	1 (1.9%)
Prefer not to say	2 (1.1%)	2 (2.1%)	0 (0.0%)	0 (0.0%)
Ethnicity				
Not Hispanic or Latino	160 (92.0%)	89 (92.7%)	23 (95.8%)	48 (88.9%)
Hispanic or Latino	11 (6.3%)	4 (4.2%)	1 (4.2%)	6 (11.1%)
Prefer not to say	3 (1.7%)	3 (3.1%)	0 (0.0%)	0 (0.0%)
Age				
19-29	51 (29.3%)	23 (24.0%)	9 (37.5%)	19 (35.2%)
30-39	68 (39.1%)	37 (38.5%)	10 (41.7%)	21 (38.9%)
40-49	29 (16.7%)	18 (18.8%)	5 (20.8%)	6 11.1%)
50-59	22 (12.6%)	15 (15.6%)	0 (0.0%)	7 (13.0)
60+	4 (2.3%)	3 (3.1%)	0 (0.0%)	1 (1.9%)
Sexual Orientation				
Heterosexual/straight	137 (78.7%)	74 (77.1%)	23 (95.8%)	40 (74.1%)
Bisexual/Pansexual	24 (13.8%)	16 (16.7%)	0 (0.0%)	8 (14.8%)
Gay/lesbian	6 (3.4%)	2 (2.1%)	0 (0.0%)	4 (7.4%)
A sexual orientation not listed [d]	2 (1.1%)	1 (1.0%)	1 (4.2%)	0 (0.0%)
Prefer not to say	5 (2.9%)	3 (3.1%)	0 (0.0%)	2 (3.7%)
Marital Status				
Committed relationship (inclusive of marriage, domestic partnership, and	110 (63.2%)	62 (64.6%)	13 (54.2%)	35 (64.8%)

short-/long-term relationship)				
Single (inclusive of divorced, legally separated, and widowed)	63 (36.2%)	34 (35.4%)	11 (45.8%)	18 (33.3%)
No answer	1 (0.6%)	0 (0.0%)	0 (0.0%)	1 (1.9%)
Annual Household Income				
Less than $20,000	9 (5.2%)	3 (3.1%)	1 (4.2%)	5 (9.3%)
$20,001 to $40,000	53 (30.5%)	29 (30.2%)	9 (37.5%)	15 (27.8%)
$40,001 to $60,000	29 (16.7%)	15 (15.6%)	3 (12.5%)	11 (20.4%)
$60,000 to $80,000	25 (14.4%)	16 (16.7%)	4 (16.7%)	5 (9.3%)
More than $80,000	48 (27.6%)	30 (31.3%)	4 (16.7%)	14 (25.9%)
I don't know	9 (5.2%)	3 (3.1%)	3 (12.5%)	3 (5.6%)
No answer	1 (0.6%)	0 (0.0%)	0 (0.0%)	1 (1.9%)
Disability Status				
Yes	14 (8.0%)	5 (5.2%)	5 (20.8%)	4 (7.4%)
No	157 (90.2%)	90 (93.8%)	17 (70.8%)	50 (92.6%)
I don't know	3 (1.7%)	1 (1.0%)	2 (8.3%)	0 (0.0%)
Region [e]				
Northeast (CT, ME, MA, NH, NJ, NY, PA, RI, VT)	53 (30.5%)	28 (29.2%)	8 (33.3%)	17 (31.5%)
Midwest (IL, IN, KS, MI, MN, MO, OH, WI)	40 (23.0%)	23 (24.0%)	3 (12.5%)	14 (25.9%)
South (AR, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX, VA, WV)	51 (29.3%)	27 (28.1%)	5 (20.8%)	19 (35.2%)
West (AZ, CA, CO, ID, MT, OR, WA)	30 (17.2%)	18 (18.8%)	8 (33.3%)	4 (7.4%)

Notes. [a] Participants were able to select from *Female*, *Male*, *Transgender man*, *Transgender woman*, *Nonbinary*, *Other*, or *Prefer not to answer*. [b] Participants were able to select more than one race. [c] Write-in responses included *Guatemalan* (*n*=1) and *Indigenous* (*n*=1). [d] Write-in responses included *Asexual* (*n*=1) and *demisexual* (*n*=1). [e] These are the 38 states from which we had at least one participant; 12 states and Washington, D.C. were not represented in our sample.

Table 2

Responses to Job-Related Questions and Ethics Training Questions

	Participants who meet inclusion criteria (n = 174)	*Participants who do not meet inclusion criteria (n = 39)*	*Participants who endorsed exposure to ethical dilemma and were included in qualitative analysis (n = 96)*
	n (%)	*n* (%)	*n* (%)
Job Title			
Veterinary Technician	86 (49.4%)	3 (7.7%)	49 (51.0%)
Veterinary Assistant	42 (24.1%)	3 (7.7%)	20 (20.8%)
Practice Manager	25 (14.4%)	1 (2.6%)	16 (16.7%)
Receptionist/Front Desk	3 (1.7%)	26 (66.7%)	1 (1.0%)
Veterinary Technologist	6 (3.4%)	0 (0.0%)	3 (3.1%)
Other	12 (6.9%) [a]	4 (10.3%) [b]	7 (7.3%)
Employed Full-time or Part-time			
Full-time (30+ hours per week)	150 (86.2%)	31 (79.5%)	82 (85.4%)
Part-time (1-29 hours per week)	19 (10.9%)	8 (20.5%)	14 (14.6%)
Other [c]	5 (2.9%)	0 (0.0%)	0 (0.0%)
Practice type			
Small Animal	108 (62.1%)	27 (69.2%	57 (59.4%)
Mixed Animal	16 (9.2%)	4 (10.3%)	8 (8.3%)
Emergency Practice	12 (6.9%)	4 (10.3%)	8 (8.3%)
Specialty	13 (7.5%)	1 (2.6%)	9 (9.4%)
University	6 (3.4%)	0 (0.0%)	4 (4.2%)
Non-profit	3 (1.7%)	0 (0.0%)	3 (3.1%)
Veterinary Technology Education	3 (1.7%)	0 (0.0%)	2 (2.1%)
Equine Practice	2 (1.1%)	0 (0.0%)	1 (1.0%)
Animal shelter practice	1 (0.6%)	0 (0.0%)	0 (0.0%)
Diagnostic/Research Lab	1 (0.6%)	0 (0.0%)	0 (0.0%)
Industry / Sales (food manufacturer, pharmaceutical, distributor)	1 (0.6%)	0 (0.0%)	0 (0.0%)
Self-employed/Consultant	1 (0.6%)	0 (0.0%)	1 (1.0%)
City/County/Federal Government	0 (0.0%)	1 (2.6%)	0 (0.0%)
Other	7 (4.0%) [d]	2 (5.1%) [e]	2 (2.1%)
Years in veterinary medicine			
Less than 1 year	6 (3.4%)	4 (10.3%)	1 (1.0%)
1-2 years	20 (11.5%)	5 (12.8%)	8 (8.3%)
3-5 years	28 (16.1%)	5 (12.8%)	14 (14.6%)
6-10 years	36 (20.7%)	12 (30.8%)	20 (20.8%)
11-20 years	41 (23.6%)	11 (28.2%)	21 (21.9%)
More than 20 years	43 (24.7%)	2 (5.1%)	32 (33.3%)

	Participants who meet inclusion criteria (n = 174)	*Participants who do not meet inclusion criteria (n = 39)*	*Participants who endorsed exposure to ethical dilemma and were included in qualitative analysis (n = 96)*
	n (%)	*n* (%)	*n* (%)
Years with current employer			
Less than 1 year	29 (16.7%)	12 (30.8%)	12 (12.5%)
1-2 years	42 (24.1%)	9 (23.1%)	21 (21.9%)
3-5 years	43 (24.7%)	6 (15.4%)	27 (28.1%)
6-10 years	29 (16.7%)	8 (20.5%)	15 (15.6%)
11-20 years	19 (10.9%)	3 (7.7%)	12 (12.5%)
More than 20 years	12 (6.9%)	1 (2.6%)	9 (9.4%)
Highest level of degree earned			
High school	43 (24.7%)	18 (46.2%)	21 (21.9%)
Associate's degree	79 (45.4%)	12 (30.8%)	47 (49.0%)
Bachelor's degree	47 (27.0%)	8 (20.5%)	26 (27.1%)
Master's degree	4 (2.3%)	1 (2.6%)	1 (1.0%)
Doctorate	1 (0.6%)	0 (0.0%)	1 (1.0%)
Degree Related to Animal Sciences	(*n = 131*) [f]	(*n = 21*) [f]	(*n = 75*) [f]
Yes	95 (72.5%)	3 (14.3%)	53 (70.7%)
No	36 (27.5%)	18 (85.7%)	22 (29.3%)
Graduated from Veterinary Technology Program			
Yes	91 (52.3%)	3 (7.7%)	49 (51.0%)
No	63 (36.2%)	33 (84.6%)	31 (32.3%)
Attended but not graduated	20 (11.5%)	3 (7.7%)	16 (16.7%)
Received Accreditation			
Yes	83 (47.7%)	4 (10.3%)	48 (50.0%)
No	91 (52.3%)	35 (89.7%)	48 (50.0%)
Received Specialty Certification			
Yes	8 (4.6%)	0 (0.0%)	7 (7.3%)
No	166 (95.4%)	39 (100.0%)	89 (92.7%)
Amount of Ethics Training Received During Veterinary Technology Program			
	(*n = 111*) [g]	(*n = 6*) [g]	(*n = 65*) [g]
None	28 (25.2%)	2 (33.3%)	17 (26.1%)
1-2 hours	32 (28.8%)	1 (16.7%)	18 (27.7%)
3-5 hours	9 (8.1%)	0 (0.0%)	6 (9.2%)
More than 5	6 (5.4%)	0 (0.0%)	4 (6.2%)
I don't know	36 (32.4%)	3 (50.0%)	20 (30.8%)

	Participants who meet inclusion criteria (n = 174)	*Participants who do not meet inclusion criteria (n = 39)*	*Participants who endorsed exposure to ethical dilemma and were included in qualitative analysis (n = 96)*
	n (%)	*n* (%)	*n* (%)
Amount of Ethics Training Received Post-graduation			
	(n = 111) [g]	*(n = 6)* [g]	*(n = 65)* [g]
None	20 (18.0%)	0 (0.0%)	12 (18.5%)
1-2 hours	24 (21.6%)	1 (16.7%)	16 (24.6%)
3-5 hours	6 (5.4%)	1 (16.7%)	3 (4.6%)
More than 5	22 (19.8%)	0 (0.0%)	10 (15.4%)
I don't know	19 (17.1%)	1 (16.7%)	8 (12.3%)
No answer	20 (18.0%)	3 (50.0%)	16 (24.6%)
Amount of Ethics Training Received On-the-Job			
	(n = 63) [h]	*(n = 33)* [h]	*(n = 31)* [h]
None	12 (19.0%)	15 (45.4%)	7 (22.6%)
1-2 hours	6 (9.5%)	2 (6.1%)	3 (9.7%)
3-5 hours	4 (6.3%)	2 (6.1%)	2 (6.5%)
More than 5	26 (41.3%)	7 (21.2%)	11 (35.5%)
I don't know	15 (23.8%)	7 (21.2%)	8 (25.8%)

Notes. [a] Write-in responses included *CVT*; *Hospital Administrator*; *Managing Veterinary Technician*; *Office Manager*; *Office manager and Assistant*; *Patient Care Advocate/Technician*; *Pharmacy technician*; *RVT CVT*; *Veterinary Technician Supervisor*; *Veterinary Technician/Practice Manager*; and *VTS ECC*. [b] Write-in responses included *Animal Care Manager*; *Food nutrition coach*; *Office Manager*; and *Pharmacy Technician*. [c] Write-in responses included *Burnout break*; *Part time working full time hours(31+)*; *Per diem but was full time in 2020*; *Recently unemployed*; and *Relief*. [d] Write-in responses included *companion animal practice, lab, and pharmacy*; *Emergency and Specialty Practice*; *Research*, *specialty, emergency, GP, mixed animal practice, on site lab and ph[armacy]*; *Urgent Care*; *Worked in small animal general practice and diagnostic lab*; and *Zoo*. [e] Write-in responses included *Emergency & Specialty* and *Mobile Vet*. [f] Only participants who endorsed *Associate's degree*, *Bachelor's degree*, *Master's degree*, or *Doctorate* as highest level of degree earned were asked this question. [g] Only participants who endorsed *Yes* or *Attended but not graduated* to graduating from a Veterinary Technology Program were asked this question. [h] Only participants who endorsed *No* to graduating from a Veterinary Technology Program were asked this question.

Table 3

Frequency of Ethical Dilemmas

	Participants who meet inclusion criteria and endorsed exposure to an ethical dilemma (n = 120) [a]	*Participants who endorsed exposure to ethical dilemma and were included in qualitative analysis (n = 96)* [a]
Frequency of Ethical Dilemmas	*n* (%)	*n* (%)
Multiple times a day	4 (3.3%)	4 (4.2%)
Once a day	2 (1.7%)	2 (2.1%)
A few times a week	15 (12.5%)	13 (13.5%)
Once a week	7 (5.8%)	6 (6.3%)
A few times a month	15 (12.5%)	11 (11.4%)
Once a month	7 (5.8%)	6 (6.3%)
A few times a year	27 (22.5%)	23 (24.0%)
Once a year	10 (8.3%)	8 (8.3%)
Every few years	22 (18.3%)	21 (21.9%)
Never	3 (2.5%)	2 (2.1%)
No answer	8 (6.7%)	0 (0.0%)

Notes. [a] Only participants who endorsed *Yes* to encountering an ethical dilemma were asked this question.

Table 4

Item-level Analysis of the Measure of Moral Distress for Healthcare Providers

	Frequency N (% of 174)						Level of Distress N (% of 174)					
	Never	Infrequently	Sometimes	Often	Very Frequently	Missing	None	Mildly Distressing	Moderately Distressing	Distressing	Very Distressing	Missing
1. Witness a veterinarian giving "false hope" to a client.	40 (23.0%)	50 (28.7%)	48 (27.6%)	12 (6.9%)	4 (2.3%)	20 (11.5%)	21 (12.1%)	27 (15.5%)	41 (23.6%)	29 (16.7%)	15 (8.6%)	41 (23.6%)
2. Follow the veterinarian's insistence to prioritize the client's needs over the animal patient's.	27 (15.5%)	48 (27.6%)	51 (29.3%)	20 (11.5%)	8 (4.6%)	20 (11.5%)	20 (11.5%)	29 (16.7%)	35 (20.1%)	27 (15.5%)	22 (12.6%)	41 (23.6%)
3. Feel pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments, including euthanasia.	32 (18.4%)	52 (29.9%)	34 (19.5%)	29 (16.7%)	7 (4.0%)	20 (11.5%)	18 (10.3%)	19 (10.9%)	21 (12.1%)	39 (22.4%)	36 (20.7%)	41 (23.6%)
4. Be unable to provide optimal care due to pressures to reduce costs.	14 (8.0%)	16 (9.2%)	53 (30.5%)	33 (19.0%)	28 (21.8%)	20 (11.5%)	15 (8.6%)	17 (9.8%)	26 (14.9%)	44 (25.3%)	31 (17.8%)	41 (23.6%)
5. Follow the client's or veterinarian's insistence to continue treatment even when you consider those efforts to be futile.	20 (11.5%)	48 (27.6%)	57 (32.8%)	18 (10.3%)	11 (6.3%)	20 (11.5%)	17 (9.8%)	28 (16.1%)	41 (23.6%)	20 (11.5%)	27 (15.5%)	41 (23.6%)

(continued)

	Frequency N (% of 174)						Level of Distress N (% of 174)					
	Never	Infrequently	Sometimes	Often	Very Frequently	Missing	None	Mildly Distressing	Moderately Distressing	Distressing	Very Distressing	Missing
6. Be pressured to avoid taking action when you learn that a veterinarian or other team member has made a medical error and does not report it.	82 (47.1%)	46 (26.4%)	14 (8.0%)	9 (5.2%)	3 (1.7%)	20 (11.5%)	42 (24.1%)	10 (5.7%)	10 (5.7%)	24 (13.8%)	46 (26.4%)	42 (24.1%)
7. Be required to perform treatments or assist in procedures when I do not feel qualified.	60 (34.5%)	51 (29.3%)	31 (17.8%)	7 (4.0%)	5 (2.9%)	20 (11.5%)	35 (20.1%)	21 (12.1%)	26 (14.9%)	23 (13.2%)	27 (15.5%)	42 (24.1%)
8. Participate in care that causes unnecessary suffering or does not adequately relieve pain or symptoms.	51 (29.3%)	62 (35.6%)	30 (17.2%)	8 (4.6%)	3 (1.7%)	20 (11.5%)	28 (16.1%)	15 (8.6%)	20 (11.5%)	23 (13.2%)	46 (26.4%)	42 (24.1%)
9. Watch patient care suffer because of a lack of provider continuity.	43 (24.7%)	44 (25.3%)	43 (24.7%)	17 (9.8%)	7 (4.0%)	20 (11.5%)	23 (13.2%)	19 (10.9%)	19 (10.9%)	37 (21.3%)	34 (19.5%)	42 (24.1%)
10. Follow a veterinarian's request not to discuss an animal patient's prognosis with the client.	100 (57.5%)	29 (16.7%)	12 (6.9%)	8 (4.6%)	5 (2.9%)	20 (11.5%)	50 (28.7%)	28 (16.1%)	21 (12.1%)	16 (9.2%)	17 (9.8%)	42 (24.1%)
11. Witness a violation of a standard of practice or a code of ethics and not feel sufficiently supported to report the violation.	87 (50.0%)	34 (19.5%)	22 (12.6%)	7 (4.0%)	4 (2.3%)	20 (11.5%)	41 (23.6%)	8 (4.6%)	21 (12.1%)	19 (10.9%)	43 (24.7%)	42 (24.1%)

	Frequency N (% of 174)						Level of Distress N (% of 174)					
	Never	Infrequently	Sometimes	Often	Very Frequently	Missing	None	Mildly Distressing	Moderately Distressing	Distressing	Very Distressing	Missing
12. Participate in care that I do not agree with, but do so because of fear of litigation or fear of job loss. (continued)	83 (47.7%)	39 (22.4%)	21 (12.1%)	6 (3.4%)	5 (2.9%)	20 (11.5%)	38 (21.8%)	9 (5.2%)	13 (7.5%)	28 (16.1%)	44 (25.3%)	42 (24.1%)
13. Be required to work with other healthcare team members who are not as competent as patient care requires.	29 (16.7%)	32 (18.4%)	48 (27.6%)	26 (14.9%)	19 (10.9%)	20 (11.5%)	17 (9.8%)	16 (9.2%)	28 (16.1%)	37 (21.3%)	34 (19.5%)	42 (24.1%)
14. Witness low quality of patient care due to poor team communication.	30 (17.2%)	52 (29.9%)	47 (27.0%)	13 (7.5%)	12 (6.9%)	20 (11.5%)	21 (12.1%)	12 (6.9%)	26 (14.9%)	33 (19.0%)	41 (23.6%)	41 (23.6%)
15. Feel pressured to ignore situations in which the client has not been given adequate information prior to treatment.	66 (37.9%)	45 (25.9%)	29 (16.7%)	13 (7.5%)	1 (0.6%)	20 (11.5%)	35 (20.1%)	16 (9.2%)	26 (14.9%)	36 (20.7%)	19 (10.9%)	42 (24.1%)
16. Be required to care for more patients than you can safely care for.	42 (24.1%)	41 (23.6%)	35 (20.1%)	17 (9.8%)	19 (10.9%)	20 (11.5%)	29 (16.7%)	12 (6.9%)	15 (8.6%)	31 (17.8%)	46 (26.4%)	41 (23.6%)
17. Experience compromised patient care due to lack of resources or equipment.	54 (31.0%)	40 (23.0%)	32 (18.4%)	14 (8.0%)	14 (8.0%)	20 (11.5%)	30 (17.2%)	14 (8.0%)	30 (17.2%)	29 (16.7%)	29 (16.7%)	42 (24.1%)
18. Experience lack of administrative action or support for a problem that is compromising patient care.	41 (23.6%)	44 (25.3%)	33 (19.0%)	20 (11.5%)	15 (8.6%)	20 (11.5%)	19 (10.9%)	15 (8.6%)	29 (16.7%)	35 (20.1%)	33 (19.0%)	43 (24.7%)

	Frequency N (% of 174)						Level of Distress N (% of 174)					
	Never	Infrequently	Sometimes	Often	Very Frequently	Missing	None	Mildly Distressing	Moderately Distressing	Distressing	Very Distressing	Missing
19. Have excessive documentation requirements that compromise patient care.	78 (44.8%)	47 (27.0%)	17 (9.8%)	8 (4.6%)	4 (2.3%)	20 (11.5%)	43 (24.7%)	33 (19.0%)	23 (13.2%)	23 (13.2%)	10 (5.7%)	42 (24.1%)
20. Fear retribution if I speak up.	48 (27.6%)	37 (21.3%)	35 (20.1%)	18 (10.3%)	16 (9.2%)	20 (11.5%)	24 (13.8%)	15 (8.6%)	23 (13.2%)	25 (14.4%)	44 (25.3%)	43 (24.7%)
21. Feel unsafe/bullied amongst my own colleagues. (continued)	74 (42.5%)	39 (22.4%)	23 (13.2%)	6 (3.4%)	12 (6.9%)	20 (11.5%)	38 (21.8%)	11 (6.3%)	17 (9.8%)	20 (11.5%)	46 (26.4%)	42 (24.1%)
22. Be required to work with abusive clients who are compromising quality of care.	21 (12.1%)	51 (29.3%)	38 (21.8%)	25 (14.4%)	19 (10.9%)	20 (11.5%)	18 (10.3%)	16 (9.2%)	11 (6.3%)	27 (15.5%)	61 (35.1%)	41 (23.6%)
23. Feel required to overemphasize tasks and productivity or quality measures at the expense of patient care.	68 (39.1%)	45 (25.9%)	26 (14.9%)	7 (4.0%)	7 (4.0%)	21 (12.1%)	37 (21.3%)	26 (14.9%)	33 (19.0%)	16 (9.2%)	20 (11.5%)	42 (24.1%)
24. Be required to care for patients who have unclear or inconsistent treatment plans.	42 (24.1%)	58 (33.3%)	34 (19.5%)	13 (7.5%)	7 (4.0%)	20 (11.5%)	28 (16.1%)	27 (15.5%)	29 (16.7%)	25 (14.4%)	23 (13.2%)	42 (24.1%)
25. Work within power hierarchies in my environment that compromise animal care.	67 (38.5%)	41 (23.6%)	27 (15.5%)	5 (2.9%)	14 (8.0%)	20 (11.5%)	32 (18.4%)	25 (14.4%)	24 (13.8%)	23 (13.2%)	28 (16.1%)	42 (24.1%)
26. Participate on a team that gives inconsistent messages to clients.	37 (21.3%)	61 (35.1%)	34 (19.5%)	14 (8.0%)	8 (4.6%)	20 (11.5%)	23 (13.2%)	27 (15.5%)	31 (17.8%)	35 (20.1%)	17 (9.8%)	41 (23.6%)

	Frequency N (% of 174)						Level of Distress N (% of 174)					
	Never	Infrequently	Sometimes	Often	Very Frequently	Missing	None	Mildly Distressing	Moderately Distressing	Distressing	Very Distressing	Missing
27. Work with team members who do not treat vulnerable animals with compassion and respect.	64 (36.8%)	44 (25.3%)	24 (13.8%)	12 (6.9%)	10 (5.7%)	20 (11.5%)	34 (19.5%)	10 (5.7%)	10 (5.7%)	23 (13.2%)	55 (31.6%)	42 (24.1%)

Table 5

Themes Identified During Qualitative Analysis (N = 82)

Theme	Code	Child Code	Description
Conflicts between competing professional obligations			
	Conflict with client over patient treatment plan		Participant indicated that the conflict was between what they believed was the best care for a patient and what the client decided.
		Financial constraint	Participant stated that the client's financial constraints prevented them from implementing what they believed to be the best care.
	Conflict with veterinarian over patient treatment plan		Participant indicated they experienced a conflict between what they believed was the best care for a patient and the treatment recommended or approved by a veterinarian.
	Conflict with organization or policy		Participant stated that they perceived a conflict between what they thought was best for the patient and a hospital- or corporate-level policy that affected their ability to provide care. This includes working for an employer who performs declaws or an employer who turns away patients who need medical care due to a client's financial constraints.
	Conflict with legal requirements		Participant reported a conflict between what they feel is right and current legal statutes. For example, they believe that veterinary professionals should legally be able or required to take possession of a patient; rehome it; and/or report to authorities in case of abuse or neglect, but they are not allowed to under current laws.
	Conflict over use of force or restraint		Participant reported feeling conflicted about how restraint is performed in their workplace, balancing compassion for the patient with maintaining the safety for coworkers. Also includes participants who state they witnessed a team member use excessive force on a patient.
	Request to cover up an error		Participant reported being asked to lie to a client or assist in maintaining a deception.
	Request to falsify records		Participant reported that they were asked to misrepresent events in a medical record or on an invoice.

Theme	Code	Child Code	Description
	Witnessed negligence by coworkers		Participant stated that they witnessed conduct lacking in due care or deviation from the standard of care that a reasonable medical professional would use. This includes a veterinarian or other team member practicing beyond their competency. (e.g., "Veterinarian performed a procedure that they did not know how to do.")
(continued)			
End-of-life issues			
	Continuing to provide care to patients that should be euthanized		Participant reported feeling obligated to continue to provide treatment to a patient that was not experiencing a good quality of life (e.g., suffocating on its own fluids). Also applies to cases where treatment would not improve their quality of life or make them adoptable in the case of a rescued animal (e.g., “wasting money” treating a pet with behavioral issues).
		Veterinarian evasive or indirect about euthanasia	Participant reported that the content of a veterinarian's communications with the client about a patient's condition resulted in prolonged suffering or delayed euthanasia.
		Client indecisive or refuses euthanasia	Participant stated that the client's inability or refusal to make a decision regarding euthanasia prolonged suffering for the patient.
	Convenience euthanasia		Participant stated that convenience euthanasias are distressing without providing more context. (e.g., "Euthanizing healthy animals")
		Convenience euthanasia due to finances	Participant mentioned conflict regarding a convenience euthanasia due to the client being unable to pay for treatment.
		Convenience euthanasia due to behavior	Participant mentioned conflict regarding a convenience euthanasia due to behavior issues.
Contributing factors			
	Heavy workload		Participant indicated that having too much to do interfered with their ability to do the right thing.
	Lack of autonomy		Participant reported that during a time of conflict, they lacked the experience or authority to be able to advocate for patients or to correct misinformation that was provided to a human client.
Actions taken by participants to resolve an ethical dilemma			Participant included evidence that they attempted to resolve the ethical dilemma.

Theme	Code	Child Code	Description
	Attempted to resolve dilemma through discussion		Participant stated that they attempted to resolve the dilemma by addressing the dilemma with one of the parties involved or with a person in authority. (e.g., the veterinarian, management, or the client).
	Refused to complete task		Participant stated that they refused to perform a task, participate in a procedure, or fill a medication when they were asked to do something they believed was wrong.
(continued)			
	Quit		Participant stated that they quit or eventually quit a job because of exposure to one or more ethical dilemmas.
	Concerns were addressed		Participant stated that their concern was addressed when they reported it. (e.g., "Management talked to the veterinarian")
	Concerns were dismissed		Participant reported that the concern raised was dismissed or ignored.

Table 6

Items from the Measure of Moral Distress ranked by the number of participants that endorsed Frequency for that item as Often or Very Frequently, listed from largest to smallest (N = 174)

Item	*n*	%
4. Be unable to provide optimal care due to pressures to reduce costs.	61	35%
13. Be required to work with other healthcare team members who are not as competent as patient care requires.	45	26%
22. Be required to work with abusive clients who are compromising quality of care.	44	25%
3. Feel pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments, including euthanasia.	36	21%
16. Be required to care for more patients than you can safely care for.	36	21%
18. Experience lack of administrative action or support for a problem that is compromising patient care.	35	20%
20. Fear retribution if I speak up.	34	20%
5. Follow the client's or veterinarian's insistence to continue treatment even when you consider those efforts to be futile.	29	17%
2. Follow the veterinarian's insistence to prioritize the client's needs over the animal patient's.	28	16%
17. Experience compromised patient care due to lack of resources or equipment.	28	16%
14. Witness low quality of patient care due to poor team communication.	25	14%
9. Watch patient care suffer because of a lack of provider continuity.	24	14%
26. Participate on a team that gives inconsistent messages to clients.	22	13%
27. Work with team members who do not treat vulnerable animals with compassion and respect.	22	13%

(continued)

Item	*n*	%
24. Be required to care for patients who have unclear or inconsistent treatment plans.	20	11%
25. Work within power hierarchies in my environment that compromise animal care.	19	11%
21. Feel unsafe/bullied amongst my own colleagues.	18	10%
1. Witness a veterinarian giving "false hope" to a client.	16	9%
15. Feel pressured to ignore situations in which the client has not been given adequate information prior to treatment.	14	8%
23. Feel required to overemphasize tasks and productivity or quality measures at the expense of patient care.	14	8%
10. Follow a veterinarian's request not to discuss an animal patient's prognosis with the client.	13	7%
6. Be pressured to avoid taking action when you learn that a veterinarian or other team member has made a medical error and does not report it.	12	7%
7. Be required to perform treatments or assist in procedures when I do not feel qualified.	12	7%
19. Have excessive documentation requirements that compromise patient care.	12	7%
8. Participate in care that causes unnecessary suffering or does not adequately relieve pain or symptoms.	11	6%
11. Witness a violation of a standard of practice or a code of ethics and not feel sufficiently supported to report the violation.	11	6%
12. Participate in care that I do not agree with but do so because of fear of litigation or fear of job loss.	11	6%

Table 7

*Items from the Measure of Moral Distress ranked by the number of participants that endorsed Level of Distress for that item as Distressing or Very Distressing, listed from largest to smallest (*N = *174)*

Item	*n*	%
22. Be required to work with abusive clients who are compromising quality of care.	88	51%
27. Work with team members who do not treat vulnerable animals with compassion and respect.	78	45%
16. Be required to care for more patients than you can safely care for.	77	44%
3. Feel pressured to order or carry out orders for what I consider to be unnecessary or inappropriate tests and treatments, including euthanasia.	75	43%
4. Be unable to provide optimal care due to pressures to reduce costs.	75	43%
14. Witness low quality of patient care due to poor team communication.	74	43%
12. Participate in care that I do not agree with but do so because of fear of litigation or fear of job loss.	72	41%
9. Watch patient care suffer because of a lack of provider continuity.	71	41%
13. Be required to work with other healthcare team members who are not as competent as patient care requires.	71	41%
6. Be pressured to avoid taking action when you learn that a veterinarian or other team member has made a medical error and does not report it.	70	40%
8. Participate in care that causes unnecessary suffering or does not adequately relieve pain or symptoms.	69	40%
20. Fear retribution if I speak up.	69	40%
18. Experience lack of administrative action or support for a problem that is compromising patient care.	68	39%
21. Feel unsafe/bullied amongst my own colleagues.	66	38%

(continued)

Item	*n*	%
11. Witness a violation of a standard of practice or a code of ethics and not feel sufficiently supported to report the violation.	62	36%
17. Experience compromised patient care due to lack of resources or equipment.	58	33%
15. Feel pressured to ignore situations in which the client has not been given adequate information prior to treatment.	55	32%
26. Participate on a team that gives inconsistent messages to clients.	52	30%
25. Work within power hierarchies in my environment that compromise animal care.	51	29%
7. Be required to perform treatments or assist in procedures when I do not feel qualified.	50	29%
2. Follow the veterinarian's insistence to prioritize the client's needs over the animal patient's.	49	28%
24. Be required to care for patients who have unclear or inconsistent treatment plans.	48	28%
5. Follow the client's or veterinarian's insistence to continue treatment even when you consider those efforts to be futile.	47	27%
1. Witness a veterinarian giving "false hope" to a client.	44	25%
23. Feel required to overemphasize tasks and productivity or quality measures at the expense of patient care.	36	21%
10. Follow a veterinarian's request not to discuss an animal patient's prognosis with the client.	33	19%
19. Have excessive documentation requirements that compromise patient care.	33	19%

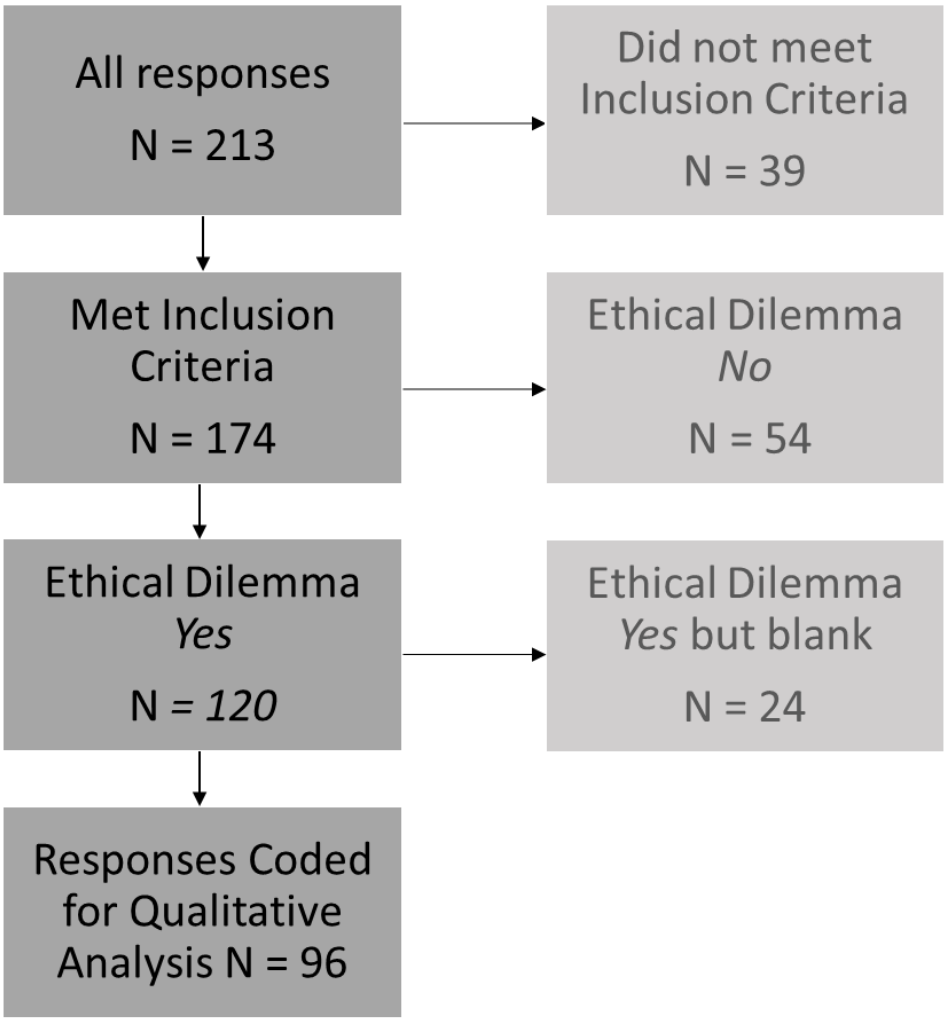

Figure 1. Flow diagram for including participant records in qualitative analysis.

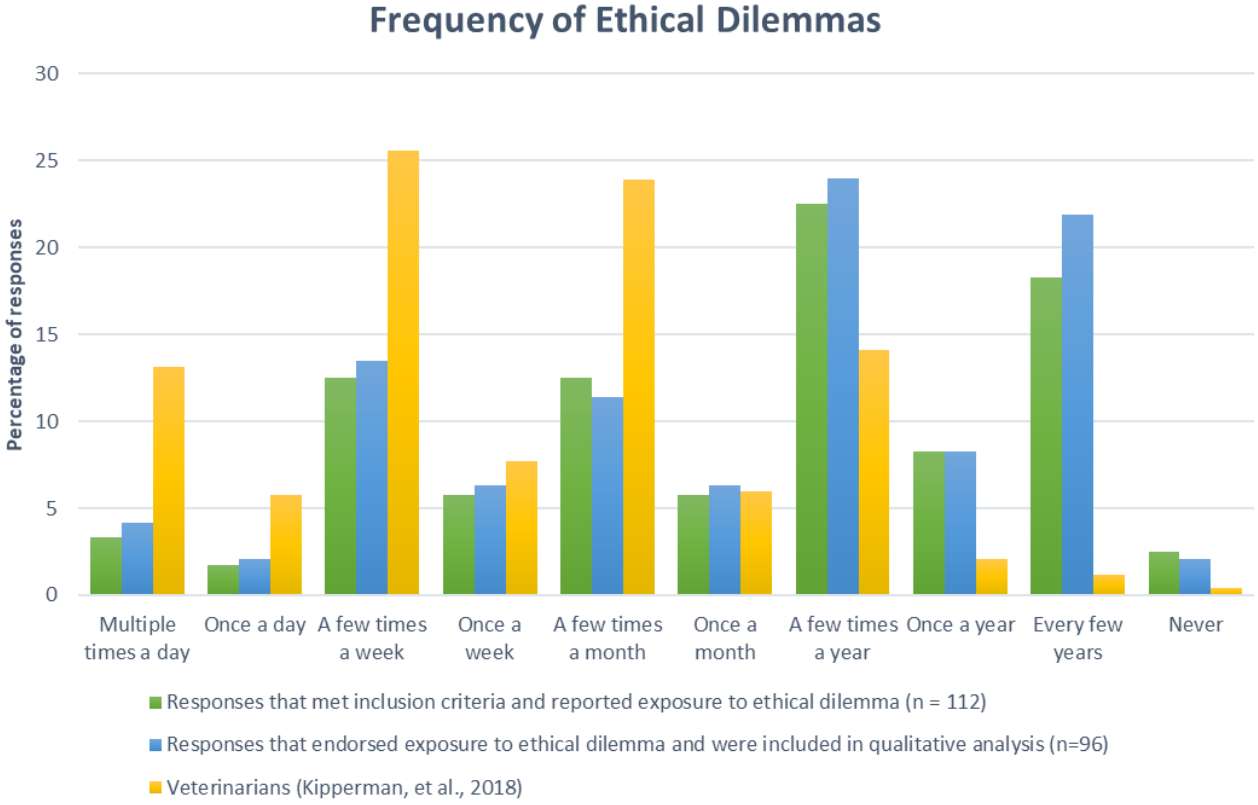

Figure 2. Frequency of exposure to ethical dilemmas.

Figure 3. Thematic mapping for theme *Conflicts between competing professional obligations*. Lines between codes indicate that the two codes co-occur within the narratives.

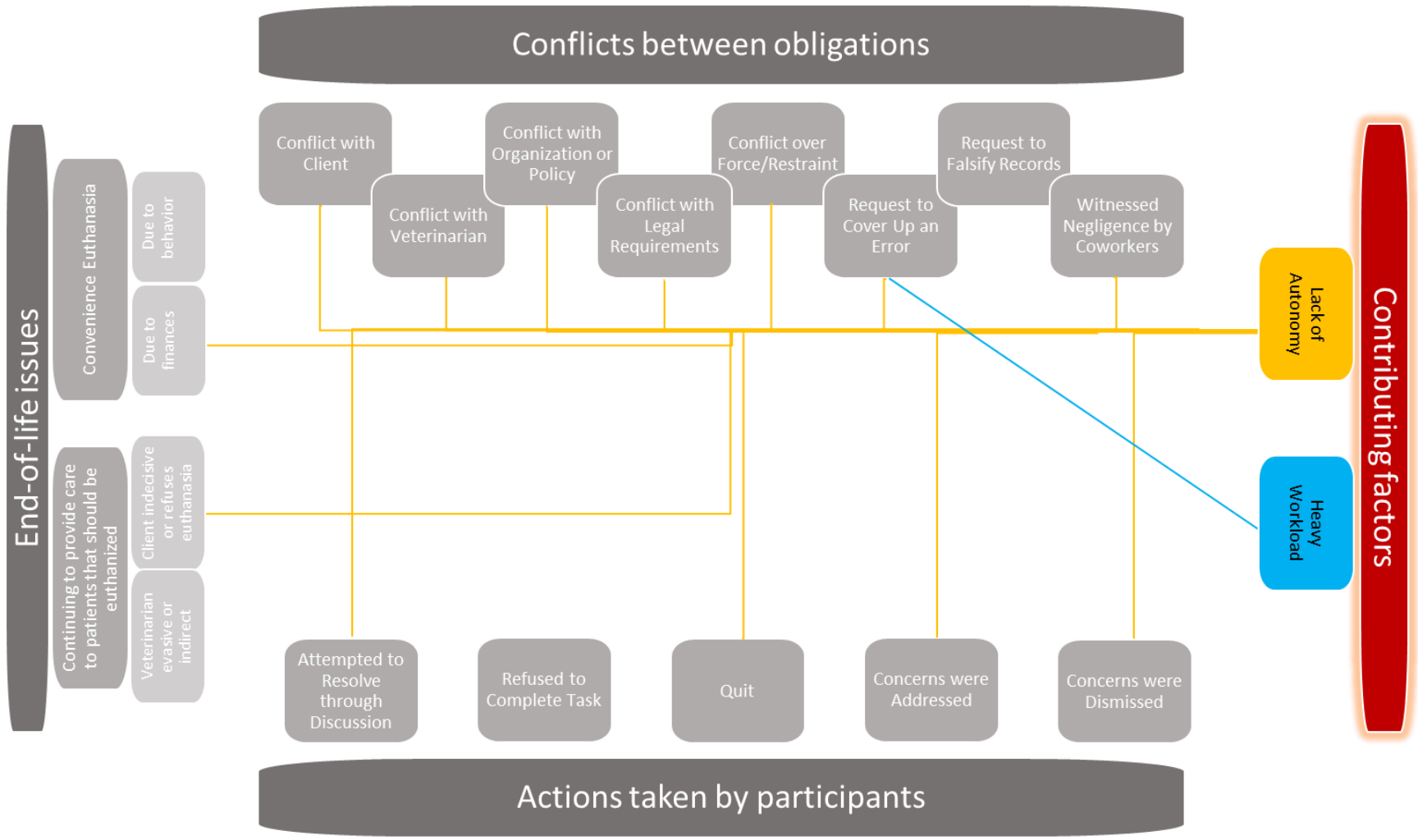

Figure 4. Thematic mapping for theme *Contributing factors*. Lines between codes indicate that the two codes co-occur within the narratives.

Figure 5. Thematic mapping for theme *Actions taken by participants*. Lines between codes indicate that the two codes co-occur within the narratives.

Figure 6. Thematic mapping for theme *End-of-life* issues. Lines between codes indicate that the two codes co-occur within the narratives.